COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA SC 29223-5666
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

(hereinafter referred to as the "Company")

DENTAL INSURANCE POLICY

IMPORTANT

This is a dental only policy. It does not pay benefits for loss from any other cause.

CONSIDERATION

This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule of Benefits. A copy of Your application is attached and is part of this Policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to Us that You are satisfied with this Policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your Policy will be void from its Effective Date. If You return the Policy, please note in writing: "This policy is returned for cancellation and refund of premium."

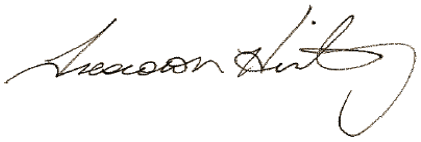
IMPORTANT NOTICE

Please read Your application attached to this Policy. This Policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this Policy if any information shown on it is not correct or complete. Incorrect information on Your application can result in the denial of a claim or termination of the Policy. No duly licensed agent may change this Policy or waive any of its provisions.

THIS POLICY IS CONDITIONALLY RENEWABLE SUBJECT TO OUR RIGHT TO DECLINE COVERAGE ON ANY INDIVIDUAL AND CHANGE PREMIUM RATES UPON ANY RENEWAL DATE. THIS POLICY CAN BE NON-RENEWED ONLY IF ALL POLICIES ON THIS FORM ARE NOT RENEWED IN THIS STATE.

We agree that this Policy will never be restricted by the addition of any rider without Your consent. We may change the established premium rates effective at Renewal Dates for subsequent policy years. If the established premium rate changes, We will notify You in writing at Your last known address at least 60 days before the change becomes effective.

Signed for by the Company



Trescott N. Hinton, Jr.
President

IMPORTANT INFORMATION REGARDING YOUR INSURANCE: In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the Company at the following address and telephone number: 7909 Parklane Road, Suite 200, Columbia, South Carolina 29223, Toll free (800) 753-0404.

THIS POLICY IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSITUTE FOR ANY REQUIRED PEDIATRIC ORAL HEALTH COVERAGE IN ESSENTIAL HEALTH BENEFIT COVERAGE.

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POLICY SCHEDULE OF BENEFITS

Insured:
Mode Of Payment:
Policy Premiums: $

Policy Number:
Policy Effective Date:

Policy Year Benefit Maximum:
Coverage: Mid Plan - $1,000 Annual Plan Maximum

Type of Service	Waiting Period	Annual Deductible
Preventive	No Waiting Period	None
Basic	No Waiting Period	$25 Annually
Major	12 Months	$25 Annually

Type of Coverage
4-Tier:
Individual - coverage for only the Insured listed above
Individual and Legal Spouse - coverage for the Insured listed above and Your Legal Spouse
Individual and Dependent Children - coverage for the Insured listed above and all Your Dependent Children
Individual and Family - coverage for the Insured listed above, Your Legal Spouse and all Your Dependent Children.]

PART 1

DEFINITIONS

ANNUAL DEDUCTIBLE means the amount shown in the Policy Schedule of Benefits that each Covered Person must satisfy before Benefits are payable by Us. To satisfy the Annual Deductible, each Covered Person must accumulate expenses for Covered Dental Procedures that are equal to or greater than the Deductible amount shown on the Policy Schedule of Benefits.

ANNUAL PLAN MAXIMUM means the maximum benefit amount the Company will pay during any Policy Year.

COVERED DENTAL EXPENSE means the lesser of the actual charge or the Schedule Amount.

COVERED DENTAL PROCEDURE means any procedure listed in the Schedule of Covered Procedures.

COVERED PERSON means an individual that is eligible for and covered under this Policy while inforce as outlined in the Policy of Schedule Benefits.

DENTAL HYGIENIST means a person, other than a member of Your Immediate Family, who is licensed to practice dental hygiene and who is practicing within the scope of his or her license.

DENTIST means a person, other than a member of Your Immediate Family, who is licensed to practice dentistry or oral surgery and who is practicing within the scope of his or her license.

DEPENDENT means Your Legal Spouse or Your Dependent Child.

DEPENDENT CHILD means (a) the Insured's natural child (from moment of birth); (b) the Insured's adopted child (from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order); (c) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or (d) any child for whom We have notice, pursuant to a medical support order, that the Insured must provide support in the form of dental insurance (from the date of such notice) and who is younger than 26. For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of dental insurance.

FUNCTIONING NATURAL TOOTH means a tooth which is performing its normal role in the mastication (i.e., chewing) process in the covered person's upper or lower arch and which is opposed in the person's other arch by another tooth or prosthetic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth for purposes of this Policy.

IMMEDIATE FAMILY means anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents(s) (includes stepparents); grandchildren; father- or mother-in-law; and spouses as applicable, of any of these.

INSURED means the individual named in the Policy Schedule of Benefits.

LEGAL SPOUSE means a lawfully recognized partner of the Insured, who is not a relative, is of legal age, is not currently married to someone else, is in a committed relationship with the Insured and shares financial obligations.

POLICY means this contract of insurance made between the Company and the Policyowner.

POLICY EFFECTIVE DATE means the date this Policy became effective as shown on the Policy Schedule of Benefits. All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Policyowner.

POLICYOWNER means the Insured named in the Policy Schedule of Benefits and to whom this Policy is issued.

POLICY YEAR means the 12 month period starting on the Renewal Date of any year and ending at the end of the day before the Renewal Date of the following year. However, the first year starts on the Effective Date as shown on the Policy Schedule of Benefits and the last year ends on the Termination Date.

RENEWAL DATE is the anniversary (month and day) of the Effective Date in each calendar year after the Effective Date.

SCHEDULE AMOUNT means the amount shown in the Schedule of Covered Procedures.

DEFINITIONS (CON'T)

TERMINATION DATE means the date that coverage under this Policy terminates.

WAITING PERIOD means the period of time between the Policy Effective Date and the date that benefits become payable for specific Covered Dental Procedures.

WE, US and **OURS** refers to Companion Life Insurance Company.

YOU and **YOURS** refers to the Insured as shown in the Policy Schedule of Benefits.

PART 2

PREMIUMS

PREMIUM DUE DATE: The initial premium is due and payable on the Policy Effective Date, as shown in the Policy Schedule of Benefits. Subsequent premiums are due and payable on the first day of the month, quarter, or year, depending on the premium mode selected as identified on the Policy Schedule of Benefits.

CHANGES IN PREMIUM RATES: We have the right to change the premium rate on the following dates:

1. After the Policy has been in force for one year, on any premium due date; or
2. The Effective Date of any change in benefits under the Policy; or
3. On the Effective Date of any law or regulation that affects Our liability under the Policy.

We will give you at least 60 days written notice prior to any change in premium rates. Any change will be effective at least 31 days after the date of the notice.

GRACE PERIOD: The Company will allow the Policyowner a 31 day Grace Period for the payment of all premiums after the first. During this 31 day period, the Policy will stay in force. If the owed premium is not paid by the 31st day, the Policy will automatically terminate. If the Policyowner gives the Company written advance notice of an earlier cancellation date, the Policy will terminate on the earlier date. Premium is due for each day the Policy is in force. The Policyholder is liable for the premium due for coverage through the Grace Period.

PART 3

EFFECTIVE DATE

The Insured's coverage will take effect on the Effective Date as shown on the Policy Schedule of Benefits.

Dependent coverage will take effect on the later of:

1. The Effective Date of Your coverage, if You enrolled Your Dependent at the same time You applied for coverage; or
2. The date Your Dependent becomes eligible, if written request and payment of any required premium is submitted within 31 days of first becoming eligible.

Newborn Dependent Children are covered from the moment of birth to the next premium due date that is at least 31 days after the Dependent Child's birth. To continue coverage after this date, the Insured must submit a request for continuation of coverage in writing and agree to make any required contributions, if any.

All other Dependents will be covered from the date of eligibility, if written request and payment of any required premium is submitted within 31 days of first eligibility.

PART 4

LIMITATIONS AND EXCLUSIONS

This Policy does not cover losses caused by or resulting from:

1. Any procedure or service not shown on the Schedule of Covered Procedures;
2. Amounts in excess of the Annual Plan Maximum;
3. For any care, services, supplies or treatment rendered on an experimental, investigational, or research basis not recognized as a generally accepted dental practice by the dental profession or The American Dental Association;
4. Services or expenses Incurred before the Policy Effective Date;
5. Services or expenses Incurred after the Termination Date;
6. Charges for dental services performed by someone other than a Dentist or Dental Hygienist;
7. Services that are not recommended by a Dentist or that are not required for the preservation or restoration of oral health;
8. Repairs to dental work within six months of the initial work;
9. Replacement prosthetics within five years of last placement;
10. Treatment involving crowns for a given tooth within five years of last placement, regardless of the type of crown;
11. Replacement for inlays or onlays for a given tooth within five years of last placement;
12. Implants (materials implanted into or on the bone or soft tissue) or the removal of implants;
13. Any services performed for cosmetic purposes, unless they are for the correction of functional disorders;
14. Treatment or services received while outside the territorial limits of the United States, Canada or Mexico;
15. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane;
16. Services performed by a Dentist or Dental Hygienist who is a member of the Insured's Immediate Family;
17. Orthodontic treatment; or
18. Treatment of Temporomandibular Joint (TMJ) dysfunctions.

No benefits will be paid for replacement of teeth missing prior to the Effective Date of coverage.

No benefits will be paid for the initial placement of removable full or partial dentures, unless it includes the replacement of a Functioning Natural Tooth extracted while the Insured or any Covered Person is covered under this Policy.

No benefits will be paid for the initial placement of a fixed partial denture, pontic, or bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the Insured or any Covered Person is covered under this Policy.

ALTERNATE PROCEDURES – If two or more procedures are adequate and appropriate treatment to correct a certain condition and the procedure performed was a Covered Dental Procedure, We will base the benefit payable on the least expensive alternate Schedule Amount in the Schedule of Covered Procedures.

See the Schedule of Covered Dental Procedures for all procedure frequencies and age limitations.

PART 5

RIGHT OF CONVERSION

If You or Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was covered under this Policy, then Your Legal Spouse can apply for and receive, without evidence of insurability, a policy providing coverage equivalent to the terminated coverage. To obtain the policy, Your Legal Spouse must make application to Us within 90 days following the entry of the decree of dissolution of marriage. If such dissolution of marriage occurs, the Insured under this Policy at the time of dissolution will retain that status. Any Dependent may be covered under either policy, but not both. Any benefits paid under the prior policy will be applied toward the benefit maximums and limitations under the new policy.

In the event of Your death, any Dependent covered under this Policy, subject to the same terms and conditions stated above, may then apply for and receive a policy providing coverage equivalent to coverage under this Policy. Any benefits paid under the prior policy will be applied toward the benefit maximums and limitations under the new policy.

PART 6

GENERAL PROVISIONS

ENTIRE CONTRACT
This Policy, together with the application (a copy of which is attached to and made part of this Policy when issued), endorsements, amendments, or riders, if any, is the entire contract of insurance.

CHANGE IN THE POLICY
No change may be made to this Policy unless approved in writing by the President; or a Vice President; an Assistant Vice President; Secretary; or Assistant Secretary of the Company. No other person may change or waive any part of this Policy. Any approved change shall be added to the Policy in writing.

TIME LIMIT ON CERTAIN DEFENSES
After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application will be used to void the coverage or to deny a claim for a loss incurred after the expiration of such two-year period.

TERM
The term of this policy begins at noon, standard time, at the place where You reside on the Effective Date shown in the Policy Schedule of Benefits. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following Renewal Date. Renewal Dates are determined by the mode of payment. The mode of payment for the original term of the Policy is shown in the Policy Schedule of Benefits. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months and monthly for one month.

REINSTATEMENT
If any premium is not paid before the Grace Period ends the Policy will lapse. Later acceptance of the premium by the Company or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the Policy. If the Company or its agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the Company has previously written You of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date. Any premiums the Company accepts for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days before the reinstatement date.

CONFORMITY WITH STATE AND FEDERAL STATUTES
Any provision of this policy that is in conflict with the laws of the state where this policy is located on its effective date is amended, to conform to the minimum requirements of the law.

INCURRED DATE FOR COVERED DENTAL PROCEDURES
A Covered Dental Procedure is incurred at the time the service is rendered or the supply is furnished. For Covered Dental Procedures requiring more than one visit, a Covered Dental Procedure is incurred on the date of the last visit.

TERMINATION
This Policy will terminate on the earliest of the following:

1. The date We terminate all policies on this Policy form in Your state.
2. The date You fail to pay the required premium, subject to the Grace Period provision.
3. The date on any notice (or the date We receive such notice if no date is specified) You send to Us asking Us to terminate Your coverage.
4. The date, which You or Your Dependent enters the Armed Forces, other than for reserve duty of 30 days or less.
5. For a Dependent, the date in which they no longer meet the definition of Dependent as defined in this Policy.

MISSTATEMENT OF FACTS
If relevant facts about the Insured or any Covered Person were not accurate:

1. An adjustment of premium will be made; and
2. The facts will decide whether and in what amount insurance is valid under this Policy.

PART 7

CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be given within 60 days after a Covered Dental Procedure starts or as soon as reasonably possible. Notice of claim should include the name of the Insured or Covered Person and the Policy Number.

CLAIM FORMS
When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given within 10 working days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof Of Loss provision.

PROOF OF LOSS
Written proof of loss must be given to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof of loss is otherwise required.

PHYSICAL EXAMINATION
At our expense, We can examine any pre-operative dental x-rays while a dental claim is pending to determine the proper procedure to be considered.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this Policy will be paid immediately upon Our receipt of written proof of loss. In no event will claims be paid more than 30 days after receipt of due written proof of loss. A valid claim not paid within this time period will be increased by interest at 1 1/2% per month, the rate required by law until the claim is settled.

PAYMENT OF CLAIMS
All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate.

LEGAL ACTIONS
No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required. No such action may be brought after three years from the time written proof of loss is required to be given.

PART 8

SCHEDULE OF COVERED PROCEDURES

SUBJECT TO THE ANNUAL DEDUCTIBLE, ANNUAL PLAN MAXIMUM AND THE LIMITATIONS AND EXCLUSIONS SECTION OF THIS POLICY, WE WILL PAY THE FOLLOWING BENEFITS UP TO THE COVERED DENTAL EXPENSE AMOUNT WHEN A CHARGE IS INCURRED BY THE INSURED OR ANY COVERED PERSON FOR A COVERED DENTAL PROCEDURE THAT OCCURS WHILE COVERAGE IS IN FORCE.

The following is a complete list of Covered Dental Procedures, applicable limitations, and Scheduled Amounts. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Limitations

(a)	Maximum of 2 procedures per 12 months
(b)	Maximum of 1 series per 12 months
(c)	Maximum of 1 per 12 months, for children under age 19
(d)	Maximum of 1 procedure per 36 months
(e)	Maximum of 1 procedure per tooth surface per 24 months
(f)	Maximum of 1 per tooth per 36 months, ages 6 thru 15
(g)	Once per 5 years

			Schedule Amount
Preventive Services		**Limitations**	**Mid Plan**
d0120	Periodic Oral Examination	(a)	$25
d0140	Limited Oral Evaluation - Problem Focused	(a)	$36
d0150	Comp Oral Evaluation - New/Established Patient	(a)	$35
d0170	Re-Evaluation - Limited Problem Focused	(a)	$20
d0270	Bitewing - Single Film	(b)	$19
d0272	Bitewings - Two Films	(b)	$29
d0273	Bitewings - Three Films	(b)	$35
d0274	Bitewings - Four Films	(b)	$41
d1110	Prophylaxis - Adult	(a)	$56
d1120	Prophylaxis - Child	(a)	$42
d1203	Topical Application Of Fluoride - Child	(c)	$23

Basic Services		**Limitations**	**Mid Plan**
d0210	Intraoral - Complete Series	(d)	$67
d0220	Intraoral - Periapical 1 Film	(d)	$13
d0230	Intraoral - Periapical Ea Add Film	(d)	$6
d0240	Intraoral - Occlusal Film	(d)	$11
d0330	Panoramic Film	(d)	$31
d2140	Amalgam-One Surface Primary Or Permanent	(e)	$56
d2150	Amalgam-Two Surfaces Primary Or Permanent	(e)	$72
d2160	Amalgam-Three Surfaces Primary Or Permanent	(e)	$87
d2161	Amalgam-Four/More Surfaces Primary/Permanent	(e)	$106
d2330	Resin-Based Composite - One Surface Anterior	(e)	$56
d2331	Resin-Based Composite - Two Surfaces Anterior	(e)	$71
d2332	Resin-Based Composite - Three Surfaces Anterior	(e)	$87
d2335	Resin Compos - 4/More Surfaces/Invlv Incisal Ang	(e)	$103
d2390	Resin-Based Composite Crown Anterior	(e)	$114
d2391	Resin Based Composite - One Surface - Posterior	(e)	$56
d2392	Resin Based Composite - Two Surfaces - Posterior	(e)	$72
d2393	Resin Based Composite - Three Surfaces - Posterior	(e)	$87
d2394	Resin Compos - Four/More Surfaces - Posterior	(e)	$106
d3110	Pulp Cap - Direct		$18

d3120	Pulp Cap - Indirect		$14
d3220	Tx Pulp-Remv Pulp Coronal Dentinocementl Junc		$42
d3221	Pulpal Debridement Primary And Permanent Teeth		$46
d3310	Anterior Root Canal		$200
d3320	Bicuspid Root Canal		$240
d3330	Molar Root Canal		$310
d3410	Apicoectomy/Periradicular Surgery - Anterior		$199
d3421	Apicoectomy/Periradicular Surgery - Bicuspid		$218
d3425	Apicoectomy/Periradicular Surgery - Molar		$246
d3426	Apicoectomy/Periradicular Surgery		$84
d3430	Retrograde Filling - Per Root		$62
d7111	Coronal Remnants - Deciduous Tooth		$56
d7140	Extraction Erupted Tooth Or Exposed Root		$75
d9110	Palliative Treatment Dental Pain - Minor Procedure		$45

Major Services		**Limitations**	**Mid Plan**
d1351	Sealant - Per Tooth	(f)	$25
d1510	Space Maintainer - Fixed-Unilateral		$78
d1515	Space Maintainer - Fixed-Bilateral		$103
d1520	Space Maintainer - Removable-Unilateral		$97
d1525	Space Maintainer - Removable-Bilateral		$133
d1550	Recementation Of Space Maintainer		$17
d2510	Inlay - Metallic - One Surface	(g)	$179
d2520	Inlay - Metallic - Two Surfaces	(g)	$203
d2530	Inlay - Metallic - Three Or More Surfaces	(g)	$234
d2542	Onlay - Metallic - Two Surfaces	(g)	$229
d2543	Onlay Metallic Three Surfaces	(g)	$240
d2544	Onlay Metallic Four Or More Surfaces	(g)	$250
d2710	Crown - Resin	(g)	$127
d2720	Crown - Resin With High Noble Metal	(g)	$312
d2721	Crown - Resin With Predominantly Base Metal	(g)	$293
d2722	Crown - Resin With Noble Metal	(g)	$299
d2740	Crown - Porcelain/Ceramic Substrate	(g)	$321
d2750	Crown - Porcelain Fused To High Noble Metal	(g)	$325
d2751	Crown - Porcelain Fused Predominantly Base Metal	(g)	$302
d2752	Crown - Porcelain Fused To Noble Metal	(g)	$309
d2790	Crown - Full Cast High Noble Metal	(g)	$300
d2791	Crown - Full Cast Predominantly Base Metal	(g)	$281
d2792	Crown - Full Cast Noble Metal	(g)	$287
d2799	Provisional Crown	(g)	$120
d2910	Recement Inlay		$21
d2920	Recement Crown		$30
d2930	Prefabrication Stainless Steel Crown - Primary Tooth		$61
d2931	Prefabrication Stainless Steel Crown - Permanent Tooth		$71
d2932	Prefabricated Resin Crown		$77
d2940	Sedative Filling		$24
d2950	Core Buildup Including Any Pins		$60
d2951	Pin Retention - Per Tooth Addition Restoration		$13
d2952	Cast Post And Core In Addition To Crown		$91
d2954	Prefabricated Post And Core In Addition To Crown		$76
d4210	Gingl/Gingivplsty 4/> Cont/Bound Teeth Space-Quad		$150
d4211	Gingl/Gingivoplasty - 1-3 Teeth Per Quad		$64
d4240	Gingl Flp Proc 4/> Cont/Bounded Teeth Space-Quad		$176
d4241	Gingl Flp Proc w/Root Planning - 1-3 Teeth-Quad		$91

d4260	Osseous Surgery 4/> Cont/Bounded Teeth Spaces-Quad		$284
d4261	Osseous Surgery - 1-3 Teeth Per Quad		$148
d4263	Bone Replacement Graft - First Site In Quad		$86
d4266	Guided Tissue Regen - Resorbable Barrier Per Site		$104
d4267	Guided Tissue Regen - Nonresorb Barrier Per Site		$133
d4270	Pedicle Soft Tissue Graft Procedure		$210
d4341	Periodontal Scaling & Root Planning 4/>Cont/Bound Teeth-Quad		$50
d4342	Periodontal Scaling & Root Planning 1-3 Teeth-Quad		$28
d4355	Full Mouth Debridment Enable Comp Evaluation & Dx		$33
d4910	Periodontal Maintenance		$30
d5110	Complete Denture - Maxillary	(g)	$362
d5120	Complete Denture - Mandibular	(g)	$362
d5130	Immediate Denture - Maxillary	(g)	$394
d5140	Immediate Denture - Mandibular	(g)	$394
d5211	Maxillary Partial Denture - Resin Base	(g)	$305
d5212	Mandibular Partial Denture - Resin Base	(g)	$355
d5213	Max Part Dentur-Cast Metal Framework w/Resin Base	(g)	$400
d5214	Mand Part Dentur- Cast Metal Framework w/Resin Base	(g)	$400
d5281	Remove Unlit Part Dentur - 1 Piece Cast Metal		$233
d5410	Adjust Complete Denture - Maxillary		$20
d5411	Adjust Complete Denture - Mandibular		$20
d5421	Adjust Partial Denture - Maxillary		$20
d5422	Adjust Partial Denture - Mandibular		$20
d5510	Repair Broken Complete Denture Base		$40
d5520	Replace Missing/Broken Teeth - Complete Denture		$33
d5610	Repair Resin Denture Base		$43
d5620	Repair Cast Framework		$46
d5630	Repair Or Replace Broken Clasp		$56
d5640	Replace Broken Teeth - Per Tooth		$36
d5650	Add Tooth To Existing Partial Denture		$50
d5660	Add Clasp To Existing Partial Denture		$59
d5710	Rebase Complete Maxillary Denture		$147
d5711	Dyn Adj Ankle Ext/Flex Devc Incl Soft Intf Matl		$140
d5720	Rebase Maxillary Partial Denture		$139
d5721	Rebase Mandibular Partial Denture		$139
d5730	Reline Complete Maxillary Denture		$83
d5731	Reline Complete Mandibular Denture		$83
d5740	Reline Maxillary Partial Denture		$76
d5741	Reline Mandibular Partial Denture		$76
d5750	Reline Complete Maxillary Denture		$111
d5751	Reline Complete Mandibular Denture		$111
d5760	Reline Maxillary Partial Denture		$109
d5761	Reline Mandibular Partial Denture		$109
d6210	Pontic - Cast High Noble Metal	(g)	$292
d6211	Pontic - Cast Predominantly Base Metal	(g)	$274
d6245	Pontic - Porcelain/Ceramic	(g)	$298
d6212	Pontic - Cast Noble Metal	(g)	$285
d6240	Pontic - Porcelain Fused To High Noble Metal	(g)	$300
d6241	Pontic - Porcelain Fused Predominantly Base Metal	(g)	$277
d6242	Pontic - Porcelain Fused To Noble Metal	(g)	$292
d6250	Pontic - Resin With High Noble Metal	(g)	$300
d6251	Pontic - Resin With Predominantly Base Metal	(g)	$275
d6252	Pontic - Resin With Noble Metal	(g)	$285

d6720	Crown - Resin With High Noble Metal	(g)	$316
d6721	Crown Resin w/Predominantly Base Metal-Denture	(g)	$300
d6722	Crown - Resin With Noble Metal	(g)	$305
d6740	Crown - Porcelain/Ceramic	(g)	$332
d6750	Crown Porcelain Fused To Hi Noble Metal-Denture	(g)	$325
d6751	Crown - Porcelain Fused Predominantly Base Metal	(g)	$305
d6752	Crown - Porcelain Fused To Noble Metal	(g)	$310
d6790	Crown Full Cast High Noble Metal-Denture	(g)	$315
d6791	Crown Full Cast Predominantly Base Metal-Denture	(g)	$300
d6792	Crown Full Cast Noble Metal-Denture	(g)	$310
d6793	Provisional Retainer Crown		$123
d6930	Recement Fixed Partial Denture		$32
d6940	Stress Breaker		$74
d6970	Cast Post & Core Addition Fix Part Dentur Retainer		$90
d6972	Prefabrication Post & Core Add Fix Part Dentur Retain		$73
d6973	Core Build Up For Retainer Including Any Pins		$59
d7210	Surgical Removal of Erupted Tooth Rqr Elev Flap & Remove Bone		$65
d7220	Removal Of Impacted Tooth - Soft Tissue		$82
d7230	Removal Of Impacted Tooth - Partially Bony		$108
d7240	Removal Of Impacted Tooth - Completely Bony		$127
d7260	Orolantral Fistula Closure		$658
d7241	Remove Imp Tooth - Complete Bony w/Unusual Surg Comps		$156
d7250	Surgical Removal Of Residual Tooth Roots		$67
d7285	Biopsy of Oral Tissue Hard		$265
d7286	Biopsy Of Oral Tissue Soft		$108
d7287	Cytology Sample Collection		$33
d7291	Transseptal Fiberot/Supra Crestal Fiberot Report		$0
d7310	Alveolplsty Conjunc w/Xtracs		$74
d7320	Alveolplsty Not Conjunc w/Xtracs		$330
d7471	Removal Of Lateral Exostosis		$244
d7472	Removal Of Torus Palatinus		$290
d7473	Removal Of Torus Mandibularis		$274
d7510	I&D Abscess - Intraoral Soft Tissue		$71
d7912	Complicated Suture - > 5 Cm		$485
d7970	Excision Hyperplstc Tissue - Per Arch		$160
d7971	Excision Pericoronal Gingiva		$51
d7972	Surgical Reduction Of Fibrous Tuberosity		$189
d7911	Comp Suture - Up 5 Cm		$269
d7960	Frenulect - Separate Procedure		$155