

EXHIBIT 12A
PLAN SUMMARY
DHMO



DHMO Enrollment Kit/Member Handbook & Benefit Schedule





National Pacific Dental (NPD) is a leading provider of managed care dental benefit programs in Texas. Operating and based in the Houston area since 1982, we have a reputation for obtaining and retaining the most sought after employer trust funds, medical plan alliances, school districts, county and local governments and corporate clients.



To get this Handbook on audio-tape, in large type, or in Braille, call 1-877-813-4259.

For TTY/TDD, call 1-800-735-2989 (TTY).

For the hearing and speech impaired, call 1-800-735-2988.

Call us at
1-877-813-4259
with any questions.

How does the group dental plan work?

We have created a Plan that offers our members quality dental health services at significant savings. We have contracted with quality, local dental professionals to provide services to you and your eligible dependents at no cost or low fixed co-payments.

Membership eligibility

This plan is designed for employees and their dependents. Dependent children are eligible to age 26.

Take advantage of the benefits

In addition to substantial savings, there are other advantages as described in this brochure. Under this plan:

- ▶ Maximum benefits allowed annually per person are unlimited
- ▶ There are no deductibles
- ▶ You know your exact "out-of-pocket" costs, if any
- ▶ No claim forms are required, in most cases
- ▶ You may select the participating dentist of your choice
- ▶ Benefits include adult and child orthodontics

- ▶ You are assured the highest standard of quality care through provider Quality Assurance Reviews
- ▶ Specialty care benefits are provided
- ▶ Coverage includes emergency care access 24 hours a day, 7 days a week

Choose your dentist and office

You and your family choose from a wide network of private dental offices. A list of dental offices is provided to permit you to choose the most convenient location. If you desire, you may transfer to a different dental office by contacting the Customer Service Department at toll-free at 1-877-813-4259. Should your treatment plan require the services of a specialty care dentist, you will be referred to one. All benefits and co-payments apply to specialty care services provided the referral has been approved by us.

Important information regarding your plan

We are licensed as a Health Maintenance Organization offering a single health care service plan. Should any provision herein not conform to the Texas Health Maintenance Organization Act or other applicable laws, it shall be construed as if it were in full compliance thereof.

Important notice

You may call our toll-free telephone number for information or to make a complaint at 1-877-813-4259.

You may also write to us:
1333 West Loop South, Suite 1100
Houston, TX 77027

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at (800) 232-3439.

You may write the Texas Department of Insurance at:
P. O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Premium or claim disputes:

Should you have a dispute concerning your premium or about a claim, you should contact us first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

Attach this notice to your policy:

This notice is for information only and does not become a part or condition of the attached document.

Aviso importante

Usted puede llamar nuestro número de teléfono de peaje-liberta para la información o para formular una queja en 1-877-813-4259.

Usted también puede escribir a nosotros:
1445 North Loop West, Suite 500
Houston, TX 77008

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al (800) 252-3439.

Puede escribir al Departamento de Seguros de Texas:
P. O. Box 149104
Austin, TX 78714-9104
FAX# (512) 475-1771

Disputas sobre primas o reclamos:

Debe tener una disputa con respecto a su prima o acerca de un reclamo, usted debe contactar primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

Alta este aviso a su póliza:

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

We are a leading provider of managed care dental benefit programs in Texas. Operating and based in the Houston area since 1982, we have a reputation for obtaining and retaining the most sought after employer trust funds, medical plan alliances, school districts, county and local governments and corporate clients.

How your plan works

Enrolling in our plan is easy! Just select a Primary Care Dentist from our network. The dentist you choose must be listed in our Directory of Participating Dentists. The Directory of Participating Dentists is updated at least quarterly and an updated printed copy is available to you upon request. Once your coverage becomes effective, you may schedule an appointment directly with your Selected Primary Care Dentist who will provide your general dental care after you register your selection with Customer Service. When you receive care, you will pay the applicable co-payment described on your Schedule of Covered Dental Services enclosed with this brochure. Your co-payment will apply to care received at your Selected Primary Care Dentist or a Specialty Care Dentist, as defined in the Evidence of Coverage. Dental providers have agreed to look only to us and not to its enrollees for payment of covered services, except for member copayments as set forth in the Schedule of Covered Dental Services. Regardless, your co-payment will be significantly less than the fees you would be charged if you were not enrolled in our DHMO Plan. You don't have to worry about meeting deductibles or exceeding maximums. There are none with us! Should you wish to transfer to another Selected Primary Care Dentist, you may do so by contacting our Customer Service Department at 1-877-813-4259. To enroll in our Plan, you must reside, live, or work in the Service Area.

Out of network services

Your HMO is required to allow a referral to non-network providers and fully reimburse such non-network providers the usual and customary or agreed rate if medically necessary covered services are not available through network providers. Services available in the network are offices in the counties noted in the included insert. Standard coverage is not available in counties not listed in the insert. Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested.

Specialty care referrals

During the course of treatment, your Selected Primary Care Dentist may encounter situations that require the services of a Specialty Care Dentist. Your Selected Primary Care Dentist will complete the required documentation. You must contact us, we will advise you of the name, address, and telephone number of the dentist who will provide the required treatment. These services are available only when the dental procedure cannot be performed by the Selected Primary Care Dentist due to the severity of the problem. All referrals must be authorized by us. Failure to follow these guidelines could result in the loss of your benefit.

About our network of dentists

All contracted Dentists are thoroughly evaluated prior to being accepted into our network. This extensive screening includes a verification of the dentist's license and supporting credentials. Each Selected Primary Care Dentist also undergoes an on-site inspection to make sure the facility, equipment, and office practices meet our standards and regulatory requirements. In addition, the dental office staff receives ongoing training on the administration of our Plan and our expectations with regard to serving our members.

We review all Selected General Dental Offices as part of our ongoing Quality Management Program. You can be confident that the network dentist that you select is well prepared to meet your dental needs.

In the event that your Selected Primary Care Dentist terminates his/her relationship with us for any reason, he/she must complete any treatment in progress. We will notify you by mail should your dentist terminate his/her agreement with us, which notice will advise you on how to select a new primary care dentist.

Emergency dental services

All contracted Selected Primary Care Dentists provide access to Emergency Care twenty-four (24) hours a day, seven (7) days a week. In the event of a dental emergency and you are within seventy-five (75) miles of your Selected Primary Care Dentist, simply contact your dentist who will make reasonable arrangements for such emergency dental care.

If you are more than seventy-five (75) miles from your Selected Primary Care Dentist, or you cannot reach your Selected Primary Care Dentist or our Customer Service, you may obtain Emergency Dental Services, as defined below, from any dentist, without regard to whether the dentist or provider furnishing the services has a contractual or other arrangement to provide services to covered individuals.

- ▶ Dental screening examinations or other evaluations required by state or federal law, which are necessary to determine whether an emergency dental condition exists.
- ▶ Necessary emergency dental care services, including the treatment and stabilization of an emergency dental condition.
- ▶ Services originating in a dental office following treatment or stabilization of an emergency dental condition, provided the treating dentist has made inquiry to and received authorization from us for the post stabilization services. We shall respond to the treating dentist within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member. But in no case to exceed one hour from the time of request.

Procedures can be administered in a dentist's office, dental clinic, or other Comparable Facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed. A Comparable Facility is defined as the location where emergency dental services are rendered, including, but not limited to, the office of a licensed dentist, a dental clinic, or other such facility.

Our Customer Service will request that you send a copy of the bill incurred as a result of such dental emergency to us. Please include your name, Social Security Number, address, and telephone number on all pages. After verifying the circumstances, you will be responsible for any applicable co-payment if a true emergency existed.

Complaint procedure

A "Complaint" is your written or oral dissatisfaction about any aspect of our operation, including, but not limited to: dissatisfaction with our plan administration; procedures; denial; reduction or termination of a service for reasons not related to medical necessity; disenrollment decisions; or the way a service is provided. A "Complaint" does not include (a) a misunderstanding or problem of misinformation that can be promptly resolved by us or clearing up the misunderstanding by supplying the correct information to your satisfaction; or (b) dissatisfaction or disagreement with an adverse determination by you or your provider.

If you or one of your eligible Dependents has a complaint with us or your Selected Primary Care Dentist, you may register a complaint by calling our Customer Service at 1-877-813-4259. Or you may submit a completed written Verbal Complaint Form (available by calling the Customer Service number) or submitting a detailed written summary of your complaint to us at:

UnitedHealthcare
P.O. Box 30569 Salt Lake City,
UT 84130-0569 Fax: 1-714-
364-6266

Please be sure to include your Name (Patient's name if different, with the Member name), Social Security Number of the Member, dental facility (or Selected Primary Care Dentist) Name, and Provider ID Number on all written correspondence. We agree, subject to our Complaint Procedure, to duly investigate and endeavor to resolve any and all complaints received from Members regarding the Plan. We will confirm receipt of your complaint in writing within five (5) business days of receipt of a complaint. We will resolve the complaint and communicate the resolution in writing with the medical, clinical, or contractual logic applied to reach this decision within thirty (30) calendar days.

Members also have access to an independent review process for members with a disability affecting the enrollee's ability to communicate or read in the appropriate format including Braille, large print, audio tape, TDD access, or an interpreter. The HMO is prohibited from retaliating against a group contract holder or enrollee because the group contract holder or enrollee has filed a complaint against the HMO or appealed a decision of the HMO, and is prohibited from retaliating against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the HMO or appealed a decision of the HMO.

Appeals

If the action taken by us is not satisfactory, you may appeal the matter. We will acknowledge all appeals within five (5) business days of receipt by us. An Appeal Panel will be appointed and will consist of equal numbers of dentists, member enrollees (not employed by the HMO), and staff members who were not previously involved in the case. No later than five (5) business days prior to the hearing, we will notify you of your right to appear before the Panel in the location where dental services are received or an agreed upon location, present expert testimony, present oral or written testimony, question persons involved in making the original determination, be informed of the names, affiliations, and specialties of the panel participants and receive copies of all documentation to be presented to the Panel by us. The providers on the panel must have experience in the area of care that is in dispute and must be independent of the provider who made the previous decision. If specialty care is under dispute, a provider under that specialty will be consulted. The Panel hearing will occur and the complainant will be advised of the Panel's determination no later than thirty (30) days following our receipt of the written appeal request using the specific medical, clinical and/or contractual logic used. Under certain circumstances, members or providers on behalf of members, have a right to appeal an adverse determination to an independent review organization. The notice of an adverse determination will include instructions for requesting an independent review.

If the appeal request involves a presently occurring dental care emergency, we will contact an appropriate dentist who has not been involved with the case within twenty-four (24) hours. We will immediately inform the Member of the final decision verbally followed by written notification no later than the third day after the date of the decision. We may not retaliate against a member, group contract holder, or provider who has filed a complaint or appealed a decision. Members appealing an adverse determination will follow the same process. Filing Complaints with the Texas Department of Insurance: Any person, including persons who have attempted to resolve complaints through our complaint process and who are dissatisfied with the resolution, may file a complaint with the Texas Department of Insurance at P. O. Box 14901, Austin, TX 78714-9091. The Department's telephone number is (800) 252-3439.

Some commonly asked questions

- Q.** Who provides the dental care services? We maintain a panel of licensed dentists who have contracted with us to deliver dental care services directly to our Members. Check your Directory of Participating Dentists for Primary Care Dentists in your area.
- Q.** Are cleanings covered? Yes. We cover routine cleanings at your Selected Primary Care Dentist office. Some members may require more than a "routine cleaning" due to more involved dental needs. When more frequent cleanings or extensive treatment such as root planing or scaling is required, your dentist will charge you in accordance with your Schedule of Covered Dental Services.
- Q.** Is there a waiting period? Once your enrollment becomes effective, simply schedule an appointment with your Selected Primary Care Dentist.
- Q.** How do I know what my co-payment will be? Refer to your Benefit Schedule included in this brochure, which lists all covered services.
- Q.** What if I want to change my dentist? Contact Customer Service by the 20th of the month so your selection will be effective by the 1st of the next month.
- Q.** What kinds of services are included in my coverage? Your Benefit Schedule included in this brochure includes all listed procedures which include preventive, diagnostic, restorative, crown and bridge, endodontics, oral surgery, periodontal services, and may include orthodontics. Contact your employer for specific plan details

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this Plan's Schedule of Covered Dental Services:

1. Dental Prophylaxis - Limited to 1 time per 6 months
2. Intraoral -Complete Series (including bitewings) - Limited to 1 time in any 2 year period.
3. Intraoral Bitewing Radiographs – Limited to 1 series of 4 films in any 6 month period
4. Fluoride Treatments – Limited to one time per calendar year
5. Scaling and Root Planing - Limited to 4 quadrants per calendar year.
6. Periodontal Maintenance - Limited to once every 6 months, following active therapy, exclusive of gross debridement
7. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 5 years from initial or supplemental placement
8. Removable Prosthetics/Fixed Prosthetics/Crowns, Inlays and Onlays (Major Restorative Services) - Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
9. Crowns - Retainers/Abutments - Limited to 1 time per tooth per 5 years.
10. Crowns – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
11. Temporary Crowns – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
12. Inlays/Onlays - Retainers/Abutments - Limited to 1 time per tooth per 5 years
13. Inlays/Onlays – Restorations - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth.
14. Stainless Steel Crowns - Limited to 1 time per tooth per 5 years. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown -primary tooth, are limited to primary anterior teeth.
15. Crowns and fixed bridges, the maximum benefit within a 12-month period is any combination of 7 crowns or pontics (artificial teeth that are part of a fixed bridge). If more than 7 crowns and/or pontics are done for a Member within a 12-month period, the dentist's fee for any additional crowns within that period would not be limited to the listed Copayment, but instead can reflect the Dentist's Billed Charges.
16. Post and Cores - Covered only for teeth that have had root canal therapy.
17. Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 6 months after the initial insertion.
18. Intravenous Sedation or General Anesthesia - Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving 1 or more impacted teeth (soft tissue, partial bony or complete bony impactions).
19. Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - Limited to 1 time per year, to Covered Persons over the age of 30.

In order for specialty services to be Covered by this plan, the following referral process must be followed:

- A Covered Person's PCD must coordinate all Dental Services.
- When the care of a Network Specialist Dentist is required, the Covered Person's PCD must contact us and request authorization.

- If the PCD's request for specialist referral is denied, the PCD and the Covered Person will be notified of the reason for the denial. If the service in question is a Covered service, and no limitations or exclusions apply, the PCD may be asked to perform the service.
- Covered Person who receives authorized specialty services must pay all applicable Copayments associated with the services provided. When we authorize specialty dental care, a Covered Person will be referred to a Network Specialist Dentist for treatment. The Network includes Network Specialist Dentists in: (a) endodontics; (b) oral surgery; (c) pediatric dentistry; and (d) orthodontics; and (e) periodontics, located in the Covered Person's Service Area. If there is no Network Specialist Dentist in the Covered Person's Service Area, we will refer the Covered Person to a Non-Participating Specialist of our choice. Except for Emergency Dental Services, in no event will we cover dental care provided to a Covered Person by a specialist not pre-authorized by us to provide such services.
- Covered Person's financial responsibility is limited to applicable Copayments. Copayments are listed in the Covered Person's Schedule of Covered Dental Services.

The following procedures and services are excluded and not Covered Services, unless otherwise specifically listed as a Covered benefit on this Plan's Schedule of Covered Dental Services:

- A. Dental Services that are not Necessary.
- B. Costs for non-Dental Services related to the provision of Dental Services in hospitals, extended care facilities, or Subscriber's home. When deemed Necessary by the Primary Care Dentist, the Subscriber's Physician and authorized by us, Covered Dental Services that are delivered in an inpatient or outpatient hospital setting are Covered as indicated in the Schedule of Covered Dental Services.
- C. Any service done for cosmetic purposes that is not listed as a Covered cosmetic service in the Schedule of Covered Dental Services.
- D. Any Dental Procedure not directly associated with dental disease.
- E. Any Dental Procedure not performed in a participating dental setting. This will not apply to Covered Emergency Dental Services..
- F. Placement of dental implants, implant-supported abutments and prostheses.
- G. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- H. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- I. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- J. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- K. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns , implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- L. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

- M. Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction.
- N. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- O. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- P. Dental Services otherwise Covered under the Contract, but rendered after the date individual Coverage under the Contract terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Contract terminates.
- Q. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- R. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

- S. Replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- T. Any Covered Person request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without referral from the PCD and our approval.
- U. Treatment which requires the services of a pediatric specialist, after the Covered Person's 8th birthday.
- V. Procedures performed to facilitate non-Covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

W. Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

X. Relative analgesia (N2O2- nitrous oxide).
Orthodontic Exclusions and Limitations (if a covered benefit under your plan)

If you require the services of an orthodontist, a referral must first be obtained. If a referral is not obtained prior to the commencement of orthodontic treatment, the Covered Person will be responsible for all costs associated with any orthodontic treatment. Orthodontic services Copayments are valid for authorized services rendered by a Network orthodontist

If you terminate Coverage after the start of orthodontic treatment, you will be responsible for any additional charges incurred for the remaining orthodontic treatment.

- A. The following are not Covered orthodontic benefits:
- Extractions required for orthodontic purposes
 - Surgical orthodontics or jaw repositioning
 - Myofunctional therapy

- Cleft palate
- Micrognathia
- Macroglossia
- Hormonal imbalances
- Orthodontic retreatment when initial treatment was rendered under this plan or for changes in orthodontic treatment necessitated by any kind of accident
- Palatal expansion appliances
- Services performed by outside laboratories
- Replacement or repair of lost, stolen or broken appliances or appliances damaged due to the neglect of the Covered Person

B. If a treatment plan is for less than 24 months, then a prorated portion of the full Copayment shall apply.

C. If Covered Person's dental eligibility ends, for whatever reason, and the Covered Person is receiving orthodontic treatment under the plan, the remaining cost for that treatment will be prorated at the orthodontist's usual fees over the number of months of treatment remaining. The Covered Person will be responsible for the payment of this balance under the terms and conditions pre-arranged with the orthodontist.

D. If the Covered Person has the orthodontist perform a "diagnostic work-up" (a consultation and diagnosis) and then decides to forgo the treatment program, the Covered Person will be charged a \$50 consultation fee, plus any lab costs incurred by the orthodontist.

E. One orthodontic benefit under this plan is available per lifetime, per Covered Person. A Covered Person may access this benefit for either Interceptive Orthodontic Treatment or Comprehensive Orthodontic Treatment, or both. If both interceptive treatment and comprehensive treatment are necessary, and both are completed within a 24 month period, the Copayments listed will apply. If both are necessary and active treatment for both extends beyond 24 months, the provider is obligated to accept the plan Copayment only for the first 24 months of active therapy. The provider may charge usual and customary fees for active treatment extending beyond the 24 month benefit period.

Unless provided elsewhere in the plan description.
The above principle limitations & exclusions apply to your coverage with us.

Inserts: [Directory of Participating Dentists](#)
[Service Area Map](#)
[Member Co-payment Schedule](#)



Benefits for the UnitedHealthcare Dental DHMO plans are provided by or through the following UnitedHealth Group companies: Dental Benefit Providers, Inc., its subsidiaries, or its affiliates including National Pacific Dental, Inc., Nevada Pacific Dental and PacificCare of Colorado, Inc.