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

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
A health plan company shall not require a provider to provide notice of intention to terminate its contract before communicating with the provider regarding contract renewals. A health plan company shall not communicate with enrollees about the possible termination until final termination notice is received from the provider. A health plan company shall not preclude a nonnetwork provider from subsequent network participation solely as a result of the provider having terminated its participation in accordance with the terms of its contract.
M.S.A. § 62Q.735

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider.
M.S.A. § 62Q.10

Any policy or contract that provides coverage for services that can be lawfully performed within the scope of the license of a duly licensed dentist shall provide benefits for such services whether performed by a duly licensed physician or dentist.
M.S.A. § 62A.043

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
No contract of any dental plan or dental organization that covers any dental services or dental provider agreement with a dentist may require, directly or indirectly, that a dentist provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the dental plan or dental organization unless the dental services are covered services. A dental plan or dental organization or other person providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services. “Covered services” means dental care services for

which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.
M.S.A. § 62Q.78
All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim. The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with applicable law. If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided above, the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third-party administrator shall not require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly. The rate of interest paid by a health plan company or third-party administrator under this law shall be 1.5 percent per month or any part of a month. A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices. Once a clean claim has been paid, there is a 12-month deadline on all adjustments to and recoupments of the payment with the exception of payments related to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.
M.S.A. § 62Q.75

A health plan company shall not prohibit providers from collecting deductibles and coinsurance from patients at or prior to the time of service. Providers may not withhold a service to a health plan company enrollee based on a patient's failure to pay a deductible or coinsurance at or prior to the time of service. Overpayments by patients to providers must be returned to the patient by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider.
M.S.A. § 62Q.751

Unless otherwise provided by contract, by or by applicable law, the health care providers and facilities must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by a health care provider or facility specified for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline.
M.S.A. § 62Q.75

A health plan company shall provide, upon request, any additional fees or fee schedules relevant to the particular provider's practice beyond those provided with the renewal documents for the next contract year to all participating providers. Health plan companies may fulfill the requirements of this section by making the full fee schedules available through a secure Web portal for contracted providers. A health plan company that is a

dental plan shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization.
M.S.A. § 62Q.735

Method of payments. Payment for dental care services may not include fees associated with the method of payment, including credit card fees and fees related to payment in the form of digital or virtual currency. Any fees that may be incurred from a payment must be disclosed to a dentist prior to entering into or renewing a dental provider contract. For purposes of this section, fees related to a provider's electronic claims processing, vendor, financial institution, or other vendor used by a provider to facilitate the submission of claims are excluded. Effective January 1, 2025

M.S.A. § 62Q.78

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>
No state-specific requirements.

<u>Required Content in Contract</u>
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.

Last modified June 8, 2023