

**AMENDMENT #2  
TO THE  
SUMMARY PLAN DESCRIPTION**

DENTAL PLAN SPONSORED BY  
ALL CHILDREN'S HEALTH SYSTEM, INC.  
GROUP #2003007

Effective January 1, 2019, the Dental Plan Sponsored by All Children's Health System, Inc. is amended as follows:

Within the "**COORDINATION OF BENEFITS**" section, the "ORDER OF BENEFIT DETERMINATION" subsection is replaced as follows:

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent:**

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. **Dependent Child Covered Under More Than One Plan:**

A. ~~The primary plan is the plan of the parent whose birthday is earlier in the year if:~~

- ~~1) The parents are married;~~
- ~~2) The parents are not separated (whether or not they have ever been married), or~~
- ~~3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.~~

~~B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.~~

~~C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.~~

~~D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:~~

- ~~1) The plan of the custodial parent.~~
- ~~2) The plan of the spouse of the custodial parent.~~
- ~~3) The plan of the non-custodial parent.~~
- ~~4) The plan of the spouse of the non-custodial parent.~~

*Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:*

A. *For a dependent child whose parents are married or are living together, whether or not they have ever been married:*

- 1) *The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or*
- 2) *If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.*

- B. *For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:*
- 1) *If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;*
  - 2) *If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph A of this paragraph shall determine the order of benefit;*
  - 3) *If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph A of this paragraph shall determine the order of benefit;*
  - 4) *If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:*
    - a) *The plan covering the custodial parent;*
    - b) *The plan covering the custodial parent's spouse;*
    - c) *The plan covering the non-custodial parent; and then*
    - d) *The plan covering the non-custodial parent's spouse.*
- C. *For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a or b of this paragraph as if those individuals were parents of the child.*
- D. *For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.*
- E. *In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph A to the dependent child's parent(s) and the dependent's spouse.*

3. **Active Employee or Inactive Retired or Laid-Off Employee:**

~~The plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.~~

- A. *The plan that covers a person as an active employee that is an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.*
- B. *If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.*
- C. *This rule does not apply if the rule in paragraph 1 can determine the order of benefits.*

4. **COBRA or State Continuation Coverage:**

- A. *If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering the same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.*
- B. *If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.*
- C. *This rule does not apply if the rule in paragraph 1 can determine the order of benefits.*

5. **Longer or Shorter Length of Coverage:**

~~If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.~~

- ~~A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.~~
- ~~B. The start of a new plan does not include:
  - ~~1) A change in the amount or scope of a plan's benefits;~~
  - ~~2) A change in the entity that pays, provides, or administers the plan's benefits; or~~
  - ~~3) A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).~~~~
- ~~C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
  - A. *If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered person for the shorter period of time is the secondary plan.*
  - B. *To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.*
  - C. *The start of a new plan does not include:
    - 1) A change in the amount or scope of a plan's benefits;
    - 2) A change in the entity that pays, provides or administers the plan's benefits; or
    - 3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.*~~
- ~~D. *The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.*~~

6. **No Rules Apply** ~~If none of the preceding rules determines the primary plan order of benefits, the Allowable Expense will be determined~~ shall be shared equally between the plans.

Within the "PROCEDURES FOR CLAIMING BENEFITS" section, item 2 (**Second Level of Benefit Determination Review**) within the "APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM" subsection is replaced as follows:

**2. Second Level of Benefit Determination Review**

The second level review of the claim in question along with the additional information submitted by the Covered Person will be reviewed by the Appeals Committee of the Plan Supervisor (Appeals Committee). The Appeals Committee will conduct a full and fair review of the claim. The Appeals Committee will be neither the original decisionmaker nor the decisionmaker's subordinate. The Appeals Committee cannot give deference to the initial benefit determination. The Appeals Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental or Investigational treatment, the Appeals Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Appeals Committee will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

*If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.*

*In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.*

*If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action under Section 502(a) of ERISA. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.*

Within the "PROCEDURES FOR CLAIMING BENEFITS" section, item 2 (**Second Level of Benefit Determination Review**) within the "APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM" subsection is replaced as follows:

**2. Second Level of Benefit Determination Review**

The second level review of the claim in question along with the additional information submitted by the Covered Person will be reviewed by the Appeals Committee of the Plan Supervisor (Appeals Committee). The Appeals Committee will conduct a full and fair review of the claim. The Appeals Committee will be neither the original decisionmaker nor the decisionmaker's subordinate. The Appeals Committee cannot give deference to the initial benefit determination. The Appeals Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental or Investigational treatment, the Appeals Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Appeals Committee will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Summary Plan Description, on file with the Plan Administrator and the Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

*If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.*

*In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.*

*If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action under Section 502(a) of ERISA. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.*

Nothing in this amendment is deemed to change any other provision of the Plan Document of which it becomes a part.

**ALL CHILDREN'S HEALTH SYSTEM, INC.**

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