GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of New Hampshire

The below policies and procedures are in addition to the contractual requirements and the GEHA Policies & Procedures for the CONNECTION Dental Network. In the event the below terms conflict with the contractual requirements or the GEHA Policies & Procedures for the CONNECTION Dental Network, the terms below shall supersede.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.

Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

I. Full and fair review shall require that:
   (a) The persons reviewing the grievance shall not be the same person or persons making the initial determination, and shall not be subordinate to or the supervisor of the person making the initial determination;
   (b) For medical necessity appeals at least one person reviewing the appeal is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;
   (c) The claimant shall have at least 180 days following receipt of a notification of a claim denial to appeal
   (d) The claimant shall have an opportunity to submit written comments, documents, records, and other information relating to the claim without regard to whether those documents or materials were considered in making the initial determination;
   (e) The claimant shall be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial adverse claim determination; and
   (f) The review shall be a *de novo* proceeding and shall consider all information, documents, or other material submitted in connection with the appeal without regard to whether the information was considered in making the denial.

II. In the appeal of a claim denial that is based in whole or in part on a medical judgment:
   (a) The review shall be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems;

(b) The titles and qualifying credentials of the person conducting the review shall be included in the decision; and
(c) The identity and qualifications of any medical or vocational expert whose advice was considered, without regard to whether it was relied upon in making the initial claim denial, shall be made available to the claimant upon request.

III. In the appeal of a claim for urgent care, a claim involving a matter that would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function, or a claim concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility, an expedited appeal process shall be made available which shall provide for:
(a) The submission of information by the claimant to the carrier by telephone, facsimile, or other expeditious method; and
(b) The determination of the appeal not more than 72 hours after the submission of the request for appeal.

IV. Timing and Notification for Determination on Appeal
(a) In the case of nonexpedited appeal of a pre-service claim or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.
(b) In the case of an expedited appeal related to an urgent care claim, a carrier or other entity shall make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is filed. If the expedited review involves ongoing urgent care services, the service shall be continued without liability to the covered person until the covered person has been notified of the determination. A carrier or other licensed entity shall provide written confirmation of its decision concerning an expedited review within 2 business days of providing notification of that decision, if the initial notification was not in writing.
(c) The period of time within which a decision shall be rendered on appeal shall begin to run at the time the appeal is filed in accordance with the appeal procedures of the carrier or other licensed entity, without regard to whether all the information necessary to make a determination on appeal is contained in the filing. In the event the claimant fails to submit information necessary to decide the appeal, the period for making the determination on appeal shall be tolled from the date the claimant is notified in writing of precisely what is required until the date the claimant responds to the request. The carrier or other licensed entity shall provide notification of incompleteness as soon as possible; but in no event more than 24 hours after the filing of the appeal in appeals involving urgent care. In the event that the claimant files, within a 45-day period from the date of notification, to provide sufficient information, the carrier may deny the appeal on the basis of incompleteness. The appeal may be reopened upon receipt of the required information.

V. Manner and Content of Notification of Determination on Appeal
(a) The carrier or other licensed entity shall provide a claimant with a written determination of the appeal that shall include:
(1) The specific reason or reasons for the determination, including reference to the specific provision, rule, protocol, or guideline on which the determination is based;
(2) A statement that the rule, protocol, or guideline governing the appeal will be provided without charge to the claimant upon request;
(3) A statement describing all other dispute resolution options available to the claimant, including, but not limited to other options for internal review and options for external review and options for bringing a legal action;
(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the claim denial and

that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(7) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your location U.S. Department of Labor Office and your state insurance regulatory agency;" and

(8) A statement describing the claimant's right to contact the insurance commissioner's office for assistance which shall include the toll-free telephone number and address of the commissioner.

(b) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall file annually with the commissioner, as part of its annual report required by RSA 420-J:5, V(g), a certificate of compliance stating that the carrier or other licensed entity has established and maintained, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this chapter. Material modifications to the procedure shall be filed with the commissioner prior to becoming effective.

(c) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall maintain written records documenting all grievances and appeals received during a calendar year, a general description of the reason fro the appeal or grievance, the name of the claimant, the dates of the appeal or grievance and the date of resolution.

(d) A carrier or other licensed entity that offers group health plans, employee benefit plans, or disability plans shall provide to consumers:

(1) A description of the internal grievance procedure required under RSA 420-J:5 for claim denials and other matters and a description of the process for obtaining external review under RSA 420-J:5-a-RSA 420-J:5-e. These descriptions shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(2) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(3) A statement that the carrier or other licensed entity will provide assistance in preparing an appeal of an adverse benefit determination, and a toll-free telephone number to contact the carrier or other licensed entity.

(e) (1) If a carrier or other licensed entity provides 2 mandatory levels of appeal, the first level shall be completed within 15 days and the second level completed within the 30-day time period beginning from the initial date of filing the appeal or grievance. If a carrier or other licensed entity provides a single mandatory level of appeal, the single mandatory level shall be completed within the 30-day time period beginning from the initial date of filing the appeal. With respect to a mandatory second level of appeal involving a claim for continuation of services or urgent care, the carrier or other licensed entity shall make a decision and notify the claimant within 72 hours after the mandatory second level appeal is filed. For appeals involving post-service claims, the carrier shall make a decision and notify the claimant within 60 days of the date the completed appeal was filed.

(2) Subparagraph (e)(1) shall not prohibit a carrier or other licensed carrier from offering additional voluntary levels of appeal in addition to any mandatory levels of appeal offered, provided that:

(A) The claimant may elect to pursue any additional level of appeal under this subparagraph voluntarily;

(B) A carrier may not assert failure to exhaust administrative remedies where a claimant elects to pursue a claim through other venues rather than through the voluntary level of appeal;

(C) Any statute of limitations or time limits to pursue other remedies shall be tolled during the voluntary appeals process;

(D) Voluntary levels of appeal are available only after a claimant has completed required mandatory levels of appeal required under the plan or by regulation;

(E) The carrier provides a claimant with sufficient information to make an informed decision whether to submit the claim through any voluntary appeals process;
(F) No fees or costs are imposed on the claimant as part of any voluntary appeals process; and
(G) Any voluntary level of appeal requested by a claimant under this subparagraph shall be completed within 30 days from the date of the request for the voluntary appeal.

(f) Annual reports shall be made to the insurance commissioner regarding plan complaints, adverse determinations, claim denials, and prior authorization statistics in such form and containing such information as the commissioner may prescribe by rule or otherwise.
(g) If the claimant has filed an appeal and the carrier or other licensed entity has not issued a decision within the required time frames, the carrier or other licensed entity shall promptly provide the claimant with a statement of the claimant's right to file an external appeal as provided in RSA 420-J:5-a-RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

VI. In an appeal of a claim denial or other matter, the claimant may authorize a representative to pursue a claim or an appeal by submitting a written statement to the carrier or other licensed entity that acknowledges the representation.
VI. No fees or costs shall be assessed against a claimant related to a request for a grievance or appeal.
N.H. Rev. Stat. § 420-J:5

Termination Procedures
See Required Content in Contract.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless whenever a policy provides for reimbursement for any service which may be legally performed by a person licensed in the state for the practice of osteopathy, chiropractic, podiatry, optometry, or licensed as an advanced practice registered nurse, said policy contains a provision for reimbursement for such service when performed by a person so licensed.
N.H. Rev. Stat. § 415:5; N.H. Rev. Stat. § 415:18

No health care insurer shall discriminate against any provider on the basis of religion, race, color, national origin, age, sex, or marital status. Reasonable terms and conditions including, but not limited to, those based on economic or geographic considerations, certain affiliations, or professional privileges shall not be prohibited under this section
N.H. Rev. Stat. § 420-C:5

Quality of Care Procedures
I. A health carrier shall:
(a) Establish and maintain a written quality assessment program designed to collect and evaluate information regarding the quality of the health care processes used by the health carrier and the health outcomes of its covered persons.
(b) Establish and maintain a written quality improvement program structured to identify opportunities to improve care, practices that result in improved health care outcomes, problematic utilization patterns, and those providers who may be responsible for either exemplary or problematic patters of utilization.

II. The quality improvement program shall at a minimum include: a statement of the objectives of the program; a description of how the health carrier will conduct its quality improvement program; the lines of

authority and accountability including data collection responsibilities; evaluation tools; performance improvement activities; and an annual effectiveness review.

III. The chief medical officer or clinical director of the health carrier shall have primary responsibility for the quality assessment and quality improvement activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this chapter relative to quality assessment and quality improvement are met.

IV. A health carrier shall:
   (a) Assure that participating providers have an opportunity to participate in developing, implementing, and evaluating the quality assessment and quality improvement programs.
   (b) Maintain at its principal office a copy of the quality assessment program and the quality improvement program which shall be available for inspection by the commissioner or designee at any time during the health carrier's regular business hours.
   (c) Certify to the commissioner on or before March 1 of each year that its quality assessment program and its quality improvement program meet the requirements of this chapter and any applicable rules.
   (d) Notify the commissioner on or before March 1 of each year of its accreditation by any external accrediting agencies and shall provide a contact person and a phone number for consumer phone calls.

N.H. Rev. Stat. § 420-J:9

Claims Procedures

I. (a) Health carriers issuing health benefit plans subject to this chapter shall pay claims submitted by health care providers for services rendered in New Hampshire to covered persons within 30 calendar days upon receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.
   (b) When the health carrier is denying or pending the claim, the carrier shall have 15 calendar days upon receipt of an electronic claim or 30 days upon receipt of a non-electronic claim to notify the health care provider or covered person of the reason fro denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon the health carrier's receipt of the requested additional information, the health carrier shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a clean claim and shall be adjudicated pursuant to subparagraph (a).
   (c) Payment of a claim shall be considered to be made on the date a check was issues or electronically transferred. The health carrier shall mail checks no later than 5 business days after the date a check was issued. Failure to mail a check within 5 business days shall constitute a violation subject to enforcement under RSA 415:20.
   (d) The health carrier's failure to comply with the time limits in this section shall not have the effective of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:
   (a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.
   (b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the health carrier and, if covered by the Health Insurance Portability and Accountability Act (HIPAA), is in such form and substance as to be in compliance with such act.

III. Any initial clean claim submission not paid within the time periods specified in subparagraph I(a) shall be deemed overdue. In that case:

(a) The health carrier shall pay the health care provider or the insured person the amount of the overdue claim plus an interest payment of 1.5 percent per month beginning from the date the payment was due; and
(b) The health care provider may recover from the carrier, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against a carrier for payment of the claim.

IV. Exceptions to the requirements of this section are as follows:
(a) No health carrier shall be in violation of this section for a claim submitted by a health care provider if:
(1) Failure to comply is caused by a directive from a court or a federal or state agency;
(2) The health carrier is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or
(3) The carrier's compliance is rendered impossible due to matters beyond the carrier's control which are not caused by such carrier.
(b) No health carrier shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.
(c) No health carrier shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review determination pursuant to RSA 420-J:5 or RSA 420-J:5-a-e.

V. The commissioner may assess an administrative fine against any health carrier or may suspend or revoke the license or certificate of authority of any health carrier after determining that the health carrier has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer. Such fine shall be up to $5,000 per violation, not to exceed $100,000. Nothing in this paragraph shall be construed to alter the commissioner's authority to investigate or take action, including, but not limited to, action pursuant to RSA 415:20, in response to individual instances of noncompliance.

N.H. Rev. Stat. § 420-J:8-a

I. In this section, "retroactive denial of a previously paid claim" means any attempt by a health carrier to retroactively collect payments already made to a health care provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments, or reducing or affecting the future claim payments to the provider in any other manner.

II. No health carrier shall impose on any health care provider any retroactive denial of a previously paid claim or any part thereof unless:
(a) The carrier has provided the reason for the retroactive denial in writing to the health care provider; and
(b) The time which has elapsed since the date of payment of the challenged claim does not exceed 18 months. The retroactive denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons:
(1) The claim was submitted fraudulently;
(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;
(3) The health care services identified in the claim were not delivered by the physician/provider;
(4) The claim payment was for services covered by Title XVIII, Title XIX, or Title XXI of the Social Security Act;
(5) The claim payment is the subject of an adjustment with a different insurer, administrator, or payor and such adjustment is not affected by a contractual relationship, association, or affiliation involving claims payment, processing, or pricing; or
(6) The claim payment is the subject of legal action.

III. A health carrier shall notify a health care provider at least 15 days in advance of the imposition of any retroactive denials of previously paid claims. The health care provider shall have 6 months from the date of notification under this paragraph to determine whether the insured has other appropriate insurance, which

was in effect on the date of service. Notwithstanding the contractual terms between the health carrier and provider, the health carrier shall allow for the submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

N.H. Rev. Stat. § 420-J:8-b

Health carriers must issue member identification cards or benefit guarantee cards as evidence of coverage of membership. Ins. 1901.09(a). The card must contain the following information:

1) Insurance company name
2) Subscriber name or member name
3) Subscriber identification number; and
4) Telephone number and website for customer services inquiries

Ins. 1901.09(b)

Further the card must identify that the benefit plan represented on the card is under the jurisdiction of the New Hampshire insurance commissioner, "so that the term 'insured' shall be printed on the member identification card so that it is (1) clearly visible; and (2) in a font size no less than the member's name on the member identification card."

Ins. 1901.09(c)

The U.S. Office of Personnel Management (OPM) has contracting authority for both the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Health Benefits (FEHB) plans. GEHA is contracted with the OPM for both its Connection Dental Federal FEDVIP plan and GEHA Health FEHB plans.

5 U.S.C.A. § 8902

The terms of GEHA's contracts with the OPM which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relate to health insurance or plans.

5 U.S.C.A. §8902(m)(1)

The GEHA Health plan, like other FEHB medical plans, offers limited dental coverage to its members and, by law, the FEHB plans are the first Payor (before FEDVIP plans) for dental coverage provided to FEDVIP Covered Enrollees.

5 U.S.C.A. § 8954(e)

To ensure consistency in the coordination of benefits among the FEDVIP carriers, the OPM has amended its contract with GEHA to state that when treating a FEDVIP Covered Enrollee, the Plan Allowance (which, for Connection Dental Federal is defined as the amount we allow for a specific procedure) is the maximum amount that may be charged to a FEDVIP Covered Enrollee. Neither GEHA nor any FEDVIP Covered Enrollee shall be held responsible or liable for any amounts greater than the FEDVIP allowable amount for services rendered by a Participating Provider to a FEDVIP Covered Enrollee. FEDVIP Covered Enrollees cannot be billed the difference between FEDVIP Plan Allowance and the first Payor's allowance, when the first Payor's allowance is greater than the FEDVIP allowable amount. Thus, FEDVIP Covered Enrollees will only be responsible for payment of the balance of the FEDVIP Plan Allowance minus all payments made by the first Payor and GEHA. FEDVIP Covered Enrollees and GEHA will not be responsible for increased out-of-pocket costs when Covered Enrollees utilize the services of a Connection Dental Participating Provider that also participates in another Payor's PPO network. This is applicable to GEHA Connection Dental Federal and the GEHA Health Plan.

FEDVIP Technical Guidance, Amendment 0005

Provider-Patient Relationship
See required Content in Contract.

Required Content in Contract
Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the covered persons, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this chapter, this agreement does not prohibit the provider from pursuing any available legal remedy.
Provider further agrees that:
(1) This provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the covered person; and that
(2) This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between provider and covered person or persons acting on their behalf.
Any modifications, additions or deletions to the provisions of this section shall become effective on a date no earlier than 15 business days after the commissioner has received written notice of such proposed changes.
N.H. Rev. Stat. § 420-J:8

The execution of a contract by GEHA, on behalf of a health carrier, shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for the compliance with any law or rule. The health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon 15 business days' prior written notice from the commissioner.
N.H. Rev. Stat. § 420-J:8

No contract between GEHA, on behalf of a health carrier, and a physician, for the purpose of delineating the rights and obligations of the parties within the provider network, shall limit the liability of the health carrier for any actions of the physician for which the health carrier might otherwise be liable. No contract between GEHA, on behalf of a health carrier, and a health care provider shall limit what information such health care provider may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of the health carrier's products as they relate to the needs of such provider's patients except for trade secrets of significant competitive value.
N.H. Rev. Stat. § 420-J:8

GEHA does not use the term "physician" in its contracts for the purpose of allowing a health carrier to avoid contracting with other health care professionals for health care services. A physician shall mean a person licensed to practice medicine under RSA 329. Nothing in this section shall be construed to require a health carrier to contract with a health care provider.
N.H. Rev. Stat. § 420-J:8

GEHA, on behalf of health carriers, shall allow a participating provider 60 days from the postmarked date to review any proposed contract and any modifications to an existing contract, excluding those modifications that are expressly permitted under the existing contract.
N.H. Rev. Stat. § 420-J:8

The contracts between GEHA, on behalf of health carriers, and participating providers do not contain any payment or reimbursement provision which create an inducement for the provider to not provide medically necessary care to covered persons.
N.H. Rev. Stat. § 420-J:8

Prior to the execution of a health care provider contract, GEHA shall furnish to the contracting entity, in writing or in electronic format, a complete copy of the proposed contract including all attachments and exhibits. GEHA makes the most current provider manual available to the contracting entity electronically at www.connectiondental.com.
N.H. Rev. Stat. § 420-J:8

The contracting entity may request that a health carrier disclose the fees applicable to specified procedure codes that pertain to the entity's practice or specialty or a method or process that allows the contracting entity to determine the fees pursuant to the terms of the contract. Upon request by the contracting entity, GEHA, on behalf of the insurer, shall furnish, in writing or in an electronic format, the requested procedure codes within 30 calendar days from receipt of the request.
N.H. Rev. Stat. § 420-J:8

No provider contract shall allow for a material change in the applicable fee schedule unless notice of such change is given at least 60 days in advance of the effective date.
N.H. Rev. Stat. § 420-J:8

The health carrier shall provide to covered persons, in the evidence of coverage, a description for the types of financial arrangements contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language.
N.H. Rev. Stat. § 420-J:8

A health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for participating in a covered person's internal grievance procedure or external review.
N.H. Rev. Stat. § 420-J:8

Every contract entered into after July 1, 2003 between a health carrier and any physician or facility shall contain a provision that ensures that covered persons will have continued access to the provider in the event that the contract is terminated for any reason other than unprofessional behavior. The continued access to providers shall be made available for 60 days from the date of termination of the contract and shall be provided and paid for in accordance with the terms and conditions of the covered person's health benefit plan and the prior contract between a health carrier and a health care provider. Within 5 business days of the contract termination, the health carrier shall provide written notice to affected covered persons explaining their continued access rights.
N.H. Rev. Stat. § 420-J:8

No health carrier shall interfere with a provider's right to legal representation during contract negotiations by restricting the provider's right to share confidential information with counsel or by refusing to negotiate directly with counsel selected by a provider as long as the provider receives assurance that counsel agrees to keep confidential the information exchanged during the course of negotiations to the same extent the provider is obligated to keep such information confidential.
N.H. Rev. Stat. § 420-J:8

No provider employed by a hospital or any affiliate is required or in any way obligated to refer patients to providers also employed or under contract with the hospital or any affiliate. Nothing in this paragraph shall be

construed to prohibit health care carriers from providing coverage for only those services which are medically necessary and subject to the terms and conditions of the covered person's policy.
N.H. Rev. Stat. § 420-J:8

All records and documents relating to a health care professional's credentialing verification process shall be retained by GEHA for seven 7 years.
N.H. Rev. Stat. § 420-J:4

These policies and procedures are subject to change without notification as permitted by law. Any changes in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the CONNECTION Dental Network are hereby incorporated into these policies and procedures.

Please note: Government Employees Health Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates the CONNECTION Dental Network, which is a non-risk bearing PPO network. The above policies and procedures may or may not be applicable to the CONNECTION Dental Network, depending on whether the network is included within the state-specific definitions that are applicable to state laws, rules and regulations.

GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

Last modified September 12, 2017.