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

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 and/or website, as specified in Participating Provider Agreement..

Terminations Procedures
Participating Providers must give at least 60 days advance notice of any proposed termination of a Participating Provider Agreement.
HRS § 432:1-407

Dispute Resolution Process
Please see Network Appeals/Grievances and/or website, as specified in Participating Provider Agreement..

Network Participation Procedures
No state-specific requirements.

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
Unless shorter payment timeframes are otherwise specified in a contract, an entity shall reimburse a claim that is not contested or denied not more than thirty calendar days after receiving the claim filed in writing, or fifteen calendar days after receiving the claim filed electronically, as appropriate. If a claim is contested or denied or requires more time for review by an entity, the entity shall notify the health care provider in writing or electronically not more than fifteen calendar days after receiving a claim filed in writing, or not more than seven calendar days after receiving a claim filed electronically, as appropriate. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information; provided that a notice shall not be required if the entity provides a reimbursement report containing the information, at least monthly, to the provider. If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than thirty calendar days after receiving the additional information in writing, or not more than fifteen calendar days after receiving the additional information filed electronically, as appropriate. Payment of a claim under this section shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment, as applicable. Interest shall be allowed at a rate of fifteen per cent a year for money owed by an entity on payment of a claim exceeding the applicable time limitations under this section. Any interest that accrues in a sum of at least $2 on a delayed clean claim in this section shall be automatically added by the entity to the amount of the unpaid claim due the provider. HRS § 431:13-108

Every entity shall implement and make accessible to providers a system that provides verification of enrollee eligibility under plans offered by the entity.
HRS § 431:13-108

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

<u>Provider-Patient Relationship</u>
In order to inform enrollees, Participating Providers shall discuss all treatment options with an enrollee, including the option of no treatment at all; ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and discuss all risks, benefits, and consequences to treatment and nontreatment. The provider shall discuss with the enrollee and the enrollee's immediate family both advanced health-care directives and durable powers of attorney in relation to medical treatment. Managed care plans shall not impose any type of prohibition, disincentive, penalty or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the managed care plan.
HRS § 432E-4

Required Content in Contract

Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, 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 covered person or person other than the health carrier or intermediary, as applicable, acting on behalf of the covered person 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 evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons; provided that a provider shall not bill or collect from a covered person or a person acting on behalf of a covered person any charges for non-covered services or services that do not meet the criteria in section 432-1.4, Hawaii Revised Statutes, unless an agreement of financial responsibility specific to the service is signed by the covered person or a person acting on behalf of the covered person and is obtained prior to the time services are rendered. This agreement does not prohibit a provider, except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person; provided that the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy. HRS § 431 D

The provider's obligation to not balance bill, as specified in Section 2.1 (d) of the Participating Provider Agreement shall continue until the earlier of:

(1) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or (2) in the event of GEHA or Payor's insolvency, the date the Agreement between GEHA and the Participating Provider, including any required extension for covered persons in an active course of treatment, would have terminated if GEHA or the Payor had remained in operation.

GEHA will provide timely notice to provider in the event a material change to the contract becomes necessary, subject to the definitions below:

A material change is defined as a decrease in the Fee Schedule.
Timely notice is defined as 60 days written notice prior to the effective date of the fee schedule change.

GEHA will not penalize a provider when, in good faith, the provider reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

When the Provider leaves the network, either voluntarily or involuntarily, the provider shall supply the health carrier with a list of the Provider's patients that are covered by a health plan.

At the time the contract is signed, GEHA will notify the participating provider in a timely manner of provisions and documents which are incorporated by reference, subject to the following definitions below:
Timely notice is defined as the date the Welcome letter and onboarding materials are sent to participating provider
HRS § 431 D

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.

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