Plan Announcement For The Long-Term Disability Insurance Plan For Regular Salaried Employees Of San Diego State University Foundation

San Diego State University Foundation 5250 Campanile Drive San Diego, CA 92182

Plan Announcement Information

This Plan Announcement together with the Certificate of Insurance provides you with a Summary Plan Description of the Long-Term Disability Insurance Plan for Regular Salaried Employees of San Diego State University Foundation. This Plan, underwritten by the Hartford, was adopted on July 1, 1982, and was last amended on January 1, 2010.

The Summary Plan Description is meant to provide you with a "plain language" guide to the benefits and conditions of coverage. Because it is a summary, this explanation is not as complete as the detailed explanation provided by the Group Insurance Policy. If any conflict arises between this document and the Policy, if any provision is not covered, or if only partially covered, the terms of the Policy will prevail in all cases.

Information regarding Plan eligibility, enrollment, cost and the procedure for applying for benefits is contained in this Plan Announcement. The Certificate of Insurance includes a description of benefits under the Plan and the conditions under which these benefits are available to insured individuals.

Administration Of This Plan

The San Diego State University Foundation shall be the Administrator of this Plan, and as such, shall have the authority to control and manage the operation and administration of the Plan, subject to the provisions of the Group Insurance Policy. The Administrator may designate in writing other persons to carry out the duties under the Plan and has designated the Human Resources Office to be responsible for enrolling eligible employees, distributing information on plan benefits, and performing other duties as required for the operation of the Plan.

Reservation Of Right To Change This Plan

The Foundation reserves the right to modify coverage, add or eliminate plan options, add or eliminate insurance carriers or providers, modify employer/employee contributions, cancel, modify or reduce this coverage, or make any changes to this Plan it may later deem necessary. Such modification or discontinuance must be effected in accordance with the terms of the Group Insurance Policy.

Who Is An Eligible Employee?

"Regular Full-Time" employees who work thirty or more hours per week are eligible to participate in the Plan. Hourly, temporary, casual, special pay, student workers, Research Scholars (SE eclass employees) and faculty employees employed in an overload status, are not eligible for the Plan.

When Does Coverage Begin?

Each employee who enters an eligible class becomes eligible for insurance under

the Plan upon employment in such class. If an employee is absent from work on the day he or she would otherwise become eligible, the employee will become eligible on the day he or she returns to work.

How To Enroll In The Plan

An employee will become insured on the date of first eligibility. No medical examination is necessary. Eligible employees will complete an online enrollment form following new hire orientation. Online enrollment forms should be completed and submitted within 30 days of date of hire. Additional information about enrollment procedures may also be obtained from Human Resources.

The Cost Of The Plan

Long-Term Disability insurance is an employer paid benefit. Employees do not contribute towards the cost of coverage. The day before each Plan anniversary, December 31, marks the end of the Plan year. Generally near the end of the Plan year, the insurance company checks the adequacy of premiums charged for the Plan and advises San Diego State University Foundation whether existing premium rates will be continued or whether adjustments will be made for the coming Plan year.

When Does Coverage End?

Insurance coverage will end for an eligible employee on the earliest of the following events:

1. The date the group policy ends, or

2. The date insurance ends for an eligible class of employees; or

3. The date an employee stops active work in an eligible class; or

4. The date that ends the period for which the last required premium contribution was made for the employee.

5. The date the employee retires in accordance with SDSURF's retirement plan

6. The date an employee's employment ends

During An Approved Leave Of Absence

An employee who is on an approved leave of absence and who will be temporarily separated from an eligible class may continue coverage under this Plan as long as they continue to be in a paid status.

If an employee goes into an unpaid status during a leave of absence, the employee will be treated as terminated for benefit purposes and coverage will end as described in the previous section. The employee will be treated as a "new hire" for benefits eligibility purposes upon return from leave. Coverage will usually be reinstated the first of the month following the employee's return to work in an eligible class.

Applications, Requests And Questions Directed To The Plan Administrator

Applications, requests and questions, regarding enrollment, participation, or other administrative matters and service of legal process on issues arising from such questions, should be directed to the Plan Administrator.

If a written application or request pertaining to enrollment, participation or administration of the Plan is denied by the Administrator, the Administrator shall, within a reasonable time, provide a written denial to the participant. It will include the specific reasons for the denial, the

provision of the Plan upon which the denial is based, a description of any material needed to complete the application or request (if appropriate) and why it is necessary, and instructions on review procedures. When the Administrator requires additional time to respond because of special circumstances, an extension of up to ninety days may be obtained by notifying the participant that a decision will be delayed, what circumstances have caused the delay and when a decision can be expected. The Administrator will inform the participant of the delay within ninety days of the date the application or request was submitted.

A participant may request in writing a review of a denied request or application, and may review pertinent documents and submit issues and comments in writing to the Administrator. The Administrator shall provide in writing to the participant a decision upon such request for review within sixty days of receipt of the request. When special circumstances require an extension, the Administrator may obtain an extension of up to sixty days by notifying the participant why the decision on the review will be delayed and when a decision can be expected.

Applying For Benefits

Claim forms may be obtained from the Human Resources Office. Complete the claim form carefully and submit it to the insurance carrier. A benefits specialist will certify your insurance uder the Group Policy with the insurance carrier.

Notice and proof of claim should be made promptly. Details on the applicable time limits for submitting benefit applications may be found in the Certificate of Insurance which each insured employee receives, as well as in the Group Policy maintained in the office of the Plan Administrator. Upon receipt by the insurance carrier of the application for benefits and supporting documentation, valid claims will be paid promptly.

If a claim is denied, the insurance carrier shall within a reasonable period of time (not exceeding ninety days) provide a written denial to the participant. It will include specific reasons for the denial, the provisions of the Group Insurance contract on which the denial is based, and how to apply for a review of the denied claim. Where appropriate, it will also include a description of any material which is needed to complete or perfect a claim and why such material is necessary. A participant may request in writing a review of a claim denied and may review pertinent documents and submit issues and comments in writing to the insurance carrier. The insurance carrier shall provide in writing to the participant a decision upon such request for review of a denied claim within sixty days of receipt of the request.

If special circumstances require a delay on the initial decision on a claim or a review of a denied claim, the insurance carrier will notify the participant within ninety days of the date the claim was initially submitted or within sixty days of the date a review was requested. The notice will explain the reasons for the delay and when a decision can be expected. In no event will the decision be provided later than 120 days after the notice is sent for an initial decision on a claim or more than sixty days after the notice is sent for a review of a denied claim.

Statement Of ERISA Rights

Participants in this plan are 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. Examine, without charge, at the Plan Administrator's office all plan documents,

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 Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective baraining agreements and copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

ERISA sets forth the duties of the people who are responsible for the operation of this plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including the employer, union, or any other person may discharge or otherwise discriminate against participants in any way to prevent them from obtaining benefits to which they are entitled under the plan or exercising their rights under ERISA. If an application for benefits under the plan is denied in whole or in part the participant or beneficiary has 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, participants may take steps to enforce these right. For example, if a participant request materials from the plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until he or she receives the materials, unless the materials were not sent due to reasons beyond the control of the administrator. If a claim for benefits is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. The court will decide who should pay the court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees, for example, if it finds the claim is frivolous.

Contact the Plan Administrator if you have any questions about this Plan. If a participant has any questions about their rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, he or she should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Employer Identification And Plan Number: 95-6042721, 501

Updated August 2020