GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Utah

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
For the first two years, an insurer may terminate its contract with a provider with or without cause upon giving the requisite amount of notice provided in the agreement, but in no case shall it be less than 60 days. An agreement may be terminated for cause as provided in the contract established between the insurer and the provider. Such contract shall contain sufficiently certain criteria so that the provider can be reasonably informed of the grounds for termination for cause. Prior to termination for cause, the insurer shall (i) inform the provider of the intent to terminate and the grounds for doing so (ii) at the request of the provider, meet with the provider to discuss the reasons for termination; (iii) if the insurer has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, the insurer may, at its discretion, place the provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and (iv) if the insurer has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the insurer may immediately suspend the provider from further performance under the contract, provided that an internal appeal process is followed in accordance with law before termination may become final. A termination may not be based on (i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or (ii) the provider's referral patterns for patients who are not covered by the insurer.
U.C.A. §31A-22-617.1

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
GEHA has established criteria for adding health care providers to its existing provider panel, and such criteria is available to any provider upon request or in the Provider Manual at www.connectiondental.com under the Dentist Info tab. Upon receipt of a provider application and upon receiving all necessary information, GEHA shall make a decision on a provider's application for participation within 120 days.
U.C.A. §31A-22-617.1

A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to contract. Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, and who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the

number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.
U.C.A. § 31A-22-617

Except as provided under applicable law, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the contract. This section does not apply to catastrophic mental health coverage provided in accordance with applicable law.
U.C.A. § 31A-22-618

An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.
U.C.A. § 31A-8-407

An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.
U.C.A. § 31A-22-617

Quality of Care Procedures

Unlawful conduct includes: (1) administering anesthesia or analgesia in the practice of dentistry or dental hygiene if the individual does not hold a permit issued by the insurance division authorizing that individual to administer the type of anesthesia or analgesia used; (2) practice of dental hygiene by a licensed dental hygienist when not under the supervision of a dentist in accordance with the provisions of law; or (3) directing or interfering with a licensed
U.C.A. § 58-69-501

An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provider by the health care providers under contract meets prevailing standards in the state.
U.C.A. § 31A-22-617

Claims Procedures

If an organization permits another private entity with which it does not share common ownership or control to use or otherwise lease one or more of the organization’s networks that include participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network unless payment for services is governed by a public program's fee schedule.
U.C.A. § 31A-8-407

In any dispute involving a provider’s claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer’s written payment policies in effect at the time services were rendered. If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared.
U.C.A. § 31A-22-617

An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.
U.C.A. § 31A-22-617

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
An insurer or person who provides, administers or manages health care insurance may not enter into a contract that limits a health care provider's ability to advise the health care provider's patients or clients fully about treatment options or other issues that affect the health care of the health care provider's patients or clients.
U.C.A. § 31A-4-106(5).

Required Content in Contract
If an organization fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for the sums owed by the organization. If the organization becomes insolvent, the rehabilitator or liquidator may require the participating provider of health care services to continue to provide health care services under the contract between the participating provider and the organization until the earlier of: (I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or (II) the date the term of the contract ends; and (B) subject to applicable law, reduce the fees the participating provider is otherwise entitled to receive from the organization under the contract between the participating provider and the organization during the time period described herein.
U.C.A. § 31A-8-407

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.