



Special Agents Mutual Benefit Association
11301 Old Georgetown Road, Rockville, MD 20852
(301) 984-1440 • (800) 638-6589 • www.SambaPlans.com

DEPENDENT CHILDREN HEALTH BENEFIT PLAN

(For Dependent Children Age 22 to 27)

SUMMARY PLAN DESCRIPTION

Introduction: The Special Agents Mutual Benefit Association (SAMBA) is under contract with the U.S. Office of Personnel Management (OPM) to provide a health benefits plan called the "SAMBA Health Benefit Plan" authorized by the Federal Employees Health Benefits (FEHB) law. The SAMBA Health Benefit Plan benefits, network providers, exclusions, and limitations are described in the Brochure (RI 72-006) authorized for distribution by OPM.

Dependent children generally lose their eligibility under the FEHB Program's Self and Family enrollment when they reach age 22. Therefore, SAMBA offers members enrolled in the SAMBA Health Benefit Plan the opportunity to enroll their eligible dependent children between the ages of 22 through 26 in SAMBA's Dependent Children Health Benefit Plan (DHBP or Plan). **This Plan is offered as an alternative to health insurance plans an eligible dependent may qualify for and enroll in under the FEHB Program's Temporary Continuation of Coverage (TCC) provision** (you may contact your employing agency or retirement office for details about TCC). While the DHBP is modeled after the SAMBA Health Benefit Plan, it is not part of the FEHB Program. The DHBP is governed by the Employee Retirement Income Security Act of 1974 (ERISA); this document is intended to serve as the Plan's "Summary Plan Description" for children enrolled under the DHBP and provides you with all relevant information regarding your rights under ERISA. This Summary Plan Description refers to our SAMBA member (active or retired employee of the agencies we serve) as "you" or "member."

The information contained in this Summary Plan Description is required to be furnished to you under the provisions of ERISA, as amended, and implemented under the U. S. Department of Labor regulations.

The Employer Identification Number ("EIN") issued to SAMBA by the Internal Revenue Service is 52-1074154.

April 1, 2006

Enrollment and Eligibility:

The DHBP is designed for our members' children age 22 through age 26, provided they remain unmarried and are wholly dependent upon the member for support and maintenance. Eligibility to enroll your child in the DHBP initially is established by your enrollment in the SAMBA Health Benefit Plan (FEHB Program) or the Employee SAMBA Health Benefit Plan. Only members enrolled under the SAMBA Health Benefit Plan may have a child enrolled in the DHBP.

Under the Plan an eligible dependent "child" means a member's recognized: 1) legitimate child; 2) an adopted child; 3) a stepchild, foster child, or recognized natural child who lives with the member in a regular parent-child relationship; 4) a recognized natural child for whom a judicial determination of support has been obtained; or 5) a recognized natural child to whose support the member makes regular and substantial contributions.

A child is deemed legally "dependent" on the member for purposes of coverage only if: 1) the child lives with the member in a regular parent-child relationship; 2) the member makes regular and substantial contributions to support the child; or 3) the child is the subject of a qualified medical child support order obligating the member, although a non-custodial parent, to provide health insurance coverage for the child. For purposes of (3) above, the Plan will issue benefits directly to either the child or the child's custodial parent or legal guardian. **Note:** A child normally is not considered dependent on the member if he/she is employed on a full time basis earning at least the equivalent of an entry level "Grade 5" federal employee.

The following are examples of proof of regular and substantial support the Plan Administrator may require in determination of a dependent's qualifications: 1) evidence of eligibility as a dependent child for benefits under state or federal programs; 2) proof of inclusion of the child as a dependent on your income tax returns; 3) canceled checks, money orders, or receipts for periodic payments from you for or on behalf of the child; 4) evidence of goods or services that show regular and substantial contributions of considerable value; 5) any other evidence which SAMBA shall find to be sufficient proof of support or paternity or maternity.

DHBP eligibility will begin:

1) immediately following the child's loss of coverage due to attainment of age 22 under the SAMBA Health Benefit Plan, provided the enrollment form is received by SAMBA within 15 days of the child's 22nd birthday; 2) the first pay period following our receipt of the enrollment application provided SAMBA receives the application within 60 days of your enrollment under the SAMBA Health Benefit Plan; 3) the first pay period following our receipt of the enrollment application provided SAMBA receives the application within 60 days following a child's loss of other health insurance coverage (proof of prior coverage is required); or 4) January 1 (for annuitants), or the first day of your first pay period that starts on or after January 1 (for active employees), provided SAMBA receives the application during the Plan's Open Season period which coincides with the FEHB Program's Open Season (generally held mid-November through mid-December, see www.opm.gov/insure for exact dates).

DHBP eligibility will terminate thirty-one (31) days ("31-day grace period") after the earliest of the following events:

1) the date the dependent child reaches age 27; 2) the date the dependent child is married; 3) the date the dependent child no longer is wholly dependent upon you (the member) for support and maintenance; 4) the date on which the member's SAMBA Health Benefit Plan coverage terminates. Eligibility will also terminate on the date you select to voluntarily cancel coverage or the last date on which the Plan premium was paid.

* **Note:** The "31-day grace period" is not provided when termination is due to voluntary cancellation or non-payment of Plan premium.

Plan Year:

The Plan year begins on January 1, and ends on December 31.

Your Contribution:

You are responsible for full payment of Plan premiums. As of April 1, 2006, the Plan premium is \$85 bi-weekly (\$552.50 quarterly) for the first dependent and \$40 bi-weekly (\$260 quarterly) for each additional child. Generally, actively employed members pay DHBP premiums through payroll allotment and retired members are billed on a quarterly basis. **Note:** SAMBA reserves the right to adjust the member contribution based primarily on Plan's experience. The DHBP is part of the SAMBA Benefit Plan, which is the umbrella plan for SAMBA's benefits programs. Should the Plan experience require

an adjustment in Plan premium, the member will be notified 30 days in advance of such adjustment. Notification will be sent by U.S. Mail to the member's current address of record and will update "Your Contribution" as stated in this Summary Plan Description.

Coverage:

The DHBP benefits, exclusions*, limitations, PPO networks, and maximums are described in the SAMBA Health Benefit Plan brochure (No. RI 72-006) authorized by OPM. The Brochure is published annually and its terms apply to charges incurred in that calendar year. DHBP coverage generally is equivalent to self-only coverage under the SAMBA Health Benefit Plan **Standard Option**. Accordingly, the current year SAMBA Health Benefit Plan brochure (No. RI 72-006) is incorporated as part of this Summary Plan Description with the exception of those references specifically addressed to Federal Health Benefits Program (FEHB) Participants and 1) "Section 8. The disputed claim process" and 2) "Section 11. FEHB facts." (**Note:** *The two Sections cited reference the 2006 brochure. This language may move to another section of the brochure in future publications.*) Additionally, there is no carryover of expenses that may have been applied under the SAMBA Health Benefit Plan, or by another plan, to a deductible or catastrophic protection out-of-pocket maximum for a child who enrolls in the DHBP during a calendar year.

A copy of the current SAMBA brochure is attached to this Summary Plan Description. SAMBA also mails a copy of the current brochure annually to all SAMBA Health Benefit Plan members. To obtain a duplicate copy of the brochure, visit SAMBA on line at www.SambaPlans.com or call SAMBA's Member Services at (800) 638-6589.

* The DHBP has a 12 month "pre-existing condition" exclusion that limits or denies benefits for a medical condition that existed before the date coverage began. The Plan defines a "medical condition" as any physical or mental condition resulting from an illness, injury, pregnancy, or congenital malformation. **Note:** A waiver of all or part of the the Plan's "pre-existing condition" exclusion may be obtained for any dependent child who meets the established requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that limits circumstances under which coverage may be excluded for medical conditions present before enrollment in the Plan.

Benefit Claims and Appeals Procedures:

The following benefit claim and appeal procedures apply to the DHBP in accordance with U.S. Labor Department regulations. This section lists: "*Definitions*" and "*Health Care Claims*," including 1) Claims Submission Periods, 2) Calculating Time Periods, 3) Notice of Benefit Determinations, 4) Pre-Service Claims, 5) Claims Involving Urgent Care, 6) Post-Service Claims, and 7) Appeal of an Adverse Benefit Determination.

Definitions

Adverse benefit determination: A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a covered dependent's eligibility to participate in the DHBP and including, with respect to the DHBP, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Claim for benefits: A request for DHBP benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims that would include pre-service, urgent and post-service claims.

Claimant: The covered dependent (or beneficiary) that the claim for benefits references.

Health care professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Notice of Notification: The delivery or furnishing of information to an individual in a manner consistent with 29 CFR 2520.104b-1(b). Essentially, this means the ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing by U.S. mail.

Post-service claims: Those claims where the treatment has been performed and the claim has been sent to the Plan to apply the plan benefits in order to calculate the plan's financial liability.

Pre-service claims: Those claims that would require pre-certification, prior approval or a referral. Failure to obtain precertification, prior approval or obtain a referral of specified services may result in a reduction of benefits.

Urgent care claims: Urgent care claims are generally defined as pre-service claims for which a decision is required immediately.

Health Care Claims

As regulated under ERISA, SAMBA has implemented the required administrative procedures and policies regarding health care claims for those individuals enrolled under the DHBP. Accordingly, the bulk of the requirements apply to health care claims and the timing and content of notices provided to a claimant under the plan. SAMBA will afford claimants the opportunity to designate an authorized representative to act on their behalf for filing a claim or to appeal an adverse benefit determination. As well, in the case of a claim involving urgent care, a health care professional with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative. Therefore, the following information is being provided in this SPD:

1. Claims Submission Periods: Benefit claims must be filed no later than December 31st of the year following the year in which the claim is incurred.

2. Calculating Time Periods: Benefit or appeal determination time periods applicable to SAMBA begin at the time a claim for benefits or appeal is filed in accordance with these claims procedures, without regard to whether all information necessary to process the claim accompanies the filing. If the necessary information is not included, SAMBA may request an extension including a request for the specific information. In such cases, the period for making the determination will be delayed from the date the notification is sent, until the date on which the claimant responds with the necessary information.

3. Notice of Benefit Determinations: SAMBA shall provide a claimant with written or electronic notification of any adverse benefit determination including the following information:

- The specific reasons for the adverse benefit determination;
- Reference to the specific plan provision on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the DHBP's review procedures and time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA § 502(a) following a review of the adverse benefit determination;
- Either a copy of the specific internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination or a statement that these documents will be provided free of charge, upon request;
- If the adverse benefit determination is based upon medical necessity, experimental/investigational or other similar limits, either an explanation of the scientific or clinical judgment for the adverse benefit determination applying the terms of the plan or a statement that such explanation will be provided free of charge, upon request; *and*
- For claims involving urgent care, a description of the expedited review process.

4. Pre-Service Claims: SAMBA's procedures for all pre-service claims are as follows:

- SAMBA must notify the claimant of any failure to follow the pre-service claims procedure. Such notice shall be provided within five (5) days following the failure. Notification may be oral, unless written correspondence is requested by the claimant or the claimant's authorized representative. This requirement shall only apply if:
a) The claimant's request is made to the SAMBA's Member Services unit; and b) The request names the claimant, medical condition or symptom, and the specific treatment, service, procedure, or product requested.
- SAMBA generally must notify a claimant of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the claim.
- If matters beyond the control of the plan require an extension, SAMBA may request up to an additional 15 days for review if SAMBA notifies the claimant prior to the expiration of the original 15-day period. SAMBA's notice must include the circumstances underlying the request for the extension and the date when a decision is

expected. If necessary information from the claimant has not been received and is the cause for the extension, the plan must notify the claimant of the specific information required and allow the claimant up to 45 days from the receipt of the notice to provide the information.

- In the case of an appeal of an adverse benefit determination, SAMBA must notify the claimant of the appeal determination within a reasonable period of time appropriate to the medical circumstances. This notice may not be made later than 30 days after receipt of the appeal request for plans with one level of appeal or 15 days for each level of appeal if the plan has two levels of appeal.

5. Claims Involving Urgent Care: SAMBA's procedures for claims involving urgent care are as follows:

- SAMBA must notify the claimant of any failure to follow the pre-service claims procedure. Such notice shall be provided within five (5) days following the failure. Notification may be oral, unless written correspondence is requested by the claimant or the claimant's authorized representative. This requirement shall only apply if: a) The request is made to the SAMBA's Members Services Unit; and b) The request names the claimant, medical condition or symptom, and the specific treatment, service, procedure, or product requested.
- SAMBA must notify the claimant or authorized representative of any benefit determination as soon as possible, but not later than 72 hours after receipt of the claim by the plan. If the claimant or authorized representative fails to provide sufficient information, SAMBA shall notify the claimant or authorized representative as soon as possible, but not later than 24 hours after receipt of the claim or the specific information needed.
- SAMBA may provide the notice of a benefit determination orally within the time frames noted in (2) above, but follow-up with a written or electronic notification not later than three days after oral notification.
- For ongoing courses of treatment over a period of time (Concurrent Care), SAMBA must treat any reduction or termination of the course of treatment as an adverse benefit determination. SAMBA must provide the claimant with the notice of an adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination prior to the reduction or termination.
- If a request to extend the course of treatment is made by the claimant at least 24 hours prior to the expiration of the prescribed period or time and this is also a claim involving urgent care, SAMBA must make a determination as soon as possible. SAMBA shall notify the claimant of the benefit determination within 24 hours after receipt of the claim by the plan.
- In the case of an appeal of an adverse benefit determination, SAMBA must notify the claimant of the appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for appeal. SAMBA shall provide an expedited review process, which allows oral or written request for appeals and the transmission of information by telephone, facsimile or other expeditious methods.

6. Post-service Claims: SAMBA's procedures for post-service claims are as follows:

- SAMBA generally must notify the claimant of the plan's adverse benefit determination within a reasonable amount of time, but not later than 30 days after receipt of the claim.
- If matters beyond SAMBA's control require an extension, SAMBA may request up to an additional 15 days for review if it notifies the claimant prior to the expiration of the original 30 day period. SAMBA's notice must include the circumstances underlying the request for the extension and the date when a decision is expected. If necessary information from the claimant has not been received, SAMBA must notify the claimant of the specific information required and allow the claimant up to 45 days from the receipt of the notice to provide the information.

7. Appeal of an Adverse Benefit Determination: If you want to appeal a denied claim, the claimant or an authorized representative must send a written appeal to SAMBA no later than 180 days after the date you received the notice of denial. The request must explain the reasons why you believe SAMBA's initial decision was wrong and attach all documents which you think will help SAMBA decide your appeal.

In the case of an appeal involving urgent care, the appeal may be submitted telephonically to SAMBA's Members Services Unit.

To help prepare the appeal, the claimant may arrange with SAMBA for an opportunity to review and copy, free of charge, all relevant materials and Plan documents under SAMBA's control relating to the claim, including those that involve any expert review(s) of your claim. If a written request for a review is not filed within the required 180-day period, the claimant

will lose the right to a review of the denial of your claim and SAMBA's initial decision will become final, binding and conclusive.

On all timely submitted appeals, SAMBA will:

- Provide a claimant the opportunity to appeal an adverse benefit determination for a full and fair review which does not afford deference to the initial adverse benefit determination;
- Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- Provide that when an adverse benefit determination is based, in whole or in part, on a medical judgment (i.e. medical necessity, experimental/investigational), the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Provide that a health care professional involved in the appeal determination is not the same person involved in the initial adverse benefit determination, nor the subordinate of such individual; *and*
- Provide for the identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination.

SAMBA generally will decide your appeal within sixty (60) days following its receipt. Unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review. Upon making a decision, the Board will send you a written decision which will explain the reasons for its decision and will refer to those provisions of the Plan on which it is based.

SAMBA possesses the sole discretion to interpret those terms of the Plan that relate to the nature or extent of coverage or benefits, including eligibility determinations and payments with respect to benefits. Therefore, a decision made by SAMBA on review of an eligibility determination or claim denial shall be final, binding and conclusive.

Vested Benefits:

There is no vested right to any benefits under this Plan other than to those benefits that are available at the time a covered expense is incurred. SAMBA reserves the right to terminate, suspend, or modify the Plan in whole or in part at any time. This means, among other things, that SAMBA, in its sole discretion, may change the level and type of benefits available under this Plan from time to time. Benefits are paid only for incurred charges for which a claim is timely made. A claim is incurred only when a charge is incurred. The Plan reimburses for incurred charges, not for an incurred illness or injury.

Name and Type of Plan:

The **SAMBA Group Insurance Plan** included, without limitation, all benefit programs that SAMBA sponsors for its membership; the DHBP, the Group Term Life with Accidental Death and Dismemberment Insurance, Dependents Group Term Life Insurance, Supplemental Group Term Life Insurance, the SAMBA Health Benefit Plan, and all other insured and self-insured programs, constitute one employee welfare benefit plan within the meaning of ERISA, the federal law that governs this Plan.

Name and Address of Plan Administrator:

Special Agents Mutual Benefit Association (SAMBA)
11301 Old Georgetown Road, Rockville, MD 20852-2800
(301) 984-1440

Plan Sponsor, Plan Administrator, Named Fiduciary, and Type of Administration:

SAMBA is the Plan Administrator, Plan Sponsor, and the Plan Fiduciary. The Plan Administrator has the right to interpret

and construe the Plan's terms, determining all questions of eligibility, and exercise the fullest discretion permitted by law regarding Plan administration. SAMBA reserves the right to modify, suspend, or terminate the Plan, including the DHBP, at any time.

SAMBA is governed by the SAMBA Bylaws and Plan Instrument, as restated February 1, 2003.

SAMBA is a named fiduciary under ERISA for purposes of making claims payment decisions and reviewing and making decisions on denied claims for the applicable coverage.

Plan Funding, Source of Benefit, and Address of Person Designated as Plan Agent:

Plan participants must pay contributions toward DHBP coverage. SAMBA Group Insurance Plan reserves are held in the SAMBA Group Insurance Plan Grantor Trust. Mercantile Safe Deposit and Trust Company of Baltimore, Maryland, serves as Trustee of this Trust.

The name and address of Person Designated as Agent for Service of Legal Process is: Corporation Guarantee & Trust Co., 1155 15th Street, NW, Suite 502, Washington, DC 20005. In addition, legal process may be served upon the Executive Director at SAMBA, 11301 Old Georgetown Road, Rockville, MD 20852-2800.

Claim Procedure:

See *page 3*, discussing "Benefit Claims Procedures and Appeal Process".

Your ERISA Rights:

As a participant in the DHBP your child is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

1) Receive information about your plan and benefits:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

2) Prudent Actions by Plan Fiduciaries: In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (welfare) benefit or exercising your rights under ERISA.

3) Enforce Your Rights: If your claim for a (welfare) benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries

misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- 4) Assistance with Your Questions: If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

COBRA Continuation of Coverage:

Under a 1986 amendment to the Internal Revenue Code and the Employee Retirement Income Security Act ("ERISA") contained in the Consolidated Omnibus Budget Reconciliation Act (COBRA), most employers sponsoring group health plans are required to extend health coverage (called "COBRA Continuation of Coverage") for a certain period on a self-pay basis. The Federal Employees Health Benefits Program offers Temporary Continuation of Coverage (TCC) which is the FEHB equivalent to COBRA continuation of coverage.

The COBRA Continuation of Coverage provision does not apply to those enrolled in the DHBP because DHBP is an alternative to TCC available under the FEHB Program when a dependent child covered under Self and Family FEHB coverage reaches age 22.

Upon termination of enrollment in the DHBP, eligible individuals will be given the opportunity to enroll in a health insurance conversion policy.

Your Responsibilities:

You - the member of the SAMBA Health Benefit Plan - are responsible for notifying SAMBA within thirty (30) days when a dependent child is no longer eligible for coverage under the DHBP (prior to the child's attainment of age 27). You will remain liable to refund the Plan for any payment made in error due to your failure to notify SAMBA when your dependents cease to qualify for this coverage. **Note:** There will be no refund of premium if this requirement is not met. Additionally, you are responsible for replying to our requests for proof of your child's dependency status.