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

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
No state-specific requirements.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
When the terms "physician" and/or "doctor" are used in any health insurance policy, terms shall include within their meaning dentists and dental hygienists licensed in accordance with state law in respect to any care, services, procedures, or benefits covered by policy of insurance or health care contract.
Ala. Code §27-1-11

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
Each insurer, health service corporation, and health benefit plan that issues or renews any policy of accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by Alabama health care providers within 45 calendar days upon receipt of a clean written claim or 30 calendar days upon receipt of a clean electronic claim. If the insurer, health service corporation, or health benefit plan is denying or pending the claim, the insurer, health service corporation, or health benefit plan shall, within 45 calendar days for a written claim and 30 calendar days for an electronic claim, notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. Any undisputed portion of the claim shall be paid in accordance with the foregoing schedule. If the insurer, health service corporation, or health benefit plan fails to provide the notice to the health care provider of the reason for denying or pending the claim, then any such claim, if and when determined to be payable, shall accrue interest at the rate as provided herein, from the date such notice should have been given in accordance with this provision. Upon receipt of the necessary information, the claim must be paid, denied, or otherwise adjudicated within 21 calendar days from the receipt of the requested information. The failure of an insurer, health service corporation, or health benefit plan to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment to providers. For the purposes of this section, an insurer, health service corporation, or health benefit plan domiciled outside of the State of Alabama is deemed to be subject to

the provisions of this section if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of patients, insureds, or beneficiaries who reside in the State of Alabama or who receive health care services in the State of Alabama.
Ala. Code 1975 § 27-1-17

With exceptions, any claim which has not been denied with notice, made pending with notice, or paid to the provider by the insurer, health service corporation, or the health benefit plan shall be overdue if the notice or payment is not received by the provider within the time periods specified. No further notice by the provider to the insurer, health service corporation, or health benefit plan shall be required under this section. If the insurer, health service corporation, or health benefit plan fails to deny or pay a clean written claim or clean electronic claim within the time periods, then the following shall occur: The amount of the overdue claim shall include an interest payment of 1.5 percent per month prorated daily which shall accrue from the date the payment was overdue and which shall be payable at the time that the claim is paid. The following are exceptions to the requirements of this section:

(1) No insurer, health service corporation, or health benefit plan shall be in violation of this section for a claim submitted by a health care provider if any of the following circumstances apply:
    a. Failure to comply is caused by a directive from a court or a federal or state agency.
    b. The insurer, health service corporation, or health benefit plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation.
    c. Compliance by the insurer, health service corporation, or health benefit plan is rendered impossible due to matters beyond its control which were not caused by such insurer, health service corporation, or health benefit plan or caused by any third party vendor, agent, or contracting party furnishing services to the insurer, health service corporation, or health benefit plan which are related directly or indirectly to the processing of claims by such insurer, health service corporation, or health benefit plan.
(2) No insurer, health service corporation, or health benefit plan shall be in violation of this section for any claim submitted more than 180 days after the service was rendered.
(3) No insurer, health service corporation, or health benefit plan shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an external review process.

Ala. Code 1975 § 27-1-17

An insurer, health service corporation, and health benefit plan shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for health care expenses submitted by a health care provider for any reason, other than fraud or coordination of benefits or for duplicate payments on claims received from the same insurer, health service corporation, or health benefit plan for the same service, after the expiration of one year from the date that the initial claim was paid or after the expiration of the same period of time that the health care provider is required to submit claims pursuant to a contract between the health care provider and an insurer, health service corporation, or health benefit plan, whichever date occurs first. Retroactive denials, adjustments, recoupments, or refunds based on coordination of benefits shall be governed by this law. Notwithstanding any other provision of law or contract to the contrary, if an insurer, health service corporation, or health benefit plan retroactively denies, adjusts, or seeks recoupment or refund of a paid claim, the health care provider shall have an additional period of six months from the date that the notice required by this law was received within which to file either a revised claim or a request for reconsideration with additional medical records or information, and the insurer, health service corporation, or health benefit plan shall process the revised claim or request for reconsideration in accordance with the requirements of this law, or in accordance with U.S. Department of Labor regulations governing the resolution of claims disputes and time for appeals, if applicable. An insurer, health service corporation, or health benefit plan shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim submitted by a health care provider for reasons related to coordination of benefits with another insurer or entity responsible for payment of the claim after the expiration of 18 months from the date that the original claim was paid. If the insurer, health service corporation, or health benefit plan retroactively denies, adjusts, or seeks recoupment or refund of a paid claim based on coordination

of benefits, the insurer, health service corporation, or health benefit plan shall provide the health care provider with notice specifying the reason for the denial, adjustment, recoupment, or refund. If requested by a health care provider, an insurer, health service corporation, or health benefit plan shall furnish any available information concerning the name and address of the entity determined to be responsible for payment of the denied claim. Notwithstanding any other provision of law or contract to the contrary, if an insurer, health service corporation, or health benefit plan retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the health care provider shall have an additional six months from the date that the health care provider received the notice specified herein to submit a claim for reimbursement for the service to the insurer, health service corporation, health benefit plan, medical assistance program, government health benefit program, or other entity responsible for payment for the services provided. An insurer, health service corporation, or health benefit plan that retroactively denies, adjusts, or seeks recoupment or refund of a paid claim submitted by a health care provider shall give the health care provider notice specifying the reason for the action taken. Any retroactive denials, adjustments, or requests for recoupment or refund of previous payments which are based upon medical necessity determinations, level of service determinations, coding errors, or billing irregularities shall be reconciled to specific claims. A health care provider who disputes or contests the basis for the retroactive denial, adjustment, or request for recoupment or refund on all or any portion of a claim shall notify the insurer, health service corporation, or health benefit plan within 30 days after the provider receives the notice that the retroactive denial, adjustment, or request for recoupment or refund for overpayment is disputed or contested. Any provision of a contract between a health care provider and an insurer, health service corporation, or health benefit plan that is in conflict with the requirements of this section is unenforceable. The requirements of this section may not be waived between the health care provider and an insurer, health service corporation, or health benefit plan. Nothing in this section shall prevent or preclude an insurer, health service corporation, or health benefit plan from recovering in the circuit or district courts from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the contract of insurance or the coverage agreement if the insurer, health service corporation, or health benefit plan is barred from seeking a retroactive denial, adjustment, or request for recoupment or refund from the health care provider under this section.
Ala. Code 1975 § 27-1-17

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 health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:
(1) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by said policy or plan or interfere with said selection provided the dentist is licensed to furnish such dental care services in this state;
(2) Deny any dentist the right to participate as a contracting provider for such policy or plan provided the dentist is licensed to furnish the dental care services offered by said policy or plan;
(3) Authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing, or healing dental illness or injury provided said dentist practices within the scope of his license; or
(4) Require that any dentist furnishing dental care services must make or obtain dental X rays or any other diagnostic aids for the purpose of preventing, alleviating, curing, or healing dental illness or injury; provided, however, that nothing herein shall prohibit requests for existing dental X rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan. Nothing herein shall prohibit the predetermination of benefits for dental care expenses prior to treatment by the attending dentist.
Ala. Code 1975 § 27-19A-3

Required Content in Contract

Any health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall, to the extent that it provides benefits for dental care expenses:
(1) Disclose, if applicable, that the benefit offered is limited to the least costly treatment;
(2) Define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary," "reasonable and customary," "usual, customary, and reasonable," fees or words of similar import or specify in dollars and cents the amount of the payment or reimbursement for dental care services to be provided. Said payment or reimbursement for a noncontracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount so specified or which is greater than the fee charged by the providing dentist for the dental care services rendered.
Ala. Code 1975 § 27-19A-4

IF A COVERED HEALTH CARE PROVIDER REQUESTS PAYMENT UNDER A HEALTH INSURANCE PLAN FROM A HEALTH INSURER OR ITS CONTRACTED VENDOR OR A REGIONAL CARE ORGANIZATION BE MADE USING ACH ELECTRONIC FUND TRANSFER, THAT REQUST MUST BE HONORED. FURTHERMORE, SUCH A REQUEST MAY NOT BE USED TO DELAY OR REJECT A TRANSACTION OR ATTEMPT TO ADVERSELY AFFECT THE COVERED HEALTH CARE PROVIDER. Ala. Code 1975 § 27-1-17.1

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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