

Summary Plan Description Emory Faculty Staff Assistance Program (FSAP/EAP)



Effective as of January 1, 2025

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Introduction

The Emory Faculty Staff Assistance Program is a benefit option under the Emory University Health Care Plan, Plan 502 (the “Plan”), and this benefit is referred to here as the FSAP (and may also sometimes be referred to as an EAP). The other benefit options under the Plan are described in different documents. This document highlights for you some important information about the FSAP and is intended to serve as the summary plan description (“SPD”) under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan and FSAP can be amended or terminated at any time at Emory’s sole discretion.

Effective Date: January 1, 2025

Eligibility Requirements

Employees

You are eligible to receive the services provided by FSAP if you are classified as a regular employee of Emory University as determined in the sole discretion of Emory.

The following individuals are not eligible:

- Any individual who is classified by Emory as an independent contractor or hired through a staffing agency;
- A regular full-time or part-time employee who is scheduled to work less than 20 hours per week; or
- An individual who is classified by Emory as a seasonal, student, or temporary employee.

Dependents

If you are an eligible employee, this benefit option is also available to your spouse and your children who are between the ages of 11 - 26 years old.

Benefits

The Faculty Staff Assistance Program (FSAP) provides professional counseling, coaching, and consultative services that are designed to enhance emotional, behavioral and workplace health, performance, and overall well-being, while also fostering a greater sense of community. The Program functions as a resource for faculty, staff, physicians, leaders, and their benefits-eligible family members.

In the Behavioral Health (BH) area, FSAP offers comprehensive assessments, confidential and professional counseling, consultations, education, coaching and referral services, as well as Well-being Check-ins (WBCins), all of which are provided by licensed mental health professionals. Some presenting problems seen in the BH area include the following: emotional and psychological issues (e.g., depression, anxiety); family problems, domestic/intimate partner and spousal relationship concerns; parenting and dual role challenges; life phase transitions; stress and burnout; conflict; alcohol and substance abuse as well as other addictive behaviors; financial pressures; legal stressors; medical conditions; workplace bullying and violence; professionalism challenges, and other work-related matters. The FSAP will cover up to eight sessions per problem/issue.

Employees are encouraged to seek FSAP services before a concern becomes a crisis. BH services are free and easy to access by calling (404-727-WELL/9355) or emailing (efsap@emory.edu) to request an appointment. Our services are **strictly confidential** with no disclosures unless the client authorizes release of information. There are some exceptions to confidentiality, which are fully explained during the first appointment at the FSAP. While our BH services are short-term, we assist with identifying long-term referrals to external treatment providers when warranted. In addition, case management services are provided by an Employee Assistance Clinician to link employees and their benefits-eligible dependents to a variety of community resources related to food insecurity, housing, utility assistance, etc. as needed.

BH services are offered via telemental health (through a HIPAA-compliant Zoom platform) and onsite appointments. Onsite, BH services are provided weekly on designated days at our main office (1762 Clifton Road, Suite 1100) and some satellite locations. We also provide 24/7 after-hours on-call services, seven days a week and during holidays. In addition, an emergency coverage clinician is available to speak with employees when an urgent issue arises during regular business hours. Also, you may visit our website (www.fsap.emory.edu) to complete a confidential self-assessment as a first step on your journey to emotional wellness. The website also provides a breadth of valuable information and educational resources to support your emotional health and well-being.

Faculty Staff Assistance Program (FSAP)
1762 Clifton Road NE, Suite 1100
Atlanta, GA 30322
(404) 727-WELL (9355) or (404) 727-4328
(404) 727-7500 (fax); efsap@emory.edu
www.fsap.emory.edu

Termination of Participation

Coverage discontinues upon your termination of employment or, if earlier, the date you (or your eligible dependents, as applicable) no longer meet the eligibility requirements. However, an employee may receive three FSAP counseling sessions after termination. In addition, coverage will terminate upon fraud or misrepresentation, or upon the termination of this program.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the Plan offers covered employees and their eligible dependents the opportunity to continue coverage (called COBRA coverage) when coverage would otherwise be lost due to a qualifying event. Specific qualifying events are identified below. COBRA coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA coverage are required to pay for that coverage.

Eligibility and Coverage

You will become a qualified beneficiary if you lose your coverage because your employment ends for any reason other than your gross misconduct.

Your covered spouse will become a qualified beneficiary if he or she loses coverage because your employment ends other than due to gross misconduct, you die, or due to divorce.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because you terminate employment other than due to gross misconduct, you die, or the child ceases to qualify as a “dependent child.”

Children born to or placed for adoption with you during the continuation coverage period may also be added to your COBRA coverage and be qualified beneficiaries, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

Required Notice of Qualifying Events

Under the law, you or a covered dependent (or a representative) has the responsibility to inform the Plan Administrator of a divorce or a child’s loss of dependent status under the Plan. This notice must be provided within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of a child after the qualifying event, you must also provide notice of the birth or adoption of the child whom you wish to enroll. If additional documentation supporting the notice is requested and not provided within 15 business days of the request, the notice will not be considered timely and COBRA coverage will not be available. If this notice is not timely and properly provided, the qualified beneficiary will not be permitted to elect COBRA continuation coverage. Notice must be provided on the forms and in the manner required by the Plan Administrator.

COBRA Election Period

Each qualified beneficiary has an independent right to elect COBRA coverage for 60 days from the later of the date coverage is lost or the date of notification to elect COBRA coverage.

If you would like COBRA coverage, you must complete the election form provided to you and return it in the time and manner set forth in that notice. If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided at the time of the qualifying event. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications, including in-person or telephonic statements about an individual’s COBRA coverage, and electronic communications (other than faxed communications), including e-mail.

You may elect COBRA coverage on behalf of your eligible spouse, and you or your spouse may elect COBRA coverage on behalf of your eligible children. If you or your spouse elect COBRA coverage without specifying whether the election is for self-only coverage, the election will be considered made on behalf of all other qualified beneficiaries with respect to that qualifying event.

Maximum Length of COBRA Coverage

The maximum COBRA coverage periods are described below.

36-Month Period. When the qualifying event is your death, your divorce, or a dependent child losing eligibility as a dependent child, the maximum COBRA period is 36 months.

18-Month Period. When the qualifying event is the end of your employment, the maximum COBRA period is generally 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA coverage for other qualified beneficiaries lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If you become entitled to Medicare after submitting your election form, you must provide notice of your Medicare entitlement as described above.

The maximum COBRA coverage period for your newborn or newly-adopted child is measured from your original qualifying event. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements. A person who becomes the spouse of a qualified beneficiary (including a new spouse of an employee) or dependent child of a qualified beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a qualified beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Disability extension: If you or anyone in your family covered under this benefit is determined by the Social Security Administration (“SSA”) to be disabled, and you provide the required notice, you and your family members who are receiving COBRA coverage may be entitled to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The SSA must determine that the disability started at some time before the 60th day of COBRA coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In addition, you or the disabled qualified beneficiary (or a representative) must provide notice in writing of the SSA's determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of: (1) the date the qualified beneficiary is determined to be disabled by the SSA; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the qualified beneficiary would lose coverage under the Plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described above.

Second qualifying event extension: If your family experiences another qualifying event while receiving 18 months (or 29 months in case of a disability extension) of COBRA coverage, your spouse and dependent children can get additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die or divorce, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose such coverage had the first qualifying event not occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For cases of second qualifying events, the qualified beneficiary must provide notice in writing (as described below) within 60 days after the later of the date (1) of the second qualifying event; or (2) on which the qualified beneficiary would have lost coverage due to the second qualifying event if it had occurred before the first qualifying event.

Failure to provide timely and proper notice of a disability determination or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if:

- The qualified beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA that does not impose pre-existing conditions on that individual.
- The qualified beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA coverage.
- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.

- Coverage is extended beyond 18 months because of disability, and the SSA makes a final determination that the qualified beneficiary is no longer disabled.
- Emory ceases to maintain a group health plan.

If during the period of COBRA coverage, a qualified beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the qualified beneficiary (or a representative) must provide notice in writing within 30 days of the later of: (1) the date the other coverage becomes effective, or (2) the exhaustion or satisfaction of any preexisting condition exclusions affecting the qualified beneficiary.

If during the period of COBRA coverage, a qualified beneficiary becomes entitled, after electing COBRA, to Medicare, you or the qualified beneficiary (or a representative of either) must provide notice in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card). If the SSA determines that a qualified beneficiary is no longer disabled, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the determination. The qualified beneficiary must provide notice in writing within 30 days after the SSA's determination that he or she is no longer disabled.

If notice of these events is not timely and properly provided, the qualified beneficiary's COBRA coverage may be terminated retroactively, and the qualified beneficiary may be required to repay a portion of the benefits received. A qualified beneficiary does not have to show that he or she is insurable to choose COBRA coverage. However, COBRA coverage is provided subject to the qualified beneficiary's eligibility for coverage. Emory reserves the right to terminate a qualified beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible or upon fraud or misrepresentation.

Premium Payments

A qualified beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

Qualified beneficiaries will be notified of the cost of continuing benefits if he or she experiences a qualifying event. The qualified beneficiary will have 45 days from the election date to pay the first premium; after that, premiums will be due and payable on the first day of the month. The first premium should cover the premium due from the date coverage is lost through the date COBRA is elected, plus any monthly premium that becomes due during the 45-day payment period. There will be a 30-day grace period to pay each subsequent monthly premium.

If the initial premium payment is not made by the end of the 45-day payment period, the qualified beneficiary will lose all COBRA rights and coverage will not take effect. If a subsequent monthly premium payment is not received by the first day of the coverage period to which it applies (e.g., the first day of the month), COBRA coverage will be suspended as of that day and then retroactively reinstated if the monthly payment is received prior to the end of the 30-day grace period. If the premium is not paid prior to the end of the grace period, the qualified beneficiary will lose all COBRA rights.

Qualified beneficiaries will be notified of any changes in rates during the COBRA period.

Notice Procedures

As a condition of receiving COBRA coverage, you or your covered dependent (or a representative) must notify the Plan Administrator or COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial qualifying events
- Second qualifying events
- A qualified beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Unless directed otherwise in the COBRA election notice (if applicable):

- Notice of an initial qualifying event must be given to the Plan Administrator by mail, fax, hand delivery (including interoffice mail) or by phone. The notice must contain the name, address, and phone number of the covered employee (or formerly covered employee) and each qualified beneficiary experiencing the COBRA-related event, the COBRA-related event being reported and the date of such event, and the date that the notice is provided.
- All other notices, including notice of a second qualifying event or a qualified beneficiary's determination or cessation of disability, must be provided to the COBRA Administrator and cannot be made orally. The notice must contain the name, address, and phone number of the covered employee (or formerly covered employee) and/or each qualified beneficiary experiencing the COBRA-related event, the name of the Plan, the COBRA-related event being reported and the date of such event. You must also provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination. For a Social Security disability determination, you must provide a copy of your award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled.

If mailed, the Notice must be postmarked no later than the applicable deadline for giving the notice. If the Notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all Qualified Beneficiaries who are required to give the notice.

Additional documentation supporting the Notice may be required. If such information is requested and it is not provided within 15 business days of the request, the Notice will not be considered timely and continuation coverage may not be available.

Keep the Plan Informed

It is important that you keep your employer informed of any changes in the addresses of your family members. It is your responsibility to provide notice of a change in your marital status or a change in your address or that of any covered family member. You should also keep a copy, for your records, of any notices you send.

If You Have Questions

If you have questions concerning the Plan or your COBRA continuation coverage rights, you should contact the COBRA Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at <http://www.dol.gov/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Important Plan Information

General Information

Plan Name:	University Health Care Plan
Plan Number:	502
Plan Sponsor:	Emory University 1599 Clifton Road NE, First Floor Atlanta, GA 30322
Plan Administrator:	Emory University Attn: Sr. VP & Chief HR Officer 1599 Clifton Road NE, First Floor Atlanta, GA 30322 (404) 727-7613
EIN of Sponsor:	58-0566256
Plan Year:	Calendar Year (January 1 – December 31)
Agent for Service of Legal Process:	Emory University Office of the General Counsel 201 Dowman Drive 101 Administration Building Atlanta, GA 30322

Type of Plan, Funding and Plan Administration

The Plan is a welfare benefit plan that provides group health benefits, including this employee assistance program (EAP). The Plan Administrator is responsible for administering the Plan and may retain third parties to provide administrative services with respect to administration of the Plan. The benefits for this option are payable from Emory's general assets.

The Plan Administrator has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious).

Amendment and Termination of Plan

Emory expects to continue the Plan indefinitely, but it reserves the right to amend or terminate the Plan, or any of the benefits provided under the Plan, at any time, in whole or in part, by action of an officer or his or her designee. The benefits provided and the cost of the benefits, including the amount paid by employees, may also change or be eliminated from time to time. The Plan does not provide any vested or lifetime benefits.

Claims Procedure

Although no claims for reimbursements are filed under the Plan, a participant or covered dependent has a right to file a claim under the Plan, ask if he or she has a right to any benefits under the Plan, or appeal the

denial of a claim for benefits under the Plan. **Legal action may not be brought until the claims procedures are exhausted.** For purposes of the Plan's claims procedure, the term "you" shall include any participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person. You must follow the Plan's procedures for appointing an authorized representative unless your claim is an urgent care claim. For additional information regarding these procedures, you should contact the Plan Administrator.

If you file a claim, you generally will receive written notice of the determination within 30 days of the date the Claims Administrator receives the claim. You will be notified if additional information is needed to process the claim, and you then have 45 days to provide the requested information (or such other period provided to you). If, for reasons beyond the control of the Plan Administrator, an extension of time is required to process the claim, you will receive written notice of the extension, an explanation of the circumstances requiring extension, and the expected date of the decision prior to the end of the 30-day period. In no event will the extension exceed a period of an additional 15 days from the end of the initial 30-day period for group health plans.

If your claim is denied, in whole or in part, you will receive a written explanation of the denial that includes the specific reason or reasons for the denial, specific reference to the plan provision on which the denial is based, a description of additional information necessary to perfect the claim and a description of the Plan's claims review procedures, and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following an adverse determination on review.

If you want your claim to be reconsidered, you must submit a written appeal to the Plan Administrator within 180 days of the date of the denial for group health and disability claims and within 60 days for other claims. In connection with an appeal, you have the right to review pertinent documents, records, and other information relevant to your claim and to submit written comments, documents, records, and other information relevant to the appeal of your claim for benefits. Copies of all information relevant to your claim will be provided free of charge by the Plan Administrator, upon request.

Your claim will be given a full and fair review. The decision on review will not give deference to the initial adverse claim determination and will be conducted by an individual who is not the same individual who made the initial adverse claim determination or a subordinate of such individual.

If you file an appeal of a claim denial, the decision regarding the appeal will be made by the Plan Administrator promptly, but not later than 60 days after receipt of your appeal. When the appeal is decided, you will be notified in writing of the results of the review.

This notice will contain (i) the specific reason or reasons for the denial; (ii) specific references to the Plan provision on which the denial is based; (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and (iv) a description of the Plan's voluntary appeal procedures and a statement of your right to bring a civil action under ERISA following an adverse determination on review.

Exhaustion of Administrative Remedies and Limitations on Legal Actions

You must use and fully exhaust all of your actual or potential rights under the administrative claims and appeals procedures by filing an initial claim and then seeking a timely appeal of any denial before filing suit. The exhaustion requirement relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit must be filed within one year after receiving a final adverse benefit determination on appeal.

Restriction of Venue

- Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the United States District Court for the Northern District of Georgia.

ERISA Statement of Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants are entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts 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 Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit that you are otherwise entitled to receive or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a welfare benefit is denied or ignored in whole or in part, you have a 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 Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a Federal court. However, you may not file suit until you have exhausted the administrative remedies provided under the Plan.

- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.