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

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

Providers may submit and seek resolution of complaints and grievances, separate and apart from submitting complaints and grievances on behalf of a Covered Person, and complaints addressing compensation and claims issues to the appropriate Carrier or GEHA/CONNECTION Dental Network, 310 Northeast Mulberry Street, Lee's Summit, MO 64086. The Network will forward any complaints or grievances regarding benefits or the payment of benefits to the appropriate Carrier. The Network will resolve complaints and grievances that are not related to benefits or the payment of benefits within 30 days following receipt of the complaint or grievance. The Network will also require the Carrier to resolve complaints and grievances within 30 days following receipt of the complaint or grievance. The Provider shall have the right to submit complaints and grievances to the DOBI if not satisfied with the resolution of the complaint or grievance through the internal Provider complaint mechanism. Appeals regarding Network participation or Participating Provider Agreement disputes should also be submitted directly to the CONNECTION Dental Network at the above address.
N.J.A.C. 11:24B-5.2(20)

Termination Procedures

No Carrier using the Network in New Jersey shall have different reasons than the Network for removing a Provider from the Network's panel.
N.J.A.C. 11:24B-5.3 (a) 1

If a Provider elects not to participate in a Carrier's panel but does not want to terminate the entire Participating Provider Agreement with the ODS (Network), the Provider shall notify GEHA in writing at: GEHA/ CONNECTION Dental Network, Attn: Provider Relations Department, 310 Northeast Mulberry Street, Lee's Summit, MO 64086.
N.J.A.C. 11:24B-5.3 (a) 2

When the Provider's status as a Participating Provider in the Network is being terminated, written notice shall be issued to the Provider no less than 90 days prior to the date of termination, except that the 90-day prior notice requirement need not apply when the contract is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of breach, alleged fraud, or because, in the opinion of the dental director of either the Network or the Carrier, if different, the health care professional presents an imminent danger to one or more Covered Persons, or the public health, safety or welfare.
N.J.A.C. 11:24B-5.3 (c)

In the event written notice of termination does not include a statement setting forth the reason(s) for termination, requests may be sent to GEHA/CONNECTION Dental Network, Attn: Provider Relations, 310 Northeast Mulberry Street, Lee's Summit, MO 64086.
N.J.A.C. 11:24B-5.3 (c) 1

The health care professional shall have the right to request a hearing following a notice that the health care professional's status as a Participating Provider is being terminated, except that the right to a hearing does not apply when the termination occurs on the date of renewal of the contract, or upon the contract's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the dental director of either the Network or the Carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.
N.J.A.C. 11:24B-5.3 (d)

Except for nonrenewal of a contract, or termination based on breach or alleged fraud, or termination based on a dental director's opinion that the health care professional presents an imminent danger to one or more covered persons or the public health, safety or welfare, a health care professional shall have the right to request a hearing in writing with respect to termination of the health care professional from the Network within 10 business days following the date of the notice by sending the request in writing to: GEHA/CONNECTION Dental Network, Attn: Provider Relations, 310 Northeast Mulberry Street, Lee's Summit, MO 64086.
N.J.A.C. 11:24B-5.3 (e)

For terminations that are subject to a hearing and initiated by the Network, the Carrier delegates the function of holding the hearing to the Network, and the Network shall hold a hearing within 30 days following receipt of a written request for a hearing by a terminated health care professional before a panel appointed by the Network.

1. The panel shall consist of no less than three people.
2. At least one person on the panel shall be a clinical peer in the same or substantially similar discipline and specialty as the Provider requesting the hearing.
3. The Network shall not preclude the Provider from being present at the hearing, nor shall the Network preclude the Provider from being represented by counsel at the hearing.

The hearing panel shall render a decision on the matter in writing within 30 days of the close of the hearing unless the panel provides notice of a need for an extension for rendering its decision, and provides the notice to both the Network and the health care professional prior to the date the panel's decision would otherwise be due. The panel's decision shall set forth the relevant contract provisions and the facts upon which the Network and the Provider have relied at the hearing. The panel shall recommend that the Provider be terminated, reinstated or provisionally reinstated. The panel shall specify its reasons for its recommendations, including the reasons for any conditions for provisional reinstatement. The panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences of a failure to meet the conditions. In the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of duration of the contract at issue. In the event that the panel recommends that the health care professional be terminated, the Carrier shall then provide notice of the termination to covered persons in accordance with N.J.A.C. 11:24A-4.8(c), as necessary and if applicable.
N.J.A.C. 11:24B-5.3 (e)

<u>Dispute Resolution Process</u>
A health insurer or its agent, hereinafter the payer, shall establish an internal appeal mechanism to resolve any dispute raised by a health care Provider regardless of whether the health care

Provider is under contract with the payer. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to applicable law shall be the subject of an appeal pursuant to this subsection. The payer shall conduct the appeal at no cost to the health care Provider. A health care Provider may initiate an appeal on or before the 90th calendar day following receipt by the health care Provider of the payer's claims determination, which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The payer shall conduct a review of the appeal and notify the health care Provider of its determination on or before the 30th calendar day following the receipt of the appeal form. If the health care Provider is not notified of the payer's determination of the appeal within 30 days, the health care Provider may refer the dispute to arbitration as provided by paragraph (2) of this subsection N.J.S.A. 17B:27-44.2 e. If the payer issues a determination in favor of the health care Provider, the payer shall comply with the provisions of this section and pay the amount of money in dispute, if applicable, with accrued interest at the rate of 12% per annum, on or before the 30th calendar day following the notification of the payer's determination on the appeal. Interest shall begin to accrue on the day the appeal was received by the payer. If the payer issues a determination against the health care Provider, the payer shall notify the health care Provider of its findings on or before the 30th calendar day following the receipt of the appeal form and shall include in the notification written instructions for referring the dispute to arbitration as provided by paragraph (2) of this subsection N.J.S.A. 17B:27-44.2 e. The payer shall report annually to the Commissioner of Banking and Insurance the number of appeals it has received and the resolution of each appeal.
N.J.S.A. 17B:27-44.2 e (1)

Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph (1) of this subsection N.J.S.A. 17B:27-44.2 e may be referred to arbitration as provided in this paragraph. The Commissioner of Banking and Insurance shall contract with a nationally recognized, independent organization that specializes in arbitration to conduct the arbitration proceedings. Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that a health care Provider may aggregate his own disputed claim amounts for the purposes of meeting the threshold requirements of this subsection. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to applicable law shall be the subject of arbitration pursuant to this subsection.
N.J.S.A. 17B:27-44.2 e (2)

The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.
N.J.S.A. 17B:27-44.2 e (3)

An arbitrator's determination shall be: (a) signed by the arbitrator; (b) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and (c) issued on or before the 30th calendar day following the receipt of the required documentation. The arbitration shall be nonappealable and binding on all parties to the dispute.
N.J.S.A. 17B:27-44.2 e (4)

If the arbitrator determines that a payer has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order the payer to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that a payer has withheld or denied payment on the basis of information submitted by the health care Provider and the payer requested, but did not receive, this information from the health care Provider when the claim was initially processed pursuant to applicable law or reviewed under internal appeal pursuant to applicable law, the payer shall not be required to pay any accrued interest.
N.J.S.A. 17B:27-44.2 e (5)

If the arbitrator determines that a health care Provider has engaged in a pattern and practice of improper billing and a refund is due to the payer, the arbitrator may award the payer a refund, including interest accrued at the rate of 12% per annum. Interest shall begin to accrue on the day the appeal was received by the payer for resolution through the internal appeals process established pursuant applicable law.
N.J.S.A. 17B:27-44.2 e (6)

The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.
N.J.S.A. 17B:27-44.2 e (7)

Network Participation Procedures

Whenever an insurance policy or contract provides for reimbursement for any service that is within the lawful scope of practice of a duly licensed dentist, the person covered shall be entitled to equal reimbursement for such service whether performed by a duly licensed physician or a duly licensed dentist.
N.J.S.A. 17B:26-44.1

Quality of Care Procedures

Providers must comply with the Network's quality assurance program. The Network will review issues or member complaints regarding a Provider who is engaged in behavior or is practicing in a manner that appears is not of a quality consistent with generally accepted standards and practices in the dental community. In response to quality assurance issues or member complaints, the Network may 1) send a Letter of Concern to the Provider; 2) monitor the Provider; 3) recredential the Provider sooner than the next regularly scheduled date; 4) schedule an onsite visit with the Provider; 5) determine that no action is needed; 6) summarily suspend a Provider; or 7) terminate a Provider. If, in the opinion of the Medical or Dental Director or the Peer Review Committee, a Provider is engaged in behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Network may suspend, pending investigation, a Provider's participation in the Network (see Network Appeals/Grievances policies and procedures).

i. The quality assurance program for the Network is that of the Network and is being adopted by the Carrier.
ii. The Network is responsible for the day-to-day administration of the quality assurance program.
iii. Providers may lodge complaints regarding the quality assurance program of CONNECTION Dental Network or provide feedback regarding the operations of CONNECTION Dental Network or a dental Carrier to GEHA/ CONNECTION Dental Network, 310 Northeast Mulberry Street, Lee's Summit, MO 64086. GEHA will forward any feedback regarding the operations of the dental Carrier to the appropriate Carrier.
N.J.A.C. 11:24B-5.2.4

Providers must provide care and services which are of a quality consistent with generally accepted standards and practices in the dental community and comply with the Network's quality assurance program.
N.J.A.C.11:24B-5.2.13

Claims Procedures
A health insurer or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by a covered person or health care Provider, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if: (a) the health care Provider is eligible at the date of service; (b) the person who received the health care service was covered on the date of service; (c) the claim is for a service or supply covered under the health benefits plan; (d) the claim is submitted with all the information requested by the payer on the claim form or in other instructions that were distributed in advance to the health care Provider or covered person in accordance with the provisions of applicable law; and (e) the payer has no reason to believe that the claim has been submitted fraudulently.
N.J.S.A. 17B:27-44.2 d (1)

If all or a portion of the claim is not paid within the time frames provided in N.J.S.A. 17B:27-44.2 d (1) above because: (a) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer; (b) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect; (c) the payer disputes the amount claimed; or (d) there is strong evidence of fraud by the Provider and the payer has initiated an investigation into the suspected fraud, the payer shall notify the health care Provider, by electronic means and the covered person in writing within 30 days of receiving an electronic claim, or notify the covered person and the health care Provider in writing within 40 days of receiving a claim submitted by other than electronic means, that: (i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim; (ii) the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim; (iii) the payer disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or (iv) the payer finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to applicable law, or referred the claim, together with the supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to applicable law.
N.J.S.A. 17B:27-44.2 d (2)

If all or a portion of an electronically submitted claim cannot be adjudicated because of the diagnosis coding, procedure coding or any other data required to be submitted with the claim was missing, the payer shall electronically notify the health care Provider or its agent within seven days of that determination and request any information required to complete adjudication of the claim.
N.J.S.A. 17B:27-44.2 d (3)

Any portion of a claim that meets the criteria established in paragraph N.J.S.A. 17B:27-44.2 d (1) above shall be paid by the payer in accordance with the time limit established in paragraph N.J.S.A. 17B:27-44.2 d (1) above.
N.J.S.A. 17B:27-44.2 d (4)

A payer shall acknowledge receipt of a claim submitted by electronic means from a health care Provider, no later than two working days following receipt of the transmission of the claim.
N.J.S.A. 17B:27-44.2 d (5)

An overdue payment shall bear simple interest at the rate of 12% per annum. The interest shall be paid to the health care Provider at the time the overdue payment is made. The amount of interest paid to a health care Provider for an overdue claim shall be credited to any civil penalty for late payment of the claim levied by the Department of Human Services against a payer that does not reserve the right to change the premium.
N.J.S.A. 17B:27-44.2 d (9)

With the exception of claims that were submitted fraudulently or submitted by health care Providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, no payer shall seek reimbursement for overpayment of a claim previously paid pursuant to this section later than 18 months after the date the first payment on the claim was made. No payer shall seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to the health care Provider, the payer shall provide written documentation that identifies the error made by the payer in the processing or payment of the claim that justifies the reimbursement request. No payer shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances: (a) in judicial or quasi-judicial proceedings, including arbitration; (b) in administrative proceedings; (c) in which relevant records required to be maintained by the health care Provider have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable; or (d) in which there is clear evidence of fraud by the health care Provider and the payer has investigated the claim in accordance with its fraud prevention plan established pursuant to applicable law and referred the claim, together with the supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to applicable law.
N.J.S.A. 17B:27-44.2 d (10)

(a) In seeking reimbursement for the overpayment from the health care Provider, except as provided for in subparagraph (b) of this paragraph, no payer shall collect or attempt to collect: (i) the funds for the reimbursement on or before the 45th calendar day following the submission of the reimbursement request to the health care Provider; (ii) the funds for the reimbursement if the health care Provider disputes the request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to the health care Provider and until the health care Provider's rights to appeal set forth under applicable law are exhausted; or (iii) a monetary penalty against the reimbursement request, including but not limited to, an interest charge or a late fee. The payer may collect the funds for the reimbursement request by assessing them against payment of any future claims submitted by the health care Provider after the 45th calendar day following the submission of the reimbursement request to the health care Provider or after the health care Provider's rights to appeal set forth under applicable law have been exhausted if the payer submits an explanation in writing to the Provider in sufficient detail so that the Provider can reconcile each covered person's bill.
(b) If a payer has determined that the overpayment to the health care Provider is a result of fraud committed by the health care Provider and the payer has conducted its investigation and reported the fraud to the Office of the Insurance Fraud Prosecutor as required by law, the payer may collect an overpayment by assessing it against payment of any future claim submitted by the health care Provider.
N.J.S.A. 17B:27-44.2 d (11)

No health care Provider shall seek reimbursement from a payer or covered person for underpayment of a claim submitted pursuant to this section later than 18 months from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to applicable law or the claim is subject to continual claims submission. No health care Provider shall seek more than one reimbursement for underpayment of a particular claim.
N.J.S.A. 17B:27-44.2 d (12)

(a) A Carrier or its agent shall acknowledge receipt of all claims. The acknowledgement shall include the date the Carrier or its agent received the claim.
1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The acknowledgement of receipt of an electronic claim shall go to the entity from which the Carrier received the claim.
2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If a Carrier or its agent remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If a Carrier offers Providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.

(d) If a Carrier offers Providers access to claims status via an automated telephone system, and the available information includes the date of receipt of the claims, and that information is made available within the timelines established in (a)2 above, the posting of that information shall constitute acknowledgement of receipt of those claims.
N.J.A.C. 11:22-1.3

A Carrier or its agent shall notify its participating health care Providers at least annually, and shall make available to covered persons on request, a listing of the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the Carrier for both manually and electronically submitted claims. Carriers or their agents may change the required information and documentation as long as participating health care Providers are given at least 30 days prior notice of the change in the requirements. Carriers or their agents shall also supply participating health care Providers with a street address where claim submissions can be delivered by hand or registered/certified mail.
N.J.A.C. 11:22-1.4

(a) A Carrier and its agent shall remit payment of clean claims pursuant to the following time frames:
1. Thirty calendar days after receipt of the claim where the claim is submitted by electronic means or the time established for the Federal Medicare program by 42 U.S.C. § 1395u(c)2(B), whichever is earlier; or
2. Forty calendar days after receipt of the claim where the claim is submitted by other than electronic means.

(b) Carriers and their agents shall pay claims that are disputed or denied because of missing information or documentation within 30 or 40 calendar days of receipt of the missing information or documentation, as applicable, pursuant to (a) above.

(c) Payment of a claim shall be considered to have been made:

1. On the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or
2. If not paid pursuant to (c)1 above, on the date of delivery of a draft or other valid instrument equivalent to payment.

(d) A Carrier or its agent shall maintain an auditable record of when payments were transmitted to health care Providers or covered persons whether by United States mail or otherwise. N.J.A.C. 11:22-1.5

(a) A Carrier or its agent shall either deny or dispute a claim, in full or in part, that has not been processed according to N.J.A.C. 11:22-1.5. If only a portion of a claim is disputed or denied, the Carrier or its agent shall remit payment for the uncontested portion in accordance with N.J.A.C. 11:22-1.5. The pending of a claim does not constitute a dispute or denial. The Carrier or its agent shall, within 30 or 40 calendar days of receipt of the claim, whichever is applicable, notify both the covered person when he or she will have increased responsibility for payment and the Provider of the basis for its decision to deny or dispute including:

1. The identification and explanation of all reasons why the claim was denied or disputed;

i. If a claim is denied because it cannot be entered into the claims system, then all reasons why the claim cannot be entered into the claims systems shall be included.

ii. Examples of reasons why a claim cannot be entered into the claims system include: group not covered on date of service; employee/dependent not covered on date of service; non-payment of premium; missing data fields; missing or incorrect data (for example, CPT code, date of service, Provider name); and ineligible Provider.

iii. If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, the Carrier's first review after the claim is entered shall identify all applicable reasons for any denial or disputed claim.

iv. A Carrier or its agent shall not deny or dispute a claim for reasons other than those identified in the first review after the claim is entered, unless information or documentation relevant to the claim is received after the first review and such documentation leads to additional reasons to deny or dispute which were not present at the time of that review.

2. Where missing information or documentation is a reason for denying or disputing a claim, the Carrier or its agent shall provide notice to the provider within the timeframes and in the manner required by P.L. 2005, c. 352;
3. If the amount of the claim is disputed, an explanation of the reason for the dispute, including any change of coding performed by the Carrier and the reasons for such change of coding; and
4. The toll free telephone number for the Carrier or its agent who can be contacted by the Provider or covered person to discuss the claim.

(b) A Carrier or its agent denies or disputes a claim in whole or in part and fails to provide the notice required by (a) above within the timeframes and in the manner required of carriers that are subject to P.L. 2005, c. 352, the claim shall be deemed to be overdue.

(c) If the Carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the Carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by the Carrier. The Carrier may aggregate interest amounts up to $25.00, with the consent of the Provider.

(d) If a Carrier subject to the provisions of N.J.S.A. 17:33A-1 et seq. has reason to believe that the claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to N.J.S.A. 17:33A-15 or, if applicable, refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

(e) Unless otherwise provided by law, every Carrier or its agent shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by the Carrier or the date of the performance by the covered person or the Provider of any conditions to payment set forth in the agreement, whichever is later.
(f) Carrier adjustments to claims previously paid shall be based only on actual identifiable error(s) in the submission, processing or payment of a particular claim(s), and shall not be based on extrapolation, with the following exceptions:

1. Where the extrapolation, including the method, is non-binding;
2. In judicial or quasi-judicial proceedings, including arbitration;
3. In governmental administrative proceedings;
4. Where relevant records required to be maintained by the Provider have been improperly altered or reconstructed, or a material number of such records are unavailable; or
5. Where there is clear evidence of claim fraud or abuse by the Provider.

N.J.A.C. 11:22-1.6

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

Providers shall have the right and obligation to communicate openly with all Covered Persons regarding diagnostic tests and treatment options.
N.J.A.C. 11:24B-5.2.14

Providers shall not be terminated or otherwise penalized because of complaints or appeals that the Provider files on his or her own behalf, or on behalf of a Covered Person, or for otherwise acting as an advocate for Covered Persons in seeking appropriate, medically necessary health care services covered under the Covered Person's health benefits plan.
N.J.A.C. 11:24B-5.2.15

Providers shall not discriminate in his or her treatment of a Carrier's Covered Persons.
N.J.A.C. 11:24B-5.2.16

Required Content in Contract

Any Carrier with whom the Network contracts will be contractually required to agree to the following:

(a) Carriers shall establish internal appeals mechanisms to resolve disputes between Carriers or their agents and participating health care Providers relating to payment of claims but not including appeals made pursuant to 11:24A-3.5 through 3.7.

1. The internal review shall be conducted by employees of the Carrier who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be provided at no cost to the Provider.
2. The internal review shall be conducted and its results communicated in a written decision to the Provider within 10 business days of the receipt of the appeal. The written decision shall include:

i. The names, titles and qualifying credentials of the persons participating in the internal review;
ii. A statement of the participating Provider's grievance;
iii. The decision of the reviewers' along with a detailed explanation of the contractual and/or medical basis for such decision;
iv. A description of the evidence or documentation which supports the decision; and
v. If the decision is adverse, a description of the method to obtain an external review of the decision.

(b) Every Carrier shall offer an independent, external ADR mechanism to participating health care providers to review adverse decisions of its internal appeals process.

1. The ADR mechanism shall be through an independent party. The costs of the process shall be borne equally by the parties. The recommended decision of the ADR mechanism shall be issued no later than 30 business days from receipt by the ADR firm of all documentation necessary to complete the review.
2. Carriers are contractually required to post ADR mechanisms, including the method to submit a claim through such mechanism, on the Connection Dental Network website at connectiondental.com under the Payor Info tab, and shall be described in the Carrier's final internal decision denying or disputing the participating health care provider's claim, in full or in part.
3. The decision of the ADR mechanism shall be non-binding unless the parties agree otherwise.

(c) Carriers shall annually notify participating Providers in writing of the internal appeals process and the ADR mechanism and how they can be utilized.

(d) Carriers shall annually report, in a format prescribed by the Department, which includes the number of internal and external Provider appeals received and how they were resolved.

N.J.A.C. 11:22-1.8

Carriers are contractually required to post their procedures for submitting and handling of claims, including any penalties that may result in the event that claims are not submitted timely, the standards for determining whether submission of a claim has been timely, and the process for Providers to dispute the handling or payment of claims, on the Connection Dental Network website at connectiondental.com under the Payor Info tab.

i. Provisions addressing claims handling shall be consistent with applicable law.
ii. The provision shall specify how interest for late payment of claims shall be remitted to the Provider, but in no instance shall the provision obligate the Provider to request payment of the interest before the interest will be paid.

N.J.A.C. 11:24B-5.2.17

Carriers are contractually required to post their utilization management program with which the Provider must comply on the Connection Dental Network website at connectiondental.com under the Payor Info tab.

i. The provision shall specify whether the utilization management program is that of the Network and is being adopted by the Carrier, is that of the Carrier and is being adopted by the Network, or is that of a separate entity and is being adopted by both the Carrier and the Network with which the Provider is contracted.
ii. The provision shall explain what entity is responsible for the day-to-day operation of the utilization management program, how the Provider is to comply with the UM standards, including the method for obtaining a UM decision and appealing UM decisions, and the right of the Provider to have the name and telephone number of the physician, or dentist if appropriate to the services at issue, denying or limiting an admission, service, procedure or length of stay.
iii. The provision shall explain how Providers may receive information regarding the UM protocols and any parameters that may be placed on the use of one or more protocols.
iv. The provision shall explain how participating Providers may review and provide comment on the applicable protocols for the Provider's practice area.
v. The provision shall explain that the Provider has the right to rely upon the written or oral authorization of a service if made by the Carrier or the entity identified as being responsible for the day-to-day operations of the utilization management program, and that the services will not be retroactively denied as not medically necessary except in cases where there was material misrepresentation of the facts to the Carrier or the entity identified as being responsible for the day-to-day operations of the utilization management program, or fraud.

N.J.A.C. 11:24B-5.2.5

The Carrier shall make available online the name of any commercially available software used by the Carrier for editing claims, together with a description of carrier-specific edits in a manner detailed enough to provide an understanding of such edits.

N.J.A.C. 11:24C-4.3

Carriers are contractually required to post their explanations of the rights and obligations of the Provider when appealing a UM decision on behalf of a Covered Person, including the right to receive a written notice of the UM determination.

i. The provision shall be clear as to whether the Provider must obtain consent of the Covered Person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth in N.J.A.C. 11:24-8 and 11:24A-3.5, or whether failure to obtain consent of the Covered Person results in review of the appeal using a separate complaint or Provider grievance process.
ii. In the event that an appeal instituted by a Provider on behalf of a Covered Person will be entertained as a member utilization management appeal without the Covered Person's consent, the provision shall explain that such appeals will not be eligible for the Independent Health Care

Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the Covered Person's specific consent to the appeal is obtained.

iii. The provision shall not limit the right of the Provider to submit an appeal on behalf of the Covered Person to situations in which the Covered Person may be financially liable for the costs of the health care services.
N.J.A.C. 11:24B-5.2.6

Any sections of the Participating Provider Agreement that conflict with State or Federal law are effectively amended to conform with the requirements of the State or Federal law.
N.J.A.C. 11:24B-5.2.1

The compensation methodology between the Network and the Provider is the Fee Schedule that is attached to the Participating Provider Agreement.

i. There are no provisions that provide financial incentives to the Provider for the withholding of covered health care services that are medically necessary, and there are no capitated payment arrangements between the Network and the Providers.
ii. No portion of the Provider compensation is tied to the occurrence of a pre-determined event, or the non-occurrence of a pre-determined event.
iii. A Provider may appeal a decision denying the Provider additional compensation to which the Provider believes he or she is entitled under the terms of the Participating Provider Agreement. Appeals not related to benefits or the payment of benefits must be submitted to the network through use of the Network Appeals/Grievances policies and procedures, and appeals regarding benefits or the payment of benefits must be submitted directly to the Carrier.
iv. Capitation is not the sole method of reimbursement to Providers that primarily provide supplies rather than services.
v. Compensation terms are not determined subsequent to the execution of the contract between the Network and the Provider.
N.J.A.C. 11:24B-5.2.2

A Provider's activities and records relevant to the provision of health care services may be monitored from time to time either by the Network, the Carrier, or another contractor acting on behalf of the Carrier in order for the Network or the Carrier to perform quality assurance and continuous quality improvement functions.
N.J.A.C. 11:24B-5.2.3

The Participating Provider Agreement is governed by New Jersey law.
N.J.A.C. 11:24B-5.2.7

Providers are prohibited from billing or otherwise pursuing payment from a Carrier's Covered Person for the costs of services or supplies rendered in-network that are covered, or for which benefits are payable, under the Covered Person's health benefits plan, except for copayment, coinsurance or deductible amounts set forth in the health benefits plan, regardless of whether the Provider agrees with the amount paid or to be paid, for the services or supplies rendered.
N.J.A.C. 11:24B-5.2.10

Providers are credentialed prior to acceptance in the Network and recredentialed every three years. Providers must cooperate with and follow credentialing procedures established by GEHA. Network Providers cannot be excluded, debarred, suspended or otherwise prohibited from participation in any state or federal health care reimbursement program including Medicare, Medicaid, TriCare and the Federal Employees Health Benefits Program and cannot

be included on the Office of Foreign Assets Control (OFAC) Listing or the Excluded Parties List System (EPLS), which are used to verify government sanctions.
N.J.A.C. 11:24B-5.2.13

Providers must maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.
N.J.A.C. 11:24B-5.2.12

The Carrier is a third party beneficiary of the Participating Provider Agreement, with privity of contract, and a right to enforce the provisions of the Participating Provider Agreement in the event that the Network fails to do so.
N.J.A.C. 11:24B-5.7 (a)

The Network, on behalf of Carriers, makes available to Network Providers and prospective Network providers all complete fee schedule(s) that are or are to be included in their agreement. Fee Schedules are supplied in writing on the Network website, or electronically to Providers.
N.J.A.C. 11:24C-4.3 (b)

A Summary of the Participating Provider Agreement is located on the last page of this document.
N.J.A.C. 11:24C-4.3 (c)

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.

SUMMARY OF TERMS AND CONDITIONS OF PROVIDER AGREEMENT

By signing the Participating Provider Agreement, you are agreeing to be a network provider for Connection Dental Network. You are aware that Connection Dental Network leases its network of providers to other Payors. Therefore, some of the information must be obtained from the Payor leasing the network.

i. The manner of payment is fee for service. Carriers must pay claims in accordance with the Provider agreement, applicable laws, and their benefit plans. Specific New Jersey Carrier policies are available on the Network's website at connectiondental.com under the Payor Info tab, New Jersey Payor Policies. Claim edit information for New Jersey Carriers is available by calling the number on the member's Identification card or by calling GEHA's marketing department, called PPO USA, at (877) 277-6872, Option 1, to be directed to the Carrier's toll free telephone number and claims address.

ii. The provider agreement applies to PPO products.

iii. The initial term of the agreement terminates on December 31st following the first anniversary date and automatically renews. The term of the agreement is referenced in Section 3.2.

iv. Adverse material changes or amendments to the agreement may only be made with 90 days' notice prior to the effective date of the adverse material change or amendment. If the Provider declines to accept the amendment, the Provider is permitted to terminate the agreement prior to the effective date of the adverse change. Fee schedule changes resulting from the introduction of, discontinuance of, or changed usage of a CDT code shall not be considered adverse material changes. The agreement is automatically renewed for an additional calendar year unless terminated by either party. Provider contracts may be terminated with 30 days' notice for immediate termination, 90 days' notice for ending at the end of the then current term, and 90 days' notice for termination without cause or termination for default. Automatic terminations are effective on the date of the occurrence of the event or the date we discover the event, whichever is later.

v. The provider contract does not require Providers to participate in preauthorization programs.

vi. New Jersey law requires Providers to maintain insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

vii. Providers may submit contract disputes to the Network within 30 days of the action or decision giving rise to the dispute, and the Network will render a written decision regarding the contract dispute to the Provider within 30 days of receipt. If the Provider is unsatisfied with the result of the dispute, such dispute may be submitted to arbitration and resolved in the manner stated in Section 3.17 of the Participating Provider Agreement. Disputes regarding Network participation are resolved in accordance with the Credentialing Policies and Procedures at connectiondental.com under the Credentialing Info tab. A summary of all Network dispute processes is available in the Provider Manual at connectiondental.com under the Dentist Info tab. Billing or adverse benefit determination appeals, claims disputes, and any complaints about claims should be sent directly to the Carrier. For New Jersey Carriers, please see the member's Identification Card or call (877) 277-6872, Option 1.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

The information provided in this Summary is a guide to the Participating Provider Agreement.

The terms and conditions of the Participating Provider Agreement constitute the contract rights of the parties. Reading this Summary is not a substitute for reading the entire Participating Provider Agreement. When you sign the Participating Provider Agreement, you will be bound by its terms and conditions. These terms and conditions may be amended over time. You are encouraged to read any proposed amendments that are sent to you after execution of the Participating Provider Agreement. Nothing in this Summary creates any additional rights or causes of action in favor of either party.

Last Modified February 15, 2017.