

APPLICATION for INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

Colorado



Monthly Rates (Issue Age 19-99)

COLORADO							
ZIP Codes	Mutual Dental Preferred DNT2		Mutual Dental Protection DNT5			Vision Rider 0PD1M	
	\$1,500	\$3,000	\$5,000	\$1,500	\$3,000	\$5,000	
811-814	\$51.14	\$58.56	\$61.11	\$27.95	\$28.73	\$29.25	\$8.07
806, 807, 810, 815, 816	\$56.31	\$64.47	\$67.29	\$30.77	\$31.63	\$32.21	\$8.07
800-805, 808,809	\$60.44	\$69.21	\$72.22	\$33.03	\$33.95	\$34.57	\$8.07

Rates Subject to Change.

As of 10/05/2023

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to \$50 every calendar year for one eye exam (no waiting period)
Up to \$150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

Internal Tracking Code _	
Group # (if applicable) _	



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Application for Individual Dental Insurance with Optional Vision Rider A. Applicant Information



Name (First, Middle Initial, Last)		Phone Nu Home	Phone Number Home Cell		
Residence Address (Street, City, State, ZIP)		E-mail			
Mailing Address (Street, City, State	e, ZIP) (if different from reside	nce address)	Deliver Po	_	lucer
Gender Date of Birth Male Female			Social Security Number		
B. Plan Information	·				
Select Dental Benefit Plan Mutual Dental Preferred Mutual Dental Protection Select Annual Maximum \$1,500 \$3,000		Requ	Requested Effective Date		
	\$5,000	Mo	nthly Premium Rate f	or Dental \$	
Optional Vision Rider (only av	ailable with Dental)	Mo	onthly Premium Rate f	or Vision \$	
			Total Monthly	Premium \$	
C. Existing Coverage	Information				
Name of vision carrier(s) Is the coverage you are applying fo Is the coverage you are applying fo D. Agreements I represent the information above is answers may void this application a the first premium is received by Mult is unlawful to knowingly provide purpose of defrauding or attemptinand civil damages. Any insurance comisleading facts or information to a certificate holder or claimant with in Colorado division of insurance with	true and complete to the best nd any issued policy. I underst tual of Omaha during my lifeti false, incomplete, or misleading to defraud the company. Per ompany or agent of an insural a certificate holder or claiman regard to a settlement or awaits	of my knowl and that no i me. ng facts or in nalties may i nce company t for the pur	edge and belief. Any ir nsurance shall take eff formation to an insura include imprisonment who knowingly provi	ncorrect or misle fect until a policy ance company for , fines, denial of des false, incom attempting to de	eading y is issued and or the finsurance nplete, or efraud the
Applicant Signature		Da	te S	igned at City	State
I/We acknowledge that if the applic	ant is replacing coverage, I/W	e have provi	ded a copy of the repla	cement notice,	if applicable.
Signature of Licensed Insurance	e Producer	Da	te		
Printed Name		Ag	ent Writing Number	Comm. %	Share
Signature of Licensed Insurance	e Producer	Da	te		
Printed Name		-Ag	ent Writing Number	Comm. %	% 6 Share

MA6025_CO REV



METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 <u>or</u> #2)		
Initial premium amount (based on age at application date)	\$	
Paper Check (submit signed check with application)		
2. Automatic Bank Account Withdrawal		
Ongoing Premium Payments (Select option #1a, #1b, or #2)	1 St through the 28 th or	
1. I want my payments automatically withdrawn from my bank	the last day of every month	
a. Choose the day payments will be deducted every month from your bank account		
OR	Week (1 st , 2 nd , 3 rd , 4 th , last)	
b. Choose the week and weekday that payments will be	Weekday (Mon, Tue, Wed,	
deducted every month from your bank account	Thu, Fri)	
(For Example: 3rd Wednesday of every month)	, ,	
2. I will mail my premium to the company every 3, 6, or 12 months.	everymonths	
(Monthly billing is not allowed. Select frequency of billing)	Insert 3, 6, or 12	
the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insure billing notices while on this premium payment option. We CANNOT establish electronic payments from fore Each month, payments will be automatically deducted from the account below on the day selected above, premiums will be deducted on the policy date (which is determined at the time the policy is issued and car Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a week will process on the following business day. Part II. Payor Information	d(s) will not receive premium eign banks. If no date is selected, he found within the policy).	
1. Account Owner Name, if different than applicant's		
2. If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account) , indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the		
following. Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) Living Trust Power of Attorney or legal guardian (documentation required)		
Business owned by applicant or applicant's spouse		



Part III. Account Information

attin. Account information
Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> is Chosen: This section is intended as authorization to debit your bank account. Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip)
Applicant A Account Type (check one): Checking Savings Name of Financial Institution Routing Number (9 digits on lower left side of check) Account Number (Do NOT use Debit/Credit Card numbers) Name as Shown on Account
 Payments cannot be postponed until a later date. Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations. All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc. Example: Account Holder Name Bo NOT include the check # in the Routing or Account Number. Example: John Doe Street Address Town, City ZIP Code Pay to: Routing/Transfer Number Financial Institution Name & Address
I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.
Applicant A
Authorized Signature as Shown on Account
Date





Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

policy will not duplicate your existing co being purchased for the following reaso		to terminate your existing coverage. The replacement policy is
Additional benefits		
No change in benefits, but	lower premiums	
Fewer benefits and lower p	remiums	
Other (please specify)		
questions on the application concernin an application may provide a basis for the has never been in force. After the appli- information has been properly recorded	g your medical and health I the company to deny any fu cation has been completed I.	r coverage, be certain to truthfully and completely answer all nistory. Failure to include all material medical information on ture claims and to refund your premium as though your polic and before you sign it, review it carefully to be certain that all policy and are sure that you want to keep it.
Applicant Signature	(Date)	Signature of Producer or Other Representative*
		*Signature not required for direct response sales



MUTUAL OF OMAHA INSURANCE COMPANY 3300 MUTUAL OF OMAHA PLAZA OMAHA, NEBRASKA 68175 (402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a standalone plan, or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

<u>Limited Benefit Dental-Only Insurance Coverage</u> – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT	
Class I Diagnostic & Preventive Services	None	
Class II – Basic Services and Class III - Major	\$50.00	
Services Combined		
COINSURANCE	PERCENTAGE PAYABLE	
Class I – Diagnostic & Preventive Services	100%	
Class II – Basic Services	80%	
Class III – Major Services	20% Day One, 50% After Year One	
WAITING PERIOD	TIME FRAME	
Class I- Diagnostic & Preventive Services	None	
Class II – Basic Services	None	
Class III- Major Services	None	
MAXIMUM BENEFIT	AMOUNT	
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000	
Implant Lifetime Maximum Benefit	\$3,000	

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the

PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

<u>Waiting Period</u> – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
 - 1. equilibration;
 - 2. periodontal splinting;
 - 3. full mouth rehabilitation and;
 - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;

- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it:
- (ff) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or;
 - misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
 - 1. extractions:
 - 2. apicoectomies or;
 - 3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
- (uu) space maintainers;
- (vv) services or treatment provided by a member of your immediate family;
- (ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

<u>Multiple Procedure Limitations</u> — When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

<u>Guaranteed Renewable For Life</u> – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

<u>Premiums Can Change</u> — We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.



MUTUAL OF OMAHA INSURANCE COMPANY 3300 MUTUAL OF OMAHA PLAZA OMAHA, NEBRASKA 68175 (402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This policy DOES NOT include coverage of pediatric dental services as required under federal law. Coverage of pediatric dental services is available for purchase in the State of Colorado, and can be purchased as a standalone plan, or as a covered benefit in another health plan. Please contact your insurance carrier, agent, or Connect for Health Colorado to purchase either a plan that includes pediatric dental coverage, or an Exchange-qualified stand-alone dental plan that includes pediatric dental coverage.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

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Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I Diagnostic & Preventive Services, Class II - Basic Services and Class III - Major Services Combined	\$100.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	TIME FRAME
Class I- Diagnostic & Preventive Services	None
Class II – Basic Services	None
Class III- Major Services	None
MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000
Implant Lifetime Maximum Benefit	\$2,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for

the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

<u>Waiting Period</u> – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
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- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
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- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;
- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;

- (ff) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or:
 - 3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
 - 1. extractions:
 - 2. apicoectomies or;
 - 3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
- (uu) space maintainers;
- (vv) services or treatment provided by a member of your immediate family;
- (ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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