

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

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

With exceptions, a defined network plan shall, with respect to covered benefits, provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the defined network plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee during the most recent open enrollment period, or if there is no open enrollment period, at the time of the enrollee's enrollment or most recent coverage renewal, whichever is later.

W.S.A. 609.24

Dispute Resolution Process

Please see Network Appeals/Grievances.

Network Participation Procedures

No provider may be required to participate exclusively in a health care plan as a condition of participation in it. Except for exclusion for cause related to the practice of his or her profession, no provider may be denied the opportunity to participate in a health care plan, other than a health maintenance organization, a limited service health organization or a preferred provider plan, under the terms of the plan.

W.S.A. § 628.36

No insurer may refuse to provide or pay for benefits for health care services provided by a licensed health care professional on the ground that the services were not rendered by a physician as defined by law, unless the contract clearly excludes services by such practitioners, but no contract or plan may exclude services in violation of the following. No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed dentist within the scope of the dentist's license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by another health care provider, as defined by applicable law.

W.S.A. § 632.87

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

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

No state-specific requirements.

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 networks. 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 January 13, 2017.