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

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, the terms below shall supersede.

The following provisions relating to carriers and insurers may be the obligations of Entities subject to Nebraska insurance regulation and not the network.

Appeal and Grievance Procedures
GEHA has procedures for resolution of administrative, payment, or other disputes between providers and GEHA.
Please see Network Appeals/Grievances Policies and Procedures.
Neb. Rev. Stat. Ann. § 44-7106(2)(q)

Termination Procedures
A health carrier shall make a good faith effort to provide written notice of termination within 15 working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.
Neb. Rev. Stat. Ann. § 44-7106(2)(k)

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
The terms and conditions of the policies or contracts between insurers or participants in an insurance arrangement and Participating Providers shall not discriminate against or among health providers. Differences in prices among providers based on individual negotiations with such providers, market conditions, patient mix, method of payment, or price differences among providers in different geographical areas shall not be deemed discrimination.
Neb. Rev. Stat. Ann. § 44-4111

Whenever an insurer provides reimbursement for a service that may be legally performed by a person licensed for the practice of osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, podiatry, or mental health practice, the person rendering such service shall be entitled to reimbursement whether the service is performed by a duly licensed medical doctor or by a duly licensed osteopathic physician, chiropractor, optometrist, psychologist, dentist, podiatrist, or mental health practitioner.
Neb. Rev. Stat. Ann. § 44-513

Quality of Care Procedures
Participating Providers shall furnish covered benefits to all Covered Persons without regard to the Covered Person's enrollment in the managed care plan as a private purchaser of the managed care plan or as a

participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render health care services due to limitations arising from lack of training, experience, skill, or licensing restrictions.
R.R.S. Neb § 44-7106.2(m)

Claims Procedures
In no event shall a Participating Provider collect or attempt to collect from a Covered Person any money owed to the Participating Provider by a health carrier.
R.R.S. Neb § 44-7106.2(e)

If a claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse. If a claim is submitted by mail, the claim is presumed to have been received five business days after the claim has been placed in the United State mail with first-class postage prepaid. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.
Neb. Rev. St. § 44-8003

A clean claim shall be paid, denied, or settled within thirty calendar days after receipt by the insurer if submitted electronically and within forty-five calendar days after receipt if submitted in a form other than electronically. If additional information is needed, those days are deducted from the clean claim timeframe.
Neb. Rev. St. § 44-8004 (1) and Neb. Rev. St. § 44-8004(2)

If the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt of the claim, give the health care provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving the request for such additional information shall submit all additional information requested by the insurer within thirty calendar days after receipt of such request. The insurer may deny a claim if a health care provider receives a request for additional information and fails to submit additional information as requested.
Neb. Rev. St. § 44-8004(2)

An insurer that fails to pay, deny, or settle a clean claim in accordance with the time periods set forth by law or to take other required action within the time periods set forth by law shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to applicable law. To the extent that interest is not paid concurrently with the claim, it may be paid on a quarterly basis or when the aggregate interest for a health care provider exceeds ten dollars.
Neb. Rev. St. § 44-8005

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
Participating Providers may discuss treatment options with Covered Persons irrespective of a health carrier's position on the treatment options and may advocate on behalf of Covered Persons within the utilization review or grievance processes established by a health carrier or a person contracting with the health carrier.
Neb. Rev. St. § 44-7106.2(i)

Required Content in Contract
The rights and responsibilities under a contract between GEHA and a Participating Provider shall not be assigned or delegated by the provider without the prior written consent of GEHA.
Neb. Rev. St. § 44-7106.2(l)

Participating Providers are responsible for the dental care and provider-patient relationship for his or her patients. The final decision to provide or receive dental care is made between the Participating Provider and Covered Enrollee.
Neb. Rev. St. § 44-7106.2(a)

Health carriers must monitor the offering of covered benefits to Covered Persons.
Neb. Rev. St. § 44-7107.2(b)

GEHA's initial credentialing and recredentialing criteria for Participating Providers are available in the Connection Dental Provider Manual at www.connectiondental.com.
Neb. Rev. St. § 44-7106.2(f)

A health carrier may deselect a Connection Dental Network Participating Provider from participating in its network for the purpose of delivering covered services to the health carrier's covered persons.
Neb. Rev. St. § 44-7107.2(c)

At the time the Participating Providers execute contracts with GEHA, GEHA notifies Participating Providers of its Provider Manual, which is located at www.connectiondental.com and includes the providers' responsibilities with respect to GEHA's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and federal or state programs, if applicable.

Neb. Rev. St. § 44-7106.2(g)

Participating Provides are not offered an inducement under a managed care plan to provide less than medically necessary health care services to a Covered Person.
Neb. Rev. St. § 44-7106.2(h)

Providers are required to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.
Neb. Rev. St. § 44-7106.2(j)

Participating Providers should collect applicable coinsurance, copayments, deductibles and/or fees for non-covered services from Covered Persons, pursuant to the terms of the applicable plan.
Neb. Rev. St. § 44-7106.2(n)

A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.
Neb. Rev. St. § 44-7106.2(o)

A health carrier shall establish a mechanism by which the Participating Providers may determine in a timely manner whether or not a person is covered by the health carrier.
Neb. Rev. St. § 44-7106.2(p)

The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Covered Persons.
Neb. Rev. St. § 44-7107.2(e)

A health carrier shall have the right, in the event of GEHA's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish Covered Services.
R.R.S. Neb § 44-7107.2(h)

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 either 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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