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

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
Please see Network Appeals/Grievances.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
A health insurance policy shall not provide a different level of payment of benefits or reimbursement, including deductibles, maximums or other cost-sharing provisions, for covered dental care services based on whether the services are provided by a contracting or non-contracting dentist.
28 TAC § 21.3604

An employee benefit plan or health insurance policy may not deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers.
V.T.C.A., Insurance Code § 1451.207

Quality of Care Procedures
An employee benefit plan or health insurance policy may not require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services. However, this section does not prohibit a request for an existing dental x-ray or other existing diagnostic aid for a determination of benefits payment under an employee benefit plan or health insurance policy.
V.T.C.A., Insurance Code § 1451.207

Claims Procedures
A health benefit plan may not directly or indirectly charge or hold a health care professional, health care facility, or person enrolled in a health benefit plan responsible for a fee for the adjudication of a claim.
V.T.C.A., Insurance Code § 1213.005

A health insurance policy shall define and explain the standard of payment or reimbursement for dental care services. In defining the standard, a policy may express the level of payment or reimbursement as a percentage of charges for dental car services, provided the insurer uses the same percentage for both contracting and non-contracting dentists. A health insurance policy may, in the same policy, apply the

percentage specified in this section to a contracted rate and a fee expressed as “usual and customary” or words of similar import.
28 TAC § 21.3604

An insurer is not required to make payment to a non-contracting dentist that is greater than the actual fee charged for the dental care services. A health insurance policy must disclose, if applicable, that the benefit offered is limited to the least costly treatment.
28 TAC § 21.3604

A health insurance policy must provide that an insured may assign the right to benefits to a dentist who provides dental care services, in which case, the insurer shall pay benefits directly to the designated dentist, and such payment shall discharge the insurer’s obligation to pay those benefits.
28 TAC § 21.3604

An entity that leases the Connection Dental Network may not limit the fee the dentist may charge for a service that is not a covered service, which is defined as a dental care service for which reimbursement is available under a patient’s employee benefit plan or health insurance policy, or for which reimbursement is available subject to a contractual limitation, including: (1) a deductible; (2) a copayment; (3) coinsurance; (4) a waiting period; (5) an annual or lifetime maximum limit; (6) a frequency limitation; or (7) an alternative benefit.
V.T.C.A., Insurance Code § 1451.2065

Predetermination of benefits for dental care expenses before the attending dentist provides treatment is not prohibited.
V.T.C.A., Insurance Code § 1451.207

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

A health insurance policy providing benefits for dental services shall not prevent an insured from selecting the dentist of his choice to furnish dental care services offered by the policy or interfere with the selection of any dentist, provided the dental care services are within the scope of the dentist's license; or authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to a patient for the purpose of providing dental care services, provided the dentist practices within the scope of the dentist's license.
28 TAC § 21.3603; See also V.T.C.A., Insurance Code § 1451.207

A dentist may contract directly with a patient to provide dental care services to the patient as authorized by law. V.T.C.A., Insurance Code § 1451.204

Required Content in Contract

Any notice regarding other contracting parties that use the CONNECTION Dental Network in Texas shall be deemed to be provided on the date the information is posted on the network's website. A list of other contracting parties using the CONNECTION Dental Network in Texas is available at connectiondental.com under the Payor Info tab, Texas Payor Policies.

A person providing a health insurance policy or employee benefit plan or any employer or any employee organization may (1) make information available to its insureds, beneficiaries, participants, employees, or members regarding dental care services through the distribution of factually accurate information about dental care services and the rates, fees, locations, and hours for the services if the information is distributed on the request of a dentist; (2) establish an administrative mechanism to facilitate payments for dental care services from an insured, beneficiary, participant, employee, or member to a dentist chosen by the insured, beneficiary, participant, employee, or member; or (3) nondiscriminatorily pay or reimburse its insured, beneficiary, participant, employee, or member for the cost of dental care services provided by a dentist chosen by the insured, beneficiary, participant, employee, or member.
V.T.C.A., Insurance Code § 1451.204

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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