Washington State Addendum to Participating Provider Agreement
GEHA Policies & Procedures
Connection Dental Network ("Network")
State Specific Policies & Procedures - State of Washington

This Addendum ("Addendum") to the Participating Provider Agreement ("Participating Provider Agreement") is made in accordance with section 3.11 of the Participating Provider Agreement. This Addendum only applies to dental plans that are subject to the applicable laws of the State of Washington and completely supersedes the applicable provisions of the Participating Provider Agreement to the contrary. This Amendment also applies to any providers or facilities subcontracting with Participating Provider to provide services to Covered Enrollees pursuant to the terms of the Participating Provider Agreement. [Source: WAC 284-170-401]

Alternative dispute resolution, such as mediation and arbitration, is not binding and is not required to the exclusion of judicial remedies.

The Participating Provider Agreement shall be governed by and construed in accordance with the laws of the State of Washington and any applicable federal law(s). The substantive law of Washington shall solely govern this Addendum and the Participating Provider Agreement, and no cause of action not specifically recognized in the State of Washington shall be implied or construed to exist.

As used herein, "Covered Enrollee" means any person who is eligible to receive dental benefits offered by GEHA or an entity that has an agreement with GEHA to access the CONNECTION Dental Network.

As used herein, "Carrier" is defined as meaning a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

As used herein, "GEHA" means Government Employees Health Association, Inc.

As used herein, "Network" or "CONNECTION Dental Network" means the national network of Participating Providers called CONNECTION Dental Network.

As used herein, "Participating Provider" means the dentist who has contracted with GEHA to participate in the Connection Dental Network.

As used herein, "Payor" means the party responsible for providing reimbursement for dental care services.

As used herein,"Connection Dental Network Payor List" means the listing available to providers which identifies payors or networks who lease the Connection Dental Network.

Provider Manual

All references to the Provider Manual in the Participating Provider Agreement are hereby deleted.

Carrier Claims/Billing Disputes regarding Benefits or the Payment of Benefits

The Carrier is responsible for accepting premiums and the payment of claims. Complaints and disputes regarding benefits or payment of claims must be addressed with the Carrier with whom GEHA contracts to provide its non-risk bearing network, CONNECTION Dental Network. Any Participating Provider may contact GEHACDWAA29

GEHA representatives for more information as to how to contact the appropriate Carrier representative to address any issues. The Carrier policies and procedures for complaints or disputes regarding benefits or payment of claims are located under Connection Dental Payor Policies in the Resource tab on the CONNECTION Dental Network website at connectiondental.com.

The Appeals/Disputes Section below modifies Sections 3.2 and 3.3 of the Participating Provider Agreement such that the appeals policy below will be followed.

Network Participation Appeals/Disputes [Source: WAC 284-170-440; RCW 48.43.055]

Except as otherwise provided in the Participating Provider Agreement, this section applies to all claims and disputes between Participating Provider and GEHA that involve professional conduct or competence, which result in a change in Participating Provider's participation in the Network. Any billing disputes or adverse benefit determinations shall be resolved under the Carrier's policies. While the processes described below are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

Network Participation First and Second Level Appeal Panels.

(a) Within thirty (30) days of the action giving rise to the Network participation dispute or controversy, the Participating Provider shall submit a written complaint initiating this dispute resolution process to GEHA at the address specified below. The complaint shall describe the issue in dispute or controversy and include any supporting documentation relevant to the issues raised.

(b) GEHA shall designate a "First Level Appeal Panel" consisting of three (3) individuals, including at least one (1) Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider submitting the complaint. The First Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within thirty (30) days of receiving the complaint. Written notice of the First Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.

(c) If the Participating Provider is unsatisfied with the result of the First Level Appeal Panel dispute determination, the Participating Provider may have the complaint considered by a "Second Level Appeal Panel" by submitting written notice to GEHA within fifteen (15) days of receipt of the First Level Appeal Panel's decision. The Second Level Appeal Panel shall be composed of at least three (3) individuals, at least one (1) of whom shall be a Participating Provider who is not otherwise involved in Network management and who is a clinical peer of the Participating Provider who submitted the complaint. Further, the Second Level Appeal Panel shall include individuals who were not involved in the decision of the First Level Appeal Panel. The Second Level Appeal Panel shall review the complaint and supporting documentation and render a decision on the matter within thirty (30) days of receiving the written request for a Second Level Appeal. Written notice of the Second Level Appeal Panel's dispute determination shall be delivered to the Participating Provider's address on file.

Alternative Dispute Resolution.

If the Participating Provider is unsatisfied with the result of the Second Level Appeal, Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties.

If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within thirty (30) days of the notice of arbitration, then

as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth in this section. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. GEHA and Participating Provider shall share equally the fees of the arbitrator.

Administrative Appeals/Disputes [Source: WAC 284-170-440; RCW; 48.43.055]

This section applies to the resolution of "administrative disputes" related to the performance or interpretation of any of the provisions of the Participating Provider Agreement, with the exception of billing disputes or adverse benefit determinations, which shall be resolved under the Carrier's policies. While the processes described below are not required to the exclusion of judicial remedies, Participating Provider shall exhaust these processes prior to seeking any judicial remedy.

A Participating Provider shall provide GEHA with written notice of an administrative dispute within thirty (30) days of the action or decision giving rise to the administrative dispute. GEHA shall designate an authorized representative who was not involved in the action or decision giving rise to the dispute to assist in this process. GEHA and Participating Provider shall use best efforts to resolve the administrative dispute. GEHA shall render a written decision regarding the administrative dispute to Participating Provider within thirty (30) days of receipt of the notice of the administrative dispute.

If the Participating Provider is unsatisfied with the result of the resolution of the administrative dispute, the Participating Provider may submit the matter to non-binding mediation. Such mediation shall be conducted under the Washington Uniform Mediation Act (Chapter 7.07 RCW, or any successor law) unless otherwise agreed by the parties.

If any party to the mediation process described above is unsatisfied with the results of this process, it may, by written notice to the other party and to JAMS, submit the dispute to non-binding arbitration before a single arbitrator agreed to by both parties (and if not agreed to within thirty (30) days of the notice of arbitration, then as selected by JAMS). The arbitration shall be conducted in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, except as otherwise set forth in this section. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. GEHA and Participating Provider shall share equally the fees of the arbitrator.

These appeal provisions are solely for resolution of Participating Provider complaints. Complaints by, or on behalf of, a Covered Enrollee are subject to the grievance processes of the Carrier with whom GEHA contracts. [Source: RCW 48.43.055]

Network Appeals, Disputes and/or Complaints

All Network Participating Provider appeals, disputes or complaints, with the exception of billing or adverse benefit determination disputes, should be sent to:

Connection Dental Network
Attn: Supervisor
P.O. Box 6707
Lee's Summit, MO 64064-6707
(800) 505-8880

Termination Procedures

GEHA and Participating Provider shall provide at least sixty (60) days written notice to each other before terminating the Participating Provider Agreement without cause, as required by the State of Washington. (WAC

284-170-421). More specifically, Sections 3.4, 3.5, and 3.6 of the Participating Provider Agreement, as restated below, will apply to provider terminations:

3.4 Either GEHA or the Participating Provider may terminate this Agreement, with or without cause, upon ninety (90) days' prior written notice to the other party, unless prohibited by applicable law. Termination shall be effective on the last day of the month in which the ninety (90) days' notice requirement is met. Further, this Agreement may be terminated if there is a default in the performance of the terms and conditions of this Agreement which default has not been cured within ninety (90) days following the effective date of written notice of default.

3.5 Notwithstanding Paragraph 3.4, GEHA may terminate the Agreement immediately for any of the following reasons: (a) Any falsification of any information on the Participating Provider's application submitted to GEHA or fraud committed on any documentation; (b) Any finding of unlawful or unprofessional conduct, as defined by state or federal law(s); or (c) Institution of bankruptcy, receivership, insolvency, liquidation or other similar proceedings by or against the Participating Provider; or (d) Any finding that a Participating Provider committed professional misconduct or caused a patient harm; or (e) Membership in the GEHA CONNECTION Dental Network and/or privileges granted to Participating Provider are terminated, revoked, restricted, suspended, discontinued or not renewed pursuant to GEHA Credentialing and Recredentialing Policies and Procedures; or (f) Noncompliance with HIPAA.

3.6 GEHA shall notify Participating Provider in writing of the reason for Participating Provider's involuntary termination, if applicable. Upon termination, the Participating Provider shall be entitled to those rights of appeal or grievance as set forth in the policies and procedures of GEHA if Participating Provider is entitled to such appeal or grievance pursuant to said policies and procedures. Further, Participating Provider shall not be entitled to such appeal and grievance policies and procedures if such policies and procedures have previously been implemented with respect to Participating Provider. If applicable, GEHA and Participating Provider agree to follow such policies and procedures. Notwithstanding other provisions in this Article III, GEHA and Participating Provider agree to abide by the laws of any applicable state which may apply to terminations. Participating Provider shall be obligated to complete a course of treatment begun prior to the effective date of termination.

Whether the termination was for cause, or without cause, GEHA will work with the appropriate carrier to ensure written notice of a termination is provided at least thirty days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty days' notice to a provider or carrier to all enrollees who are patients seen:

(a) On a regular basis by a specialist;

(b) By a provider for whom they have a standing referral; or

(c) By a primary care provider.

[Source: WAC 284-170-421 (10]

Network Participation Procedures

In developing its Network of Participating Providers, GEHA shall not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered as essential health benefits, as defined in WAC 284-43-5640, WAC 284-43-5642 and RCW 48.43.715. To the extent that BHP would cover a dental condition, GEHA may not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless

such services would not meet the GEHA's standards regarding: (1) the provision, utilization review and cost containment of health services; (2) the management and administrative procedures; and (3) the provision of cost-effective and clinically efficacious health services. [Source: WAC 284-170-270(1)]

GEHA is not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers or from using restricted networks. If GEHA contracts with Carriers offering plans with restricted networks, it may select the individual providers in any category of provider with whom they will contract or reimburse. [Source: WAC 284-170-270(4)]

Whistleblower Protection

GEHA will not penalize a Participating Provider because the Participating Provider, in good faith, reports to state or federal authorities any act or practice by the Carrier or by GEHA that jeopardizes patient health or welfare or that may violate state or federal law. [Source: WAC 246-15-001]

Claims Procedures and Reimbursements for Providers Upon Completion of Credentialing Process
Participating Providers can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits, by calling the telephone number on the back of the member identification card or by calling the Carrier with whom GEHA contracts to provide the Network. Participating Providers may also call GEHA’s Client Relations Department at (877) 277-6872 to obtain Carrier telephone numbers. Nothing contained in GEHA's Participating Provider Agreement may have the effect of modifying benefits, terms, or conditions contained in the Carrier's health plan. In the event of any conflict between the Participating Provider Agreement and the Carrier's health plan, the benefits, terms, and conditions of the health plan shall govern with respect to coverage provided to Covered Enrollees. [Source: WAC 284-170-421 (3)(c)

Participating Providers will adhere to the accepted standards of care for health care providers when arranging for the provision of medically necessary health care services, and GEHA shall not be responsible for determining such standards. When a Participating Provider works with the Carrier who contracts with GEHA for the provider network to make arrangements for the health care services, if the Carrier fails to follow the accepted standard of care, the Carrier will be liable for any and all harm caused to an enrollee when the failure resulted in the denial, delay or modification of the health care services recommended for or furnished to an enrollee. This liability cannot be shifted, waived or modified by contract to Participating Provider or to GEHA. Furthermore, the duty of the Carrier to ensure that medically necessary care is provided in accordance with accepted standards cannot be delegated to any other entity or person. [Source: RCW 48.43.545]

Under Washington law, if Participating Provider is found to have willfully collected or attempted to collect an amount from a Covered Enrollee knowing that collection to be in violation of the Participating Provider Agreement, Participating Provider is guilty of a class C felony under RCW 48.80.030(5) [Source: WAC 284-170-421].

Overpayment Recovery –Except in the case of fraud, an issuer may not request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date payment was made. The time period must be reciprocal. RCW 48.43.600. In the case of COB, the issuer must request a refund from a health care provider of payment previously made to satisfy a claim within 30 months after the date payment was made. Additional refund/payment cannot be requested any sooner than six months after the initial request is made. RCW 48.43.600Any Carrier with whom GEHA contracts may at any time request a refund from a Participating Provider of a payment previously made to satisfy a claim if (a) a third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the Carrier is unable to recover

directly from the third party because the third party has either already paid or will pay the Participating Provider for the health services covered by the claim.

(1) For purposes of this section, “refund” means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a Participating Provider.

[Source: RCW 48.43.600 and RCW 48.43.605]

Reimbursement requirements – Upon Completion of Credentialing Process

(1) Any carrier who delegates credentialing responsibilities to GEHA must reimburse a Participating Provider upon completion of the credentialing process, under the following circumstances:

(a) the carrier must reimburse the health care provider for covered services provided to the carrier's enrollee retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract.
(b) Where a relationship existed between the carrier and the health care provider or the entity for whom the health care provider is employed or engaged at the time the health care provider submitted the completed credentialing application, the carrier must reimburse the health care provider for covered health care services provided to the carrier's enrollees during the credentialing process beginning when the health care provider submitted a completed credentialing application to the carrier.

(2) The health carrier must reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed by the carrier.

(3) Nothing in this section requires reimbursement of health care provider-rendered services that are not benefits or services covered by the health carrier's health benefit plan.

(4) Nothing in this section requires a health carrier to pay reimbursement for any covered medical services provided by a health care provider applicant if the health care provider's credentialing application is not approved or if the carrier and health care provider do not enter into a contractual relationship. RCW 48.43.757

General Standards [Source: WAC 284-170-421]

(1) Participating Provider hereby agrees that in no event, including, but not limited to nonpayment by a Carrier, a Carrier’s insolvency, or breach of the Participating Provider Agreement, shall a Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Enrollee or person acting on their behalf, other than a Carrier, for services provided pursuant to the Participating Provider Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance and/or non-covered services, which have not otherwise been paid by a primary or secondary Carrier in accordance with regulatory standards for coordination of benefits, from Covered Enrollees in accordance with the terms of the Covered Enrollee’s health plan. [Source: WAC 284-170-421(a)]
(2) Participating Provider agrees, in the event of a Carrier’s insolvency, to continue to provide the services promised in the Participating Provider Agreement to Covered Enrollees of the Carrier for the duration of the period for which premiums on behalf of the Covered Enrollee were paid to the Carrier or until the Covered Enrollee’s discharge from inpatient facilities, whichever time is greater. [Source: WAC 284-170-421(b)]
(3) Notwithstanding any other provision of the Participating Provider Agreement, nothing in the Participating Provider Agreement shall be construed to modify the rights and benefits contained in the Covered Enrollee’s health plan. [Source: WAC 284-170-421(c)]

(4) Participating Provider may not bill the Covered Enrollee for covered services (except for deductibles, copayments, or coinsurance) when a Carrier denies payments because the Participating Provider has failed to comply with the terms or conditions of the Participating Provider Agreement. [Source: WAC 284-170-421(d)]
(5) Participating Provider further agrees: (i) that sections (1)–(4) above shall survive termination of the Participating Provider Agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of a Carrier's Covered Enrollees, and (ii) that sections (1)-(4) above supersede any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and Covered Enrollees or persons acting on their behalf. [Source: WAC 284-170-421(e)]
(6) If Participating Provider contracts with other providers or facilities that agree to provide covered services to Covered Enrollees of a Carrier with the expectation of receiving payment directly or indirectly from a Carrier, such providers or facilities must agree to abide by sections (1)-(5), above. [Source: WAC 284-170-421(f)]
(7) Every GEHA Participating Provider Agreement entered into in the State of Washington must set forth a schedule for the prompt payment of amounts owed by the Carrier to the Participating Provider and will include penalties for Carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards below:
    (a) For health services provided to Covered Enrollees, Participating Providers must be paid as soon as practical but subject to the following minimum standards:
        (i) Ninety-five percent of the monthly clean claims shall be paid within thirty (30) days of receipt by the responsible Carrier; and
        (ii) Ninety-five percent (95%) of the monthly claims shall be paid or denied within sixty (60) days of receipt by the responsible Carrier. [Source: WAC 284-170-431(1), (2)(a)(i)(ii)]
    (b) The receipt date of a claim is the date the responsible Carrier or its agent receives either written or electronic notice of the claim. [Source: WAC 284-170-431(2)(b)]
    (c) The Carrier with whom GEHA contracts will establish a reasonable method for confirming receipt of claims and responding to Participating Provider inquiries about claims. The Carrier will provide information to Participating Providers with regard to the method of confirmation by including the information in its policies and procedures which will be available through the CONNECTION Dental network website at connectiondental.com under Washington Payor Policies at the Payor Info tab. [Source: WAC 284-170-431(c)]
    (d) If a Carrier fails to pay claims within the standard established by Washington law, the Carrier is responsible for paying interest on undenied and unpaid clean claims more than sixty-one (61) days old.[Source: WAC 284-170-431(d)]
    (e) Interest shall be assessed at the rate of one percent per month and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person. [Source: WAC 284-170-431 2 (d)]
    (f) When the Carrier issues payment in either the Participating Provider or facility and the Covered Enrollee names, the Carrier shall make claim checks payable in the name of the Participating Provider or facility first and the Covered Enrollee second. [Source: WAC 284-170-431(e)]
(8) For purposes of section (7) above, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section. [Source: WAC 284-170-321(3)]

(9)

Denial of a claim must be communicated to the Participating Provider by the Carrier on an Explanation of Benefits and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, the Participating Provider must be given information supporting basis for the decision upon his or her request. For example, the Carrier must describe how the claim failed to meet medical necessity guidelines. [Source: WAC 284-170-431(4)]
Every Carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the Carrier or acting pursuant to Carrier standards or requirements complies with all billing and claim payment standards set forth at WAC 284-170-431. [Source: WAC 284-170-431(5)] Further, Carriers must follow the utilization review standards set forth at WAC 284-43-2000 and standards for coordination of benefits set forth at WAC 284-170-431 and WAC 284-51-215.

These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Participating Providers, facilities or Covered Enrollees, or instances where the Carrier has not been granted reasonable access to information under the Participating Provider's or facility's control. [Source: WAC 284-170-431(6)]

(10)Participating Providers, facilities, and Carriers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute. [Source: WAC 284-170-431(7)}

(11)Every Carrier will their post their written statement relative to the process for a prescription exception on the Connection Dental website, under their respective Payor tab. [Source: RCW 48.43.420 (1)]

(12)If a Participating Provider intends to bill a patient or the patient's health plan for an audio-only telemedicine service, the Provider must obtain patient consent for the billing in advance of the being delivered. [Source: RCW 48.43.735]. If is not obtained, disciplinary action could be taken against the provider. [Source: WAC 284-170-433(8)(a), RCW 48.43.735 (8)(a)(b)(c).]

(13))No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service. Further, no health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

Participating Providers will have the ability to review any and all documents, payor lists, procedures, and other administrative policies and programs referenced in the Participating Provider Agreement prior to entering into the Participating Provider Agreement at the Network website at connectiondental.com. The Network's policies and procedures (Provider Manual), as well as carrier specific policies are located on the Connection Dental Network website under the Resource tab. The Network shall give Participating Providers reasonable written notice of not less than sixty (60) days of changes that affect Participating Provider compensation, and the Carriers shall give Participating Providers reasonable notice of not less than sixty (60) days of changes that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as

possible. Subject to any termination and continuity of care provisions of the Participating Provider Agreement, a Participating Provider may terminate the Participating Provider Agreement without penalty if the Participating Provider does not agree with the changes. No change to the Participating Provider Agreement may be made retroactive without the express consent of the Participating Provider. [Source: WAC 284-170-421]

Participating Providers can view the Connection Dental Network Payor List, which is updated every 30 days, by accessing the Resources tab at www.connectiondental.com or may be obtained by calling 800-505-8880. This listing is included in Welcome letter packets when a new provider enters into a contract with Connection Dental Network. Not all employer groups associated with these Payors will utilize the Connection Dental network. Therefore, it is crucial to verify benefits and eligibility with the insurer and/or Payor prior to performing services. A Provider should contact a Payor or network directly for information regarding participation status or reimbursements within each of the network plans or products, and/or for a complete list of all network plans and products the Payor offers to consumers, as applicable. [Source: WAC 284-170-480 (7).

Participating Provider-Patient Relationship

GEHA will not discourage Participating Providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the Carrier. GEHA does not prohibit, discourage, or penalize any Participating Provider otherwise practicing in compliance with the law from advocating on behalf of a patient with the Carrier; however, nothing in this policy shall be construed to authorize Participating Providers to bind Carriers to pay for any service. GEHA does not preclude or discourage Participating Providers from discussing the comparative merits of different Carriers with their patients or those paying for the patient's coverage. [Source: WAC 284-170-421 (7)(a) and (b)]

Books and Records

Participating Provider shall make health records available to appropriate State and Federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Enrollees subject to applicable State and Federal laws related to the confidentiality of medical records. [Source: WAC 284-170-421(8)]

Non-Discrimination

Participating Provider shall furnish services to Covered Enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply when Participating Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. [Source: WAC 284-170-421(11)]

Reporting

GEHA shall not penalize Participating Provider because Participating Provider, in good faith, reports to State or Federal authorities any act or practice by GEHA or a Carrier that jeopardizes patient health or welfare or that may violate State or Federal law. [Source: WAC 284-170-421(12)]

Contracting Outside of Plan

Notwithstanding any other provision of law, a Carrier may not prohibit directly or indirectly Covered Enrollees from freely contracting at any time to obtain any health care services outside their health care plan on any

terms or conditions the Covered Enrollees choose. Nothing in this section shall be construed to bind any Carrier for services delivered outside the health plan. [Source: RCW 48.43.085

Audit Guidelines

Carriers shall not have access to health information and other similar records of Participating Provider unrelated to Covered Enrollees. Any access to patient records of Participating Provider by a Carrier shall be limited to only that necessary to perform the audit. This provision shall not limit a Carrier's or GEHA's right to ask for and receive information relating to the ability of the Participating Provider to deliver health care services that meet the accepted standards of care in the prevalent community. Carriers shall provide a complete record of Participating Provider's claim activity upon request by the Participating Provider. [Source: WAC 284-170-460]

Medicare or Medicare Advantage

Participating Providers in the Connection Dental Network who provide care or treatment to Medicare or Medicare Advantage Covered Enrollees must: (1) comply with, and require any subcontractors to comply with, all applicable Medicare laws, regulations, and CMS instructions and agree that any services provided by Participating Provider or his/her subcontractors to Covered Enrollees will be consistent with and comply with Medicare Advantage Organizations' contractual obligations;
(2) comply with all applicable Federal laws and regulations, including, but not limited to: Federal Criminal law; the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act);
(3) acknowledge that Medicare Advantage Organizations shall oversee and is/are accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards. Further, Participating Provider acknowledges that Medicare Advantage Organizations may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §422.504(i)(4).
(4)acknowledge that the Department of Health and Human Services, the Comptroller General, or their designees have the right to audit, evaluate, or inspect any books, contracts, computer or other electronic systems (including medical records and documentation of first tier, downstream, and entities related to CMS's contract with Medicare Advantage Organizations), patient care documentation, and other records of Participating Providers, subcontractors or transferees involving transactions related to the Medicare Advantage program through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable law, whichever is later. Dentist agrees to provide all information necessary for Medicare Advantage Organizations to meet data reporting and submission obligations to CMS and data necessary for the Medicare Advantage Organizations to meet reporting requirements under 42 CFR §422.516 and §422.310. Participating Provider must also make available Participating Provider's office, premises, physical facilities and equipment, records relating to patients, and any additional relevant information that CMS may require.;
(5) maintain related records for ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable period, whichever is later; (6) maintain accurate and complete dental records and other information with respect to Covered Enrollees in an accurate and timely manner and ensure timely access by Covered Enrollees to the records and information that pertain to them.
(7) ensure that services are provided in a culturally competent manner to all Covered Enrollees, including those with limited English proficiency, limited reading skills or hearing incapacity, and those with diverse cultural and ethnic backgrounds.
(8) for all Covered Enrollees eligible for both Medicare and Medicaid, Participating Provider agrees that: Covered Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts; cost sharing will not be imposed that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Further, Participating Provider will:

(1) accept the Medicare Advantage plan payment as payment in full, or
(2) bill the appropriate State source.

This section is required by the U.S. Office of Personnel Management

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. [Source: 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. [Source: 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. [Source: 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. [Source: FEDVIP Technical Guidance, Amendment 0005]

The policies and procedures described in this Addendum 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. (GEHA) owns and operates the CONNECTION Dental Network, which is a non-risk bearing PPO network.

The above requirements related to Carriers are the responsibility of the Carrier with whom GEHA contracts and not GEHA or the CONNECTION Dental Network.

Last updated January 2, 2023