EMPLOYEE ASSISTANCE PROGRAM

This summary plan description, or SPD, outlines the major provisions of the Deseret Employee Assistance Program (EAP) as of January 1, 2024.

The EAP is administered by Carelon Behavioral Health. To obtain EAP services, call Carelon Behavioral Health at 844-280-9629.

Table of Contents

Eligibility and Enrollment

Full-time and part-time employees are eligible for EAP benefits. Independently contracted employees and students employed at an educational institution are not eligible. Seasonal agricultural workers should check with a human resources representative at their employer to determine eligibility. Eligible dependents include spouses, children younger than 26, and individuals residing in the eligible employee's home. Your coverage and coverage for your eligible dependents is automatic; you do not need to take any steps to enroll. Please note that eligibility standards for the EAP are different from other benefit plans offered by the plan administrator.

Cost

Your employer pays the full cost of participation in the EAP for you and your eligible dependents. There are no premiums, copayments, coinsurance, or deductible payments applicable to EAP services.

Covered Services

Personal consultation services

The EAP provides confidential assessment, counseling, and referral services to help with problems that could affect your health, relationships, and job performance. You and each of your eligible dependents may participate in up to six sessions per problem per calendar year (as considered clinically necessary by the EAP). EAP services include the following:

Counseling services

In-person, instant messaging, telephone, or video counseling sessions with an experienced, licensed counselor offer support with stress management, strengthening relationships, work/life balance, grief and loss, and more. Each covered member can receive up to six counseling sessions per calendar year (per problem). Clinical assistance is available 24 hours a day, seven days a week, and conversations are strictly confidential. If the counselor determines the situation requires it, he or she may refer you for additional assistance through the mental health or substance abuse benefit in your medical plan.

Legal services

A free consultation with a local attorney is provided per issue: up to 60 minutes for family law and up to 30 minutes for other legal needs. You pay for any services beyond the initial consultation, at 25% off the attorney's usual hourly rate for most cases (family law matters are 35% off). Legal services include, but are not limited to, estate planning, family law, and consumer and financial matters.

Financial services

A free consultation up to 60 minutes with a financial coach is provided per issue. You receive discounted rates for subsequent meetings. Financial coaches offer guidance on issues including, but not limited to, family budgeting, debt consolidation, retirement questions, and general tax questions.

The attorneys and financial professionals will assist you with most situations, but some restrictions do apply. The plan administrator and your employer provide no warranties or representations regarding the quality of services provided by each individual attorney or financial professional.

What is not covered

Services excluded from this plan include, but are not limited to, the following:

- **Employment issues:** No advice will be offered on disputes between employee and employer.
- **Corporate law:** Questions pertaining to corporate law, including those generated from employee- or spouse-owned businesses, will not be answered.
- **Second opinions:** Advice will not be given on how another attorney is handling a legal situation or rendering a subsequent opinion in case law.
- **Third-party callers:** Participants cannot seek advice to help with someone else's legal problems.
- **Investments:** Financial professionals will not provide advice regarding specific investment vehicles, such as stocks, bonds, or mutual funds. They can, however, provide advice on investment strategies.
- **Counseling services in excess** of six sessions per problem
- **Services from a non-participating EAP provider**

Obtaining EAP Services

To obtain EAP services, call 844-280-9629. Carelon Behavioral Health representatives are available 24 hours a day, seven days a week. You will need to provide sufficient information to establish eligibility when contacting your EAP.

You can access additional information at www.carelonwellbeing.com/myeaphelper.

Reimbursement of Claims

You do not have to file EAP claims. There are no copayments, coinsurance, or deductibles. You should not pay or agree to pay a provider for EAP services. However, you will be responsible to pay for services that you obtain without receiving prior authorization for an EAP case with a particular EAP counselor.

Appeals

If you believe your claim for EAP benefits was denied in error, you may appeal the decision. Your appeal must be submitted in writing within 180 days following your receipt of a denial notice:

Carelon Behavioral Health
P.O. Box 1850
Latham, NY 11802-1850

Your appeal should state the reasons why you feel your claim for EAP benefits is valid and include any additional documentation that you feel supports your claim for EAP benefits. You can also include any additional questions or comments. You may submit written comments, documents, records, and other information relating to your appeal, whether or not the comments, documents, records, or information were submitted in connection with the initial claim for EAP benefits. On your request, Carelon Behavioral Health will make relevant documents available to you.

The review of the initial decision will consider all new information, whether or not it was presented or available for the initial decision. Carelon Behavioral Health conducts the appeal review.

You or your authorized representative will be notified of the appeal decision within the following time frames:

- If the appeal involves an adverse determination on a request for EAP services or a pre-service adverse determination relating to reimbursement, within 30 days of Carelon Behavioral Health's receipt of the request for appeal
- If the appeal involves a post-service adverse determination relating to reimbursement, within 30 days of Carelon Behavioral Health's receipt of the request for appeal

Appeal decisions

Carelon Behavioral Health will give you or your authorized representative the decision on the appeal in writing. If the denial is upheld on appeal, the notice will include

- the specific reason or reasons for the denial decision;
- identification of plan provisions on which the decision is based;
- notice of your right to receive, free of charge, upon your request, any internal rule, guidelines, protocol, or similar criterion relied on in making the decision;
- notice of your right to receive, free of charge, upon your request, an explanation of the clinical judgment on which the decision is based (if the denial is based on exclusion of experimental treatment services or because EAP services are not clinically appropriate);
- notice of your right to receive, free of charge, upon your request, reasonable access to, and copies of, all documents, records, and other information relevant to the appeal; and
- notice of your right to bring a civil lawsuit under ERISA §502(a).

If you do not agree with the final decision of Carelon Behavioral Health, you may bring a lawsuit in federal district court. You may not initiate a legal action for the benefits unless you use all available appeal processes as described above.

Notification of Discretionary Authority

The plan administrator has contracted with Carelon Behavioral Health to manage the services under the program as claims administrator. The plan administrator has delegated to Carelon Behavioral Health the authority to make final determinations regarding eligibility for benefits and procedures for obtaining benefits under the EAP. To the extent that a responsibility has not been delegated to another party, the plan administrator has the final discretionary authority to construe the terms of the plan to resolve any ambiguities and to decide any question that may arise with the plan's application or administration.

Continuation of Coverage (COBRA)

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act. It allows individuals and their dependents to continue certain benefits for a limited time after a qualifying event causes them to lose benefits.

If your employment with your employer ends (for reasons other than gross misconduct on your part), you and your dependents can be covered for up to 18 months. You and your eligible dependents do not need to elect continuation coverage for EAP benefits for resulting loss in coverage, as those benefits will be paid by your employer for the applicable COBRA period of coverage.

If you get divorced, your former spouse (and any stepchildren, if applicable) may be covered for up to 36 months. If a dependent child exceeds the maximum age for benefits as your dependent, and loses coverage as a result, your dependent may be covered for up to 36 months. You must notify us within 60 days of these changes.

COBRA benefits may end for any of the following reasons:

- The employer ends the EAP.
- A person eligible for continued benefits becomes covered under another EAP.
- A disabled qualified beneficiary whose disability extends the maximum coverage period to 29 months is determined not to be disabled before the end of the extended period.
- The qualified beneficiary's COBRA benefit is terminated for cause (for example, for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA beneficiary in the plan.

Plan Termination or Amendment

The plan administrator and your employer also reserve the right to terminate, discontinue, change, or amend this plan at any time. If this happens, you will be notified.

Plan Administrator

The plan administrator:

DMBA
P.O. Box 45530
Salt Lake City, UT 84145-0530

800-777-3622

Notification of Benefit Changes

The plan administrator is subject to the Employee Retirement Income Security Act (ERISA) and reserves the right to amend or terminate this plan at any time. If benefits change, we'll notify you at least 30 days before the effective date of change.

Legal Notice

We have made every effort to accurately describe the benefits and ensure that information given to you is consistent with other benefit-related communications. However, if there is any discrepancy or conflict between information in this document and other plan materials, the terms outlined in the plan document will govern.