Dental Plus Provider Agreement

This Agreement, offered by the State of South Carolina Public Employee Benefit Authority ("PEBA"), is voluntarily entered into by the undersigned Provider and shall be effective _____.

WHEREAS: PEBA offers a benefit plan for dental services ("Dental Plus") to certain individuals and their dependents ("Covered Persons") that provides significantly higher reimbursement levels than the standard dental benefits plan offered by PEBA, and is administered by BlueCross BlueShield of South Carolina ("BCBSSC"), a third party claims administrator, and,

WHEREAS: Provider may, on occasion, provide dental services to Covered Persons, that are eligible for full or partial reimbursement under Dental Plus; and,

WHEREAS; PEBA desires to protect Covered Persons from being billed for certain amounts over and above the Usual and Customary allowance available under Dental Plus;

NOW, THEREFORE, in consideration of the mutual promises contained herein, Provider and PEBA agree as follows:

Provider agrees not to pursue payment from Covered Persons for amounts over and above the Dental Plus allowance amount, as identified on the Explanation of Benefits forms issued by BCBSSC for each claim submitted for reimbursement under Dental Plus. Provider and PEBA acknowledge that Provider may pursue payment from Covered persons for any amount other than amounts over and above the Dental Plus allowance. This includes, but is not limited to Charges for non-covered services and amounts identified as deductible and/or coinsurance on the Explanation of Benefits form issued by BCBSSC.

Provider agrees to allow PEBA, and BCBSSC on behalf of PEBA, to publish Provider's name and address to be accessible by Covered Persons solely for the purposes of identifying providers who have agreed to the terms of this Agreement.

Provider and PEBA acknowledge that, by signing this Agreement, Provider is not joining a Preferred Provider Organization. Further, Provider will not be under any obligation to provide PEBA or Covered Persons with any information or services that Provider would not be required to provide if he or she had not signed this Agreement.

Provider and PEBA acknowledge that Covered Persons will not be instructed or influenced by PEBA, or BCBSSC on behalf of PEBA, to seek services from a particular provider or providers, and that Dental Plus will not provide a higher level of reimbursement based solely on Covered Person's choice of provider.

This Agreement is effective for services rendered on or after the date reflected above until the termination date. Either party may terminate this Agreement at any time, by providing written notice to the other party, at least 90 days in advance of the desired termination date. If Provider violates the terms of this Agreement, PEBA reserves the right to terminate the Agreement, effective immediately. Notice to Provider will be sent to the address below. Notice to PEBA must be sent to the following address:

State of South Carolina PEBA, Dental Plus Program
P. O. Box 100300
Columbia, SC 29202

The undersigned Provider agrees to the terms of this Agreement:

Signature: _____ Date: _____

Printed Name: _____ Individual NPI: _____

Street Address: _____ City/State: _____ Zip Code: _____

County: _____ Telephone Number: _____