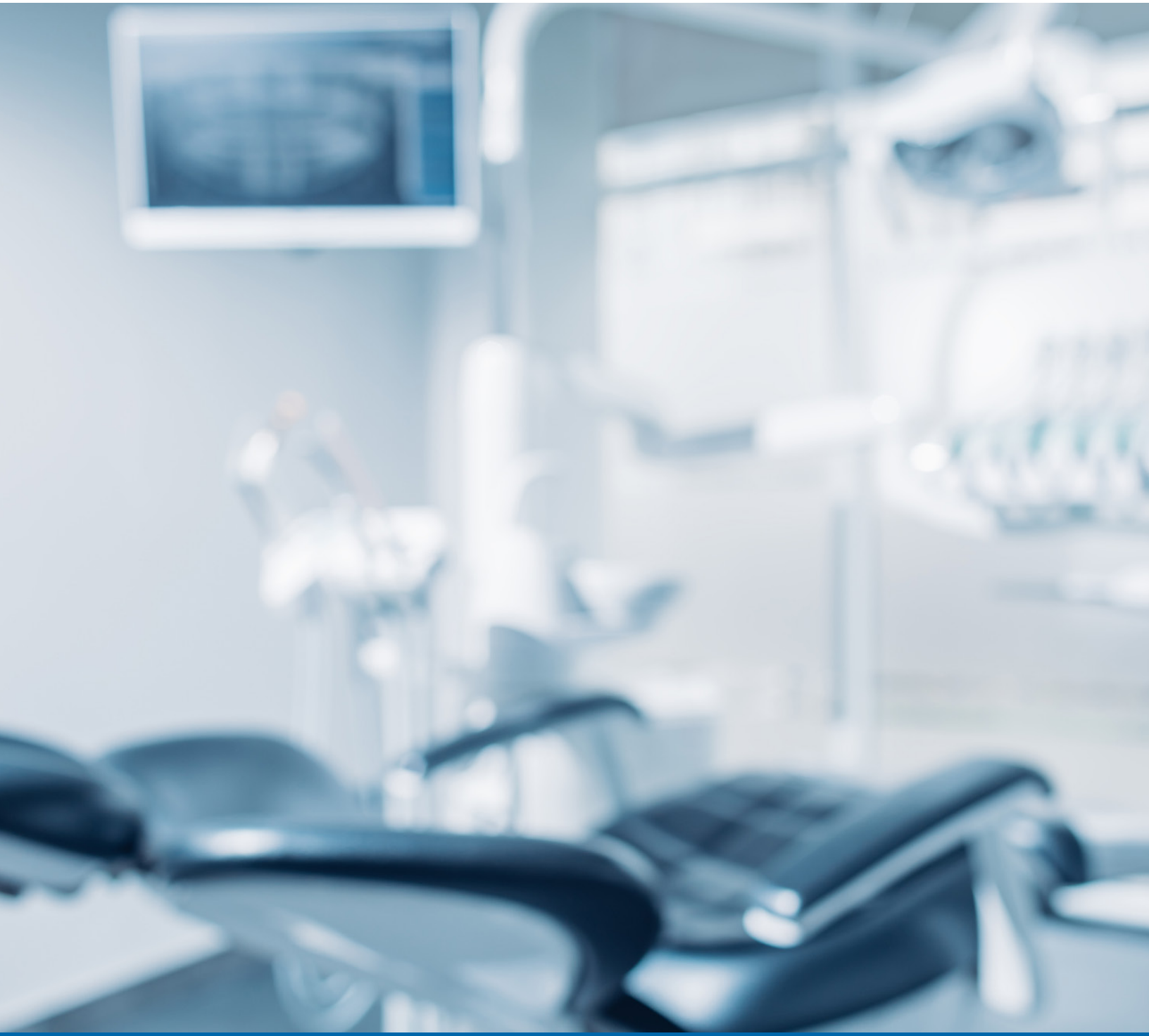
BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

DENTAL PROVIDER ADMINISTRATIVE OFFICE MANUAL



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INTRODUCTION

Established in 1946 in Greenville, South Carolina, BlueCross BlueShield of South Carolina is a mutual insurance company now headquartered in Columbia, South Carolina. We have major offices in Columbia, Florence, Surfside Beach, Greenville, Charleston and Camden, South Carolina; Dallas, Texas; Augusta, Georgia; and Nashville, Tennessee — all serving multiple lines of business.

The BlueCross BlueShield Division of the company offers health insurance to individuals and small groups in South Carolina. It also provides administrative services for larger, self-funded group health plans in South Carolina.

Subsidiary companies offer products related to other types of insurance, such as life, mental health and substance abuse benefits. The largest subsidiaries administer federal Medicare and TRICARE contracts. Some subsidiaries are technology-focused, offering back-office claims processing, cloud hosting and other services to outside companies in our data centers.

The only South Carolina-owned and operated health insurance carrier, BlueCross is a major supporter of community and charitable causes in all its locations. It also supports health care-related research, education and service in South Carolina through the BlueCross BlueShield of South Carolina Foundation.

AM Best (**www.ambest.com**), the world's oldest and most authoritative insurance rating and information source, has rated our group of companies at A+ (Superior*). Only a few health insurance companies in the nation hold this high rating.

BlueCross is committed to providing quality service, education and problem resolution to the health care community. This Administrative Office Manual for Providers is part of that commitment. We developed this manual to guide you through claim filing and to help you deal more effectively with our company.

We have put great effort into making sure the information in these pages is accurate. If there is any conflict between the contents of this manual and a contract or member's certificate, the contract or certificate will prevail. Likewise, if a conflict exists between the contents of this manual and a provider's contract with BlueCross, the contract will prevail.

We will make annual revisions and updates to this manual. We will update provider information in the Education Center of our website at **www.SouthCarolinaBlues.com** as needed.

In the event of any inconsistency between information in this manual and the agreement(s) between you and BlueCross BlueShield of South Carolina (BlueCross) the terms of such agreement(s) shall govern. Also, please note that BlueCross and other Blue Cross and/or Blue Shield Plans may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of BlueCross identification cards in no way creates nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

*AM Best A+ rating as of Dec. 20, 2023. For latest rating, access **www.ambest.com**.

In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

Websites marked with an asterisk (*) link to third-party websites. Those organizations are responsible for the content and privacy policies on their sites.

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SECTION 1: GENERAL INFORMATION

1.1 Website

Visit the Provider page at **www.SouthCarolinaBlues.com** for educational information, news, updates, resources and forms.

1.1.1 News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website. By placing our publications on the website, we can provide you with important information quickly and accurately.

1.1.2 Resources

We've developed several resources to make your interactions with BlueCross easy and efficient. Document types include instructional manuals, user guides, managed care magazines, quick reference guides and educational handouts. Resources are available to view online or to print. You can find the following documents:

- Dental Provider Administrative Office Manual
- BlueNews℠ for Providers newsletter
- Dental presentation
- My Insurance Manager user guides
- Provider web tools presentation
- News bulletins

1.1.3 Forms

All forms are available to download and print on the Forms page of **www.SouthCarolinaBlues.com**. Many are also available in Spanish. Some of the forms you may find most useful are explained here:

- **Other Health/Dental Insurance Questionnaire** — Ask your patients to update this information annually or when a change occurs in other health and/or dental coverage, including Medicare, that the subscriber or any covered dependent may have.
- **Electronic Funds Transfer Enrollment Form** — Complete this form if you want to participate in the EFT program. The authorized person who signs this form must sign the EFT terms and conditions. You can fax completed forms to 803-870-8065, Attn: EFT Coordinator, or email to **Provider.EFT@bcbssc.com**. An authorized person at your company must sign the form and the required EFT terms and conditions.
- **Overpayment Refund Form** — Complete this form when sending BlueCross unsolicited (voluntary) refund checks.
- **Provider Reconsideration (Appeal) Form** — Use this form to request review of a claim that has processed with an adverse determination. It ensures the medical information and supporting documentation you fax or mail get to the right area at BlueCross.

1.2 Registering for Training

As part of our service efforts, we host monthly webinars and annual workshops. These trainings educate new and experienced providers, along with their staff, on our business objectives and processes.

From the Provider page at **www.SouthCarolinaBlues.com**, select News and Events. Next, select Upcoming Trainings.

You will get a confirmation email that includes instructions for logging in to the selected webinar.

1.3 Contact Us

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. It serves as a liaison between BlueCross and the health care community to promote positive relationships through continued education and problem resolution. The staff is available for on-site office training and participation in regional practice manager meetings. If you have a training request or question about a topic — such as compliance requirements, electronic claim filing updates and changes, or problem identification or resolution — please contact the Provider Education department by calling 803-264-4730, emailing your provider advocate or using the Provider Advocate Contact Form available at **www.SouthCarolinaBlues.com**.

1.3.1 Provider Advocates

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. We will route your inquiry to the appropriate staff member for resolution.

1.3.2 Lines of Business

Use the contact information in the chart for our dental networks.

Lines of Business		
Name	**Contact Description or Service Specialty**	**Email**
Takisha Pearson	Blue Dental Operations	Takisha.Pearson@bcbssc.com
Shakemia Sumpter	Blue Dental Operations	Shakemia.Sumpter@bcbssc.com
James S. Thompson	State Dental Plan Operations	James.S.Thompson@bcbssc.com
Scott Stewart	State Dental Plan Operations	Scott.Stewart@bcbssc.com
Sherry Lawson	Blue Cross Blue Shield FEP Dental	Sherry.Lawson@bcbsa.com
Rick Tifft	Dental Provider Contracting	Richard.Tifft@bcbssc.com

1.3.3 Other Service Areas

Use this contact information for other helpful resources.

Other Service Area Contacts			
Name	**Contact Description or Service Specialty**	**Telephone**	**Email/Web**
Electronic Data Interchange (EDI)	Problems submitting claims electronically	N/A	EDI.Services@bcbssc.com
Electronic Data Interchange Gateway (EDIG)	Enroll your practice or billing service as a recipient of electronic data	N/A	EDIG.Support@PalmettoGBA-Services.com
Provider Enrollment	Provider enrollment (credentialing), recredentialing, provider updates and network information	N/A	My Provider Enrollment Portal
Technology Support Center	Technical problems with My Insurance Manager.	855-229-5720	N/A

1.4 Provider Credentialing

1.4.1 Network Participation

We credential each new dental provider who wishes to join our dental network. Participating in our dental network opens your doors to nearly 600,000 South Carolina members — including those enrolled with private employers, Dental Plus, Companion Life, Blue Cross Blue Shield FEP Dental, and FEP's Basic and Standard plans — wishing to seek services from a network provider. Companion Life is a separate company that administers life insurance. It is responsible for all services related to life insurance.

Blue Cross and Blue Shield Plans around the nation have developed a network allowing dentists to treat patients from other participating Blue Cross and Blue Shield Plans at local plan reimbursement levels. We call this program GRID. GRID is an independent company that offers a dental network on behalf of BlueCross. BlueCross' participating dental providers have access to GRID members nationwide who are living or traveling in South Carolina seeking dental services.

BlueCross gives potential network applicants the South Carolina Dental Credentialing Application, specific network contracts and professional agreements for network participation. The South Carolina Dental Credentialing Application is available in the Providers area of the website.

Select Provider Enrollment and then use the **My Provider Enrollment Portal (MyPEP)** to select, complete and submit associated dental forms for the request. For contract or professional agreements, use the Contracts Request Form on our website and include the specific network contracts you need.

To apply for network participation, you must complete the application, attach the required documentation and submit the entire package to BlueCross. We will notify you of any missing or incomplete information. The average processing time for credentialing is 90 business days from when we receive a completed package. Any missing or incomplete information will delay the credentialing process.

You must submit these documents with your application:

- State license(s)
- Current DEA certificate
- Proof of malpractice coverage, including supplemental coverage
- Board specialists' certificate if applicable
- Authorization for Clinic/Group to Bill for Services
- NPI National Plan and Provider Enumeration System (NPPES) confirmation letter or email
- Appropriate IRS documentation (letter 147C, CP 575 E or tax coupon 8109-C)
- A signed contract signature page for each network to which you wish to apply

You only need to submit one application, regardless of the number of networks for which you are applying.

1.4.2 Initial Credentialing and Recredentialing

The average processing time for initial credentialing is up to 90 business days from when we receive a completed package. Any missing or incomplete information will delay the credentialing process.

Recredentialing occurs every three years. Use the same credentialing application for this process. It typically takes up to 30 days to complete the recredentialing process.

You can see patients while in the credentialing process. However, claims are not guaranteed to process as in network until the credentialing process is complete.

1.4.3 Provider File Updates

To maintain accurate participating provider directories and for reimbursement purposes, providers are contractually required to report all changes of address or other practice information electronically. Changes may include:

- Provider name.
- Practice URL (website).
- Federal tax ID number.
- Name changes, mergers or consolidations.
- NPI.
- Languages spoken.
- Physical and billing addresses.
- Accepting new patients.
- Telephone number, including daytime and 24-hour numbers.
- Age range and gender of patients accepted.
- Fax number.
- Group affiliations.
- Email address.
- Practice management system.
- Hours of operation.

As part of the Consolidated Appropriations Act (CAA), effective Jan. 1, 2022, providers must verify and/or update their demographic data at least every 90 days. Validations can be made within My Insurance Manager using M.D. Checkup and are determined based on the number of days since the last validation was made. If more than 90 days has passed since the provider's last validation, we must suppress them from our directories.

We will continue to reach out to dental providers to verify your office information is complete and accurate. Be sure to respond to requests from **Provider.Directory@bcbssc.com**, **Provider.Blue.Updates@bcbssc.com** or your provider advocate when contacted about this matter.

1.4.4 Change of Ownership

You must promptly notify BlueCross if your organization changes ownership. Complete the Group Application located in My Provider Enrollment Portal.

1.5 Health Insurance Portability and Accountability Act (HIPAA) and Electronic Data Interchange (EDI) Services

HIPAA became law in 1996. HIPAA portability provisions ensure that insurance companies do not deny individuals health insurance coverage under pre-existing conditions when the individual moves from one employer group health plan to another. HIPAA includes provisions for administrative simplification. The purpose of these provisions is to improve the efficiency and effectiveness of health care transactions by standardizing the electronic exchange of administrative and financial data, as well as protecting the privacy and security of individual health information that insurance companies maintain or transmit electronically.

HIPAA administrative simplification imposes stringent privacy and security requirements on health plans, health care providers and health care clearinghouses that maintain and/or transmit individual health information in electronic form. In addition, HIPAA mandates EDI complies with the adoption of national uniform transaction standards and code sets and requires new unique provider identifiers.

1.5.1 HIPAA Transactions

The BlueCross Gateway processes these HIPAA-required ASC X12N Version 4010A1 transactions:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claim Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim — Professional)
- 837 D (Dental Claims)
- 837 I (Health Care Claim — Institutional)

1.5.2 Trading Partner Agreements

In general, a trading partner is any organization that enters a business arrangement with another organization and agrees to exchange information electronically. Typically, the two organizations develop a contract or agreement to describe this arrangement. BlueCross requires providers or their vendors to complete a Trading Partner Agreement (TPA). You can find the TPA application at **www.HIPAACriticalCenter.com*** under Enrollments and Agreements.

Companion Guide. A companion guide clarifies the specifics about the data content a provider transmits electronically to a specified health plan. For example, it may clarify what identification number is needed for the Payer Identifier data element. We call our companion guides "Supplemental Implementation Guides" (SIGs) since they supplement the HIPAA Implementation Guides. These guides address the situational fields that HIPAA allows for and explain how we use these fields. You can find all our guides at **www.HIPAACriticalCenter.com***.

Supplemental Implementation Guide (SIG). There are data elements we require in all cases (these are called "required"), and there are data elements we require only when the situation calls for them (these are called "situational"). Many situational data elements are related to the specialty of the physician. While you may choose to rely on your vendor to provide you with the necessary upgrade to capture applicable data, it may be prudent to validate the vendor has supplied all the necessary data for two reasons:

- It is the provider's responsibility to be compliant. If you are not compliant, you risk having us return claims or fine you for noncompliance.
- Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients in becoming HIPAA-compliant, but it is critical for you to ensure your software upgrade meets HIPAA requirements.

The capture of additional data usually means changes in business processes. You may need to change procedures or alter workflow. By understanding the new data you need to capture, you can plan where to make any necessary changes in your office.

Understanding the data requirements, however, is not easy. You may want to consider getting expert assistance, especially if you are a multispecialty practice. If you decide to validate your data requirements yourself, you should get a copy of the SIGs.

1.5.3 Electronic Funds Transfer (EFT)

EFT deposits payments directly into your bank accounts, allowing you to receive funds before BlueCross mails checks. EFTs are generated based on your NPI number. The EFT payment will show the NPI instead of the tax ID.

1.5.4 Electronic Remittance Advice (ERA)

Dental providers with electronic file transfer capabilities can choose to receive the 835 ERA containing their provider payment registers. Once you download the remittance files at your office, you can upload the files into an automated posting system. This eliminates several manual procedures.

If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum — Billing Services and Clearinghouse or ERA Addendum — Corporate Headquarters found on **www.HIPAACriticalCenter.com***. You will not need the BlueCross EDIG Trading Partner Enrollment Form when only requesting 835 transactions for existing trading partners.

Remittance advices are available in My Insurance Manager and My Remit Manager.

1.6 My Insurance Manager

My Insurance Manager is an online tool providers can use to access:

- Benefits and eligibility information.
- Claims entry.
- Prior authorization requests and status.
- Claims status.
- Remittance information.
- A mailbox.

It is a valuable provider tool you can access after registering with a valid tax ID number in our system. Secure encryption technology ensures any information you send or receive is completely confidential. My Insurance Manager can provide you with eligibility information and general benefits for members in Preferred Blue, Federal Employee Program (FEP), State Dental/Dental Plus Plans and Health Insurance Marketplace plans. For GRID members, you should refer to the information on the member's ID card.

My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. until midnight.

How To Register. Select the My Insurance Manager tab on the website at **www.SouthCarolinaBlues.com**. Choose Create a Profile, and then enter your BlueCross tax ID number. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are now ready to access My Insurance Manager.

1.7 My Remit Manager

My Remit Manager is an online tool dental providers can use to search remittances by patient, account number and check number. It is free to all dental providers who receive EFT payments and electronic remittance advices. It accepts 835s from all commercial BlueCross lines of business, and it works independently of your practice management system or clearinghouse.

Use My Remit Manager to:

- View ERA information by file and see all details. You have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that BlueCross has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or black out other patient information on the remit.
- Print remits for selected patients. Print individual or group remits.
- Generate and analyze reports. Analyze claim, payment, subscriber, CPT code, etc. and specific data over a specific time period.

How To Register. You can register to use My Remit Manager by completing the request form at **www.SouthCarolinaBlues.com/web/public/brands/sc/providers/tools-and-resources/my-remit-manager/**.

SECTION 2: PRODUCT (PLAN) INFORMATION

2.1 Benefit Structure

Each BlueCross insurance plan offers a variety of coverage and differs by employer. Please verify eligibility and benefits before providing services.

2.2 Identifying Members

When members arrive at your office, remember to ask to see their current member identification (ID) cards at each visit. This will help you identify the product the member has and get dental plan contact information. It will also help you with filing claims. Please note that all ID cards do not look the same and are for identification purposes only. They do not guarantee eligibility or payment of your claim.

Important facts about the ID card prefix:

- Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions.
- It is important to capture all ID card data at the time of service.
- Do not assume that a member's ID card number is his or her benefits identification number.
- Be sure all your system upgrades accommodate the ID card prefix and all characters that follow it.
- Do not add, delete or change the sequence of characters or numbers in a member's ID card number.
- Make copies of the front and back of the ID card. Share this information with your billing staff.

2.3 Verifying Eligibility and Benefits

Use My Insurance Manager to verify eligibility and benefits. Select the dental plan for which you want to review eligibility and benefits. Choose your eligibility view according to general benefits, service type or procedure code. Unless otherwise required by state law, the notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as deductible, may change as additional claims are processed.

Eligibility and Benefits Contacts

Plan	Provider Services Voice Response Unit (VRU)	Fax
Blue Secure Dental and Blue Dental℠	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)	803-264-7629
State Dental and Dental Plus	888-214-6230 (toll free) 803-264-3702 (Columbia area)	803-264-7739
Blue Cross Blue Shield FEP Dental	855-504-2583	843-763-0631
FEP Dental (Medical)	800-444-4325	
Medicare Advantage BlueCross Secure℠ and BlueCross Total℠	800-222-7156	803-264-7629

2.4 Blue Dental Plans

Commercial dental plans for BlueCross and BlueChoice® are now referred to as Blue Dental.

It is available to large and small group employers with a medical plan or stand-alone option. All new groups effective Jan. 1, 2017, and later will have access to the network. Small employer groups with effective dates prior to Jan. 1, 2017, may choose to retain their current dental plan that does not have a network.

Levels of dental coverage for these plans include:

- Preventive care.
- Restorative care.
- Major restorative care.
- Orthodontic care (optional).

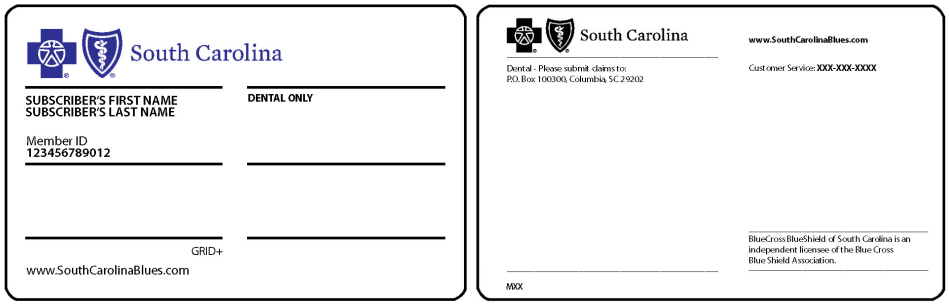
All standard Blue Dental plans provide 100 percent coverage for preventive (Class 1) services. For larger groups, there are no deductibles and preventive and diagnostic services do not accumulate toward the plan's annual maximum, if members receive services in network. Members can also use the national Dental GRID network.

2.4.1 How To Identify Members

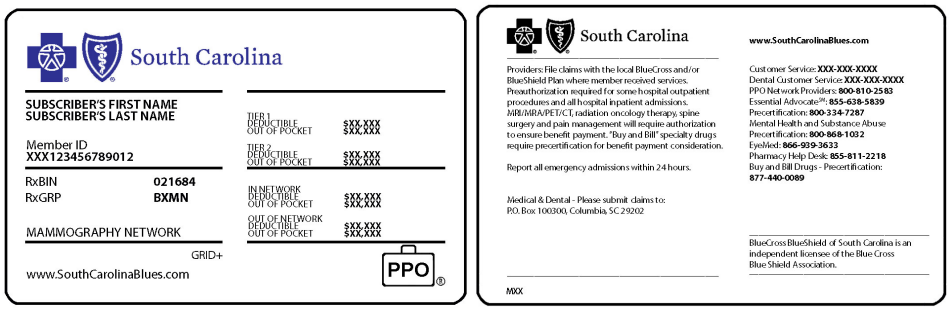
The ID card shows the plan, member's identification number and plan code number. On the back of the card, you'll see the customer service telephone number. Depending on the plan, coverage may be for dental only or offered in conjunction with a member's health benefits.

2.4.2 Sample Blue Dental ID Card(s)

Blue Dental-Only ID Card



Blue Dental Medical and Dental ID Card



2.5 Dental GRID

Dental GRID allows dentists to see members from other participating Blue Cross and Blue Shield Plans at local Plan reimbursement levels. We consider you an in-network dental provider to more patients who may be members of out-of-state plans. Your reimbursement levels or provider agreements will not change. GRID is a separate company that offers a dental network on behalf of BlueCross and BlueChoice.

2.5.1 Participating Plans

These participating plans are all independent licensees of the Blue Cross Blue Shield Association.

Lines of Business		
Anthem Blue Cross of California	Anthem Blue Cross and Blue Shield of Colorado	Anthem Blue Cross and Blue Shield of Connecticut
Blue Cross and Blue Shield of Georgia	Anthem Blue Cross and Blue Shield of Indiana	Anthem Blue Cross and Blue Shield of Kentucky
Anthem Blue Cross and Blue Shield of Maine	Anthem Blue Cross and Blue Shield of Missouri	Anthem Blue Cross and Blue Shield of Nevada
Anthem Blue Cross and Blue Shield of New Hampshire	Empire Blue Cross and Blue Shield of New York	Anthem Blue Cross and Blue Shield of Ohio
Anthem Blue Cross and Blue Shield of Virginia	Anthem Blue Cross and Blue Shield of Wisconsin	
Health Care Service Corporation (HCSC)		
Blue Cross and Blue Shield of Illinois	Blue Cross and Blue Shield of Montana	Blue Cross and Blue Shield of New Mexico
Blue Cross and Blue Shield of Oklahoma	Blue Cross and Blue Shield of Texas	
Other		
Blue Cross and Blue Shield of Arizona	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Massachusetts	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Vermont (CBA Blue)
Blue Cross and Blue Shield of North Carolina	Blue Cross and Blue Shield of Tennessee	BlueCross of Idaho
BlueCross & BlueShield of Western/ BlueShield of Northeastern New York	Capital Blue Cross (Central Pennsylvania)	CareFirst Blue Cross and Blue Shield (Maryland/ District of Columbia)
Excellus BlueCross BlueShield (Rochester, New York)	Horizon Blue Cross and Blue Shield of New Jersey	Wellmark Blue Cross and Blue Shield of Iowa

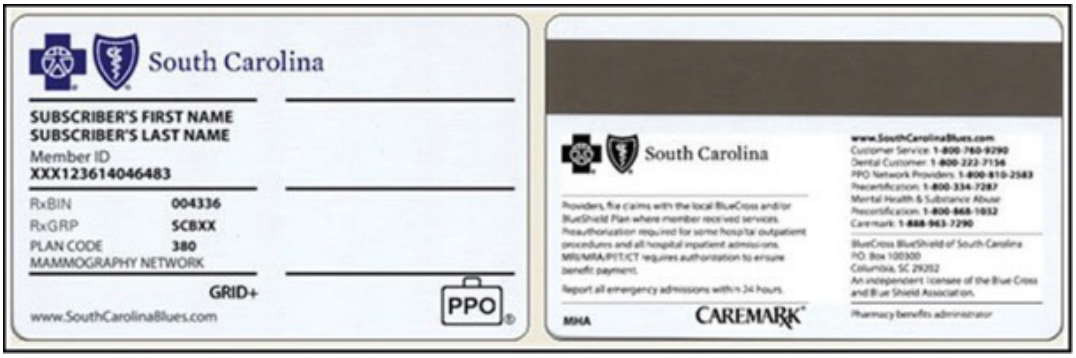
2.5.2 How To Identify Members

You should see “GRID” or “GRID+” on the member’s identification card. There will also be a customer service number to call with your benefit or eligibility questions.

A small number of participating Blue Cross and/or Blue Shield Plans may not immediately update their member ID cards to add the word “GRID.” If a member states he or she has the GRID network, but you don’t see “GRID” on his or her card, please verify participation by calling the provider service or customer service phone number on the ID card.

2.5.3 Sample GRID ID Card

Sample Commercial Medical and Dental With Dental GRID ID Card



2.6 State Dental and Dental Plus Plans

BlueCross administers the State Dental Plan and Dental Plus Plan. The dental benefits have four classes: diagnostic and preventive services, basic dental services, prosthodontics, and orthodontics. We pay covered services under the State Dental Plan based on its Schedule of Dental Procedures and Allowable Charges.

Dental Plus is a supplement dental plan to the State Dental Plan that provides a higher level of reimbursement for dental services the State Dental Plan covers. Members pay the entire premium with no contribution from the state. Dental Plus pays up to $1,000 for covered services in each benefit period for each covered member, in addition to the $1,000 maximum payment under the State Dental Plan.

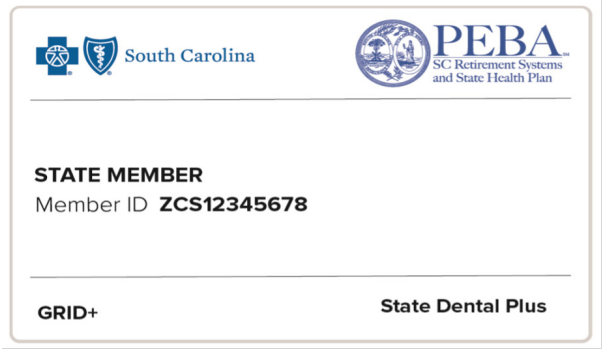
Dental Plus does not cover services that are not covered under the State Dental Plan. Instead, it covers the same procedures and services (except orthodontics) at the same percentage of coverage as the State Dental Plan. The allowances are based on whether the provider participates in the BlueCross dental provider network.

2.6.1 How To Identify Members

The ID card displays the subscriber's first and last name, the identification number, including the three-character prefix, and the plan name. The Public Employee Benefit Authority logo is a distinct marker of this ID card. The reverse side of the ID card gives a summary of benefits, the claims mailing address and the customer service telephone number.

2.6.2 Sample ID Card

Sample State Dental Plus ID Card



2.6.3 State Dental Plan Fee Schedule

Use the State Dental Plan fee schedule to determine if a service applies to dental or health benefits. You can find this fee schedule when you log into My Insurance Manager and accept the State Dental Plan Fee Schedule Agreement.

2.7 Blue Cross Blue Shield FEP Dental and Dental Benefits under the Federal Employee Program (FEP)

As of Jan. 1, 2021, FEP BlueDental, is known as Blue Cross Blue Shield (BCBS) FEP Dental. The Blue Cross Blue Shield Association (BCBSA) has partnered with the GRID Dental Corporation (GDC) to administer FEP BlueDental (BCBS) FEP Dental on behalf of BlueCross. BCBS FEP Dental can either be a supplementary dental plan to the Federal Employee Health Benefit Program (FEHBP) and Tricare or as a primary dental plan if the member does not have dental benefits under their FEHBP. FEP Dental members use the GRID+ network as an in-network provider source. Participating providers now have access to Blue Cross Blue Shield FEP Dental members.

2.7.1 How To Identify Members

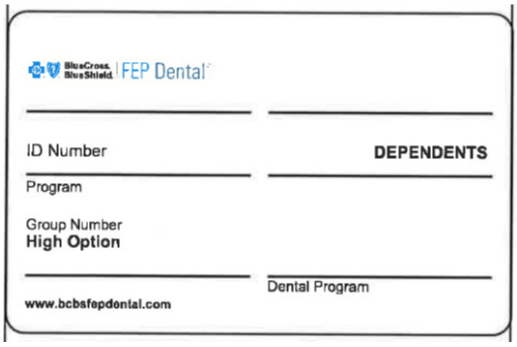
The ID card will indicate the provider network (GRID+), member's identification number, group number and program name and, on the reverse side, claims filing address and the customer service telephone number. The top left corner on the back of the member's ID card will display GRID+, indicating the use of the GRID+ network.

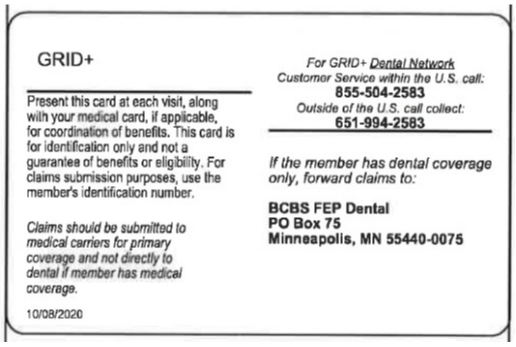
The member's medical ID cards do not have a three-character prefix. All Blue Cross Blue Shield FEP Dental identification numbers begin with the letter F, while the other FEP member identification numbers begin with the letter R. The Basic plan ID card includes enrollment code 111, 112 or 113 and a solid blue space in the middle of the card. It is labeled as "Basic" in the top right corner. The Standard plan ID card includes enrollment code 104, 105 or 106. It is labeled as "PPO" in the top right corner.

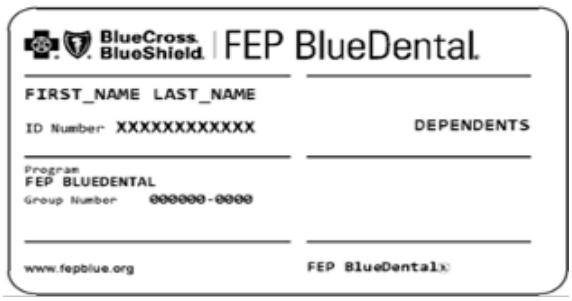
The ID card is for identification only. The ID card is not a guarantee of eligibility or benefits. When a member provides your office with his or her Blue Cross Blue Shield FEB Dental ID card, it is important to also ask for his or her medical ID card. The medical ID card is important, because by law, the member's medical plan is the primary carrier.

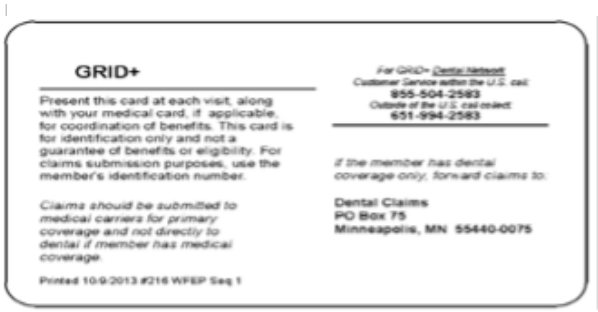
2.7.2 Sample ID Cards

Sample Blue Cross Blue Shield FEP Dental ID Card



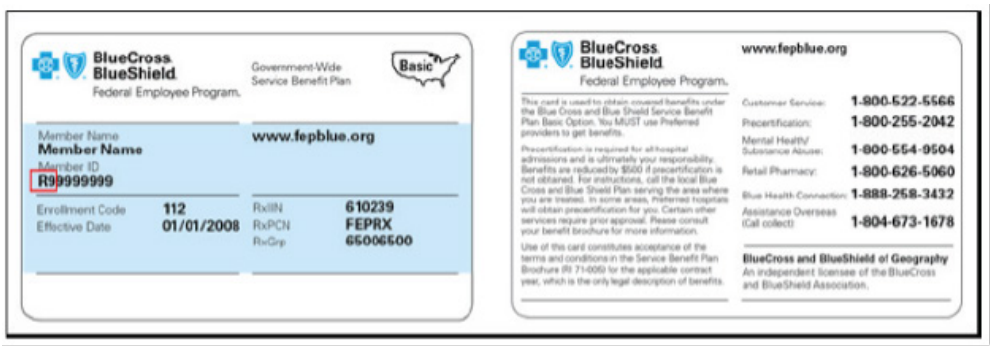




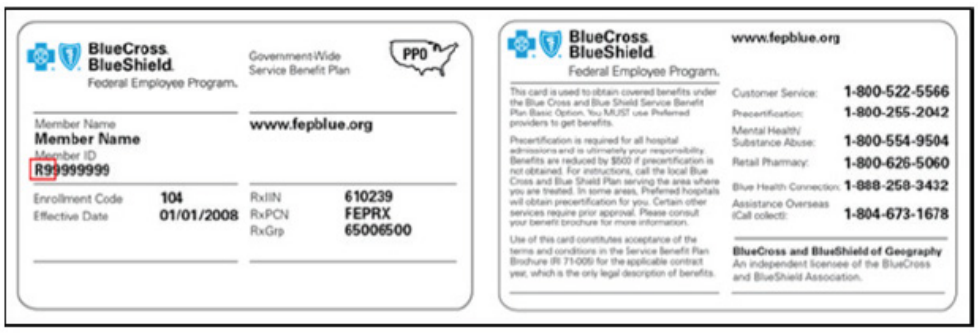


Note: Existing members may have an ID card with the previous name FEP BlueDental. New ID cards are not being issued to all existing members.

Sample FEP Basic ID Card



Sample FEP Standard ID Card



2.7.3 FEP Standard Option Dental Benefits

Under Standard Option, FEP pays for the following services, up to the amounts shown per service, as listed in the Schedule of Dental Allowances below. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments or coinsurance. A member pays all charges in excess of the listed fee schedule amounts when using a nonpreferred dentist. The member pays the difference between the fee schedule amount and the BlueCross Participating Dental Allowance when using a preferred dentist.

Covered Service	FEP Pays		Member Pays
Clinical Oral Evaluations	**To Age 13**	**Age 13 and Over**	**In Network** The difference between the amounts listed to the left and the BlueCross Participating Dental Allowance **Out of Network** All charges in excess of the scheduled amounts listed to the left
Periodic oral evaluation (up to two per person per calendar year)	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic Imaging			
Intraoral complete series	$36	$22	
Palliative Treatment			
Palliative treatment of dental pain — minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis — adult (up to two per person per calendar year)	---	$16	
Prophylaxis — child (up to two per person per calendar year)	$22	$14	
Topical application of fluoride or fluoride varnish (up to two per person per calendar year)	$13	$8	
Not covered: Any service not specifically listed above	Nothing	Nothing	All charges

2.7.4 FEP Basic Option Dental Benefits

Under Basic Option, FEP provides benefits for the services listed below. Member pays a $35 copayment for each evaluation, and FEP pays any balances up to the BlueCross Preferred Blue Participating Dental Allowance. Basic Option members must use preferred dentists to receive benefits.

Covered Service	FEP Pays	Member Pays
Clinical Oral Evaluations	**Preferred:** All charges in excess of member's $35 copayment **Participating/ Nonparticipating:** Nothing	**Preferred:** $35 copayment per evaluation **Participating/ Nonparticipating:** All charges
Periodic oral evaluation*		
Limited oral evaluation		
Comprehensive oral evaluation*		
**Benefits are limited to a combined total of two evaluations per person per calendar year*		
Diagnostic Imaging		
Intraoral — complete series including bitewings (limited to one complete series every three years)		
Preventive		
Prophylaxis — adult (up to two per calendar year)		
Prophylaxis — child (up to two per calendar year)		
Topical application of fluoride or fluoride varnish — for children only (up to two per calendar year)		
Sealant — per tooth, first and second molars only (once per tooth for children up to age 16 only)		
Not covered: Any service not specifically listed above	Nothing	All charges

2.7.5 Other Blue Cross Blue Shield FEP Dental Information

When a member is covered by an FEP medical plan with dental benefits and a separate FEP dental plan, those two policies will coordinate to pay benefits on dental claims. We recommend that the dentist not charge the patient for any copayment or coinsurance associated with the medical plan benefits at the time of his or her office visit because, in most cases, these amounts will be addressed by the dental plan. When a member has the Basic plan and Medicare Part B as primary payer, the $35 office visit copayment is waived.

Members covered by FEP medical Basic Option Plan and a Blue Cross Blue Shield FEP Dental policy will not be responsible for the annual (calendar year) $35 copayment. You should not collect copayments from these members. If a copayment is collected from the member, the provider is required to reimburse the copayment in full once the claim has processed under Blue Cross Blue Shield FEP Dental.

2.7.6 FEP Blue Focus

FEP Blue Focus (enrollment codes 131, 133 and 132) members do not have dental benefits under their medical plan and so are fully liable for dental services. Providers of service should file directly to dental supplements their patients may have.

2.7.7 FEP Dental

FEP Dental consists of two plans: High Option and Standard Option.

	High Option		Standard Option	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Class A (Basic) services (e.g., exams, cleanings, X-rays, sealants)	$0	10% coinsurance	$0	40% coinsurance
Class B (Intermediate) services (e.g., oral surgery, fillings, gum scaling)	30% coinsurance	40% coinsurance	45% coinsurance	60% coinsurance
Class C (Major) services (e.g., crowns, bridges, root canals, dentures)	50% coinsurance	60% coinsurance	65% coinsurance	80% coinsurance
Class D (Orthodontics) services (adults and children)	50% coinsurance up to $3,500 lifetime maximumper person	50% coinsurance up to $3,500 lifetime maximum per person	50% coinsurance up to $2,500 lifetime maximum per person	50% coinsurance up to $1,250 lifetime maximum per person
Annual Deductible Class A, B and C services (does not include Class D services)	$0	$50 per person	$0	$75 per person
Annual Maximum Class A, B and C services (does not include Class D services)	No benefit limit	$3,000 per person	$1,500 per person	$750 per person

2.8 Medicare Advantage BlueCross Total, Blue Basic and Total Value

BlueCross Medicare Advantage plans include dental benefits as of Jan. 1, 2019. Members must use the participating dental network.

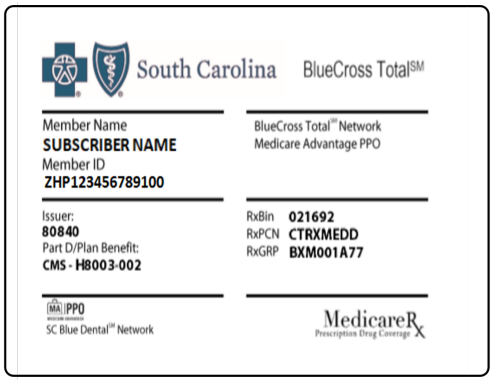
2.8.1 How To Identify Members

The ID card will indicate the provider network (South Carolina Blue Dental Network), member's first and last name, and the identification number, including the three-character prefix and the plan name. The reverse side of the ID card gives the website address and telephone number for customer service.

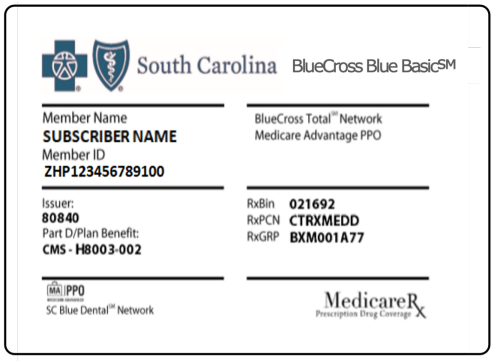
The ID card is for identification only. The ID card is not a guarantee of eligibility or benefits.

2.8.2 Sample ID Cards

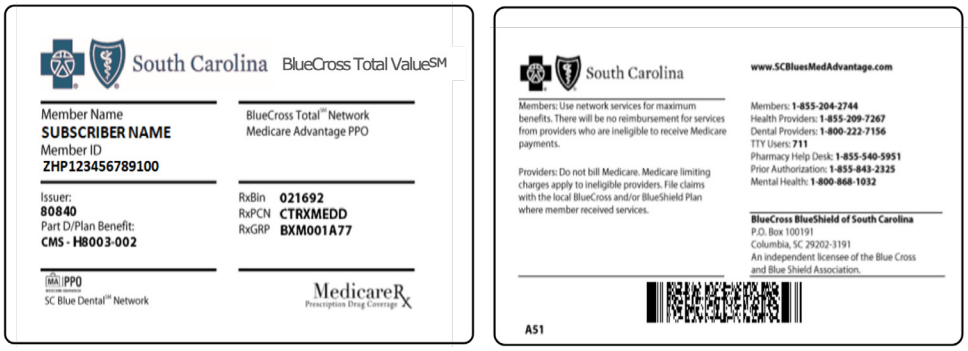
Sample BlueCross Total ID Card



Sample BlueCross Blue Basic ID Card



Sample BlueCross Total Value ID Card



2.8.3 Medicare Advantage BlueCross Total, Blue Basic and Total Value Benefits

Effective Jan. 1, 2023, there are some updates available for BlueCross BlueShield of South Carolina Medicare Advantage. Dental benefits were updated to reflect three benefit levels under the Total, Blue Basic and Total Value plans.

	BlueCross PPO Dental Benefit Highlights			
	Service	**In-Network**	**Visits (per year)**	**Out-of-Network**
Preventive Dental	**Oral exams Cleanings**	$0	2	50% COINS
	Dental x-rays	$0	1	50% COINS
Comprehensive Dental* **(Non-Medicare covered services)**	Restorative Anesthesia Endodontics Other oral/maxillofacial surgery Extractions Other services (e.g., deep cleanings, fillings, Prosthodontics Crowns, root canal, dentures, bridges) ***Note: Implants are not covered.***			50% COINS (INN and OON)
Annual Maximum **(Per member, per year)**	BlueCross Total℠: **$4,500** (Comprehensive and preventive combined) Total Value℠: **$3,500** (Comprehensive and preventive combined) Blue Basic℠: **$3,000** (Comprehensive and preventive combined)			

*SC Blue Dental Network

2.9 Blue Secure Dental

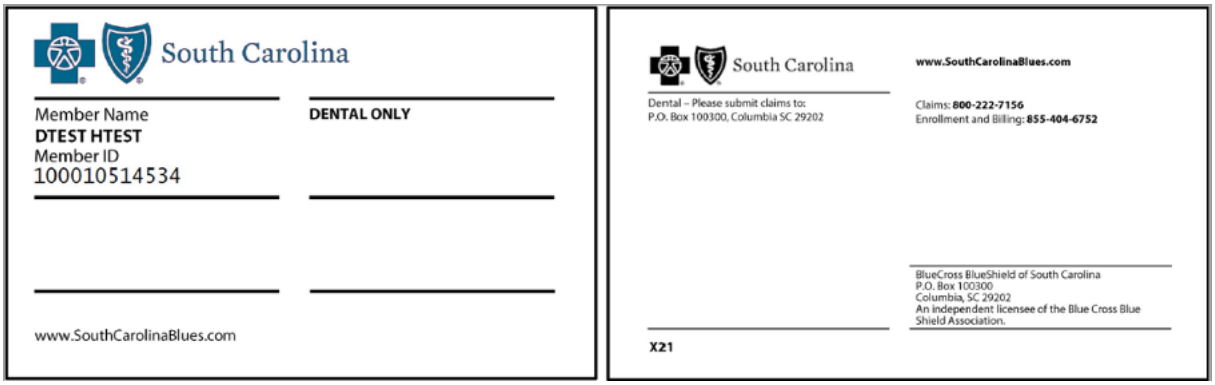
As of Jan. 1, 2023, we have added a new dental plan to our offerings. It is called Blue Secure Dental and it is a stand-alone Federally Funded Marketplace (FFM) Exchange plan. It works just like traditional dental coverage and is only sold on the Marketplace.

2.9.1 How To Identify Members

The ID card will state "Dental Only" and include the member's first and last name and the identification number, including the three-character prefix. The reverse side of the ID card gives the website address and telephone number for customer service.

The ID card is for identification only. The ID card is not a guarantee of eligibility or benefits.

2.9.2 Sample ID Card



2.9.3 Blue Secure Dental Benefits

Member age 19 or older

	Blue Secure Dental Gold		Blue Secure Dental Silver	
	In-network	Out-of-network	In-network	Out-of-network
Annual Deductible	$50 individual/$150 Family		$50 individual/$150 Family	
Annual Maximum (Coverage Limit)	$1500		$1000	
Class I — Preventive Procedures and Exams	0% coinsurance	20% coinsurance	0% coinsurance	30% coinsurance
Class II — Basic and Restorative Care	30% coinsurance (after 6 months)	50% coinsurance (after 6 months)	50% coinsurance (after 6 months)	70% coinsurance (after 6 months)
Class III — Major Procedures	50% coinsurance (after 6 months)	70% coinsurance (after 6 months)	70% coinsurance (after 6 months)	Not covered
Class IV — Orthodontia Service	Not covered			
Maximum Out-of-Pocket Total	N/A			

Member under 19 years

	Blue Secure Dental Gold		Blue Secure Dental Silver	
	In-network	Out-of-network	In-network	Out-of-network
Annual Deductible	$50 individual/$150 Family		$50 individual/$150 Family	
Annual Maximum (Coverage Limit)	No Limit			
Class I — Preventive Procedures and Exams	0% coinsurance	20% coinsurance	0% coinsurance	30% coinsurance
Class II — Basic and Restorative Care	30% coinsurance	50% coinsurance	40% coinsurance	60% coinsurance
Class III — Major Procedures	50% coinsurance	70% coinsurance	70% coinsurance	Not covered
Class IV — Orthodontia Services (If Medically Necessary)	50% coinsurance		50% coinsurance	
Maximum Out-of-Pocket Total per Child	$425	$850	$425	$850
Maximum Out-of-Pocket Total (All Children)	$850	$1700	$850	$1700

SECTION 3: CLAIMS AND BILLING GUIDELINES

3.1 Electronic Claims Filing

Submit claims electronically to BlueCross in the HIPAA 837D format. This is our preferred method of claim submission for all providers.

This table gives general guidance on filing requirements according to the dental plan.

Dental Plan	Claims Filing Procedure	Timely Filing*
Blue Dental	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card.	Varies (Verify when checking eligibility and benefits.)
Dental GRID	Send claims to the mailing address on the member's ID card.	Varies (Verify when checking eligibility and benefits.)
State Dental and Dental Plus	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. Do not file a separate claim for Dental Plus members. When necessary, use the ADA State Claim Form found on our website to mail paper claims to BlueCross.	24 months from date of service
Blue Cross Blue Shield FEP Dental++	Submit all claims to the member's primary medical plan first. See the member's medical ID card for submission.	12 months from date of service
Medicare Advantage Blue Cross Total, Blue Basic and Total Value	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card	12 months from date of service
Blue Secure Dental	Submit claims electronically using HIPAA 837D format. Use carrier (payer) code 38520. If applicable, mail paper claims to the mailing address on the back of the member's ID card.	12 months from date of service

**Note: Timely filing limits are subject to change. You can verify timely filing limits by checking eligibility and benefits in My Insurance Manager.*

++ Service Benefit Plan (FEP) medical member claims should be submitted to the local Blue Cross Blue Shield Plan. Primary payment will be sent to you, and then FEP medical will forward the claim, along with the primary payment amount, to Blue Cross Blue Shield FEP Dental. The primary benefit will be coordinated on the claim received from the medical carrier and upon completion of coordination of benefits. Blue Cross Blue Shield FEP Dental will send the secondary payment to you.

3.1.1 Filing Orthodontic Claims Electronically

When you file one of the following claims, you do not need to file any more orthodontic claims to BlueCross or BlueChoice for the patient. In either instance, we will automatically send you payment for the monthly adjustments on or around the first day of each month until:

- The patient exhausts his or her lifetime orthodontic benefits.
- The patient's dental coverage terminates under his or her current policy.
- The patient reaches the maximum age allowed for orthodontic coverage under his or her policy.

We will notify you via your remittance and stop our automatic claim spin-off process. There is no need to submit future claims to us, as this will cause the claim to reject.

Initial Banding and Monthly Adjustments. Submit one line with the banding fee code (D8080 – D8090) and the charge for the banding. Submit one line with the monthly adjustment code (D8670), the total months of treatment and the combined total charge for all monthly adjustments. The total months of treatment should be filed in the DN1 segment of Loop 2300. We will calculate the monthly charge by dividing the total charge of the monthly adjustments by the total months of treatment.

Filing a Claim for a Transfer Case. Submit one line with the monthly adjustment code (D8670), the total months of treatment remaining and the total charge for the remaining monthly adjustments. In this case, the total months of treatment remaining should be filed in the DN1 segment of Loop 2300.

3.1.2 Filing Dental Under Medical Benefits Electronically

If billing for medical services, dental providers should file an electronic health claim using My Insurance Manager.

An example of a dental service that is covered under a member's medical benefit is the extraction of an impacted tooth. For Blue Cross Blue Shield FEP Dental, claims should be submitted to the member's primary medical plan first.

3.2 Paper Claims Filing

3.2.1 American Dental Association (ADA) Claim Form

The ADA Claim Form J430D provides a common format for reporting dental services to a patient's dental benefit plan. ADA policy promotes use and acceptance of the most current version of the ADA dental claim form by dentists and payers.

3.2.2 Filing Dental Under Medical Benefits via Paper Claim

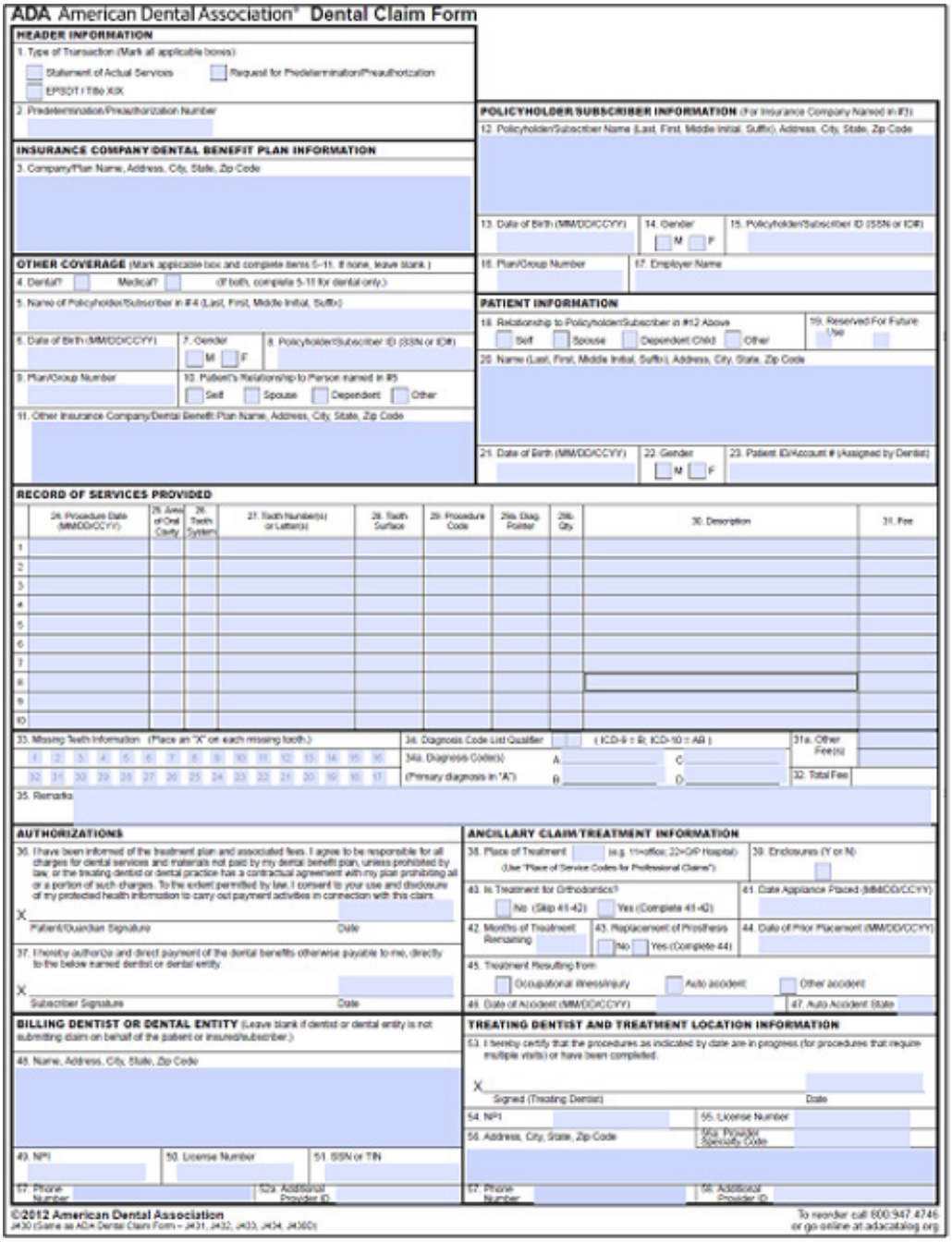
If billing for medical services, dental providers should use a CMS-1500 claim form. An example of a dental service that is covered under a member's medical benefit is the extraction of an impacted tooth.

3.2.3 State Dental Claim Form

The State Dental Plan has customized the current version of the ADA Claim Form J430D. This helps dental providers submit the appropriate form to the correct plan for processing. You can find it at **www.StateSC.SouthCarolinaBlues.com** in the Member Resources section.

NOTE: Claims should only be submitted to State Health when the procedure is covered by both State Health and State Dental. Once State Health processes the medical portion of the claim, State Dental is notified to process the dental portion.

Sample State Dental Services Claim Form



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services | Request for Predetermination/Preauthorization | EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5–11. If none, leave blank.)

4. Dental? | Medical? | (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender M F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5: Self | Spouse | Dependent | Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender M F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: Self | Spouse | Dependent Child | Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender M F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A B C D (Primary diagnosis in "A")

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian Signature | Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber Signature | Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office, 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N)

40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis No Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from: Occupational Illness/Injury | Auto accident | Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Signed (Treating Dentist) | Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

©2012 American Dental Association
J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J435D)

To reorder call 800.947.4746 or go online at adacatalog.org

3.2.4 Plan Addresses

Use this table to locate the claims address for the appropriate network.

Dental Plan	Address
Blue Dental	[Locate the mailing address on the back of the member's ID card.]
Dental GRID	[Locate the mailing address on the front or back of the member's ID card.]
State Dental and Dental Plus	BlueCross BlueShield of South Carolina State Dental Claims PO Box 100300 Columbia, SC 29202-3300
Blue Cross Blue Shield FEP Dental	[Locate the mailing address on the back of the member's medical ID card, as you are required to file to medical policy first.]
Medicare Advantage Blue Cross Total, Blue Basic and Total Value	Medicare Advantage PO Box 100191 Columbia, SC 29202-3191
Blue Secure Dental	BlueCross BlueShield of South Carolina PO Box 100300 Columbia, SC 29202-3300

3.3 Using the Correct Provider Identifier

Each dental provider should use his or her TIN or NPI when filing claims. This will ensure accurate and timely payment. An exception to this occurs if a dental provider does not have a TIN and uses his or her Social Security number to report income.

Place your provider number in the appropriate form indicator for the 837D when filing claims. Please also include the NPI of the rendering provider if it is different from the NPI of the billing NPI.

3.4 Diagnosis Codes

Dental providers are exempt from billing with diagnosis codes, in general. If a dental provider chooses to bill with a diagnosis code, use of International Classification of Diseases, 10th revision (ICD-10) coding is required.

3.5 Procedure Codes

BlueCross uses current dental terminology (CDT), a systematic listing and coding of procedures and services providers perform, for processing claims. Because dental nomenclature and procedural coding is a rapidly changing field, certain codes may be added, modified or deleted each year. Please make sure your office uses the current edition of the codebook when filing claims. BlueCross will reject claims containing invalid codes at the EDI Gateway and return paper claims to you.

3.6 Carrier Codes

BlueCross uses carrier codes (payer ID) to route electronic transactions to the appropriate line of business once the Gateway accepts the claim. Failure to use the correct electronic carrier code will result in misrouted claims or delayed payments. If you transmit through a clearinghouse, check with the clearinghouse to see if it requires a different carrier code for claim submission.

Use the following carrier code for dental claim submission:

- 38520 — BlueCross BlueShield of South Carolina and State Dental/Dental Plus

3.7 Claim Status

You can submit claim status inquiries by visiting **www.SouthCarolinaBlues.com** and logging in to My Insurance Manager. You can also access claim status through the voice response unit by calling the appropriate plan.

Claim Status Contacts	
Plan	**Provider Services Voice Response Unit (VRU)**
Blue Dental	800-222-7156 (Columbia center) 800-922-1185 (Greenville center)
State Dental and Dental Plus	888-214-6230 (toll free) 803-264-3702 (Columbia area)
Blue Cross Blue Shield FEP Dental	855-504-2583
FEP Dental (Medical)	800-444-4325
Medicare Advantage BlueCross Total, Blue Basic and Total Value	800-222-7156
Blue Secure Dental	800-222-7156

3.8 Remittances

3.8.1 Remittance Types

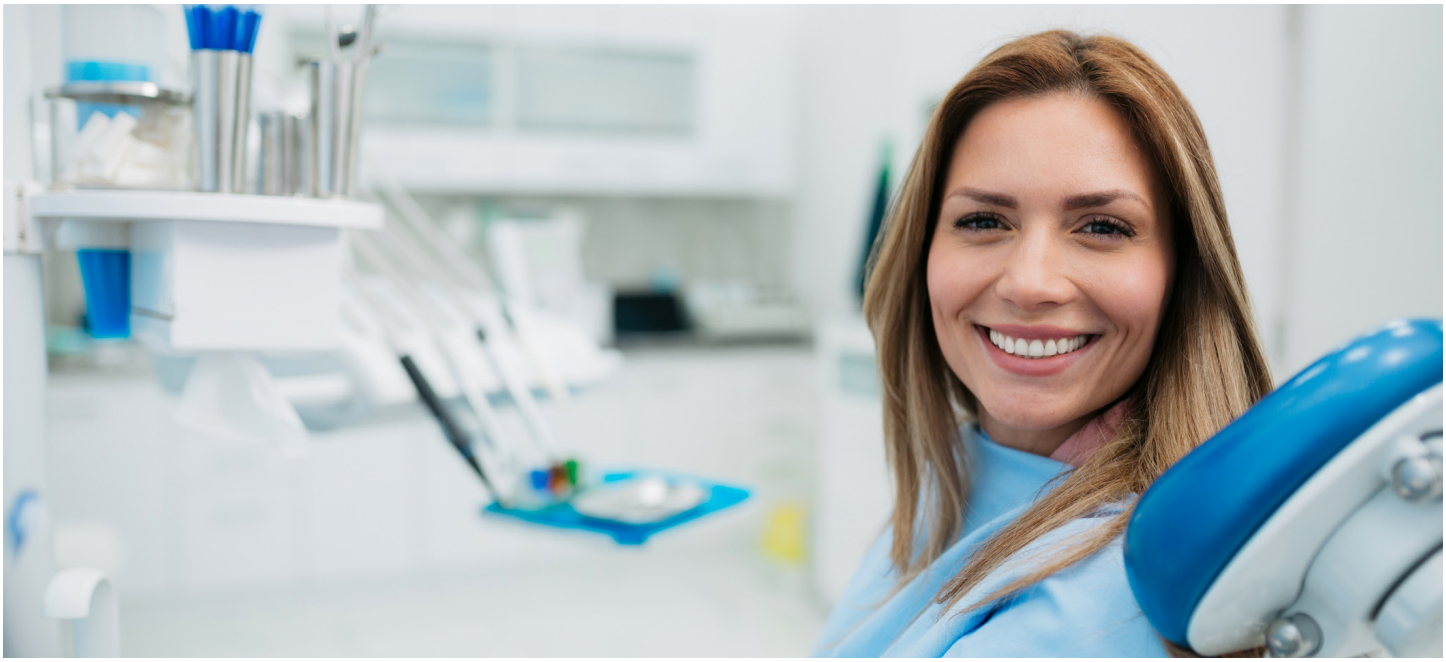
Determine a claim's submission channel by reviewing the BlueCross claim number. Electronic claims through the HIPAA X12N or web formats will result in faster reimbursement, reduced administrative costs and the elimination of keying errors. Channels include these:

- Electronic claim (claim you submit through clearinghouse)
- Web claim (claim you submit through our website at **www.SouthCarolinaBlues.com**)
- Superbill claim (claim you submit for professional providers who want to file multiple charges for one date of service)
- Hard copy claim (claim you mail hard copy)

3.8.2 Payments

We issue payments once a week. Patients are responsible for amounts shown in the Total Patient Liability column on your remit if you are a participating provider. You can view or print remittance advices by logging in to My Remit Manager or My Insurance Manager.

If you got an NPI for each location previously loaded to the BlueCross provider file, only minor changes are reflected on your remittances (i.e., the NPI number will be printed on your hard copy remits, and My Remit Manager [835s] will have the NPI number shown on them, as well). If you did not get an NPI for each location, your remittances are summarized at the NPI level. You will no longer get separate remittances for each location. Everything will be summarized by NPI.



SECTION 4: PROVIDER ADMINISTRATION

4.1 Pretreatment Estimates

You can submit a pretreatment estimate using My Insurance Manager. Use it for more estimation of costly procedures such as crowns, wisdom teeth extractions, bridges, dentures, implants or periodontal surgery. All services are subject to any limitations or exclusions in the contract that is in effect at the time the patient receives services.

You can also check the status of a pretreatment estimate using My Insurance Manager.

4.2 Tooth Chart

View a member's graphical tooth chart for primary and permanent teeth in My Insurance Manager.

4.3 Prior Authorization

4.3.1 Pretreatment Estimate

A pretreatment estimate is a real-time snapshot of the benefits that are payable at the time the pretreatment processes. It is considered a prior authorization. Commercial dental plan members: It is recommended but not required to request a pretreatment estimate for services over $300.

4.3.2 Prescription Drug

You should use the prescription monitoring program known as the South Carolina Reporting & Identification Prescription Tracking System (SCRIPTS). SCRIPTS requires dispensing practitioners and pharmacies to collect and report the dispensing activity of all category 2 through category 4 controlled substances.

Create an account to use SCRIPTS at **www.SouthCarolina.PMPAware.net***. When using SCRIPTS, you can view prescriber and dispenser information for these category prescriptions your patient has filled for a specified period. The South Carolina Boards of Medical Examiners, Dentistry and Nursing asserts that SCRIPTS should be part of every patient's initial evaluation and subsequent monitoring and is considered the standard of care.

SCRIPTS use is required for all State Health Plan — including State Dental and Dental Plus — members who are being prescribed opioids beginning March 15, 2016.

Additional information about SCRIPTS use and access is available at **www.scdhec.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/***.

4.4 Provider Obligations

Each provider's professional agreement lists the contractual responsibilities of both BlueCross and the provider. Here is a general summary of the professional agreement:

- The provider will file all claims for BlueCross members.
- BlueCross will reimburse the provider for covered services based on the member's contract. Fee allowances are the lower of the provider's charge for a procedure or the fee schedule of maximum allowances.
- The provider will accept BlueCross' payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The provider will not bill the patient for more than his or her applicable patient liability amount, not to exceed the fee allowance.
- The provider agrees to cooperate fully with the utilization review procedures.
- The provider agrees to bill promptly for all services and in a manner BlueCross approves. Electronic claims submission (EMC) in the 837D HIPAA-compliant format is the preferred method of filing.
- For State Dental and Dental Plus, we pay based on the assignment indicators you file on the claim, regardless of network affiliation.

4.4.1 Provider Fee Allowances

The Participating Dental Agreement states that a network provider will accept the fee allowance for covered services (defined as the provider's normal charge or the fee schedule allowance, whichever is lower) as payment in full. The member is not financially responsible for anything other than applicable copayments, coinsurance and deductibles. You should not bill members for any amount that exceeds the fee allowance. You should not balance bill members or bill them upfront for covered services.

4.4.2 Exceptions

The exception to this is when you bill a code and BlueCross applies an alternate procedure code when processing the claim. You can bill the member the difference between the allowance for the alternate procedure code and the code you filed.

For example, you charge $100 for a procedure. The fee allowance for this procedure is $90. The fee allowance for the alternate procedure code is $80. The difference between the allowance for the procedure you file ($90), and the alternate procedure ($80) is $10.

You would accept the difference in your charge and the allowance for the procedure filed, $10, as a write-off.

The member is responsible for the difference in our payment and the fee allowance of $90.

If you have any questions about your fee schedule, please contact your contracting specialist.

4.5 Provider Reconsideration

BlueCross accepts provider reconsideration requests to review a claim that has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member, such as increased liability. Requests are reviewed in conjunction with our policies and the member's benefit plan.

Provider reconsideration is a provider's written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct. Common reasons a provider may seek reconsideration of a claim include:

- There is disagreement with our interpretation of the member's plan of benefits, such as the definition of dental necessity.
- There is disagreement with our denial of a claim regarding provider versus member financial responsibilities.

Submitting Provider Reconsiderations. A dental provider can pursue provider reconsideration by using the Dental Provider Reconsideration Form. It can be found on the Forms page at **www.SouthCarolinaBlues.com**. Please be sure to complete the form in its entirety and attach all supporting documentation.

Provider reconsideration requests should include an explanation of the issue(s) to be reconsidered, such as seeking additional benefits, or why we should reconsider the service. We require you to include any supporting documentation, such as member's office records, pre- and post-op X-rays, and periodontal charting. We are unable to review requests that are submitted without supporting documentation.

Send the Dental Provider Reconsideration Form to the appropriate fax number or address, as provided on the form.

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews, an education specialist may initiate a training session to discuss proper procedure.

Determinations. It generally takes BlueCross 30 days after we receive all supporting documentation to complete provider reconsideration reviews. After the review is complete, the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

Blue Cross Blue Shield FEP Dental members: If you and your Blue Cross Blue Shield FEP Dental patient disagree with the initial decision of how dental services were processed, please encourage your Blue Cross Blue Shield FEP Dental patient to refer to his or her Blue Cross Blue Shield FEP Dental brochure on how to submit a reconsideration.

4.6 Coordination of Benefits

Our dental plans coordinate up to our payment. We will not pay anything as secondary if the primary plan's payment is equal to or greater than our primary payment.

Dental providers can assist members who need to update their other health/dental insurance (OHI) information. We require our members to update this information yearly. You can make it easy by giving members computer access right in your office. Ask them to log in to My Health Toolkit® and update their information. Have the member follow a link to the Other Health/Dental Insurance Questionnaire. Or you can print the OHI form from **www.SouthCarolinaBlues.com** and give it to your patient if he or she does not have access to our website.

Blue Cross Blue Shield FEP Dental members: The member's medical coverage is always primary. Blue Cross Blue Shield FEP Dental is secondary. Submit all claims to the primary medical plan first. Refer to the back of the member's medical ID card for submission. Submit pre-estimates of benefits directly to Blue Cross Blue Shield FEP Dental. Upon completion of the dental care, submit the claim to the primary medical plan.

4.7 Release of Records

There are times when BlueCross may request office records from you for a patient. We may request records to determine the necessity or appropriateness of services performed. When you receive a request for records, please respond to the appropriate mailing address or fax number provided with the request. We also accept clinical documentation through NEA. NEA is a separate company that provides electronic documentation exchange services on behalf of BlueCross and BlueChoice. We do not accept coordination of benefits documentation through NEA currently.

You or any entity designated for such responsibilities should not charge BlueCross for the creation or submission of office records. Because you are a participating provider, your contract states you agree to permit BlueCross or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records on your behalf without delay or request for payment.

APPENDICES

Appendix Glossary

1. **Adjustments** — The reprocessing of a claim to make changes to information submitted on the original claim. Benefit – Services and supplies a dental plan pays for. The term may refer to the amount a dental plan will pay.
2. **Claim** – A billing record generated and submitted by a provider or member using either paper or electronic media.
3. **Coinsurance** — A provision in a member's coverage that limits the amount of coverage by the Plan to a certain percentage (e.g., 80 percent). The member pays the remaining percentage.
4. **Copayment** — A cost sharing arrangement in which the member pays a specified amount for a specific service.
5. **Coordination of Benefits (COB)** — Provision ensuring that members receive full benefits and preventing double payment for services when a member has coverage from more than one source.
6. **Covered service** — Specific services the Plan will pay for.
7. **Deductible** — A required payment from the member during a given time period before benefits become payable. It is usually a set amount or percentage determined by the member's contract.
8. **Electronic funds transfer (EFT)** — Any transfer of funds — other than a transaction originated by cash, check or similar paper instrument — that is initiated through an electronic terminal, telephone, computer or magnetic tape, for the purpose of ordering, instructing or authorizing a financial institution to debit or credit an account.
9. **Member** — Any person entitled to receive benefits under a Plan.
10. **National Provider Identifier (NPI)** — A unique 10-digit identification number issued to providers in the United States by the Centers for Medicare & Medicaid Services (CMS).
11. **Network** — Group of physicians, hospitals and other medical or dental care providers that a specific Plan has contracted with to deliver services to its members.
12. **Remittance (remit)** — A statement to the member and/or provider that explains how and why benefit calculations were determined; also termed an Explanation of Benefits (EOB).
13. **Tax identification number (tax ID)** — A unique nine-digit identification number assigned by the Internal Revenue Service to business entities operating in the United States for the purpose of identification; also referred to as employer identification number (EIN).

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