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

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
If GEHA denies enrollment or renewal of credentials to a health care provider, GEHA will provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision. Further, GEHA will not exclude or terminate a health care provider because the provider advocated for medically necessary and appropriate health care for a patient, filed a grievance pursuant to the procedures set forth in applicable law, protested a decision, policy or practice that the provider reasonably believed would interfere with his or her ability to provide medically necessary and appropriate health care, has a practice that includes a substantial number of patients with expensive medical conditions, or objects to the provision of or refused to provide a health care service on moral or religious grounds.
40 P.S. § 991.2121

Except in cases of termination for cause, including breach of contract, fraud, criminal activity or posing a danger to an enrollee or to the health, safety or welfare of the public, if GEHA initiates termination of a provider contract on behalf of a managed care plan, an enrollee may continue an ongoing course of treatment with that provider for up to 60 days from the date the enrollee was notified by the managed care plan of the termination or pending termination. The managed care plan, in consultation with the enrollee and the health care provider, may extend the transitional period if determined to be clinically appropriate. Any health care service provided under this section shall be covered by the managed care plan under the same terms and conditions as applicable for participating health care providers.
40 P.S. § 991.2121

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
No state-specific requirements.

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
No state-specific requirements.

Required Content in Contract
GEHA does not penalize or restrict a provider from discussing: (1) the process that a plan or any entity contracting with a plan uses or proposes to use to deny payment for a health care service; (2) medically necessary and appropriate care with or on behalf of an enrollee, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests; or (3) the decision of any managed care plan to deny payment for a health care service.
40 P.S. § 991.2113

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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