**GEHA Policies & Procedures**
**Connection Dental Network**
**State Specific Policies & Procedures - State of Tennessee**

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.

Terminations Procedures
If a provider who is a member of a managed health insurer issuer's network terminates its agreement with the issuer, or the issuer terminates the provider without cause, then the provider and the issuer shall allow a covered person who is under active treatment for a particular injury or sickness, to continue to receive covered benefits from the treating provider for the injury or sickness for a period of 120 days from the date of notice of termination. This shall apply only if the treating provider agrees to continue to be bound by the terms, conditions and reimbursement rates of the provider's agreement with the issuer.
T.C.A. § 56-7-2358

Subject to any applicable continuity of care requirements, provisions of the provider network contract or contrary law: (1) A third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated; (2) Claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and (3) Claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.
T.C.A.§ 56-60-105

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
No state-specific requirements.

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
Not later than 30 calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, a health insurance entity shall: (i) if the clam is clean, pay the total covered amount of the claim; (ii) pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or (iii) notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than 21 calendar days after receiving a claim by electronic transmission, a health insurance entity shall: (i) if the clam is

clean, pay the total covered amount of the claim; (ii) pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or (iii) notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. No paper claim may be denied upon resubmission for lack of substantiating documentation or information that has been previously provided by the health care provider. Health insurance entities shall timely provide contracted providers with all necessary information to properly submit a claim. Any health insurance entity that does not comply with this section shall pay 1% interest per month, accruing from the day after the payment was due, on that amount of the claim that remains unpaid. ("Health insurance entity" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including, but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation.")
T.C.A. § 56-7-109(b)(1)(A) and (B)

A clean claim does not include any claim submitted more than 90 days after the date of service.
T.C.A. § 56-7-109(a)(1)(C)

A health insurance entity must properly pay at least 95% of clean claims submitted to it or it could be subject to a series of fines as established by the Insurance Commissioner.
T.C.A. § 56-7-109(c)(2)

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
No state-specific requirements.

Required Content in Contract
The Participating Provider authorizes GEHA to contract with Payors, or with entities on behalf of Payors, to make Participating Provider's services available to Payors upon the same terms and conditions that such services are made available to GEHA pursuant to this Agreement.
T.C.A. § 56-60-105(a)

No contract offered by any insurer, dental service plan, third party administrator or other party that covers any dental services, and no contract or participating provider agreement with a dentist may require, directly or indirectly, that a dentist who is a participating provider, provide services to an enrollee at a fee set by, or at a fee subject to the approval of the dental service plan, insurer, third party administrator or other party that covers any dental plan services unless the dental services are covered services. No contract offered by any insurer, dental service plan, third party administrator or other party with a participating provider that covers any covered services may provide nominal or de minimis coverage for covered services under the contract for the sole purpose of avoiding the requirements of this section. "Covered services" means dental care for which a reimbursement is available under the enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefits payments, or any other limitation; and "Participating provider" means a dentist licensed to practice dentistry in this state, who provides dental services to an enrollee at a fee set by or at a fee subject to the approval of an insurer, dental services plan, third party administrator or any other party that contracts to provide dental services.
T.C.A. § 56-7-1017

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.

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