

CEBT
EMPLOYEE ASSISTANCE PROGRAM
PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

JULY 1, 2020

The CEBT Employee Assistance Program (“EAP”) provides counseling services to Employees and their eligible Dependents. This document describes the benefits available through the EAP as well as eligibility, claims and appeals, and other terms, conditions, and information.

As of July 1, 2020, the EAP service provider is Triad. For more information about the EAP, including benefits and services available, contact:

CEBT Plan Office

2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222
(303) 773-1373 or 1-800-332-1168
www.cebt.org

Triad EAP

844 Grand Avenue, Unit A
Grand Junction, CO 81501
(877) 679-1100
www.triadeap.com

DEFINITIONS

EAP means the CEBT Employee Assistance Program, as described in this Plan Document and Summary Plan Description.

EAP Service Provider means Triad for purposes of providing the EAP benefits to eligible Employees.

Employee means an Employee of the Employer who is eligible for the EAP, pursuant to the Employer's eligibility requirements. An eligible Employee may be referred to as "you" throughout this Plan Document.

Dependent means an Employee's lawful spouse, civil union partner or domestic partner who resides with the Employee, and dependent children (by birth, marriage or adoption, placement for adoption, foster care, or legal guardianship by court order) ages twenty-six (26) years and under. An eligible Dependent may be referred to as "you" throughout this Plan Document.

Employer means a contributing employer in the CEBT EAP who employs the Employee.

Network means the network of providers and counselors contracted with the EAP Service Provider to provide benefits under the EAP.

Plan, sometimes referred to as the "EAP," means this CEBT Employee Assistance Program, as may be amended from time to time.

ELIGIBILITY

Employees of the Employer as well as Dependents of Employees, as defined above, are eligible to participate in the EAP, subject to the Employer's eligibility requirements.

Participation in the EAP will terminate upon the Employee's termination of employment with the Employer.

BENEFITS

The EAP benefits described herein are provided through the EAP Service Provider, Triad. For pre-authorization or for more information about these benefits, contact Triad at:

970-242-9536 or 877-679-1100

www.triadeap.com

Counseling Services

The EAP provides six counseling sessions per incident, per eligible individual in a calendar year for Employees and Dependents. This benefit is provided at no cost to you. In the event the EAP provider determines that long-term attention or specialized care is required, it may, at its discretion, refer the eligible Employee or Dependents to a non-EAP provider during or after the conclusion of the EAP sessions. Expenses associated with subsequent referrals to non-Network providers or services not otherwise covered by the EAP will not be covered by the Plan and will be your responsibility.

Pre-Authorization

Pre-authorization is required for the EAP counseling sessions. To obtain pre-authorization and contact an EAP counselor, contact Triad.

Financial and Legal Services

The EAP also offers services including legal consultation, financial planning, and identity theft and recovery.

CLAIMS AND APPEAL PROCEDURES

If you request a benefit under the EAP and your request is denied in whole or in part, you will receive written notification.

- The information set forth in the notice will be provided in a manner calculated to be understood by you (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements), and will include the following:
- Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable);
- A statement of the specific reason(s) for the adverse benefit determination, including any denial code and its corresponding meaning and any Plan standard used in denying the claim;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- A statement advising you of the right to request diagnosis and treatment codes and their corresponding meanings;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Plan's claims procedures;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided at no charge upon request;
- If the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

Claims will normally be approved or denied within 30 days after they are received, although an extra 15 days may sometimes be necessary. You will receive notice of any extension prior to the expiration of the initial 30-day period, and the notice will tell you why the extension was necessary and when a decision will be made.

You or your representative may appeal a denial within 180 days after the denial, by submitting a written request for reconsideration to:

CEBT: EAP Appeals Coordinator
2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222

A final decision on review will be made in writing and sent to you by the Appeals Coordinator within 60 days of the receipt of your request for review. In ruling on your appeal, the Appeals Coordinator will take into account all comments, documents, records and other information you submit, without regard to whether that information was submitted or considered in ruling on your claim. Moreover, the Appeals Coordinator will afford no deference to the decision previously made on your claim. Finally, to ensure that you receive a fair hearing on your appeal, the Appeals Coordinator will include no individuals who were involved in ruling on your claim, nor any subordinate of such an individual.

If your appeal is denied, the denial notice will contain the following:

- Information sufficient to identify the claim including the date of service, the health care provider, and the claim amount (if applicable);
- The specific reason(s) for the appeal decision including any denial code and its corresponding meaning and any Plan standard used in denying the claim, including a discussion of the decision;
- A reference to the specific Plan provision(s) on which the decision is based;
- A statement advising you of the right to request diagnosis and treatment codes and their corresponding meanings;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- A description of the available external review process;
- A statement of the right to sue in federal court;
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- If the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided at no charge upon request; and

Contact information for any applicable state consumer assistance program. You may request external review of an adverse benefit determination by filing a request for external review within 4 months after the date of receipt of a notice of a final adverse benefit determination. The request for external review must be made in writing to CEBT: EAP Appeals Coordinator (address above).

Upon completion of the Plan's review procedures, either you or the Plan may request judicial review of the final decision on the claim. Any action brought by you, or on your behalf, for Plan benefits must be filed not later than 24 months after completion of the Plan's claims process (including, if applicable, external review).

COBRA COVERAGE

You have the right to continue coverage under the EAP in certain instances where your coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is referred to as “COBRA” coverage.

Under COBRA, an Employee or Dependent may elect to continue health coverage for up to the Maximum COBRA coverage period if that coverage would otherwise terminate due to one of the following Qualifying Events.

18-month COBRA Coverage Events

- Covered Employee’s termination of employment, for reasons other than gross misconduct, or reduction in work hours;

36-month COBRA Coverage Events

- Death of the covered Employee;
- Dependent ceasing to meet the eligible Dependent definition of the Plan (for example, an adult Dependent reaching age 26)'
- Divorce or legal separation from the covered Employee; and
- Covered Employee’s entitlement to Medicare.

Maximum Coverage Continuation Periods

Coverage under COBRA may continue for up to the Maximum COBRA coverage periods provided above. COBRA may continue for up to 29 months (*i.e.* 18 plus 11) if you are a qualified beneficiary and:

- You become entitled to the 18 months of continued coverage available after an Employee’s termination of employment or reduction in work hours;
- You or your covered family member is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage; and
- You notify the Plan of that disability determination within 60 days after it is issued and while you are still covered under your first 18 months of COBRA.

COBRA Qualified Beneficiaries

A COBRA “qualified beneficiary” is an individual who was covered by the Plan on the day before experiencing one of the qualifying events listed above and who lost coverage under the Plan as a result of that event within the maximum COBRA coverage period that applies to that event (listed below). The following persons are also COBRA qualified beneficiaries:

- Children born to, adopted by or placed for adoption with Employees or former Employees while they are receiving COBRA coverage. These children have an independent right to maintain their COBRA coverage in the event an Employee or former Employee drops his or her own COBRA coverage before the end of the maximum coverage period; and

- Individuals whose coverage is reduced or eliminated in anticipation of a COBRA qualifying event. Such individuals become eligible to elect COBRA coverage upon the occurrence of the qualifying event.

Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then, during the original coverage continuation period, another COBRA qualifying event occurs that would otherwise entitle the Employee's Dependent to 36 months COBRA coverage, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. In order to be eligible for extended coverage under this Section, an individual must be eligible to elect COBRA coverage, above, at the time of the second qualifying event.

Termination of COBRA Coverage

Once you elect to continue your coverage, your coverage may continue for the period described above, but will terminate when:

- If you were a disabled individual entitled to 29 months of COBRA coverage, the Social Security Administration determines that you are no longer disabled, in which case your extended COBRA coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;
- You become entitled to Medicare, after the date of COBRA election;
- You fail to make a required monthly payment within the 30-day grace period pursuant to this provision;
- You become covered, after the date of COBRA election, under another employer group health plan (because of employment or otherwise) and that coverage applies no exclusion or limitation with respect to any pre-existing condition you have at that time; and
- The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

Notification of a Qualifying Event

To preserve your right to COBRA continuation coverage you must notify the Plan Sponsor within 60 days of a divorce or legal separation, or of the Social Security Administration's determination of disability. In addition, if you were a disabled individual who obtained 29 months of COBRA coverage, you must notify the Plan Sponsor of any determination by the Social Security Administration that you are no longer disabled. Notification to the Plan Sponsor must be made within 30 days of the date such determination is made.

The Cost of COBRA Coverage

Unless a special rule applicable only during the 11-month disability extension applies, your monthly payment for COBRA continuation coverage will be no greater than the total cost of providing continued coverage to similarly situated Employees and their Dependents under the Plan, plus a 2% administrative fee. During the 11-month extension of COBRA continuation coverage (to a total of 29 months) available to qualified beneficiaries who meet the requirements set forth above, your monthly

payment for COBRA continuation coverage may cost up to 150% of the total cost of providing continued coverage to similarly situated Employees and their family members under the Plan. This special rule applies only as long as the individual whose disability gave rise to the extension maintains COBRA continuation coverage as a member of the family group of qualified beneficiaries who obtained extended COBRA coverage under the disability extension.

Cost, Election, and More Information

After you experience a COBRA qualifying event and provide any required notice, you will be sent a more detailed COBRA Election Notice, which will explain how to elect COBRA coverage, the cost of COBRA coverage, and additional details about COBRA coverage and other options that may be available.

Your Address

To protect your family's rights, keep the Plan Administrator informed of your and your family members' current addresses and notify the Plan Administrator of any address changes.

FMLA COVERAGE

If you take a period of leave authorized by your Employer under the Family and Medical Leave Act ("FMLA Leave"), your coverage under this Plan (and that of your covered family members) will continue during your leave just as if you had not taken the leave but instead had continued working for your Employer. However, if you inform your Employer before or after beginning your leave that you do not intend to return to work for your Employer at the conclusion of your leave, you will not have the right to continue coverage under this FMLA provision.

DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plan will disclose protected health information ("PHI") that is created or received to the Employer only to the extent permitted by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and its regulations (the "Privacy Rule" and the "Security Rule"). The provisions in this Plan will be interpreted and applied in a manner consistent with the Privacy Rule and the Security Rule.

The Employer agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI, including the implementation of reasonable and appropriate security measures to protect electronic PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including any security incident of which it becomes aware;
- Make PHI available to an individual in accordance with the Privacy Rule's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule;
- Make available the information required to provide an accounting of disclosures;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with the Privacy Rule;
- If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Ensure that adequate separation between the Plan and the Employer is established and supported by reasonable and appropriate security measures with respect to electronic PHI.
- Limit access to PHI to members of the employer's Human Resources and Finance Departments that work with the Plan, and provide only the minimum necessary information to carry out the Plan functions they perform.
- Provide an effective process for addressing and resolving issues of noncompliance, including appropriate disciplinary sanctions.

INTERPRETATION, AMENDMENT, AND TERMINATION

The Plan may be terminated or amended at any time by the Plan Sponsor, CEBT, who retains sole discretion to interpret and apply to the terms of the Plan.

GENERAL PLAN INFORMATION

Funding: The EAP Plan is funded by Employer contributions to CEBT.

EIN: CEBT's employer identification number is 74-2141123.

Plan Year: The EAP's Plan Year is January 1 through December 31.

Plan Sponsor/Plan Administrator

CEBT
 2000 S. Colorado Blvd., Tower II, Suite 900
 Denver, CO 80222
 (303) 773-1373 or 1-800-332-1168

Agent for Service of Legal Process

CEBT
2000 S. Colorado Blvd., Tower II, Suite 900
Denver, CO 80222
(303) 773-1373 or 1-800-332-1168

EAP Benefits/Claims Service Provider

Triad EAP
844 Grand Avenue, Unit A
Grand Junction, CO 81501
(877) 679-1100
www.triadeap.com