DELTA DENTAL®

DELTA DENTAL OF IOWA
PROFESSIONAL APPLICATION & CREDENTIALING FORM

Delta Dental of Iowa (DDIA) is dedicated to improving the health and smiles of the people we serve. Part of that commitment is meeting the credentialing standards set by Delta Dental Plans Association, State and Federal Government Regulations, and Group Purchasers of dental benefits. To meet this requirement of participation with DDIA, please complete this credentialing form and return with all required documents by email, mail, or fax to:

Email: credentialing@deltadentalia.com
Mail: Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131, ATTN: Provider Relations
Fax: (515) 261-5608

Questions can be sent to credentialing@deltadentalia.com

Use the checklist below to ensure that you have included all necessary information before submitting to Delta Dental.

- ☐ **Complete and submit** all required and applicable fields of the credentialing form, with signature, including:
  - Explanation of any gaps in work history
  - Please provide an explanation in the space provided to any YES responses to the QUALITY FOCUSED QUESTIONS
- ☐ A copy of current professional liability insurance information that includes carrier name, covered dentist's name, policy number, limits (per occurrence and aggregate), and coverage period. Each dentist shall maintain minimal malpractice policy limits of $1,000,000 per claim and $3,000,000 aggregate.
- ☐ A copy of current Drug Enforcement Administration (DEA) registration, if applicable
- ☐ A copy of current Iowa Controlled Substance Act (CSA) registration, if applicable
- ☐ A copy of specialty certification, if applicable
- ☐ Sign and date applicable provider agreements
- ☐ For a new business, a completed W-9 for each office location
- ☐ For a new business, complete an Ownership & Control Disclosure Form. Make sure each page is completed. Signature page must be signed by owner or managing employee.

DELTA DENTAL®

Confidentiality Statement

Delta Dental of Iowa maintains all credentialing and re-credentialing information in a confidential manner and strictly enforces provisions designed to safeguard information and ensure confidentiality.

Practitioners Right to Review

As an applicant applying for and credentialing within the Delta Dental of Iowa (DDIA) network, you are entitled to specific rights. Our established processes are in place to facilitate your access to these rights.

Your rights include:

- The right to review information we have obtained from outside verification sources (e.g., Malpractice carriers, board certification and licensing organizations) that are not peer-review protected information.
- The ability to review and correct erroneous information.
- The right to request information on the status of your application.

For inquiries about the mentioned processes, kindly reach out to the Credentialing Coordinators at DDIA via the provided phone number or email address.

- Phone number – 1-800-544-0718
- Email – Provrelations@deltadentalia.com

If you are correcting information that has been submitted, you have thirty (30) calendar days from your application date to correct that information. We will need the corrected information sent to us in writing, preferably by email. The email address for submitting those corrections is: Credentialing@deltadentalia.com.

If you need information on the status of your application, you can contact the DDIA Credentialing Coordinators at Provrelations@deltadentalia.com. DDIA will respond to you within five (5) business days by email with information as to what stage your application is in and if we need additional information or assistance from you and how to contact us.

PROVIDER INFORMATION

Name (First) (Middle) (Last)	Other Known Names(s) (i.e. maiden name, nickname)
Effective Date: (Note: Credentialing can take up to 30 days from receipt of completed application. DDIA will no longer be able to backdate.) ☐ Completion of Credentialing date ☐ Future Effective date:	Are you an Iowa Medicaid Provider? ☐ YES ☐ NO **See note below.*

Individual NPI (Type 1)	Date of Birth	Social Security Number	Gender
Required	***Required***	***Required***	☐ M ☐ F ☐ Prefer not to disclose

Race / Ethnicity: Choose one ☐ *I consent to display on the Provider Directory*

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ Asian ☐ Hispanic or Latino ☐ White ☐ Prefer not to disclose

Dentist email address: ***NOTE: email will not be published on our website or shared with others.***

Please note: *Federal requirements states for DWP and Hawki participation the provider's individual NPI and the office's TIN and Organizational NPI must be enrolled with Iowa Medicaid (IM). To verify enrollment or start new application, please contact IM directly at 800-338-7909, email imeproviderservices@dhs.state.ia.us or visit their website (https://hhs.iowa.gov)*

DEA & CSA REGISTRATION

Do you currently have an active DEA in the state(s) in which you practice? ☐ YES ☐ NO

DEA #	Expiration Date

If "NO":
☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room
☐ _____ will write my prescriptions for me. (Please list Practicing Provider's DEA #: _____)

Do you currently have an active CSA / CDS in the state(s) in which you practice? ☐ YES ☐ NO

CSA #	Expiration Date

If "NO":
☐ I refer my patients to their Primary Care Physician or Urgent Care / Emergency Room
☐ _____ will write my prescriptions for me. (Please list Practicing Provider's CSA #: _____)

LICENSE & EDUCATION

Iowa Dental License #	Expiration Date
List any active, pending, or inactive licenses to practice dentistry in a state other than Iowa:	

Dental School	Graduation Date	Degree
Graduate / Residency Dental Program	Graduation Date	☐ DDS ☐ DMD ☐ MDS ☐ BDS ☐ MSD

Residency / Postgraduate Training

☐ I do not currently have any specialty training.
☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist
☐ Pediatric Dentist ☐ Periodontist ☐ Prosthodontist
☐ Other: _____

Board Certified? ☐ YES ☐ NO
Board Certification Issued By: _____
****Please provide a copy of certification.****

OFFICE / PRACTICE SITE INFORMATION

For additional sites, please utilize Page 7.

Please provide the following information for the primary site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): _____

Practice Location Name	Tax ID Number	Organizational NPI

Address (include suite #, if applicable)

City	State	Zip Code	County

Phone Number	Fax

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

Payment Address (P.O. Boxes are acceptable)	City, State, Zip

General Office Email *(required)* — *Note: Email will be listed on the Provider Directory*

Office Website ☐ *We do not have a website.*

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?
☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO

b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO

c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO

d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

PROVIDER INFORMATION

Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO

b) After 5 PM? ☐ YES ☐ NO

c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO

b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO

c) Accepting new DWP adult patients? ☐ YES ☐ NO

d) Accepting new DWP Kids patients? ☐ YES ☐ NO

e) Have you completed cultural competency training? ☐ YES ☐ NO

Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO

b) Intellectual Disability? ☐ YES ☐ NO

WORK HISTORY

☐ Check here if you are a new graduate.

Please list your dentist work history for the last 5 years below. Alternatively, you may attach a current Curriculum Vitae. Provide an explanation for any gaps in work history.

From *(MM/YYYY)*	Position		
To *(MM/YYYY)* Current	Employer Name		
Address			
City	State	ZIP	Phone Number
From *(MM/YYYY)*	Position		
To *(MM/YYYY)*	Employer Name		
Address			
City	State	ZIP	Phone Number
From *(MM/YYYY)*	Position		
To *(MM/YYYY)*	Employer Name		
Address			
City	State	ZIP	Phone Number
Work Gap Explanation:			

HOSPITAL AFFILIATION (IF APPLICABLE)

☐ I do not currently have any hospital or facility privileges.

From *(MM/YYYY)*	Facility Name		
To *(MM/YYYY)*	Address		
City	State	ZIP	Phone Number
Admitting Privileges: ☐ YES ☐ NO			
From *(MM/YYYY)*	Facility Name		
To *(MM/YYYY)*	Address		
City	State	ZIP	Phone Number
Admitting Privileges: ☐ YES ☐ NO			

QUALITY FOCUSED QUESTIONS

An explanation is required if you answer "yes" to any of the following questions. For required explanations, use the section below the questions and include the question number, dates, circumstances, and dispositions.

1. Are you **ineligible** for DEA or CSA registrations or has your DEA or CSA certification been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.*	☐ YES	☐ NO
2. Have you ever been disciplined by a state dental board? *If yes, explanation required.*	☐ YES	☐ NO
3. Have you ever been subject to any litigation or had any malpractice claims or suits pertaining to your dental practice filed against you? *If yes, explanation required.*	☐ YES	☐ NO
4. Has information pertaining to you been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? *If yes, explanation required.*	☐ YES	☐ NO
5. Has your professional license or privileges in any state ever been denied, revoked, limited, suspended, put on probation, or voluntarily relinquished? *If yes, explanation required.*	☐ YES	☐ NO
6. Have you ever been convicted of a felony or are any felony charges now pending against you for any reason? *If yes, explanation required.*	☐ YES	☐ NO
7. Have you ever been excluded by the federal Office of the Inspector General or denied, expelled, or suspended from participating in a state or federal health care program including Medicare or Medicaid? *If yes, explanation required.*	☐ YES	☐ NO
8. Do you presently use any drugs illegally? *If yes, explanation required.*	☐ YES	☐ NO
9 Do you presently have a chemical dependency, substance abuse condition, mental health condition, or physical condition (such as infectious disease) that would interfere with your ability to perform the essential functions of the practice of dentistry with or without accommodations? *If yes, explanation required.*	☐ YES	☐ NO

Explanation of Yes Answer(s) | Please attach additional explanation on separate sheet, if needed.

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☐ I acknowledge I have reviewed the Fraud, Waste and Abuse Training located on the Dentist Connection under Resources > Education Materials.

☐ I acknowledge DDIA provides American Sign Language and Translation Services at no cost to myself or my patients and that more information is located on the Dentist Connection under Resources > Value-Added Services.

I understand that it is my responsibility to provide correct and complete credentialing information to DDIA. I certify that the information provided by me is true to the best of my knowledge. I agree to notify DDIA of any changes in this information (including professional liability information) within 30 calendar days. I understand that the information I have provided will be reviewed by DDIA and that other information may be obtained in accordance with the DDIA credentialing program. I further understand that my willingness to provide complete and truthful information will help ensure the continuation of my participating status with Delta Dental.

Dentist's Signature: _____ Date: _____

OFFICE / PRACTICE SITE INFORMATION

For additional sites, please copy Page 7.

Please provide the following information for each additional site at which you practice.

☐ Primary ☐ Secondary ☐ Part-Time ☐ Other (please explain): _____

Practice Location Name	Tax ID Number	Organizational NPI

Address (include suite #, if applicable)

City	State	Zip Code	County

Phone Number	Fax

Is the payment address the same as the treatment office address? ☐ YES ☐ NO

Payment Address (P.O. Boxes are acceptable)	City, State, Zip

General Office Email *(required)* — *Note: Email will be listed on the Provider Directory*

Office Website ☐ *We do not have a website.*

Emergency service line available 24 hours per day / 7 days a week? ☐ YES ☐ NO

If no, is there a phone message when office is closed directing patients where to seek emergency care? ☐ YES ☐ NO

a) Does this office comply with ADA standards (accessible parking spaces, exterior and interior routes, entrances, waiting rooms, public restrooms, and employee work areas)?
☐ YES ☐ NO

c) Free parking? ☐ YES ☐ NO

d) Public transit access? (e.g. bus)? ☐ YES ☐ NO

b) In addition, does this office offer the following?

a. Automated doors ☐ YES ☐ NO
b. Wide entries / operatories to accommodate motorized wheelchairs ☐ YES ☐ NO
c. One or more exam rooms where a patient can be treated in their wheelchair ☐ YES ☐ NO
d. Diagnostic equipment to accommodate patients with disabilities ☐ YES ☐ NO

List languages spoken other than English:

PROVIDER INFORMATION

Office Hours:

a) Open before 8 AM? ☐ YES ☐ NO
b) After 5 PM? ☐ YES ☐ NO
c) Weekends? ☐ YES ☐ NO

a) Telehealth services available? ☐ YES ☐ NO
b) Accepting new Premier and/or PPO patients? ☐ YES ☐ NO
c) Accepting new DWP adult patients? ☐ YES ☐ NO
d) Accepting new DWP Kids patients? ☐ YES ☐ NO
e) Have you completed cultural competency training? ☐ YES ☐ NO

Do you treat disabled children?

a) Physical Disability? ☐ YES ☐ NO
b) Intellectual Disability? ☐ YES ☐ NO

Do you treat disabled adults?

a) Physical Disability? ☐ YES ☐ NO
b) Intellectual Disability? ☐ YES ☐ NO

DELTA DENTAL

DELTA DENTAL
PARTICIPATING DENTIST'S DENTAL WELLNESS PLAN
AND CHILDREN'S DENTAL MEDICAID PLAN AGREEMENT

This Participating Dentist's Dental Wellness Plan and Children's Dental Medicaid Plan Agreement (this **"Agreement"**) is made by and between Delta Dental of Iowa, an Iowa not-for-profit corporation (**"Delta Dental"**), and the undersigned individual licensed to engage in the practice of dentistry in the State of Iowa in accordance with Chapter 153 of the Iowa Code (**"Participating Dentist"**) and shall be effective on the date accepted by Delta Dental.

RECITALS:

A. Delta Dental has entered into agreements with the State of Iowa acting by and through the Iowa Department of Human Services to administer certain dental benefits to Covered Enrollees (as such term is defined below).

B. Participating Dentist wishes to enter into this Agreement to provide dental services to Covered Enrollees.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

1. Defined Terms. The following terms shall have the following meanings when used in this Agreement:

   a) **"Children's Dental Medicaid Contract"** means the contract for the provision of dental coverage for children Iowa Medicaid members between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental, as the same may be amended or restated from time to time. Notwithstanding that the State of Iowa may use a different name to refer to the Medicaid program for children or its contract with Delta Dental, the parties intend "**Children's Dental Medicaid**" to refer to that program.

   b) **"Covered Enrollee"** means an individual eligible to receive dental services under the Dental Wellness Plan Contract or Children's Dental Medicaid Contract through Delta Dental.

   c) **"Covered Services"** means dental services that meet both of the following requirements: (i) a Covered Enrollee is eligible to receive the dental services under the Dental Wellness Plan or Children's Dental Medicaid Contract; and (ii) Participating Dentist is entitled to payment for the dental services under the terms and conditions of this Agreement.

d) **"Contracts for Dental Care Services"** refers to both the Dental Wellness Plan Contract and the Children's Dental Medicaid Contract, as applicable.

e) **"Dental Wellness Plan Contract"** means the contract for the provision of dental coverage for adult Iowa Medicaid members between the State of Iowa acting by and through the Iowa Department of Human Services and Delta Dental, as the same may be amended or restated from time to time.

2. Entire Agreement; Applicability. This Agreement, together with the Incorporated Documents (as defined below), constitute the complete agreement between Participating Dentist and Delta Dental concerning the Contracts for Dental Care Services and supersede all negotiations, preliminary agreements and all prior or contemporaneous discussions and understandings between them in connection with the subject matters hereof. All the Incorporated Documents are incorporated into this Agreement as if set forth in their entirety and constitute a part hereof. This Agreement applies only to Contracts for Dental Care Services. This Agreement does not apply to any other product of Delta Dental, including, without limitation, any product described in any Delta Dental Premier Participating Dentist's Agreement, any Delta Dental PPO Agreement Supplement to any Delta Dental Premier Participating Dentist's Agreement or any Delta Dental Participating Hawk-i Orthodontic Services Agreement that may now or hereafter be in effect between Delta Dental and Participating Dentist from time to time, and any such agreement shall be unmodified by this Agreement and shall remain in full force and effect.

3. Incorporated Documents.

a) **"Incorporated Documents"** means all of the following documents and agreements, as the same may be amended or restated from time to time: (i) all documented rules and regulations of Delta Dental relating to the Dental Wellness Plan and Children's Dental Medicaid products, including, without limitation, the Delta Dental of Iowa Dental Wellness Plan and Children's Dental Medicaid Uniform Regulations (the **"Uniform Regulations"**); (ii) the Delta Dental of Iowa Dental Wellness Plan and Children's Dental Medicaid Office Manual (the **"Office Manual"**); (iii) any documented utilization, pre-treatment, pre-determination, post-treatment, office audit, focused review or other programs, and any Dental Wellness Plan and Children's Dental Medicaid incentive or bonus program, established and implemented by Delta Dental; (iv) the Dental Wellness Plan and Children's Dental Medicaid Fee Schedule (the **"Fee Schedule"**); and (v) the Contracts for Dental Care Services.

b) Delta Dental shall make all Incorporated Documents accessible to Participating Dentist by posting the same to Delta Dental of Iowa's provider Internet site promptly after the Incorporated Documents are completed, amended or restated by, or are otherwise made available to, Delta Dental.

c) Delta Dental may amend or restate this Agreement or the Incorporated Documents or may add or remove documents and agreements to or from the definition of Incorporated Documents from time to time without the consent of Participating Dentist. Any such amendment, restatement, addition or removal shall be effective immediately upon notice to Participating Dentist unless a later effective date is set forth in such notice. No such amendment, restatement, addition or removal shall retroactively apply to dental services provided prior to the effective date of such amendment, restatement, addition or removal, unless such retroactive application is required by law.

d) In the event of a conflict between the terms of this Agreement and the terms of an Incorporated Document (other than the mandatory provisions of the Contracts for Dental Care Services), the terms of this Agreement shall control. In the event of a conflict between the mandatory provisions of the Contracts for Dental Care Services and the terms of this Agreement or any other Incorporated Document, the mandatory provisions of the Contracts for Dental Care Services shall control.

4. Obligations of Participating Dentist; Indemnification. Participating Dentist agrees to abide by and comply with (a) all applicable federal and state laws, rules and regulations, and (b) the terms and conditions of all Incorporated Documents, including, without limitation, the credentialing requirements contained therein. Participating Dentist shall immediately notify Delta Dental in writing of any breach or non-compliance by Participating Dentist of this Section. Delta Dental shall not be responsible or liable in any manner whatsoever for any act or omission of Participating Dentist, including, without limitation, Participating Dentist's noncompliance with this Section or Participating Dentist's negligent or wrongful acts. Participating Dentist shall defend, indemnify and hold Delta Dental, its affiliates, and their respective officers, directors, agents and employees harmless from and against any and all claims, demands, liabilities, losses, damages, actions, judgments, costs, expenses, fines and reasonable attorneys' fees incurred by any of them arising out of or relating to any breach of this Agreement by Participating Dentist, Participating Dentist's negligent acts, omissions or willful misconduct or any violation by Participating Dentist of any applicable federal or state law, rule or regulation.

5. Payment. Subject in all events to the terms and conditions of this Agreement and all Incorporated Documents, including, without limitation, Section 5 of the Uniform Regulations, Participating Dentist shall accept from Delta Dental as payment in full for Covered Services the lesser of: (i) the applicable amount set forth in the Fee Schedule or (ii) Participating Dentist's standard fees for such Covered Services. Participating Dentist shall not bill the Covered Enrollee for the balance, if any, between Participating Dentist's standard fees for such Covered Services and the applicable amount paid under the Fee Schedule.

6. Termination. Either party may terminate this Agreement, with or without cause, by giving the other party at least sixty (60) days prior notice. In addition, Delta Dental may terminate this Agreement for cause as provided in the Uniform

Regulations. This Agreement will automatically terminate upon the death of Participating Dentist.

7. Notice.

a) All notices, demands, requests, and other communications desired or required to be given hereunder, shall be in writing and shall be given by: (i) hand delivery to the applicable address for notices set forth below; (ii) delivery by overnight courier service to the applicable address for notices set forth below; or (iii) sending the same by United States mail, postage prepaid, certified mail, return receipt requested, addressed to the applicable address for notices set forth below. In addition to the foregoing, Delta Dental may provide notice to Participating Dentist of any amendment or restatement of this Agreement or of an Incorporated Document, or any addition or removal of an agreement or document to or from the definition of Incorporated Documents by e-mailing such notice to Participating Dentist.

b) All notices shall be deemed given and effective upon the earliest to occur of: (i) the hand delivery of such notice to the applicable address for notices set forth below; (ii) one business day after the deposit of such notice with an overnight courier service by the time deadline for next day delivery addressed to the applicable address for notices set forth below; or (iii) three business days after depositing the notice in the United States mail as set forth in (a)(iii) above addressed to the applicable address for notices set forth below. E-mail notices from Delta Dental to Participating Dentist permitted under Section 7(a) above shall be deemed given and effective on the date and at the time sent by Delta Dental, and no acknowledgement of receipt shall be required to make any such e-mail notice effective.

c) Notices to Delta Dental shall be provided to Delta Dental of Iowa, 9000 Northpark Drive, Johnston, Iowa 50131, Attn: Professional Relations, or to such other address as may be updated from time to time by Delta Dental informing Participating Dentist of the same. Notices to Participating Dentist shall be provided to the address or e-mail address, as applicable set forth on the signature page to this Agreement, as the same may be updated by Participating Dentist from time to time by Participating Dentist providing notice to Delta Dental of the same. Participating Dentist shall ensure that Delta Dental has at all times an updated e-mail address for Participating Dentist.

8. Non-Exclusivity. Nothing herein shall preclude Participating Dentist from contracting with other insurance companies or carriers related to dental services. Nothing herein shall preclude Delta Dental from contracting with other dentists and providers to provide Covered Services to Covered Enrollees. Delta Dental may establish networks limited to certain dentists and provide financial and other incentive programs that may cause a Covered Enrollee to use the services of dentists or other providers other than Participating Dentist. Participating Dentist may not be eligible for such networks and programs, and such networks and programs may not be offered to all dentists.

9. General Provisions. Participating Dentist is an independent contractor of Delta Dental and none of the provisions of this Agreement are intended to create or to be construed as creating any employee-employer or agency relationship between them. Participating Dentist may not assign, delegate or subcontract Participating Dentist's rights, duties or obligations under this Agreement, in whole or in part, without the prior written consent of Delta Dental, which consent Delta Dental may withhold in its sole and unfettered discretion. Any assignment not in accordance with this Agreement shall be null and void. No failure or delay on the part of any party in exercising any right, power or remedy hereunder shall operate as a waiver thereof, nor shall any single or partial exercise of any such right, power or remedy preclude any other or further exercise thereof or the exercise of any other right, power or remedy. The remedies provided for herein are cumulative and are not exclusive of any remedies that may be available to any party at law or in equity or otherwise. Except as provided in Sections 3(c) and 7(a) of this Agreement, no amendment, modification, supplement, termination or waiver of or to any provision of this Agreement, nor consent to any departure therefrom, shall be effective unless the same shall be in writing and signed by or on behalf of the party to be charged with the enforcement thereof. Any amendment, modification or supplement of or to any provision of this Agreement, any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provision of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given. In the event any provision of this Agreement is held invalid, illegal or unenforceable, in whole or in part, the remaining provisions of this Agreement shall not be affected thereby and shall continue to be valid and enforceable. In the event any provision of this Agreement is held to be unenforceable as written, but enforceable if modified, then such provision shall be deemed to be amended to such extent as shall be necessary for such provision to be enforceable and it shall be enforced to that extent. This Agreement may be executed by the parties to this Agreement on any number of separate counterparts (including by facsimile or electronic transmission), and all of said counterparts taken together shall be deemed to constitute one and the same instrument. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective heirs, successors, legal representatives and permitted assigns. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto (and their respective heirs, successors, legal representatives and permitted assigns) any rights, remedies, liabilities or obligations under or by reason of this Agreement. This Agreement shall not be construed more strongly against either party regardless of who was more responsible for its preparation.

10. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Iowa, without regard to provisions thereof relating to conflicts of law.

11. Venue. Each of the parties hereby irrevocably submits to the exclusive jurisdiction of any United States or Iowa District Court sitting in Des Moines, Iowa in any action or proceeding arising out of or relating to this Agreement,

and each party hereby irrevocably agrees that all claims in respect of such action or proceeding may be heard and determined in any such court. Each of the parties irrevocably waives any objection, including without limitation, any objection to the laying of venue or based on the grounds of forum non conveniens, which it may now or hereafter have to the bringing of any such action or proceedings in such respective jurisdictions. Each of the parties irrevocably consents to the service of any and all process in any such action or proceeding brought in any court in or of the State of Iowa by the delivery of copies of such process to each party, at its address specified for notices to be given hereunder.

12. Actions and Jury Trial Waiver. Participating Dentist may not bring any legal or equitable action on or with respect to any claim arising out of or relating to this Agreement more than two (2) years after the cause of action arises. Delta Dental and Participating Dentist each hereby voluntarily, irrevocably and unconditionally waives all right to trial by jury in any action, proceeding or counterclaim arising out of or relating to this Agreement.

[Signature page follows]

Accepted by: Delta Dental of Iowa on this _____day of_____, _____ Chief Dental Officer, Delta Dental of Iowa _____	Participating Dentist: Signature _____ (Name of Participating Dentist) Print Name_____ Address_____ City/Zip_____ Email_____ Tax ID Number_____ Date_____

Effective: 1.01.2021

DELTA DENTAL®

www.deltadentalia.com

Delta Dental of Iowa
Direct Deposit / Electronic Funds Transfer (EFT)
Authorization Agreement – Instructions and Enrollment Form

Special Notes	If you are also participating in Electronic Remittance Advice (ERA)/835, please contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
Where to Submit Completed Enrollment Form	Professional Relations Delta Dental of Iowa 9000 Northpark Drive Johnston, IA 50131 Fax 515-261-5608 provrelations@deltadentalia.com
General Instructions	If you have multiple offices and would like Direct Deposit for each location, you must complete a form for each office location. Accuracy of all information is essential. If you have any questions, please contact Delta Dental's Professional Relations Team.
Delta Dental of Iowa Contact Information	Professional Relations Delta Dental of Iowa 9000 Northpark Drive Johnston, IA 50131 800-544-0718 Fax 515-261-5608 provrelations@deltadentalia.com
Enrollment Confirmation	Once enrollment processes are complete, Delta Dental of Iowa will notify the provider via email or phone call to confirm the Direct Deposit/EFT start date.
Late or Missing Direct Deposit/EFT	If the expected Direct Deposit/EFT appears to be late or missing, please contact Delta Dental of Iowa's Professional Relations Team at 800-544-0718 or provrelations@deltadentalia.com.

DELTA DENTAL

www.deltadentalia.com

Delta Dental of Iowa Direct Deposit / Electronic Funds Transfer (EFT) Enrollment Form

PROVIDER INFORMATION

Provider Name

_____

Provider Address

_____ (Street) _____ (City) _____ (State) _____ (ZIP Code)

PROVIDER IDENTIFIERS INFORMATION

Provider Identifiers

_____
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

_____
National Provider Identifier (Individual Provider - NPI 1)

_____
National Provider Identifier (Organizational - NPI 2)

PROVIDER CONTACT INFORMATION

Provider Contact Name:

_____

_____
Telephone Number

_____
Email Address

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name: _____

Financial Institution Telephone Number: _____

Financial Institution Routing Number: _____

Type of Account at Financial Institution: ❑ **Checking** ❑ **Savings**

Provider's Account Number with Financial Institution: _____

Account Number Linkage to Provider Identifier: _____
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

SUBMISSION INFORMATION

Reason for Submission

(check one) ❑ New Enrollment ❑ Change Enrollment ❑ Cancel Enrollment

Include with Enrollment Submission

(check one) ❑ Voided Check
❑ Bank Letter (A letter on bank letterhead that formally certifies the account owners routing and account numbers)

Authorized Signature (The signature of an individual authorized by the provider or its agent to initiate, modify, or terminate an enrollment) This authority is to remain in full force and effective until Delta Dental of Iowa (DDIA) receives written notification from me/us of its termination in such time and manner as to afford DDIA reasonable opportunity to act on it. In addition, I (we) certify to the best of my (our) knowledge that the banking information given is not that of a foreign banking institution (located outside of the United States).*

Please sign, date and return completed form, along with voided check or bank letter to: Professional Relations, Delta Dental of Iowa, 9000 Northpark Dr., Johnston, IA 50131 or Fax to 515-261-5608

_____
Written Signature of Person Submitting Enrollment and Title

_____
Printed Name of Person Submitting Enrollment

Submission Date: _____

Requested Direct Deposit Start/Change/Cancel Date: _____

*If you banking institution is a foreign bank, please contact Delta Dental of Iowa at 800-544-0718 for further instructions.

REMITTANCE ADVICE DELIVERY

Delivery Option:

❑ E-mail notification with delivery of the Remittance Advice to the website

_____
E-mail to receive direct deposit notification

Delta Dental of Iowa Administrative Use Only:

_____ _____ _____
Date DDIA Representative Initials Payee Number

DELTA DENTAL NATIONAL EFT/ERA AUTHORIZATION FORM

Delta Dental of Iowa is making enhancements to allow you to receive Electronic Funds Transfers (EFT) from all Delta Dental Member companies, and not just Delta Dental of Iowa. This solution will simplify electronic payments to participating providers and provide access to Electronic Remittance Advice (ERA) information. This means that all dentists signed up for direct deposit (EFT) can be enrolled in to accepting direct deposit from other Delta Dental member companies instead of receiving a paper check if you opt in to the National EFT/ERA feature by signing below. If you currently receive direct deposit from Delta Dental of Iowa and do not wish to opt into the national solution you do not need to do anything. Your office will continue to receive direct deposit (EFT) from Delta Dental of Iowa.

☐ **Yes, I wish to receive Delta Dental National EFT/ERA**

Email: _____

By marking the above and returning this form with signature, I give consent to Delta Dental of Iowa to provide my direct deposit information to other Delta Dental member companies. I do understand I will continue to receive direct deposit(s)/electronic funds transfers (EFT) from Delta Dental of Iowa with access to Remittance Advice (RA) / Electronic Remittance Advice (ERA).

In consideration for the provision of direct deposit services, by signing below, and notwithstanding any language to the contrary herein, you hereby acknowledge and agree that (i) any information you have provided, including but not limited to, the information you supplied Delta Dental of Iowa under the heading "Banking Information", may be transferred, shared or otherwise provided by us to or with any entity that is an affiliate of Delta Dental, as defined above, with other Delta Dental member companies and their affiliates, and with Delta Dental Plans Association, for use in connection with funds to be deposited to your account, (ii) any election to discontinue enrollment in this direct deposit program will take 45 business days to process, and may not be effective to halt any deposits that were initiated while your enrollment in this direct deposit program was in effect, and (iii) in the absence of gross negligence or willful misconduct, neither we, any of our members and affiliates, other Delta Dental member companies and their affiliates, or Delta Dental Plans Association, will be responsible for any damages, or for any fee, charge or other expense assessed against the Bank Account identified above, in conjunction with this direct deposit program. Further, by signing below, you represent and warrant that (i) all of the information you supplied is true and accurate, (ii), the information provided under the heading "Banking Information," above, identifies a bank account held by the Business you identified above, and (iii) the signatory to this Direct Deposit Enrollment Form ("Form") has all necessary power and authority to execute this Form.

Dentist / Office Name: _____

Address, City, State, Zip: _____

Office Phone Number: _____

Provider Tax ID#: _____ NPI: _____

Authorized Signature: _____ Title: _____

Please mail or fax form back to:

Attn: Professional Relations
Delta Dental of Iowa
9000 Northpark Drive
Johnston, Iowa 50131

Fax: 515-261-5608

Questions?

Contact Delta Dental of Iowa Professional Relations at provrelations@deltadentalia.com or 800-544-0718

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

DELTA DENTAL®

OWNERSHIP & CONTROL DISCLOSURE FORM

Delta Dental of Iowa is obligated by law to ensure it is not doing business with a person or entity that has been excluded from participation in government programs.[1] Completion and submission of this form is a condition to participation in any government program. Please complete this form as fully as possible. You must disclose all responsive information you know or should know. You ensure all information is accurate and must immediately report any changes by completing a new form. Thank you.

Entity Name:	Tax I.D. Number:
Individual NPI (if applicable):	Organizational NPI (if applicable):

A. Required Disclosures. Below, providers need to disclose 1) each person or entity that has a direct or indirect[2] ownership or control interest in the above entity, 2) each person who is a managing employee[3] of the above entity, 3) any subcontractor[4] in which the above entity has a direct or indirect ownership of five percent (5%) or more, 4) the family relationship, if any, between those with ownership or control interests in the above entity, 5) any other business entities involved with a government program in which the persons listed below have an ownership or control interest, 6) the ownership of any subcontractor to which the above entity has paid more than $25,000 during the last year, 7) any wholly-owned supplier with which the above entity has any significant transactions during the last 5 years, and 8) any subcontractor with which the above entity has had any significant transactions the last 5 years. **Please use tables on pages 3-4 to disclose the information in response to each category.**

B. Final Adverse Actions. Delta Dental of Iowa is obligated to determine whether any provider, supplier or any owner of any provider or supplier has been the subject of a final adverse action. Such disclosure is required for all persons or entities listed herein and the disclosing entity. All final adverse actions must be reported, regardless of whether the action has been appealed or expunged. You are required to report all final adverse actions within 30 days of the event. A final adverse action means any convictions of criminal offenses related to or arising from any Medicare, Medicaid, or Title XX program, including any felony or misdemeanor convictions. It also includes any revocation, suspension or surrender of any health care-related license or accreditation and any suspension, revocation, exclusion or disbarment from participation in or any other sanction imposed by a federal or state health care program or any federal executive branch procurement or non-procurement program.

On page 4, please list all persons and entities disclosed above and 1) if the person or entity has not had a final adverse action, put an “N” in the “Y or N” box after the name; 2) if the person or entity has had a final adverse action, put a “Y” in the “Y or N” box and provide the requested details.

---

[1] 42 C.F.R. § 438.610; 42 C.F.R.§§ 455-104-106; 42 C.F.R. §§ 424.516, 519

[2] Direct ownership includes possession of equity in the capital, stock or profits of entity identified above. Indirect ownership includes an ownership interest in an entity that owns the entity identified above or an ownership interest in any entity that has an indirect ownership interest in the entity identified above.

[3] A managing employee means a general manager, business manager, office manager, administrator, director, or any person who exercises operational or managerial control over the disclosing entity. This includes any independent contractor in such a position. All managing employees at all the disclosing entity’s locations must be disclosed.

[4] Subcontractor means a person or entity to which the disclosing entity as contracted or delegated some management function(s) or responsibility of providing medical care, and any person or entity with which the fiscal agent has entered into an agreement to obtain space, goods or services provided under the Medicaid agreement.

C. Other Affiliations. Does the disclosing entity have any current or previous direct or indirect affiliation[5] with a present or former Medicaid provider? ☐ Y ☐ N. If yes, please identify the Medicaid provider(s) on page 4.

D. Outstanding Debt. Do any of the persons or entities listed part B. above have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa state governments? ☐ Y ☐ N ☐ Unknown. If yes, please identify the person or entity on page 4.

E. Other Sanctions. Have any of the persons or entities listed in part B. above been subject to a payment suspension under a federally-funded health care program, had billing privileges denied or revoked, or been excluded from participation under any federally-funded health care program?

- Payment Suspension: ☐ Y ☐ N ☐ Uknown
- Denied or Revoked Billing Privileges: ☐ Y ☐ N ☐ Uknown
- Excluded: ☐ Y ☐ N ☐ Uknown. If yes to any, please identify the person or entity on page 4.

F. National Provider Identifier (NPI). Do any of the persons or entities listed in part B. share a NPI or Federal Tax Identification number with another provider who has uncollected debt?
☐ Y ☐ N ☐ Unknown. If Yes, please identify the person or entity on page 4.

The disclosing entity certifies that the information submitted on this form is true, accurate and complete to the best of the entity's knowledge; that the disclosing entity has read all entries before signing; the disclosing entity agrees to contact Delta Dental of Iowa within 30 days of any changes in the information herein; the disclosing entity understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal or state law. Thank you very much.

Printed Name of Legal Entity Signatory:	
Signature:	Date:

Please use following pages for disclosures.

[5] Affiliation includes, but is not limited to, direct or indirect relationships between individuals or entities or a combination of the two. Such a relationship includes, but is not limited to, a compensation arrangement, an ownership arrangement, managerial authority over any member of the affiliation, the ability of one member of the affiliation to control the other, or the ability of a third party to control a member of the affiliation.

Please use these tables to complete your disclosures. They reference the parts of this disclosure form above. If you need more space, please copy this form for use.

A.1) OWNERS

Name (Legal and Doing Business)	Address	Social Security or Taxpayer ID Number	Describe Ownership Interest

A.2) MANAGING EMPLOYEES

Name	Date of Birth	Social Security Number	Job Title

A.3) SUBCONTRACTOR OWNERSHIP (5% OR MORE)

Name	Tax ID Number	Address

A.4) FAMILY RELATIONSHIPS

A.5) OTHER OWNED ENTITIES

Name	Fiscal Agent / Medicaid No.	Tax ID Number	Primary Address

A.6) SUBCONTRACTORS PAID $25,000

Name	Tax ID Number	Address

A.7) OWNED SUPPLIER SIGNIFICANT TRANSACTIONS

Name	Tax ID Number	Address

A.8) SUBCONTRACTOR SIGNIFICANT TRANSACTIONS

Name	Tax ID Number	Address

B) FINAL ADVERSE ACTIONS

Name	Y or N	Date	Action Taken	Resolution

C) OTHER AFFILIATIONS

Name of Person or Entity	Primary Address	Tax ID Number	Primary Address

D) OUTSTANDING DEBT

Name of Person or Entity	Primary Address

E) OTHER SANCTIONS

Name of Person or Entity	Primary Address	Type of Sanction

F) NATIONAL PROVIDER IDENTIFIER

Name of Person or Entity	Primary Address	NP or Tax ID Number

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D0120	periodic oral evaluation - established patient	$19.64
D0140	limited oral evaluation - problem focused	$28.15
D0150	comprehensive oral evaluation - new or established patient	$28.25
D0170	re-evaluation-limited, problem focused (established patient; not post operative visit)	$28.15
D0180	comprehensive periodontal evaluation - new or established patient	$28.25
D0190	screening of a patient	$16.27
D0210	intraoral - comprehensive series of radiographic images	$56.29
D0220	intraoral - periapical first radiographic image	$11.25
D0230	intraoral - periapical each additional radiographic image	$9.00
D0240	intraoral-occlusal radiographic image	$13.50
D0250	extraoral-2D projection radiographic image created using a stationary radiation source, and detector	$29.92
D0251	extra oral posterior dental radiograph image	$29.92
D0270	bitewing-single radiographic image	$10.13
D0272	bitewings - two radiographic images	$18.01
D0273	bitewings - three radiographic images	$21.86
D0274	bitewings - four radiographic images	$27.03
D0321	other temporomandibular joint radiographic images, by report	$29.27
D0330	panoramic radiographic image	$50.65
D0340	2D cephalometric radiographic image-acquisition, measurement, and analysis	$50.65
D0364	cone beam CT capture and interpretation with limited field of view-less than one whole jaw	$207.97
D0365	cone beam CT capture and interpretation with field of view of one full dental arch-mandible	$207.97
D0366	cone beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium	$207.97
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	$207.97
D0368	cone beam CT capture and interpretation for temporomandibular joint series including two or more exposures	$207.97
D0380	cone beam CT image capture with limited field of view-less than one whole jaw	$207.97
D0381	cone beam CT image capture with field of view of one full dental arch-mandible	$207.97

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D0382	cone beam CT image capture with field of view of one full dental arch-maxilla, with or without cranium	$207.97
D0383	cone beam CT image capture with field of view of both jaws, with or without cranium	$207.97
D0384	cone beam CT image capture for TMJ series including two or more exposures	$207.97
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	$222.04
D0393	virtual treatment simulation using 3D image volume or surface scan	$307.62
D0394	digital subtraction of two or more images or image volumes of the same modality	$79.07
D0395	fusion of two or more 3D image volumes of one or more modalities	$79.07
D0460	pulp vitality tests	$20.00
D0470	diagnostic casts	$39.40
D0601	caries risk assessment and documentation	$0.00
D0602	caries risk assessment and documentation, with a finding of low risk	$0.00
D0603	caries risk assessment and documentation, with a finding of high risk	$0.00
D1110	prophylaxis – adult	$42.98
D1120	prophylaxis - child	$29.48
D1206	topical application of fluoride varnish	$17.20
D1208	topical application of fluoride - excluding varnish	$17.20
D1351	sealant - per tooth	$24.56
D1353	sealant repair-per tooth	$21.94
D1354	application of caries arresting medicant-per tooth	$4.30
D1510	space maintainer-fixed, unilateral-per quadrant	$112.59
D1516	space maintainer-fixed-bilateral, maxillary	$180.15
D1517	space maintainer-fixed-bilateral, mandibular	$180.15
D1520	space maintainer-removable, unilateral-per quadrant	$159.87
D1526	space maintainer-removable-bilateral, maxillary	$168.89
D1527	space maintainer-removable-bilateral, mandibular	$168.89
D1551	re-cement or re-bond bilateral space maintainer-maxillary	$28.15
D1552	re-cement or re-bond bilateral space maintainer-mandibular	$28.15
D1553	re-cement or re-bond unilateral space maintainer-per quadrant	$28.15
D1556	removal of fixed unilateral space maintainer-per quadrant	$27.32
D1557	removal of fixed bilateral space maintainer-maxillary	$27.32
D1558	removal of fixed bilateral space maintainer-mandibular	$27.32
D1999	unspecified preventive procedure, by report	$96.80

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D2140	amalgam - one surface, primary or permanent	$50.65
D2150	amalgam - two surfaces, primary or permanent	$64.18
D2160	amalgam - three surfaces, primary or permanent	$77.68
D2161	amalgam - four or more surfaces, primary or permanent	$87.81
D2330	resin-based composite - one surface, anterior	$57.41
D2331	resin-based composite - two surfaces, anterior	$73.18
D2332	resin-based composite - three surfaces, anterior	$84.44
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$95.69
D2390	resin-based composite crown, anterior	$95.69
D2391	resin-based composite - one surface, posterior	$57.41
D2392	resin-based composite - two surfaces, posterior	$79.71
D2393	resin-based composite - three surfaces, posterior	$84.44
D2394	resin-based composite - four or more surfaces, posterior	$95.69
D2710	crown - resin-based composite (indirect)	$168.89
D2712	crown-3/4 resin-based composite (indirect)	$168.89
D2720	crown - resin with high noble metal	$289.75
D2721	crown - resin with predominantly base metal	$557.29
D2740	crown - porcelain/ceramic substrate	$466.11
D2750	crown - porcelain fused to high noble metal	$517.90
D2751	crown - porcelain fused to predominantly base metal	$461.60
D2752	crown - porcelain fused to noble metal	$523.54
D2781	crown-3/4 case predominantly base metal	$440.43
D2790	crown - full cast high noble metal	$461.60
D2791	crown - full cast predominantly base metal	$444.70
D2792	crown - full cast noble metal	$476.24
D2910	re-cement or re-bond inlay, overlay, veneer or partial coverage restoration	$42.77
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	$33.78
D2920	re-cement or re-bond crown	$33.78
D2921	reattachment of tooth fragment, incisional edge or cusp	$116.99
D2928	prefabricated porcelain/ceramic crown-permanent tooth	$151.30
D2929	prefabricated porcelain/ceramic crown-primary tooth	$138.64
D2930	prefabricated stainless steel crown-primary tooth	$112.59
D2931	prefabricated stainless steel crown-permanent tooth	$123.84
D2932	prefabricated resin crown	$129.48
D2933	prefabricated stainless steel crown with resin window	$138.64
D2934	prefabricated esthetic coated stainless-steel crown-primary tooth	$138.64
D2940	protective restoration	$34.90
D2950	core buildup, including any pins when required	$121.86
D2951	pin retention-per tooth, in addition to restoration	$13.50
D2952	post and core in addition to crown, indirectly fabricated	$140.74
D2954	prefabricated post and core in addition to crown	$83.31

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D2971	additional procedures to customize a crown to fit under an existing partial	$55.08
D2976	band stabilization per tooth	$28.15
D2980	crown repair necessitated by restorative material failure	$151.26
D2990	resin infiltration of incipient smooth surface lesions	$68.76
D2999	unspecified restorative procedure, by report	$24.91
D3220	therapeutic pulpotomy (excluding final restoration)-removal of pulp coronal	$65.30
D3221	pulpal debridement, primary and permanent teeth	$81.24
D3222	partial pulpotomy for apexogenesis-permanent tooth with incomplete root	$146.66
D3310	endodontic therapy, anterior tooth (excluding final restoration)	$356.45
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	$412.75
D3330	endodontic therapy, molar (excluding final restoration)	$508.45
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$233.76
D3346	retreatment of previous root canal therapy-anterior	$384.59
D3347	retreatment of previous root canal therapy-premolar	$446.54
D3348	retreatment of previous root canal therapy-molar	$632.29
D3351	apexification/recalcification-initial visit (apical closure/calcific repair of	$84.44
D3352	apexification/recalcification-interim medication replacement	$56.29
D3353	apexification/recalcification-final visit (includes completed root canal	$154.87
D3355	pulpal regeneration-initial visit	$173.32
D3356	pulpal regeneration-interim medication replacement	$121.31
D3357	pulpal regeneration-completion or treatment	$121.31
D3410	apicoectomy-anterior	$260.07
D3421	apicoectomy-premolar (first root)	$347.88
D3425	apicoectomy-molar (first root)	$157.60
D3426	apicoectomy (each additional root)	$56.31
D3427	Periradicular surgery without apicectomy	$132.15
D3430	retrograde filling-per root	$210.62
D3450	root amputation-per root	$71.11
D3471	surgical repair of root resorption-anterior	$132.15
D3472	surgical repair of root resorption-premolar	$132.15
D3473	surgical repair of root resorption-molar	$132.15
D3501	surgical exposure of root surface without apicoectomy or repair of root	$132.15
D3502	surgical exposure of root surface without apicoectomy or repair of root	$132.15
D3503	surgical exposure of root surface without apicoectomy or repair of the root	$132.15
D3921	decoration or submergence of an erupted tooth	$56.29
D3999	unspecified endodontic procedure, by report	$162.67
D4210	gingivectomy or gingivoplasty-four or more contiguous teeth or tooth	$253.31
D4211	gingivectomy or gingivoplasty-one to three contiguous teeth or tooth	$126.66
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$22.51

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D4240	gingival flap procedure, including root planing-four or more contiguous teeth or tooth bounded spaces per quadrant	$389.40
D4241	gingival flap procedure, including root planing-one to three contiguous teeth or tooth bounded spaces per quadrant	$324.50
D4245	apically positioned flap	$344.42
D4249	clinical crown lengthening-hard tissue	$393.80
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$461.60
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$173.09
D4263	bone replacement graft-retained natural tooth-first site in quadrant	$197.03
D4264	bone replacement graft-retained natural tooth-each additional site in quadrant	$197.03
D4265	biologic materials to aid in soft and osseous tissue regeneration, per site	$399.96
D4266	guided tissue regeneration, natural teeth-resorbable barrier, per site	$489.53
D4267	guided tissue regeneration, natural teeth-non-resorbable barrier, per site	$505.54
D4270	pedicle soft tissue graft procedure	$427.84
D4273	autogenous connective tissue graft procedure (including donor and recipient surgical sites)-each additional contiguous tooth, implant or edentulous tooth position in graft	$247.50
D4275	non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$427.84
D4276	combined connective tissue and pedicle graft, per tooth	$577.50
D4277	free soft tissue graft procedure, (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$394.05
D4278	free soft tissue graft procedure, (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$315.52
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites)-each additional contiguous tooth, implant or edentulous tooth position in same graft site	$82.50
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)-each additional contiguous tooth, implant or edentulous tooth position in same graft site	$110.00
D4286	removal of non-resorbable barrier	$202.50
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$112.59
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$42.24
D4346	scaling in the presence of generalized moderate or severe gingival	$39.40
D4355	full mouth debridement to enable a comprehensive periodontal evaluation	$56.29
D4910	periodontal maintenance	$67.55
D4920	unscheduled dressing change (by someone other than the treating dentist or	$18.01
D4999	unspecified periodontal procedure, by report	$33.00
D5110	complete denture - maxillary	$585.44
D5120	complete denture - mandibular	$579.83
D5130	immediate denture-maxillary	$619.24

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D5140	immediate denture-mandibular	$562.94
D5211	maxillary partial denture-resin base (including retentive/clasping materials, rests, and teeth)	$281.45
D5212	mandibular partial denture-resin base (including retentive clasping materials, rests, and teeth)	$365.90
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	$650.14
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$650.14
D5225	maxillary partial denture-flexible base (including retentive/clasping materials, rests and teeth)	$555.04
D5226	mandibular partial denture-flexible base (including retentive/clasping materials, rests and teeth)	$555.04
D5410	adjust complete denture-maxillary	$22.51
D5411	adjust complete denture-mandibular	$22.51
D5421	adjust partial denture-maxillary	$22.51
D5422	adjust partial denture-mandibular	$22.51
D5511	repair broken complete denture base, mandibular	$82.50
D5520	replace missing or broken teeth-complete denture (each tooth)	$56.29
D5611	repair resin partial denture base, mandibular	$82.50
D5612	repair resin partial denture base, maxillary	$108.90
D5621	repair cast partial framework, mandibular	$125.40
D5622	repair cast partial framework, maxillary	$152.90
D5630	repair or replace broken retentive/clasping materials-per tooth	$58.54
D5640	replace broken teeth-per tooth	$55.08
D5650	add tooth to existing partial denture	$75.45
D5660	add clasp to existing partial denture-per tooth	$89.81
D5710	rebase complete maxillary denture	$261.09
D5711	rebase complete mandibular denture	$261.09
D5720	rebase maxillary partial denture	$298.66
D5721	rebase mandibular partial denture	$297.56
D5730	reline complete maxillary denture (direct)	$140.74
D5731	reline complete mandibular denture (direct)	$123.84
D5740	reline maxillary partial denture (direct)	$95.69
D5741	reline mandibular partial denture (direct)	$112.59
D5750	reline complete maxillary partial denture (indirect)	$180.15
D5751	reline complete mandibular partial denture (indirect)	$180.15
D5760	reline maxillary partial denture (indirect)	$168.89
D5761	reline mandibular partial denture (indirect)	$168.89

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D5765	soft liner for complete or partial removable denture-indirect	$132.28
D5850	tissue conditioning, maxillary	$33.78
D5851	tissue conditioning, mandibular	$33.78
D5862	precision attachment, by report	$112.62
D5863	overdenture-complete maxillary	$839.50
D5864	overdenture-complete partial maxillary	$860.07
D5865	overdenture-complete mandibular	$839.50
D5866	overdenture-partial mandibular	860.07
D5899	unspecified removable prosthodontic procedure, by report	$165.00
D5931	obturator prosthesis, surgical	$1,100.00
D5932	obturator prosthesis, definitive	$1,111.29
D5933	obturator prosthesis, modification	$76.20
D5954	palatal augmentation prosthesis	$1,583.69
D5958	palatal lift prosthesis, interim	$429.00
D5992	adjust maxillofacial prosthetic appliance, by report	$180.41
D5999	unspecified maxillofacial prosthesis, by report	$24.45
D6010	surgical placement of implant body: endosteal implant	$1,186.84
D6012	surgical placement of interim implant body for transitional prosthesis:	$825.00
D6013	surgical placement of mini-implant	$736.59
D6040	surgical placement: eposteal implant	$4,106.30
D6050	surgical placement: transosteal implant	$2,881.46
D6055	connecting bar-implant supported or abutment supported	$1,675.22
D6056	prefabricated abutment-includes modification and placement	$518.57
D6057	custom fabricated abutment-includes placement	$607.20
D6058	abutment supported porcelain/ceramic crown	$853.37
D6059	abutment supported porcelain fused to metal crown (high noble	$750.76
D6060	abutment supported porcelain fused to metal crown (predominantly	$710.60
D6061	abutment supported porcelain fused to metal crown (noble crown)	$797.55
D6062	abutment supported cast metal crown (high noble metal)	$748.56
D6063	abutment supported cast metal crown (predominantly base metal)	$696.86
D6064	abutment supported cast metal crown (noble metal)	$711.70
D6065	implant supported porcelain/ceramic crown	$784.86
D6066	implant supported crown-porcelain fused to high noble alloys	$789.26
D6067	implant supported crown-high noble alloys	$797.50
D6068	abutment supported retainer for porcelain/ceramic FPD	$768.90
D6069	abutment supported retainer for porcelain fused to metal FPD (high	$763.96
D6070	abutment supported retainer for porcelain fused to metal FPD	$709.50

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	$859.93
D6072	abutment supported retainer for cast metal FPD (high noble metal)	$768.90
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	$713.90
D6074	abutment supported retainer for cast metal FPD (noble metal)	$715.00
D6075	implant supported retainer for ceramic FPD	$789.80
D6076	implant supported retainer for FPD-porcelain fused to high noble alloys	$807.96
D6077	implant supported retainer for metal FPD-high noble alloys	$808.50
D6080	implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prosthesis and abutments	$151.26
D6082	implant supported crown-porcelain fused to predominantly base alloys	$789.26
D6083	implant supported crown-porcelain fused to noble alloys	$789.26
D6084	implant supported crown-porcelain fused to titanium or titanium alloys	$789.26
D6086	implant supported crown-predominantly base alloys	$789.26
D6087	implant supported crown-high noble alloys	$797.50
D6088	implant supported crown-titanium and titanium alloys	$797.50
D6089	accessing and retorquing loose implant screw-per screw	$82.50
D6090	repair implant supported prosthesis, by report	$383.90
D6091	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	$318.46
D6092	re-cement or re-bond implant/abutment supported crown	$83.60
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	$97.90
D6094	abutment supported crown-titanium and titanium alloys	$696.30
D6095	repair implant abutment, by report	$385.00
D6097	abutment supported crown-porcelain fused to titanium or titanium alloys	$789.29
D6098	implant supported retainer-porcelain fused to predominantly base alloys	$789.26
D6099	implant supported retainer for FPD-porcelain fused to noble alloys	$763.96
D6100	surgical removal of implant body	$401.50
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$253.30
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of	$304.42
D6105	removal of implant body not requiring bone removal nor flap elevation	$200.75
D6110	implant/abutment supported removable denture for edentulous arch-maxillary	$1,478.40
D6111	implant/abutment supported removable denture for edentulous arch-	$1,452.00

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D6112	implant/abutment supported removable denture for partially edentulous arch-maxillary	$1,445.40
D6113	implant/abutment supported removable denture for partially edentulous arch-mandibular	$1,419.00
D6114	implant/abutment supported fixed denture for edentulous arch-maxillary	$2,889.16
D6115	implant/abutment supported fixed denture for edentulous arch-mandibular	$2,860.00
D6116	implant/abutment supported fixed denture for partially edentulous arch-maxillary	$2,061.96
D6117	implant/abutment supported fixed denture for partially edentulous arch-mandibular	$1,017.50
D6120	implant supported retainer – porcelain fused to titanium and titanium alloys	$763.96
D6121	implant supported retainer for metal FPD – predominantly base alloys	$709.50
D6122	implant supported retainer for metal FPD – noble alloys	$763.96
D6123	implant supported retainer for metal FPD – titanium and titanium alloys	$763.96
D6190	radiographic/Surgical implant index, by report	$189.76
D6191	semi-precision abutment - placement	$639.37
D6192	semi-precision attachment - placement	$639.37
D6194	abutment-supported retainer crown for FPD, titanium	$712.80
D6195	abutment supported retainer – porcelain fused to titanium and titanium alloys	$763.96
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$57.41
D6199	unspecified implant procedure, by report	$138.60
D6205	pontic – indirect resin-based composite	$181.01
D6210	pontic - cast high noble metal	$181.01
D6211	pontic - cast predominantly base metal	$168.10
D6212	pontic - cast noble metal	$168.10
D6240	pontic - porcelain fused to high noble metal	$439.09
D6241	pontic - porcelain fused to predominantly base metal	$258.20
D6242	pontic - porcelain fused to noble metal	$365.90
D6243	pontic – porcelain fused to titanium and titanium alloys	$439.09
D6245	pontic - porcelain/ceramic	$439.09
D6250	pontic - resin with high noble metal	$206.89
D6251	pontic - resin with predominantly base metal	$181.01
D6252	pontic - resin with noble metal	$181.01
D6545	retainer – cast metal for resin-bonded fixed prosthesis	$112.59
D6549	resin retainer – for resin bonded fixed prosthesis	$498.86

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D6710	retainer crown - indirect resin based composite	$168.89
D6720	retainer crown - resin with high noble metal	$206.89
D6721	retainer crown - resin with predominantly base metal	$200.42
D6722	retainer crown - resin with noble metal	$200.42
D6740	retainer crown - porcelain/ceramic	$466.11
D6750	retainer crown - porcelain fused to high noble metal	$473.97
D6751	retainer crown - porcelain fused to predominantly base metal	$316.81
D6752	retainer crown - porcelain fused to noble metal	$377.16
D6753	retainer crown – porcelain fused to titanium and titanium alloys	$473.97
D6780	retainer Crown – ¾ cast high noble metal	$187.47
D6784	retainer crown ¾ – titanium and titanium alloys	$187.47
D6790	retainer crown - full cast high noble metal	$288.63
D6791	retainer crown - full cast predominantly base metal	$233.71
D6792	retainer crown - full cast noble metal	$248.78
D6920	connector bar	$524.70
D6930	re-cement or re-bond bridge	$50.65
D6940	stress breaker	$56.31
D6950	precision attachments	$112.62
D6980	fixed partial denture (bridge) repair, necessitated by restorative material failure	$202.40
D6999	unspecified fixed prosthodontic procedure, by report	$55.00
D7111	extraction, coronal remnants - deciduous tooth	$42.23
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$56.29
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$106.95
D7220	removal of impacted tooth – soft tissue	$151.99
D7230	removal of impacted tooth - partially bony	$202.65
D7240	removal of impacted tooth - completely bony	$236.42
D7241	removal of impacted tooth – completely bony, with unusual surgical complications	$210.52
D7250	surgical removal of residual tooth roots (cutting procedure)	$110.34
D7251	coronectomy- intentional partial tooth removal, impacted teeth only	$242.48
D7260	oroantral fistula closure	$327.15
D7261	primary closure of a sinus perforation	$327.15
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$129.30
D7280	surgical access of unerupted tooth	$264.58
D7282	mobilization of erupted or mal-positioned tooth to aid eruption	$273.30
D7283	placement of device to facilitate eruption of impacted tooth	$168.89

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D7284	excisional biopsy of minor salivary glands	$107.47
D7285	incisional biopsy of oral tissue – hard (bone, tooth)	$197.03
D7286	biopsy of oral tissue – soft (all others)	$118.21
D7287	cytology exfoliative sample collection	$3.58
D7295	harvest of bone for use in autogenous grafting procedure	$778.13
D7310	alveoloplasty in conjunction with extractions – per quadrant	$93.94
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth	$93.94
D7320	alveoloplasty, not in conjunction with extractions – per quadrant	$106.95
D7321	alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$106.95
D7340	vestibuloplasty – ridge extension (secondary epithelialization)	$844.40
D7350	vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$1,125.87
D7410	excision of benign lesion, up to 1.25 cm	$253.31
D7411	excision of benign lesion > 1.25 cm	$202.65
D7412	excision of benign lesion; complicated	$222.91
D7413	excision of malignant lesion, up to 1.25 cm	$194.26
D7414	excision of malignant lesion > 1.25 cm	$222.33
D7415	excision of malignant lesion, complicated	$244.56
D7440	excision of malignant tumor-lesion, diameter up to 1.25 cm	$121.71
D7441	excision of malignant tumor-lesion, diameter >1.25 cm	$140.12
D7450	removal of benign odontogenic cyst or tumor lesion, diameter up to 1.25 cm	$116.37
D7451	removal of benign odontogenic cyst or tumor, lesion diameter > 1.25 cm	$253.31
D7460	removal of benign non-odontogenic cyst or tumor, lesion, diameter up to 1.25 cm	$121.71
D7461	processing and interpretation of exfoliative cytologic smears, including preparation and transmission of written report	$253.31
D7465	destruction of lesion(s) by physical or chemical methods, by report	$168.89
D7471	removal of exostosis – per site	$131.72
D7472	removal of torus palatinus	$131.72
D7473	removal of torus mandibularis	$131.72
D7485	surgical reduction of osseous tuberosity	$173.89
D7490	radical resection of maxilla mandible	$4,198.70

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D7509	marsupialization of odontogenic cyst	$168.89
D7510	incision and drainage of abscess – intraoral soft tissue	$58.54
D7511	incision and drainage of abscess intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$58.54
D7520	incision and drainage of abscess – extraoral soft tissue	$253.31
D7521	incision and drainage of abscess extraoral soft tissue complicated (includes drainage of multiple fascial spaces)	$253.31
D7530	removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue	$103.43
D7540	removal of reaction-producing foreign bodies –musculoskeletal system	$174.55
D7550	partial ostectomy, sequestrectomy for removal of nonvital bone	$172.25
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	$281.45
D7610	maxilla – open reduction (teeth immobilized, if present)	$3,462.04
D7620	maxilla – closed reduction (teeth immobilized, if present)	$562.94
D7630	mandible – open reduction (teeth immobilized, if present)	$1,970.27
D7640	mandible – closed reduction (teeth immobilized, if present)	$1,238.44
D7650	malar and/or zygomatic arch – open reduction	$549.53
D7660	malar and/or zygomatic arch – closed reduction	$374.96
D7670	aveolus – closed reduction, may include stabilization of teeth	$374.96
D7671	alveolus – open reduction, may include stabilization of teeth	$450.35
D7680	facial bones – complicated reduction with fixation and multiple surgical approaches	$1,048.34
D7710	maxilla – open reduction, stabilization of teeth	$840.46
D7720	maxilla – closed reduction	$549.53
D7730	mandible – open reduction	$1,970.27
D7740	mandible – closed reduction	$549.53
D7750	malar and/or zygomatic arch – open reduction	$549.53
D7760	malar and/or zygomatic arch – closed reduction	$258.58
D7770	alveolus – open reduction stabilization of teeth	$450.35
D7771	alveolus – closed reduction, stabilization of teeth	$374.96
D7780	facial bones – complicated reduction with fixation and multiple surgical approaches	$4,402.20
D7810	open reduction of dislocation	$1,159.84
D7820	closed reduction of dislocation	$96.99
D7830	manipulation under anesthesia	$96.99
D7840	condylectomy	$1,043.42
D7850	surgical discectomy, with/without implant	$695.61
D7860	arthrotomy	$2,251.72
D7870	arthrocentesis	$562.94
D7880	occlusal orthotic device, by report	$339.16
D7881	occlusal orthotic device adjustment	$44.00
D7910	suture of recent small wounds up to 5 cm	$96.99
D7911	complicated suture up to 5 cm	$168.89
D7912	complicated suture > 5 cm	$315.23
D7920	skin grafts (identify defect covered, location, and type of graft)	$778.13

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D7940	osteoplasty – for orthognathic deformities	$1,739.02
D7941	osteotomy – mandibular rami	$1,043.42
D7943	osteotomy – mandibular rami with bone graft; includes obtaining the graft	$1,043.42
D7944	osteotomy – segmented or sub-apical, per sextant or quadrant	$1,079.84
D7945	osteotomy – body of mandible	$1,043.42
D7946	leFort I (maxilla – total)	$3,940.54
D7947	leFort I (maxilla – segmented)	$1,739.02
D7948	leFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$1,739.02
D7949	leFort II or LeFort II – with bone graft	$2,086.79
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla, autogenous or nonautogenous, by report	$1,043.42
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	$1,515.80
D7952	sinus augmentation via a vertical approach	$563.20
D7953	bone replacement graft for ridge preservation – per site	$261.26
D7955	repair of maxillofacial soft and/or hard tissue defect	$778.13
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	$489.53
D7957	guided tissue regeneration, edentulous area – non resorbable barrier, per site	$505.54
D7961	buccal / labial frenectomy (frenulectomy)	$140.74
D7962	lingual frenectomy (frenulectomy)	$140.74
D7963	frenuloplasty	$235.40
D7970	excision of hyperplastic tissue – per arch	$106.95
D7971	excision of pericoronal gingiva	$106.95
D7972	surgical reduction of fibrous tuberosity	$106.95
D7980	sialolithotomy	$258.58
D7981	excision of salivary gland, by report	$258.58
D7982	sialodochoplasty	$258.58
D7983	closure of salivary fistula	$258.58
D7990	emergency tracheotomy	$258.58
D7991	coronoidectomy	$869.49
D7995	synthetic graft, mandible or facial bones, by report	$605.88
D7998	intraoral placement of a fixation device not in conjunction with a fracture	$1,346.40
D8020	limited orthodontic treatment of the transitional dentition	$298.11
D8070	comprehensive orthodontic treatment of the transitional dentition	$1,104.03
D8080	comprehensive orthodontic treatment of the adolescent dentition	$3,172.88
D8210	removable appliance therapy	$153.53
D8220	fixed appliance therapy	$250.75

DELTA DENTAL

Delta Dental of Iowa
Dental Wellness Program Fee Schedule

CDT Code	Description of Service	7/1/2024 DWP Fee
D8680	orthodontic retention (removal of appliances, construction and placement of retainer(s))	$149.06
D8701	repair of fixed retainer, includes reattachment – maxillary	$86.65
D8702	repair of fixed retainer, includes reattachment – mandibular	$86.65
D8703	replacement of lost or broken retainer – maxillary	$149.06
D8704	replacement of lost or broken retainer – mandibular	$149.06
D8999	unspecified orthodontic procedure, by report; Used for procedures not adequately described by a code	Prorated
D9110	palliative (emergency) treatment of dental pain - minor procedure	$24.91
D9120	fixed partial denture sectioning	$54.71
D9222	deep sedation/general anesthesia – first 15 minutes	$115.00
D9223	deep sedation/general anesthesia - each subsequent 15-minute increment	$105.00
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	$24.44
D9239	intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$84.44
D9243	intravenous moderate (conscious) sedation/analgesia – each subsequent 15-minute increment	$84.44
D9248	non- intravenous (conscious) sedation. This includes non-IV minimal and moderate sedation.	$168.89
D9310	consultation (diagnostic service by dentist or physician other than the practitioner providing	$28.15
D9410	house call	$22.51
D9420	hospital or ambulatory surgical center call	$45.03
D9440	office visit – after regularly scheduled hours	$39.40
D9610	therapeutic drug injection, by report	$14.64
D9910	application of desensitizing medicament	$20.26
D9930	treatment of complications (post-surgical) – unusual circumstances, by	$17.82
D9942	repair and/ or reline of occlusal guard	$130.90
D9943	occlusal guard adjustment	$44.00
D9944	occlusal guard – hard appliance, full arch	$238.95
D9946	occlusal guard – hard appliance, partial arch	$150.53
D9995	teledentistry-synchronous	$0.01
D9996	teledentistry-asynchronous	$0.01
D9999	unspecified, adjunctive procedure, by report	$5.42

Delta Dental of Iowa

Dental Wellness Plan and

Children's Dental Medicaid Plan

Uniform Regulations

1. Incorporation by Reference. These Delta Dental of Iowa Dental Wellness Plan and Children's Dental Medicaid[1] program Uniform Regulations ("Uniform Regulations") are incorporated by reference into, and made a part of, the Delta Dental Participating Dentist Dental Wellness Plan Agreement (the "Agreement"), as amended, made between Delta Dental of Iowa ("Delta Dental") and Participating Dentist.

2. Terms Defined.

   a) "Board of Directors" means the Board of Directors of Delta Dental.
   b) "Dentally Necessary" has the meaning set forth at Section 12 of these Uniform Regulations.
   c) Capitalized terms used but not otherwise defined herein shall have the meaning ascribed to such terms in the Agreement.

3. Acceptance of Covered Enrollees. Participating Dentist shall accept and provide Covered Services to Covered Enrollees upon the terms and conditions provided herein. If an individual was an existing patient of Participating Dentist under a different Delta Dental product prior to becoming, or when such individual became, a Covered Enrollee, Participating Dentist shall continue to provide dental services to such individual notwithstanding such individual's enrollment in the Dental Wellness Plan or Children's Dental Medicaid.

4. Prior Authorization. The Office Manual will provide a listing of dental services that require prior authorization from Delta Dental. In the event a Participating Dentist does not obtain prior authorization for a dental service that requires prior authorization, no payment shall be made or required for such dental service.

5. Payment.

   a) Participating Dentist shall be paid according to the terms of the Agreement, including these Uniform Regulations, the Dental Wellness Plan or Children's Dental Medicaid Contract, the Fee Schedule and the Office Manual. In connection with the foregoing, Participating Dentist acknowledges and agrees that what is considered a Covered Service will be determined, in part, by (i) Delta Dental's interpretation of the Dental Wellness Plan Contract or Children's Dental Medicaid Contract and (ii) Delta Dental's criteria for payment.
   b) Notwithstanding the foregoing or anything in the Agreement or any other Incorporated Document that is or may appear to be to the contrary, Participating Dentist understands that Delta Dental shall not be liable for and shall have no obligation to pay for any dental services whatsoever to the extent Delta Dental does not receive payment therefor from the Iowa Medicaid Enterprise, if the Participating Dentist is included on the List of Excluded Individuals/Entities maintained by the United States Office of Inspector General, or any other similar list of excluded individual/entities maintained by any regulatory entity.
   c) Enrollee for or with respect to any Covered Services. Without limiting the generality of the foregoing, Covered Enrollee shall under no circumstances whatsoever, including, without limitation, the insolvency of Delta Dental or the lack of adequate funding from the Iowa Medicaid Enterprise, be liable for Participating Dentist collect, or attempt to collect, from a Covered Enrollee any money owed to Participating Dentist by Delta Dental.

[1] The State of Iowa may use a different name to refer to the Medicaid program for children or its contract with Delta Dental. The parties intend "Children's Dental Medicaid" to refer to that program and contract.

d) Without limiting Participating Dentist's obligations under Section 12 of these Uniform Regulations, Participating Dentist shall inform Covered Enrollees of all available treatment options and associated financial responsibilities.
e) Participating Dentist shall not charge greater fees for Covered Services provided to Covered Enrollee than Participating Dentist charges for Participating Dentist's other patients. All Covered Services shall be provided to Covered Enrollees with the same quality and accessibility in terms of timeliness, duration and scope as provided to Participating Dentist's other patients.
f) Participating Dentist shall accept payment from Delta Dental by electronic funds transfer (direct deposit) to an account designated by Participating Dentist. Participating Dentist shall provide Delta Dental with all appropriate documents in order to set up such direct deposit.

6. Information and Records. Participating Dentist shall furnish information to Delta Dental accurately and on a timely basis, using applicable reporting forms or other means of transmittal supplied or approved by Delta Dental, and in accordance with instructions issued by Delta Dental. Participating Dentist shall prepare, retain and preserve in accordance with prudent record-keeping practices and procedures and otherwise as required by law, legible dental, financial and other records and data with respect to the Covered Services and Participating Dentist's compliance with the terms and conditions of the Agreement and applicable law, including dental records, claim forms and other evidence that sufficiently documents charges for all Covered Services. Participating Dentist shall make available to Delta Dental and any regulatory authority or other agency or body with oversight over Delta Dental or Participating Dentist upon request all such records. Participating Dentist shall obtain from Covered Enrollees any consents and authorizations necessary in order to provide such records and information to Delta Dental. Participating Dentist's obligations under this Section shall apply during the term of the Agreement and for a period of not less than seven (7) years from the date of service, or in the case of a minor patient or client, for a period consistent with that established by Iowa Code Section 614.1(9), whichever is greater. Participating Dentist and Delta Dental agree that the electronic signatures of the parties on a writing are intended to authenticate the writing and to have the same force and effect as manual signatures. Electronic signature means any electronic sound, symbol, or process attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including facsimile or email electronic signatures.

7. Claims Filing. Participating Dentist shall file, at no charge, cost or expense to Delta Dental or the Covered Enrollee, claims for all completed Covered Services furnished to Covered Enrollees. Claims shall be submitted electronically and in accordance with the billing instructions of Delta Dental as communicated to Participating Dentist from time to time.

a) Claim forms must be signed or submitted by the Participating Dentist. A Participating Dentist may not sign or submit a claim form on behalf of any other dentist, including, without limitation, any non-participating dentist.
b) Claims submitted to Delta Dental more than three hundred and sixty-five (365) days after the date the dental services were rendered will be not billable to the member absent a showing of exceptional circumstances by Participating Dentist. Exceptional circumstances will be determined by Delta Dental in its sole discretion on a case-by-case basis, but exceptional circumstances may include, without limitation, claims that include coordination of benefits or

require information from a third-party outside of the Participating Dentist's control. In all events, claims must be completed and finalized within 365 days after the date the dental services were rendered, or they will not be billable to the member.

8. In-Office Records Verification. Delta Dental and its representatives may make periodic examinations of a Participating Dentist's office and records (including, without limitation, the records required to be maintained under Section 6 of these Uniform Regulations) during regular office hours to determine Participating Dentist's compliance with the Agreement. Without limiting the generality of the foregoing, Delta Dental may request, and Participating Dentist shall provide at no cost to Delta Dental, data regarding fees charged to other patients. Participating Dentist understands and agrees that governmental agencies with regulatory authority over the Dental Wellness Plan and Children's Dental Medicaid shall also have access to Participating Dentist's office and records as required or permitted under applicable law.

9. Recoupment. In the event Delta Dental makes payments to a Participating Dentist and the payments are later determined by Delta Dental to have been made in error for any reason, including, without limitation, because the payments were for dental services that were not Covered Services because they were not Dentally Necessary, or because of Participating Dentist's error, Delta Dental's error, overpayment by Delta Dental or Medicaid, or a patient's ineligibility for coverage, Delta Dental may deduct from future payments due Participating Dentist amounts equal to the amount of the incorrect or unearned payments. Nothing in this Section shall be deemed to be a limitation on Delta Dental's or any regulatory agency's ability to recover from Participating Dentist any amounts recoverable by Delta Dental or the regulatory agency under applicable law governing the Dental Wellness Plan and Children's Dental Medicaid Coordination of Benefits.

10. Coordination of Benefits. Benefits shall be coordinated with any other coverage the Covered Enrollee may have available to pay Covered Services. If a Covered Enrollee is enrolled with other health or dental benefit coverage, the other benefit plan shall be the primary payor and the Dental Wellness Plan product shall be the payor of last resort. Participating Dentist shall cooperate, to the extent permitted by law, with Delta Dental's coordination of benefits and subrogation efforts, providing to Delta Dental such information as Participating Dentist may obtain regarding other payors. Participating Dentist shall ask prior to the performance of a Covered Service for a Covered Enrollee whether Covered Enrollee has private insurance.

11. Confidentiality; Product Data. All dental records containing specific patient information disclosed to Delta Dental shall be considered confidential to the extent required by applicable law. Upon request of the Covered Enrollee or the Covered Enrollee's legal representative, Participating Dentist shall transfer or copy such Covered Enrollee's treatment records. Participating Dentist may charge a nominal fee for duplication of the records but may not refuse to transfer records for nonpayment of any fees, in accordance with applicable Iowa Dental Board regulations.

To the extent Delta Dental develops or collects information related to its products, including, without limitation, any claims, cost, utilization, outcomes, quality and financial performance information (collectively, "Product Data"), Delta Dental shall be the sole and exclusive owner of all such Product Data, including, without limitation, any Product Data that relates to dental services provided by Participating Dentist to a Covered Enrollee (collectively, such Product Data is referred to as "Dentist

Specific Product Data"). Participating Dentist shall keep all Product Data confidential and shall only use Product Data for the purpose of carrying out Participating Dentist's obligations hereunder. Upon termination of this Agreement, Participating Dentist shall return to Delta Dental all Product Data that is not Dentist Specific Product Data. To the extent permitted by law, Delta Dental reserves the right to use and disclose, in its discretion, Product Data and information derived from Product Data. Such information may explicitly or implicitly identify Participating Dentist and include, but not be limited to, actual or projected payment levels made to Participating Dentist.

12. Dentally Necessary. In addition to the further terms and conditions of the Agreement, including the Incorporated Documents, Participating Dentist shall furnish and will receive payment only for dental services that are Dentally Necessary. Delta Dental shall not be responsible to pay for dental services that are not Dentally Necessary. Prior to providing a Covered Enrollee with dental services that are not Dentally Necessary, a Participating Dentist shall inform the Covered Enrollee of Delta Dental's payment policies and obtain a written acknowledgement from the Covered Enrollee that he/she has been informed that the dental services may not be paid by a third party. In the event a payment is made to Participating Dentist by Delta Dental for dental services that are later determined not to be Dentally Necessary, Delta Dental (or the applicable regulatory agency) may recoup payment pursuant to Section 9 above.

A procedure, service or supply shall be considered "Dentally Necessary" if and only if Delta Dental determines that each of the following statements is true with respect to such procedure, service or supply:

- The diagnosis is proper;
- The treatment is necessary to preserve or restore the basic form and the function of the teeth and the health of the gums, bone and other tissues, which support the teeth;
- It is the most appropriate procedure, service or supply for the Covered Enrollee's individual circumstances; and
- It is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Delta Dental.

Participating Dentist acknowledges that payments for alternate dental services in lieu of payments for services submitted as a claim may be made to Participating Dentist if such alternate dental services are equally effective for the treatment or maintenance of the teeth and their supporting structures.

Notwithstanding the foregoing and in all events Participating Dentist shall exercise his or her independent professional judgment in providing dental services. Nothing herein shall be construed to (a) interfere with or otherwise affect the rendering of dental services by Participating Dentist in accordance with Participating Dentist's independent professional judgment, or (b) prohibit or otherwise restrict Participating Dentist, acting within the lawful scope of his or her profession, from discussing with a Covered Enrollee the Covered Enrollee's health status and dental care or treatment options.

13. Availability of Services. Emergency services must be available 24 hours per day, 7 days per week for covered Dental Wellness Plan and Children's Dental Medicaid members. When Participating

Dentist's office is not open, there must be information publicly available to such members on where to seek such services (i.e., answering machine informing members that the office is closed, and they may seek emergency care at another named provider's office or named urgent care or emergency department).

14. Credentialing; Quality Assurance. Participating Dentist shall furnish Delta Dental all credentialing information requested by Delta Dental, including professional application and profile information, to assist Delta Dental in its evaluation of Participating Dentist's dental practice. In addition to such other information as Delta Dental may request from time to time, Participating Dentist shall provide the following credentialing documents and information: (i) an accurate and complete Professional Application and Credentialing Form at least every four (4) years; (ii) an active state-issued dental license; (iii) evidence of malpractice liability coverage in amounts required by Delta Dental; (iv) disclosure of any termination, suspension, limitation, surrender or restriction on Participating Dentist's license, accreditation, certification, permit or other governmental authorization; (v) disclosure of any licensing board actions, malpractice claims and other adverse personal matters (including any criminal charges); and (vi) compliance with Occupational Safety and Health Administration requirements and Centers for Disease Control recommended infection control guidelines. Participating Dentist shall notify Delta Dental immediately of any changes to this credentialing information or the occurrence of any matter requiring disclosure. All of Participating Dentist's rights and Delta Dental's obligations under the Agreement, including these Uniform Regulations, are conditioned upon Participating Dentist's continued maintenance of such credentialing requirements including, but not limited to, licenses and professional liability insurance, with no restrictions placed thereon and non-exclusion status on the HHS-OIG report, or any other exclusion list maintained by any regulatory entity, and the non-occurrence of any event requiring disclosure. So long as Participating Dentist has been and is currently credentialed with Delta Dental his or her name will be included in all directories for the Dental Wellness Plan product. The information furnished by the Participating Dentist relating to or in connection with the Agreement shall remain true, correct and complete with no material omissions at all times during the term of the Agreement. The Agreement has been authorized by all necessary action on behalf of Participating Dentist, is duly executed and delivered, and constitutes a legal and binding obligation of Participating Dentist.

15. Discrimination. Participating Dentist shall not differentiate or discriminate in the treatment of Covered Enrollees or in the quality of service because of race, sex, color, creed, national origin, age, religion, physical or mental disability, political belief, sexual orientation or health status. In addition, Participating Dentist may not discriminate based on payment policies of Delta Dental or against Covered Enrollees who are participants in a publicly financed program, including the Dental Wellness Plan and Children's Dental Medicaid. Participating Dentist also shall abide by the requirements of 41 C.F.R. §§ 60-1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status or disability.

16. Compliance with Laws; ADA and IDB Principles and Ethics. Participating Dentist shall conduct Participating Dentist's practice in accordance with the principles and ethics of the American Dental Association and the Iowa Dental Board. Participating Dentist shall comply with all applicable state and federal laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

17. Communications. Participating Dentist shall not make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating or circulating of any oral or written statement or pamphlet, circular, article, or literature that is false or maliciously critical of Delta Dental and that may have an adverse effect on Delta Dental. Participating Dentist shall not misrepresent the provisions, terms, or requirements of policies approved by and plans administered by Delta Dental. Nothing herein shall prohibit a Participating Dentist from reporting to state or federal authorities any act or practice by Delta Dental that jeopardizes patient health or welfare.

18. Safety and Hygiene. Participating Dentist shall comply with and be responsible for any and all applicable legal requirements related to dental practice safety and hygiene. Infection control is an integral part of all dental procedures. Delta Dental's payment pursuant to the Agreement includes reimbursement to the Participating Dentist for infection control costs and, therefore, infection control may not be billed separately from other dental procedures to either the Covered Enrollee or Delta Dental.

19. Insurance. Participating Dentist shall maintain, at Participating Dentist's expense, professional liability insurance coverage in an amount of not less than $200,000 per claim and $500,000 aggregate. If Participating Dentist practices oral surgery, such professional liability insurance coverage shall be in an amount of not less than $1,000,000 per claim and $3,000,000 aggregate. The insurance required by this paragraph shall include coverage for any claims related to Covered Services which may arise in connection with Participating Provider's obligations under this Agreement. Participating Dentist shall promptly notify Delta Dental whenever Participating Dentist learns that a Covered Enrollee has filed a claim or notice of intent to commence a claim against Participating Provider in connection with Covered Services. Upon request, Participating Dentist shall provide full details to Delta Dental, to the extent of Participating Dentist's knowledge, regarding the nature, circumstances and disposition of such claims.

20. Changes in Participating Status. Delta Dental may notify Covered Enrollees when the Agreement is terminated. Participating Dentist must promptly notify Covered Enrollees who have been patients of Participating Dentist in the event the Agreement is terminated prior to additional services being rendered. A copy of any form of written communication from Delta Dental to a Covered Enrollee regarding a termination of the Agreement will be provided to Participating Dentist. Similarly, a copy of any written communication from Participating Dentist to a Covered Enrollee regarding a termination of the Agreement shall be provided to Delta Dental.

21. Suspension. Delta Dental may immediately suspend or limit Participating Dentist's participation under the Dental Wellness Plan and/or Children's Dental Medicaid Contract where the failure to take such immediate action could, in Delta Dental's judgment, result in imminent danger to the health of any Covered Enrollee.

22. Termination of Participating Dentist's Agreement for Cause by Delta Dental. Without limiting Delta Dental's right to terminate the Agreement without cause as provided in the Agreement, Delta Dental may also terminate the Agreement if: (i) the Participating Dentist breaches or violates any of the provisions of the Agreement or these Uniform Regulations; (ii), Participating Dentist's license to practice dentistry issued by the Iowa Dental Board is suspended or terminated, or other sanctions are issued by the Iowa Dental Board; (iii) Participating Dentist's lack of adherence to published national clinical dental standards; or (iv) Participating Dentist's conduct is determined by Delta Dental, in Delta Dental's sole discretion, to be unprofessional and/or such conduct could be detrimental to Delta Dental, its contract holders, or Covered Persons.

Any such termination shall be effective on the date designated by Delta Dental in a notice of termination (the "Notice of Termination") provided to Participating Dentist (which may be immediate). The Notice of Termination will state the reasons for such termination and that the Participating Dentist has a right to request a hearing on the termination as provided in Section 23 of these Uniform Regulations.

23. Termination of Participating Dentist for Cause – Appeal Process.

a) Provider Appeals Committee. The Chair of the Board of Directors (the "Chair") with the approval of the Board of Directors shall appoint a Provider Appeals Committee to hear appeals from Participating Dentists whose Agreements with Delta Dental have been terminated for cause. The Provider Appeals Committee shall consist of not more than twelve (12) persons, none of whom may be current members of the Board of Directors. When an appeal is filed by a Participating Dentist who has been terminated for cause, such appeal shall be determined as set forth hereafter.

b) Request for Appeal. Any Participating Dentist who has been served with a Notice of Termination that Delta Dental has terminated or intends to terminate the Participating Dentist's Agreement for cause may appeal the Notice of Termination. A Participating Dentist who has been served with a Notice of Termination for cause shall begin the appeal process by sending a written notice of appeal and request for a hearing ("Notice of Appeal") by certified mail, return receipt requested to the Chief Executive Officer at Delta Dental's address for notices. A Notice of Appeal must be received by Delta Dental within thirty (30) days after the date of the Notice of Termination. The Notice of Appeal shall state the grounds for appeal and the reasons the Participating Dentist believes Delta Dental should not terminate the Agreement. Failure to deliver the Notice of Appeal within the thirty (30)-day period noted above shall constitute a waiver of the Participating Dentist's right to the hearing and subsequent review and appeal.

c) Appeal May Stay Termination. Upon timely receipt of a written Notice of Appeal, the Chief Executive Officer may, but is not required to, stay the termination of the Agreement until the appeal process is completed.

d) Provider Appeals Committee Panel. The Chief Executive Officer shall appoint a panel (the "Panel") comprised of no fewer than three (3) members of the Provider Appeals Committee to hear and decide an appeal filed by a Participating Dentist. The Panel shall be comprised of at least one (1) person who is a Participating Dentist. A Participating Dentist appointed to the Panel shall not be in direct economic competition with the Participating Dentist who has filed an appeal. The Chief Executive Officer shall select one member of the Panel to serve as chair of the Panel (the "Panel Chair") who shall preside over the hearing and the deliberations incident to said appeal. The Panel Chair shall have a vote in the proceedings.

e) Setting a Hearing Date. Within thirty (30) days after receiving the Notice of Appeal, the Panel Chair shall set the date of the hearing and so notify the Participating Dentist. The date of the hearing shall not be more than thirty (30) days after such notice is received by the Participating Dentist. The Panel shall conduct an oral hearing on the Notice of Appeal at the offices of Delta Dental.

f) Conduct of Hearing. A hearing conducted by the Panel shall be presided over by the Panel Chair. The hearing will be reported by a Certified Shorthand Reporter (CSR) authorized to administer oaths within the State of Iowa. The CSR shall administer the oath to all witnesses. At such hearing, Delta Dental shall state its grounds for terminating the Participating Dentist's Agreement. The Participating Dentist shall then be allowed to state the reasons why the Agreement should not be terminated. The Participating Dentist and Delta Dental may be represented by counsel and each party may call witnesses. Each party shall be responsible for any costs associated with its presentation. The personal presence of the Participating Dentist for whom the hearing has been scheduled shall be required. A Participating Dentist who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the right to appeal the termination and to have accepted the termination. Postponement of hearings beyond the time set forth in these Uniform Regulations shall be made only with the approval of the Panel. The granting of such postponements shall only be for good cause shown and shall be in the sole discretion of the Panel. If either party is to have counsel present, that party shall inform the other party of the name and address of such counsel no less than ten (10) days prior to the hearing. Nothing contained herein shall preclude Delta Dental and the Participating Dentist from resolving the matter prior to the time scheduled for the hearing.

g) Decisions by Provider Appeals Committee Panel. At the conclusion of the hearing, the Panel shall deliberate in executive session. Decisions by the Panel shall be reached by a majority vote of the members present at the hearing. The decision shall be in writing and a copy shall be mailed to the Participating Dentist within ten (10) days after the oral hearing.

h) Review of Appeal of Provider Appeals Committee Panel Decisions. Decisions made by the Panel may be appealed to the Board of Directors for review ("Review of Appeal") by sending a written Notice of Appeal by certified mail, return receipt requested to the Chair of the Board of Directors at Delta Dental's corporate offices within thirty (30) days after the date of the Panel's decision. No new or additional matters not raised during the original hearing and not otherwise reflected in the record shall be introduced at the Board of Directors Review of Appeal unless the Board of Directors shall, in its sole discretion, allow such new matters to be offered. Participating Dentist shall not be entitled to more than one hearing and one Board of Directors Review of Appeal of a termination. Failure of the Panel or Board of Directors to comply with a time limit specified herein shall not invalidate their actions. Failure to appeal the Panel's decision within the time and in the manner herein provided shall be a waiver of the Participating Dentist's right to such an appeal.

i) Board of Directors Review of Appeal. Within thirty (30) days after receiving the Notice of Appeal, the Board of Directors shall review the Notice of Appeal and the proceedings before the Panel and shall either schedule an oral hearing or decide the matter based on the record of proceedings before the Panel. The Participating Dentist may submit a written statement on Participating Dentist's behalf by sending it to the Board of Directors through Delta Dental's Chief Executive Officer at least five (5) days prior to the scheduled date for the review of the appeal.

j) Conduct of Hearing. If the Board of Directors elects to hold a hearing, the hearing shall be conducted in the following manner. The hearing shall be presided over by the Chair and shall

be held at the offices of Delta Dental. Delta Dental shall state its grounds for terminating the Agreement. The Participating Dentist shall then be allowed to state the reasons why the Agreement should not be terminated. The Participating Dentist's presentation must comply with Section 23(h). The Participating Dentist and Delta Dental may be represented by counsel and each party may call witnesses. Each party shall be responsible for any costs associated with its presentation. The personal presence of the Participating Dentist for whom the hearing has been scheduled shall be required. A Participating Dentist who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the Participating Dentist's rights to appeal the termination to the Board of Directors and to have accepted the termination.

k) Decisions by Board of Directors. Decisions by the Board of Directors shall be reached by a majority vote of the members present at the hearing and shall be conclusive, final and non-appealable if made in good faith. The Board of Directors shall notify the Participating Dentist within ten (10) days of its decision on the appeal.

l) Quorum of the Board of Directors. A quorum of the Board of Directors, as provided in the Bylaws of Delta Dental, shall be required for the Board of Directors to conduct the hearing.

m) Conference Telephone Meetings. Attendance at the hearing may be by means of conference telephone or similar communications equipment through which all persons participating in the hearing can hear each other. Participation in the hearing pursuant to this provision shall constitute presence in person at such hearing.

n) Continuance. The Provider Appeals Committee Panel and the Board of Directors may grant a continuance on any appeal.

o) Legal Action. The Participating Dentist waives any and all legal action that the Participating Dentist may have against the Provider Appeals Committee, the Panel, the Board of Directors, and Delta Dental, its officers, agents and employees, arising out of or in the conduct of appeals pursuant to this Section 23.

24. Survival. The requirements contained in the Agreement and these Uniform Regulations that contemplate continued obligations of one or both of the parties, including but not limited to, Sections 6, 8, 9, 11, 17, and 22-24 of these Uniform Regulations shall survive any termination of the Agreement.