

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

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 at connectiondental.com.

Termination Procedures

Each managed care organization shall establish an appeal process through which a health care provider denied a contract with the managed care organization, or whose contract is not renewed based on its selection criteria, may obtain review of that decision. The appeal process shall include written notification to the provider of the decision against allowing contracting, or against renewal of a contract, which shall include a statement of the reasons for the managed care organization's decision not to contract or to renew the contract. It shall also include reasonable time limits for taking and resolving the appeals, and a reasonable opportunity for providers to respond to the managed care organization's statement of reasons supporting its decision not to contract or to renew a contract. Appeal information related to network decisions denying providers entry into the Connection Dental Network is in the Credentialing and Recredentialing Policies and Procedures at connectiondental.com. Appeal information related to network decisions not to continue contracting with providers is in the Provider Manual and the Credentialing and Recredentialing Policies and Procedures at connectiondental.com.

Rule H-2009-03(5.3)(D)

Dispute Resolution Process

Please see Network Appeals/Grievances located in the Provider Manual at connectiondental.com.

Network Participation Procedures

All managed care organizations shall have policies and procedures that clearly state the requirements and responsibilities of the managed care organizations and contracted providers with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality improvement programs, chronic care programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any other applicable provisions required by federal or state law. The managed care organization must allow the provider to participate in the managed care organization's quality management program, dispute resolution process, and utilization management program.

Rule H-2009-03(5.3)(G)

Contracted providers are required to notify GEHA, on behalf of the managed care organizations, of any changes that would impact the provider's credentialing status or ongoing availability to members.

Rule H-2009-03(5.3)(G)

Quality of Care Procedures

All information gathered by the network's Peer Review Committee or in conjunction with the network's quality assurance program shall be maintained as confidential and privileged. If this information is made available to the Department of Banking, Insurance, Securities and Health Care Administration, it will be furnished in a manner that does not disclose the identity of individual patients, health care providers or other individuals, unless otherwise specified by the Department.

Rule H-2009-03(1.5)(A) and Rule H-2009-03(1.5)(B)

Claims Procedures

The specific web address that will link to Payors' contact information, including telephone, fax and e-mail is: connectiondental.com/pdfs/vermontpayor.pdf.

18 V.S.A. § 9418c

No later than 30 days following receipt of a claim, a health plan, contracting entity, or payer shall do one of the following: 1) Pay or reimburse the claim; 2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim.

If a claim is contested because the health plan, contracting entity, or payer was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by this section, then the health plan, contracting entity, or payer shall have 30 days after receipt of the additional information to complete consideration of the claim.

A health plan, contracting entity or payer shall acknowledge receipt of an electronic claim to the submitting party within 24 hours after the beginning of the next business day following receipt of the claim. For purposes of this subsection, the term "submitting party" means: 1) a health care provider submitting a claim to a contracting entity, health plan, or payer; or 2) a clearinghouse submitting a claim on behalf of a health care provider to a contracting entity, health plan, or payer.

Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows: 1) For a claim that is uncontested, from the first calendar day following the 30-day period following the date the claim is received by the health plan, contracting entity, or payer; 2) For a nonelectronic contested claim for which notice was provided as required by this section, or for an electronic contested claim for which notice and acknowledgment were provided as required in this section, from the first calendar day after the 30-day period following the date that sufficient additional information is received; 3) For a nonelectronic contested claim for which notice was not provided as required by this section or for which notice was provided later than the 30 days required by this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer; 4) For a contested electronic claim, for which notice and acknowledgment were not provided as required by this section, or for which notice or acknowledgment were provided later than the time required by this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer; 5) For a claim that was denied or for which notice of denial was provided as required by this section, from the first calendar day after the 30-day period following the date of a final arbitration award, judgment, or administrative order that found a plan, contracting entity, or payer to be liable for payment of the claim; 6) For a claim that was denied, for which notice of denial was not provided as required by this section, or for which notice was provided later than the 30 days required by this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

The commissioner may suspend the accrual of interest under this section if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall

provide notice as required by this section and pay interest on uncontested and contested claims as required in this section from the day following the contract payment period, unless otherwise specified in the contract.

A health plan in this state shall not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim, unless: 1) The health plan has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to the provider. The notice must include: A) the patient's name; B) the service date; C) the payment amount; D) the proposed adjustment; and E) a reasonably specific explanation of the proposed adjustment; 2) The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

The retrospective denial of a previously paid claim shall be permitted beyond 12 months from the date of payment for any of the following reasons: 1) The plan has a reasonable belief that fraud or other intentional misconduct has occurred; 2) The claim payment was incorrect because the health care provider was already paid for the health services identified in the claim; 3) The health care services identified in the claim were not delivered by the provider; 4) The claim payment is the subject of adjustment with another health plan; or 5) The claim is the subject of legal action.

[F]or routine recoveries as described in this subdivision, retrospective denial or overpayment recovery of any or all of a previously paid claim shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies: A) Duplicate payment to a health care provider for the same professional service; B) Payment with respect to an individual who was not a plan member as of the date the service was provided; C) Payment for a noncovered service, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism; D) Erroneous payment for services due to plan administrative error; E) Erroneous payment for services where the claim was processed in a manner inconsistent with the data submitted by the provider; F) Payment where the health care provider provides the plan with new or additional information demonstrating an overpayment; G) Payment to a health care provider at an incorrect rate or using an incorrect fee schedule; H) Payment of claims for the same plan member that are received by the health plan out of the chronological order in which the services were performed; I) Payment where the health care provider has received payment for the same services from another payer whose obligation is primary; or J) Payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the claim.

Notwithstanding the above, recoveries which, in the reasonable business judgment of the payer, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more of the situations in this subsection apply.

Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner relating to claims administration and adjudication standards, and rules adopted by the commissioner relating to pay for performance or other payment methodology standards.

The provisions of this section shall not apply to stand-alone dental plans licensed to do business in Vermont.
18 V.S.A. § 9418

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

The health care provider is not prohibited from disclosing to members or potential members information about the contract or the members' health benefit plan that may affective their health or any decision regarding health.

Rule H-2009-03(5.3)(B)

Required Content in Contract

A Summary Disclosure Form of the provider contract is located on the last page of this document.

18 V.S.A. §9418c(b)(5)

Participating Providers authorize GEHA to contract with Payors, or with entities on behalf of Payors, to make Participating Providers' services available to Payors upon the same terms and conditions that such services are made available to GEHA pursuant to the agreement.

18 V.S.A. §9418f(d)(1)(A)

Provider agrees that in no event, including nonpayment by the managed care organization, insolvency of the managed care organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than the managed care organization) acting on behalf of the member 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 certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members. This agreement does prohibit the provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Banking, Insurance, Securities and Health Care Administration pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug.

H-2009-03(5.3)(L)

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 DISCLOSURE FORM

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.

1. Compensation terms

Manner of payment: Fee for service

The reimbursement schedule is attached to the Participating Provider Agreement.

Claim edit information is available by calling GEHA's Client Relations Department at (877) 277-6872, and you will be directed to the Payor's toll free telephone number, fax number or email address or website address.

2. List of products, product types, or networks covered by this contract (fill in names as applicable): PPO Plans

The term of this contract is referenced in Section 3.2. The initial term terminates on December 31st following the first anniversary date, but the agreement renews for an additional calendar year unless terminated by either party.

Termination notice period – Sections 3.2 through 3.5. – 30 days for immediate termination, 90 days for ending at the end of the then current term, and 90 days for termination without cause or termination for default. Automatic terminations are effective on the date of the occurrence of the event.

3. Contracting entity, covered entity, or Payor responsible for processing payment available at connectiondental.com under the Payor Info tab, Vermont Payor Policies.

4. Internal mechanism for resolving disputes regarding contract terms available in Section 3.17 of the Participating Provider Agreement and in the Provider Manual at connectiondental.com.

5. Addenda to contract (list addenda, if any): Not applicable.

6. Telephone number to access a readily available mechanism, such as a specific website address, to allow a participating provider to receive the information listed above from the Payor: (877) 277-6872

7. Rental network information is available at connectiondental.com under the Payor Info tab, Vermont Payor Policies.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form 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 Disclosure Form 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 pursuant to 18 V.S.A. § 9418d. You are encouraged to read any proposed amendments that are sent to you after execution of the Participating Provider Agreement.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.