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

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.

Third Party Access to the Provider Network

This contract grants third-party access to the Connection Dental Network. The provider network contracting entity has entered into an agreement with other dental plans or third parties that allows the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. The list of all third parties with access to the Connection Dental Network can be found at https://www.connectiondental.com/ and clicking on the Resource Tab.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures
A plan is required to disclose the reasons for the termination of a contract with a provider to the provider only when the termination occurs during the contract year. A plan that is terminating a provider's contract for quality-of-care reasons is required to state specifically what those reasons are.
Cal. Health & Safety Code § 1373.65

Dispute Resolution Process
Please see Network Appeals/Grievances.

CONNECTION Dental Network
Attn: Provider Relations Department
P.O. Box 6707
Lee's Summit, MO 64064
(800) 505-8880

Knox-Keene Health Care Service Plan Act.

SECTION 1.
(a) The Legislature finds and declares the following:
(1) Health care services must be available to Californians without unnecessary administrative procedures, interruptions, or delays.
(2) As of May 2002, the Department of Insurance estimated that it regulated insurers covering 28.79 percent of the total accident and health care market and that, with respect to those commercial products that are comparable between the Department of Insurance and the Department of Managed Health Care regulated products, the Department of Insurance regulated 16.8 percent of the comprehensive commercial health insurance provided to Californians.
(3) With two separate departments responsible for regulating entities that provide health care coverage, patients and their health care providers are often confused about the identity of the appropriate regulator.

(b) It is the intent of the Legislature to reduce confusion about the identity of the appropriate regulator, to provide all patients who have health care coverage and their health care providers with an easy and effective mechanism within the Department of Insurance to effectively resolve complaints as already intended for health care providers through the Department of Managed Health Care, and to assure the public that the law is properly implemented.

SECTION 2.

This act shall be known and may be cited as the Patient and Provider Protection Act.

SECTION 3.

Section 10123.13 of the Insurance Code is amended to read:

10123.13

(a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason fro contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SECTION 4.

Section 10123.137 is added to the Insurance Code, to read:

10123.137

(a) Each contract between a health insurer and a provider shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer, and requiring the insurer to inform its providers, upon contracting with the insurer, or upon change to these

provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(b) An insurer shall also ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(c) Disputes are to be submitted to the insurer in writing and shall include provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and, if applicable, billed and paid amounts. The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.

(d) On and after July 1, 2007, an insurer shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall be public information and include, at a minimum, information on the number of providers that utilized the dispute resolution mechanism and a summary of the disposition of those disputes. To the extent the commissioner requires detailed information disclosing emerging or established patterns of provider disputes or corrective action by the insurer, the commissioner may maintain the confidentiality of any information found to be proprietary, upon written request of the insurer. In no event shall the commissioner find the required minimum information described in this subdivision to be proprietary.

(e) If an insurer has an affiliated or subsidiary company that is licensed as a health care service plan under Chapter 2.2 (commencing with Section 1340) of the Division 2 of the Health and Safety Code, the insurer may use the same procedures relating to the provider dispute resolution process established by the affiliated or subsidiary entity pursuant to subdivision (h) of Section 1367 of the Health and Safety Code.

SECTION 5.

Section 10123.147 of the Insurance Code is amended to read:

10123.147

(a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at the time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first

calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefore.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to claimant, with requiring a request therefore.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

California Insurance Code

<u>Network Participation Procedures</u>
None.

<u>Quality of Care Procedures</u>
None.

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

California law prohibits a person or entity from publicly posting or displaying an individual's social security number, printing the number on a card required for access to services or products, putting the number on materials mailed to the individual or otherwise requiring someone to utilize the number. Existing law is amended to include a provision that prohibits a social security number that is otherwise permitted to be mailed out from being printed, in whole or in part, on a postcard or other mailer or visible on the envelope or without the envelope having been opened.
Ann.Cal.Civ.Code § 1798.85

Required Content in Contract
California Insurance Code § 10133.15 (j)(1)(2)(3) and California Health and Safety Code § 1367.27.

1. Participating Provider shall inform CONNECTION Dental Network within five (5) business days if either of the following occurs:

a. The Provider is not accepting new patients; or
b. If the Provider had previously not accepted new patients, the Provider is currently accepting new patients.

2. If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both GEHA/Connection Dental for additional assistance in finding a provider and to the California Department of Insurance to report any inaccuracy in a directory.

3. If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory, the plan shall promptly investigate, and if, necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory.

GEHA shall not prohibit, restrict, or limit a health care provider from advertising.
Ann.Cal.Bus. & Prof.Code § 512

Contracting agents that sell, lease, assign, transfer or convey their lists of contracted health care providers and their contracted reimbursement rates to a payor or another contracting agent must make various disclosures to the provider upon entering into or renewing a provider contract.
Ann.Cal.Bus. & Prof.Code § 511.1

CONNECTION Dental Network, as a contracting agent in California, hereby makes the following disclosures:

1) The CONNECTION Dental Network's list of contracted providers may be leased to other payors or contracting agents that do not include workers' compensation insurers or automobile insurers.
2) Payors actively encourage its beneficiaries to use the list of contracted providers when obtaining medical care by offering direct financial incentives to the beneficiaries to use the contracted providers. Payors either provide information directly to beneficiaries advising them of the existence of the list of contracted providers or make this information available to beneficiaries prior to their selection of a health care provider. The list of contracted providers includes the names, addresses and telephone numbers of the providers.
3) Payors to which the list of contracted providers may be leased are required to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care through the use of directories and financial incentives.
4) Upon execution of a Participating Provider Agreement or within 30 days of a written request from a provider or provider panel, the network shall disclose a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent. California S.B. 559, Section 1(b).

Contracting agents are required to allow providers to decline to be included in a list of providers sold, leased, transferred or conveyed to payers that do not actively encourage beneficiaries to use the provider network. If a provider requests that he not be included in a particular payor list, then the contracting agent cannot exclude the provider from any other list of network providers available to any other payor.
Ann.Cal.Bus. & Prof.Code § 511.1

If a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.
Ann.Cal.Bus. & Prof.Code § 511.3

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 January 15, 2020.