TDA CHOICE PLAN

PLAN CERTIFICATE (PPO)

INDIVIDUAL, FAMILY AND SELF-EMPLOYED DENTAL PLAN
Underwritten by Companion Life Insurance Company

TDA

Dental · Life · Disability · Vision

Home Office: Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, South Carolina 29223-5666

Administrative Office: Total Dental Administrators
2111 East Highland Avenue, Suite 250
Phoenix, Arizona 85016
Toll Free Telephone No: (888) 422-1995

DENTAL INSURANCE POLICY

The Named Insured as shown in the Policy Schedule of Benefits will be referred to as "You", "Your" or "Yours". Companion Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT
This is a dental only policy. It does not pay benefits for loss from any other cause. Read it carefully with the Outline of Coverage, if applicable.

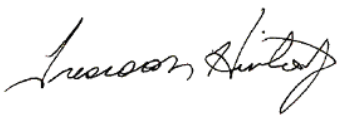
CONSIDERATION
This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule of Benefits. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations 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 10 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.



Trescott N. Hinton, Jr.
President

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POLICY SCHEDULE OF BENEFITS

Policy Number: UT IND CLICO 1.1.13
Policy Effective Date: 01/01/2013

Mode of Payment: Monthly, Quarterly, Semi-Annual or Annual
Policy Premiums:

Individual: $34.89
Individual & One: $67.14
Individual & Family: $110.05

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

Deductible

Type of Service	Deductible
Preventive	$0.00 Annually
Basic	$50.00 Annually
Major	$50.00 Annually

Waiting Period

Type of Service	Waiting Period
Preventive	No Waiting Period
Basic	No Waiting Period
Major	12 Month Waiting Period

Type of Coverage

3-Tier:
Individual - coverage for only you, the covered person listed in the Policy Schedule of Benefits.
Individual and One Dependent - coverage for you, the covered person, and one dependent.
Individual and Two or More Dependents - coverage for you, the covered person, and all your dependents

Part 1
DEFINITIONS

A. DENTAL HYGIENIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

B. DENTIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

C. IMMEDIATE FAMILY: 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.

D. INSURED PERSON: anyone who is insured under this policy to the extent specified in the Policy Schedule of Benefits.

E. POLICY YEAR:

1. **First Policy Year:** the period of time that begins on the effective date of coverage as shown in the Policy Schedule of Benefits and ends 365 days from the effective date.

2. **Each Subsequent Policy Year:** every 12-month period thereafter.

F. TYPE OF COVERAGE: See the Policy Schedule of Benefits to determine the Type of Coverage issued: Individual, or Individual and Dependents.

1. **Individual:** insurance for only one person.
2. **Spouse:** you may elect to insure Your legal spouse, as defined in Your state of residence.
3. **Dependent Child:** You may elect to insure any of Your Dependent Children until the end of the month of their 26th birthday. Coverage will be provided for newborn children from the moment of birth and for adopted children and children placed for adoption from the moment of placement. 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)

   Coverage for a dependent child will not terminate upon attainment of the limiting age if the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the Insured for support and maintenance. Proof of such incapacity and dependency shall be furnished to Us by the Insured within 31 days of the child's attainment of the limiting age and subsequently as may be required by Us but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

G. COVERED DENTAL EXPENSE: is the lesser of the actual charge or the Schedule Amount.

H. SCHEDULE AMOUNT: the amount shown in the Schedule of Covered Procedures.

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

J. SCHEDULE OF COVERED PROCEDURES: a listing of all Covered Dental Procedures and the corresponding Schedule Amounts.

K. 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.

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

Part 2
PREMIUMS

A. 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 elected.

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

a. After the policy has been in force for one year, on any premium due date; or
b. The effective date of any change in benefits under the policy; or
c. 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.

C. GRACE PERIOD: A grace period of 30 days will be granted for the payment of each premium due after the initial premium. During the grace period, this policy shall continue in force.

D. FAILURE TO PAY PREMIUM WHEN DUE: If a premium is not paid within the Grace Period, this Policy will terminate at the end of the last day of the Grace Period.

Part 3
LIMITATIONS AND EXCLUSIONS

A. This policy does not cover losses caused by or resulting from:

1. Any procedure or service not shown on the Schedule of Covered Procedures or the Policy Schedule of Benefits.
2. Amounts in excess of the Annual Plan Maximum.
3. Services or supplies We consider being experimental or investigative.
4. Services or expenses Incurred before Your effective date.
5. Services or expenses Incurred after Your coverage terminates.
6. Charges for dental services performed by other than a licensed 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. Services that are not medically necessary or appropriate for the condition treated based on current dental standards.
9. Repairs to dental work within six months of the initial work.
10. Replacement prosthetics within five years of last placement.
11. Treatment involving crowns for a given tooth within five years of last placement, regardless of the type of crown.
12. Replacement for inlays or onlays for a given tooth within five years of last placement.
13. Implants (materials implanted into or on the bone or soft tissue) or the removal of implants.
14. Any services performed for cosmetic purposes, unless they are for the correction of functional disorders.
15. Treatment or services received while outside the territorial limits of the United States, Canada or Mexico.
16. 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.
17. Services performed by a Dentist who is a member of the covered person's Immediate Family.
18. Orthodontic treatment.
19. Temporomandibular Joint (TMJ) dysfunctions.

B. No benefits will be paid for replacement of teeth missing prior to the effective date of coverage.

C. 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 covered person is insured under this policy.

D. 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 covered person is insured under this policy.

E. 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.

F. See the Schedule of Covered Dental Procedures for all other specific procedure frequency and aged limitations.

Part 4
RIGHT OF CONVERSION

A. If You or Your spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your spouse was covered under this policy, then Your ex-spouse can apply for and receive, without evidence of insurability, a policy providing coverage equivalent to the terminated coverage. To obtain the policy, Your ex-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 Named Insured under this policy at the time of dissolution will retain that status. Any covered 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.

B. In the event of Your death, any covered dependent, subject to the same terms and conditions stated in A. 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 5
GENERAL PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president and Secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.

B. 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.

C. 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.

D. REINSTATEMENT: If the renewal 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, the insured 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 the insured 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.
In all other respects the rights of the insured and the company will remain the same, subject to any provisions noted on or attached to the reinstated policy. 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.

E. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provisions of this policy that on its effective date is in conflict with the statutes of the state in which it was issued or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.

F. 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.

G. 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.

Part 6
CLAIM PROVISIONS

A. 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 covered person and the policy number.

B. 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 to You 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.

C. 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.

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

D. TIME OF PAYMENT OF CLAIMS: benefits payable under this policy will be paid immediately upon Our receipt of written proof of loss.

E. 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.

F. 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.

SCHEDULE OF COVERED PROCEDURES

SUBJECT TO THE 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 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

MID-LEVEL PLAN IS FOR UTAH ONLY!!!

Preventive Services		**Limitations**	**Mid-Plan**
d0120	Periodic Oral Examination	(a)	$20
d0140	Limited Oral Evaluation - Problem Focused	(a)	$29
d0150	Comp Oral Evaluation - New/Established Patient	(a)	$28
d0170	Re-Evaluation - Limited Problem Focused	(a)	$16
d0270	Bitewing - Single Film	(b)	$15
d0272	Bitewings - Two Films	(b)	$23
d0273	Bitewings - Three Films	(b)	$28
d0274	Bitewings - Four Films	(b)	$33
d1110	Prophylaxis - Adult	(a)	$45
d1120	Prophylaxis - Child	(a)	$34
d1203	Topical Application Of Fluoride - Child	(c)	$18

Basic Services		**Limitations**	**Mid-Plan**
d0210	Intraoral - Complete Series	(d)	$54
d0220	Intraoral - Periapical 1 Film	(d)	$10
d0230	Intraoral - Periapical Ea Add Film	(d)	$5
d0240	Intraoral - Occlusal Film	(d)	$9
d0330	Panoramic Film	(d)	$25
d2140	Amalgam-One Surface Primary Or Permanent	(e)	$45
d2150	Amalgam-Two Surfaces Primary Or Permanent	(e)	$58
d2160	Amalgam-Three Surfaces Primary Or Permanent	(e)	$70
d2161	Amalgam-Four/More Surfaces Primary/Permanent	(e)	$85
d2330	Resin-Based Composite - One Surface Anterior	(e)	$45
d2331	Resin-Based Composite - Two Surfaces Anterior	(e)	$57
d2332	Resin-Based Composite - Three Surfaces Anterior	(e)	$70

d2335	Resin Compos - 4/More Surfaces/Invlv Incisal Ang	(e)	$82
d2390	Resin-Based Composite Crown Anterior	(e)	$91
d2391	Resin Based Composite - One Surface - Posterior	(e)	$45
d2392	Resin Based Composite - Two Surfaces - Posterior	(e)	$58
d2393	Resin Based Composite - Three Surfaces - Posterior	(e)	$70
d2394	Resin Compos - Four/More Surfaces - Posterior	(e)	$85
d3110	Pulp Cap - Direct		$14
d3120	Pulp Cap - Indirect		$11
d3220	Tx Pulp-Remv Pulp Coronal Dentinocementl Junc		$34
d3221	Pulpal Debridement Primary And Permanent Teeth		$37
d3310	Anterior Root Canal		$160
d3320	Bicuspid Root Canal		$192
d3330	Molar Root Canal		$248
d3410	Apicoectomy/Periradicular Surgery - Anterior		$159
d3421	Apicoectomy/Periradicular Surgery - Bicuspid		$174
d3425	Apicoectomy/Periradicular Surgery - Molar		$197
d3426	Apicoectomy/Periradicular Surgery		$67
d3430	Retrograde Filling - Per Root		$49
d7111	Coronal Remnants - Deciduous Tooth		$45
d7140	Extraction Erupted Tooth Or Exposed Root		$60
d9110	Palliative Treatment Dental Pain - Minor Procedure		$36

Major Services		**Limitations**	**Mid-Plan**
d1351	Sealant - Per Tooth	(f)	$20
d1510	Space Maintainer - Fixed-Unilateral		$62
d1515	Space Maintainer - Fixed-Bilateral		$82
d1520	Space Maintainer - Removable-Unilateral		$77
d1525	Space Maintainer - Removable-Bilateral		$106
d1550	Recementation Of Space Maintainer		$13
d2510	Inlay - Metallic - One Surface	(g)	$143
d2520	Inlay - Metallic - Two Surfaces	(g)	$162
d2530	Inlay - Metallic - Three Or More Surfaces	(g)	$187
d2542	Onlay - Metallic - Two Surfaces	(g)	$184
d2543	Onlay Metallic Three Surfaces	(g)	$192
d2544	Onlay Metallic Four Or More Surfaces	(g)	$200
d2710	Crown - Resin	(g)	$101
d2720	Crown - Resin With High Noble Metal	(g)	$250
d2721	Crown - Resin With Predominantly Base Metal	(g)	$234
d2722	Crown - Resin With Noble Metal	(g)	$239
d2740	Crown - Porcelain/Ceramic Substrate	(g)	$256
d2750	Crown - Porcelain Fused To High Noble Metal	(g)	$260

d2751	Crown - Porcelain Fused Predominantly Base Metal	(g)	$242
d2752	Crown - Porcelain Fused To Noble Metal	(g)	$247
d2790	Crown - Full Cast High Noble Metal	(g)	$240
d2791	Crown - Full Cast Predominantly Base Metal	(g)	$225
d2792	Crown - Full Cast Noble Metal	(g)	$229
d2799	Provisional Crown	(g)	$96
d2910	Recement Inlay		$17
d2920	Recement Crown		$24
d2930	Prefabrication Stainless Steel Crown - Primary Tooth		$49
d2931	Prefabrication Stainless Steel Crown - Permanent Tooth		$57
d2932	Prefabricated Resin Crown		$62
d2940	Sedative Filling		$19
d2950	Core Buildup Including Any Pins		$48
d2951	Pin Retention - Per Tooth Addition Restoration		$10
d2952	Cast Post And Core In Addition To Crown		$73
d2954	Prefabricated Post And Core In Addition To Crown		$60
d4210	Gingl/Gingivplsty 4/> Cont/Bound Teeth Space-Quad		$120
d4211	Gingl/Gingivoplasty - 1-3 Teeth Per Quad		$51
d4240	Gingl Flp Proc 4/> Cont/Bounded Teeth Space-Quad		$141
d4241	Gingl Flp Proc w/Root Planning - 1-3 Teeth-Quad		$73
d4260	Osseous Surgery 4/> Cont/Bounded Teeth Spaces-Quad		$227
d4261	Osseous Surgery - 1-3 Teeth Per Quad		$118
d4263	Bone Replacement Graft - First Site In Quad		$69
d4266	Guided Tissue Regen - Resorbable Barrier Per Site		$83
d4267	Guided Tissue Regen - Nonresorb Barrier Per Site		$107
d4270	Pedicle Soft Tissue Graft Procedure		$168
d4341	Periodontal Scaling & Root Planning 4/>Cont/Bound Teeth-Quad		$40
d4342	Periodontal Scaling & Root Planning 1-3 Teeth-Quad		$22
d4355	Full Mouth Debridment Enable Comp Evaluation & Dx		$27
d4910	Periodontal Maintenance		$24
d5110	Complete Denture - Maxillary	(g)	$289
d5120	Complete Denture - Mandibular	(g)	$289
d5130	Immediate Denture - Maxillary	(g)	$316
d5140	Immediate Denture - Mandibular	(g)	$316
d5211	Maxillary Partial Denture - Resin Base	(g)	$244
d5212	Mandibular Partial Denture - Resin Base	(g)	$284
d5213	Max Part Dentur-Cast Metal Framework w/Resin Base	(g)	$320
d5214	Mand Part Dentur- Cast Metal Framework w/Resin Base	(g)	$320
d5281	Remove Unlit Part Dentur - 1 Piece Cast Metal		$186
d5410	Adjust Complete Denture - Maxillary		$16

d5411	Adjust Complete Denture - Mandibular		$16
d5421	Adjust Partial Denture - Maxillary		$16
d5422	Adjust Partial Denture - Mandibular		$16
d5510	Repair Broken Complete Denture Base		$32
d5520	Replace Missing/Broken Teeth - Complete Denture		$26
d5610	Repair Resin Denture Base		$34
d5620	Repair Cast Framework		$37
d5630	Repair Or Replace Broken Clasp		$45
d5640	Replace Broken Teeth - Per Tooth		$29
d5650	Add Tooth To Existing Partial Denture		$40
d5660	Add Clasp To Existing Partial Denture		$48
d5710	Rebase Complete Maxillary Denture		$117
d5711	Dyn Adj Ankle Ext/Flex Devc Incl Soft Intf Matl		$112
d5720	Rebase Maxillary Partial Denture		$111
d5721	Rebase Mandibular Partial Denture		$111
d5730	Reline Complete Maxillary Denture		$66
d5731	Reline Complete Mandibular Denture		$66
d5740	Reline Maxillary Partial Denture		$61
d5741	Reline Mandibular Partial Denture		$61
d5750	Reline Complete Maxillary Denture		$88
d5751	Reline Complete Mandibular Denture		$88
d5760	Reline Maxillary Partial Denture		$87
d5761	Reline Mandibular Partial Denture		$87
d6210	Pontic - Cast High Noble Metal	(g)	$234
d6211	Pontic - Cast Predominantly Base Metal	(g)	$219
d6245	Pontic - Porcelain/Ceramic	(g)	$238
d6212	Pontic - Cast Noble Metal	(g)	$228
d6240	Pontic - Porcelain Fused To High Noble Metal	(g)	$240
d6241	Pontic - Porcelain Fused Predominantly Base Metal	(g)	$222
d6242	Pontic - Porcelain Fused To Noble Metal	(g)	$234
d6250	Pontic - Resin With High Noble Metal	(g)	$240
d6251	Pontic - Resin With Predominantly Base Metal	(g)	$220
d6252	Pontic - Resin With Noble Metal	(g)	$228
d6720	Crown - Resin With High Noble Metal	(g)	$253
d6721	Crown Resin w/Predominantly Base Metal-Denture	(g)	$240
d6722	Crown - Resin With Noble Metal	(g)	$244
d6740	Crown - Porcelain/Ceramic	(g)	$266
d6750	Crown Porcelain Fused To Hi Noble Metal-Denture	(g)	$260
d6751	Crown - Porcelain Fused Predominantly Base Metal	(g)	$244
d6752	Crown - Porcelain Fused To Noble Metal	(g)	$248
d6790	Crown Full Cast High Noble Metal-Denture	(g)	$252

d6791	Crown Full Cast Predominantly Base Metal-Denture	(g)	$240
d6792	Crown Full Cast Noble Metal-Denture	(g)	$248
d6793	Provisional Retainer Crown		$99
d6930	Recement Fixed Partial Denture		$26
d6940	Stress Breaker		$59
d6970	Cast Post & Core Addition Fix Part Dentur Retainer		$72
d6972	Prefabrication Post & Core Add Fix Part Dentur Retain		$58
d6973	Core Build Up For Retainer Including Any Pins		$47
d7210	Surgical Removal of Erupted Tooth Rqr Elev Flap & Remove Bone		$52
d7220	Removal Of Impacted Tooth - Soft Tissue		$66
d7230	Removal Of Impacted Tooth - Partially Bony		$86
d7240	Removal Of Impacted Tooth - Completely Bony		$102
d7260	Orolantral Fistula Closure		$526
d7241	Remove Imp Tooth - Complete Bony w/Unusual Surg Comps		$125
d7250	Surgical Removal Of Residual Tooth Roots		$54
d7285	Biopsy of Oral Tissue Hard		$212
d7286	Biopsy Of Oral Tissue Soft		$87
d7287	Cytology Sample Collection		$26
d7291	Transseptal Fiberot/Supra Crestal Fiberot Report		$0
d7310	Alveolplsty Conjunc w/Xtracs		$59
d7320	Alveolplsty Not Conjunc w/Xtracs		$264
d7471	Removal Of Lateral Exostosis		$195
d7472	Removal Of Torus Palatinus		$232
d7473	Removal Of Torus Mandibularis		$219
d7510	I&D Abscess - Intraoral Soft Tissue		$57
d7912	Complicated Suture - > 5 Cm		$388
d7970	Excision Hyperplstc Tissue - Per Arch		$128
d7971	Excision Pericoronal Gingiva		$41
d7972	Surgical Reduction Of Fibrous Tuberosity		$151
d7911	Comp Suture - Up 5 Cm		$215
d7960	Frenulect - Separate Procedure		$124