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

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.

Termination Procedures
Please see Network Appeals/Grievances.

Dispute Resolution Process
Providers are afforded a fair, prompt and mutual dispute resolution process that at a minimum: provides for an initial meeting at which all parties are present or represented by individuals with authority regarding the matter in dispute; that the meeting must be held within 10 working days after the plan receives written notice of the dispute or gives written notice to the provider, unless the parties agree in writing to a different schedule; that if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute will be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; that each party must bear its proportionate share of the cost of the mediation, including the mediator fees; that if, after 60 days following commencement of mediation, the parties are unable to resolve the dispute that either party may seek other relief allowed by law; and that the parties must agree to negotiate in good faith in the initial meeting and in mediation.
AS § 21.07.010
Please also see Network Appeals/Grievances.

Network Participation Procedures
Under this Agreement, there are no financial incentives to the providers for withholding covered health care services that are medically necessary; providers are not required to contract for all products that are currently offered or that may be offered in the future by the managed care entity; and providers are not required to be compensated for medical care services performed at the same rate as the provider has contracted with another managed care entity.
AS § 21.07.010

A person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense-incurred basis, or under a group service or indemnity-type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license.
AS § 21.36.090

Quality of Care Procedures
Network providers shall have the right to communicate openly with covered persons about all appropriate diagnostic testing and treatment options.

AS § 21.07.010

Claims Procedures

(a) A health care insurer shall pay or deny indemnities under a health care insurance policy, whether or not services were provided by a participating provider, within 30 calendar days after the insurer or a third- party administrator under contract with the insurer receives a clean claim.
(b) If a health care insurer does not pay or denies a health care insurance claim, the insurer shall give notice to the covered person, or to the provider of the medical care services or supplies if the claim was assigned or if the covered person elected direct payment, of the basis for denial or the specific information that is needed for the insurer to adjudicate the claim. The health care insurer shall provide the notice required under this subsection within 30 calendar days after the insurer or third-party administrator under contract with the insurer receives the claim.
(c) If a health care insurer does not provide the notice as required under (b) of this section, the claim is presumed a clean claim, and interest shall accrue at a rate of 15 percent annually beginning on the day following the day that the notice was due and continues to accrue until the date that the claim is paid.
(d) If a health care insurer provides the notice required under (b) of this section and requests specific information that is needed to adjudicate the claim, the insurer shall pay the claim not later than 15 calendar days after receipt of the information specified in the notice or within 30 days after receipt of the claim. If a health care insurer does not pay the claim within the time period required under this subsection, the claim is presumed to be a clean claim, interest at a rate of 15 percent accrues, and interest continues to accrue until the date the claim is paid.
(e) For purposes of (c) and (d) of this section, if only a portion of a claim is covered under the terms of the insurance policy, interest accrues based only on the portion of the claim that is covered.
(f) For the purposes of this section, a claim is considered paid on the day payment is mailed or transmitted electronically.
(g) If interest is accrued on a claim under (c) or (d) of this section, a health care insurer may not include the amount of interest accrued in calculating an applicable limit on benefits payable to a covered person or other person claiming payments under the health insurance policy.
(h) A health care insurer is not required to pay interest due as a result of the application of (c) or (d) of this section if the amount of the interest is $1 or less.
(i) In this section, (1) "clean claim" means a claim that does not have a defect or impropriety, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents timely payment of the claim; (2) "health care insurer" has the meaning given in AS 21.54.500.

AS 21.36.128

On the written request of a covered person, a health care insurer shall pay amounts due under a health insurance policy directly to the provider of medical care services. If a health care insurer makes a claim payment to the covered person after the covered person has given written notice electing direct payment to the provider of the service, the health care insurer shall also pay that amount to the provider of the service.
AS 21.54.020(a)

For health care insurance plans that allow the health care insurer to review a treatment plan or conduct a utilization review, such treatment plan review or utilization review relating to dental care for a covered person receiving treatment in this state must be conducted by a dentist if the claim for reimbursement or payment is denied.
AS §21.42.392(b)

A health care insurer that provides coverage for dental care: (1) may reimburse a covered person at a different rate because of the person's choice of a dentist if the dentist is not a part of the covered person's dental network or preferred provider organization agreement; the covered expense for non-network providers may not be less than that allowed to a network provider, although the covered expense may be reimbursed at a lower

percentage or with higher deductibles than if the service had been provided within the network; (2) may not limit a fee set by a dentist for a service unless the service is covered under the insurer's plan or contract; and (3) may offer a dentist the option of entering into a preferred provider contract with the insurer that provides a fee schedule for covered services only or a fee schedule for both covered and uncovered services.
AS §21.42.392(c)

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>
A health care provider may not be penalized or the health care provider's contract terminated by the managed care entity because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary medical care services.
AS § 21.07.010

<u>Required Content in Contract</u>
Health care providers are not required to indemnify or hold harmless a managed care entity for the acts or conduct of the managed care entity. An indemnification or hold harmless clause entered into in violation of this subsection is void.
AS § 21.07.010

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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