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

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
An insurer that proposes to terminate or not renew a contract with a professional health care provider shall give a minimum of 60 days written notice thereof to the provider prior to the effective date of the termination of the contract. This notice shall include a statement of the provider's right to request a written explanation and to request an internal administrative review within 20 days.
18 Del.C. § 3339

A provider who reasonably believes than an insurer's decision to terminate or not renew a contract was solely based on reasons prohibited may request that this concern be addressed in the written explanation and administrative review provided by the insurer. Upon request, such a provider shall submit to the insurer a list of the insurer's enrollees with whom the provider has communicated and upon whom the provider relies to support his/her belief and a statement of the nature of the information provided to each enrollee that is protected.
18 Del.C. § 3339

If an insurer collects and maintains professional profiling data, and the written explanation provided upon termination states that the insurer used such data to evaluate the performance or practice of the provider, this data shall be provided to the provider and be discussed during the administrative review portion of the proceedings.
18 Del.C. § 3339

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
All individual and group health insurance policies shall provide that if medically necessary covered services are not available through network providers, or the network providers are not available within a reasonable period of time, the insurer, on the request of a network provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall reimburse the non-network physician or provider at a previously agreed-upon or negotiated rate. In such circumstances, the non-network physician or provider may not balance bill the insured. Such a referral shall not be refused by the insurer absent a decision by a physician in the same or a similar specialty as the physician to whom a referral is sought that the referral is not reasonably related to the provision of medically necessary services. All individual and group health insurance policies which do not allow insureds to have direct access to health care specialists shall establish and implement a procedure by

which insureds can obtain a standing referral to a health care specialist.
18 Del.C. § 3348

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
An insurer shall not refuse to contract with or compensate for covered services a participating or contracting healthcare provider solely because that provider has in good faith communicated with 1 or more of the provider's current, former or prospective patients regarding the provisions, terms or requirements of the insurer's products or services as they relate to the needs of that provider's patients.
18 Del.C. § 3339

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 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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