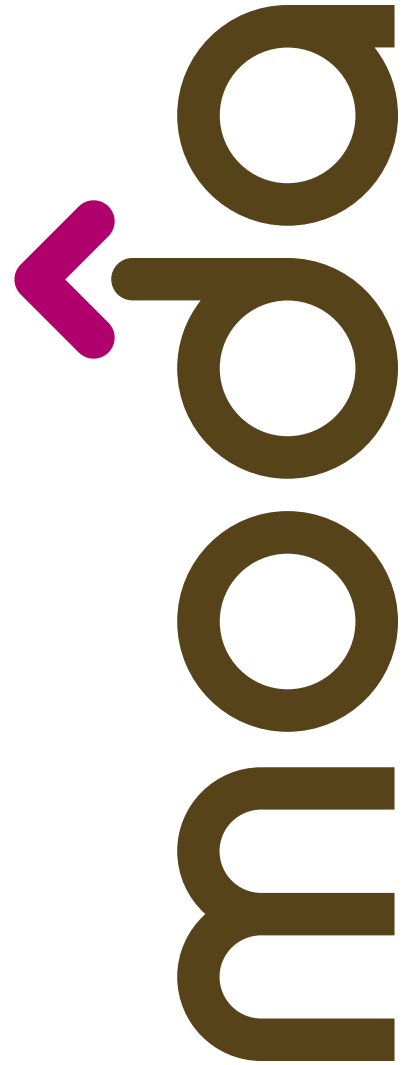


UAW Retirees of DTNA Welfare Benefit Trust

Group #10013360



Dental Customer Service

503-265-2965 or 800-452-1058

Customer Service hours

Monday through Friday, 7:30 a.m. - 5:30 p.m. PST

modahealth.com

Be in charge of your healthy smile

Get to know your benefits! myModa, your personalized member website, helps you manage your dental plan and find ways to improve and maintain your oral health.

Discover more ways to better oral health

- > Click on Find Care to find a dentist near you
 - > Get in touch with a dental health coach and find answers to your oral health questions
 - > Use the Dental Optimizer for a cavity risk assessment, treatment cost estimates and dental health tips
 - > Find dental care while travelling outside the U.S.
- > Download your digital ID card or order a new one
 - > Check the status of pending claims, view your personal claims history and access claim forms

Easily see and manage your benefits

- > View your benefit eligibility and history
- > Receive and view electronic explanations of benefits (EOBs)
- > View account information, such as your contact information and dependents

Log in to myModa 24/7

To sign in to myModa, visit modahealth.com. On the right-hand side of the home page, type in your username and password and click the Go! button.

If you don't have a myModa account, creating one is easy. You'll love everything you can do on myModa, like check your benefits, use interactive health tools, see your Member Handbook and more.



Questions?

We're here to help. Call us toll-free at 888-374-8907. TTY users, please call 711.



modahealth.com



Dental Benefits Summary
Daimler Trucks North America (UAW)
PPO and Premier Dental Network

How To Use this Dental Plan

When you visit your dental provider, tell him or her you are a member of a Delta Dental program.

Calendar year maximum, per member (does not apply to members under age 19)	\$1,500
Calendar year deductible, per member	\$0
SERVICE	Benefit Amount
PREVENTIVE <ul style="list-style-type: none"> - <u>Examination/X-rays</u> (routine exam & bitewing x-rays) - <u>Prophylaxis</u> (cleanings) / <u>Periodontal Maintenance</u> - <u>Sealants</u> - <u>Fluoride</u> - <u>Space Maintainers</u> 	100%
BASIC <ul style="list-style-type: none"> - <u>Restorative Fillings</u> - <u>Oral Surgery</u> (extractions & certain minor surgical procedures) - <u>Endodontic</u> (pulp therapy & root canal filling) - <u>Periodontics</u> (treatment of diseases of the gums and supporting structures of the teeth) 	80%
MAJOR <ul style="list-style-type: none"> - <u>Crowns</u> - <u>Cast Restorations</u> - <u>Implants</u> - <u>Denture and Bridge Work</u> (construction or repair of fixed bridges, partials, and complete dentures) 	80%
ORTHODONTIA-(up to \$1,500 lifetime maximum) Adult and Children	80%
When the member visits: <ul style="list-style-type: none"> * Preferred Dentists (PPO): Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee). * Premier, Non Preferred Dentists: Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee). * Non-participating Dentists: Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable. 	

Advantages

- * **Freedom to choose your dentist:** As a Delta Dental Plan, we offer access to over 134,000 dental professionals nationwide. Look up network providers at www.deltadental.com, and choose the PPO or Premier network.
- * **Professional Arrangements** ODS has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file with ODS and our Delta Dental affiliates. We believe that the underlying unique feature inherent to all ODS programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to ODS for you.
- * **myModa** is a customized member website with current, accurate and easy to understand information about the member's plan. Log onto www.modahealth.com/members to access myModa.

Dependent Eligibility

Dependent eligibility is defined as per your collective bargaining contract.

LIMITATIONS

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class I Services)

- * **Diagnostic** Routine examination and bitewing x-rays limited to twice per calendar year. Full mouth x-rays limited to once every 36 months.
- * **Preventive** Prophylaxis (cleaning) is limited to twice per calendar year. Topical application of fluoride is covered twice per calendar year for members age 18 and under. Sealant benefits are limited one time per tooth every 36 months for members through age 14.
- * **Periodontic** maintenance is limited to 4 times per year.

Basic (Class II Services)

- * **Oral Surgery** Limited to extractions and other minor surgical procedures.
- * **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- * **Periodontic** Scaling and root planning is limited to 4 times per year.

Major (Class III Services)

- * **Restorative** Cast restorations (including pontics) are limited to once every 60 months.
- * **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once every 60 months only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 60 months. Specialized or personalized prosthetics are limited to the cost of standard devices.

EXCLUSIONS

- * Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- * Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- * Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- * Services started prior to the date the individual became eligible for services under the program.
- * Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- * Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- * General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- * Plaque control and oral hygiene or dietary instructions.
- * Experimental procedures.
- * Missed or broken appointments.
- * Precision attachments.
- * Services for cosmetic reasons.
- * Claims submitted more than 12 months after the date of service are not covered.
- * All other services or supplies, not specifically covered.

Visit our website at www.modahealth.com

This is a benefit summary only.

For a more detailed description of benefits, refer to your member handbook.



> Oral Health, Total Health

Dental benefits that protect more than just your smile

If you are diabetic or pregnant in your third trimester, the Oral Health, Total Health program offers more ways to care for your teeth and mouth – and keep the rest of your body healthy, too.

If you have diabetes

Diabetes increases the risk of cavities, periodontal (gum) disease, tooth loss, dry mouth and infection. If you have been diagnosed with this disease you are eligible for four prophylactic (preventive) cleanings or periodontal maintenance visits per year through our Oral Health, Total Health program. Protect your teeth and gums by enrolling today.

For details on the Oral Health, Total Health program, refer to the dental Member Handbook or visit myModa, your personalized member website.

If you're pregnant

Pregnant women who have periodontal (gum) disease are more likely to have a premature and underweight baby. Bacteria can enter the bloodstream through the mouth, and the body's response to the infection can trigger early labor.

If you are expecting, you can enroll in the Oral Health, Total Health program to help prevent gum disease. If you've already had two cleanings for the year, you'll be eligible for another cleaning or checkup during your third trimester. This added preventive (prophylactic) visit is covered regardless of normal plan frequency limits. That way, you can receive a dental cleaning during the third trimester, no matter what.

Learn more and enroll

To enroll in the Oral Health, Total Health program, fill out the form on the reverse side of this sheet or access the form online by logging in to myModa at modahealth.com. Once you've signed in, simply click on "Oral Health, Total Health" in the myHealth tab.



Questions?

To learn more or to enroll, just call us toll-free at 877-277-7280.



modahealth.com

Oral Health, Total Health enrollment form

To enroll in our Oral Health, Total Health program, please follow the instructions below.

For expectant moms, enrolling is a one-step process

If you are pregnant, you can enroll in the Oral Health, Total Health program by calling Moda Health Dental Customer Service at 877-277-7280 after you have scheduled your third trimester cleaning appointment. Be sure to tell us the date of your appointment. It's that easy.

For diabetics, enrolling is as easy as 1-2-3

- 1 Complete the form below.
- 2 Include proof of diagnosis.
- 3 Mail or fax both to Moda Health.

Section 1 ▶ Insurance information

If you are diabetic and wish to enroll in the Oral Health, Total Health program, complete this enrollment form and fax it – along with proof of diagnosis.

Member name	Subscriber name	Subscriber ID number*
Group (plan) number*	Group name*	

*Find this information on your ID card and through myModa at modahealth.com.

Section 2 ▶ Proof of diagnosis

Please select one of the following:

- ☐ I have attached proof of my diabetes diagnosis. *Examples of proof of diagnosis include a doctor's note or a copy of a prescription supporting a diabetes diagnosis.*
- ☐ I have Moda Health medical coverage and have had a claim paid by Moda Health for medical or pharmacy services related to my diabetes. *We will verify the diagnosis on your behalf.*

Section 3 ▶ Authorization

I certify that the information above has been truly and accurately recorded.

Signature	Date
-----------	------

When is it effective?

Your enrollment will be effective the first of the month after we receive and process both your completed Oral Health, Total Health enrollment form and proof of diagnosis.

Ready to submit? Mail or fax this form to Moda Health:

Mail: Moda Health, 601 S.W. Second Ave., Portland, OR 97204 **Fax:** 503-243-3959

Questions? We're to help. Just call us toll-free at 877-277-7280. (TTY users, dial 711.)

modahealth.com



Enrollment application & change of information form

Dental (100+)

Moda Health use only

Group number _____

Subscriber number _____

To expedite your application, please print legibly in black or blue ink and return as instructed. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed.

Section 1 > Application type

You'll need a special enrollment reason for some changes made outside the open enrollment period. Special enrollment includes adding dependents to an existing plan and enrolling in the plan due to loss of other coverage. The reason I am applying or making a change is:

Open enrollment

- ☐ New policy/subscriber
- ☐ Add dependent on existing plan
- ☐ Plan change only

Changes

- ☐ Name change
New name: _____
Old name: _____
- ☐ New address
(please write new address in Section 3)

Special enrollment

Date of event: _____ / _____ / _____

- ☐ Marriage
- ☐ Registered domestic partner (RDP)
- ☐ Birth, adoption or placement for adoption
- ☐ Loss of coverage because I turned 26
- ☐ Loss of coverage due to end of marriage or registered domestic partnership (RDP)
- ☐ Involuntary loss of group coverage
- ☐ COBRA ended due to exhausting benefit
- ☐ Other _____

Section 2 > Coverage

☒ Dental coverage

Group name	Group number
Subgroup	Class

Section 3 > Employee information

*First name	M.I.	*Last name	*Social Security number	
*Mailing address		*City	*State	*ZIP
Home phone	*Date of birth (mm/dd/yyyy) ____ / ____ / ____	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Date of employment (mm/dd/yyyy) ____ / ____ / ____	
Primary language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____		Email address		

Section 4 > Dependents

Relationship code: SP = spouse, DP = domestic partner, RDP = registered domestic partner (DP and RDP only if applicable to your plan)

Add	Term	*Dependent first name	*Last	*Social Security number	*Date of birth (mm/dd/yyyy)	*Gender	*Relationship	Primary language (if different from employee)
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SP <input type="checkbox"/> DP <input type="checkbox"/> RDP	
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child ¹	
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child ¹ <input type="checkbox"/> Ward	

* Enrollment will be delayed if fields with an asterisk are not filled out.

¹ Please list only eligible dependent children. See Section 6 for dependent children qualifications.

9020743 (7/14) BE-1167

Section 5 > Other insurance (coordination of benefits)

Will employee or any dependents have other insurance? ☐ Yes ☐ No

Section 6 > Dependent(s) not living with employee

Are any of the dependent(s) not living with the employee? If yes, please provide the state and ZIP code. This is for informational purposes only and does not impact eligibility.

Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP
Dependent name	State	ZIP

Children are eligible to enroll for coverage through age 25. Please see your Member Handbook for additional eligibility information. The following are eligible dependent children:

- > Your or your spouse’s natural or adopted child
- > Children placed with you for adoption
- > Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
- > Children related by blood or marriage for whom you are the legal guardian (you will need to attach a signed court order showing legal guardianship)
- > Your domestic partner’s natural child or adopted child (if domestic partners by affidavit can enroll in your employer plan)
- > Your registered domestic partner’s natural child or adopted child

Section 7 > Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.² Health information requested or disclosed may be related to treatment or services performed by:

- > A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- > A clinic, hospital, long term care or other medical facility;
- > Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- > An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions. It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health coverage.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.

*Employee signature 	*Signature date
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¹ Enrollment will be delayed if fields with an asterisk are not filled out.
² For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

Questions? Contact your benefits administrator or visit modahealth.com

601 S.W. Second Ave., Portland, OR 97204-3156