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

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
Health carrier and participating provider shall provide at least ninety (90) days written notice to each other before the health carrier removes a participating provider from the network or the participating provider leaves the network. This provision does not apply when lack of such notice is necessary for the health or safety of enrollees, a provider contract is based on fraud or material misrepresentation or a provider engages in any fraudulent activity related to the terms of the contract. Each provider that receives a notice of removal or issues a notice of departure shall provide to the health carrier a list of participating provider's patients who are covered persons under the network plans of such health carrier within 30 days from the date the health carrier receives the initial notice of removal or departure. C.G.S.A. § 38a-472 C.G.S.A. § 38a-472 f

Every managed care plan issued after October 1, 1997, must contain a provision setting forth the terms and conditions of continuation of coverage.
1997 Conn. Legis. Serv. P.A. 97-99, s 8.

Dispute Resolution Process
Please see Network Appeals/Grievances.

To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee shall, not later than thirty days after receiving final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in this subsection. If the Insurance Commissioner receives three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedural or diagnostic coding, the Insurance Commissioner may, on said commissioner's own motion, issue an order specifying how such managed care organization or utilization review company shall make determinations about such procedural or diagnostic coding.
C.G.S.A. § 38a-226c

Network Participation Procedures
In the event provider elects to discontinue accepting new patients, provider will notify GEHA within 10 business days of the occurrence.

Provider shall not charge more than his or her usual and customary rate for dental services, procedures, or products not covered under GEHA plans or plans of other Payors. C.G.S.A § 38a-473(h)

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
For any policy delivered, issued for delivery, renewed, amended or continued in this state or on after October 1, 2004, that provides coverage for inpatient or outpatient dental services only, the person who issues the policy shall provide the insured or a licensed dentist acting on behalf of the insured, upon request, an estimate of reimbursement under the policy with respect to specific dental procedure codes ordered or recommended for the insured by a licensed dentist, except that the actual reimbursement may be adjusted based on factors such as the insured's eligibility, plan design, utilization of benefits and the actual claim submitted.
C.G.S.A. § 38a-472c

When possible, Participating Providers shall notify covered enrollees of their financial obligations for non-covered services prior to delivery of said services. C.G.S.A. § 38a-472f.

Required Content in Agreement

In no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to the Agreement. This does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this Agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. This Agreement does not prohibit the provider from pursuing any available legal remedy.

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

Providers are not prohibited from discussing with an enrollee any treatment options and services available in or out of the provider network, including experimental treatments. Providers are not prohibited from disclosing the method the managed care organization uses to compensate the provider to any enrollee who inquires. C.G.S.A. § 38a-478k

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 November 17, 2020.