ARTICLE VI
INTERIM DEATH AND DISABILITY BENEFITS

6.1 PURPOSE

The purpose of this article is, in accordance with section 151 of the City of San Diego City Charter (hereinafter Charter), to implement an interim death and disability benefit for certain Eligible Employees who are killed in the line of duty or who become permanently incapacitated from the performance of duty as a result of injury or disease arising out of or in the course of their City employment or as a result of a non-work related injury or disease, and who are not otherwise eligible to participate in SDCERS.

6.2 EFFECTIVE DATE

This article will become effective on the date the San Diego City Council approves an amendment adding it to the Plan. The benefits under this article are also retroactively applicable to certain Eligible Employees, as defined under Section 6.3, who became disabled or died on or after July 20, 2012.

6.3 ELIGIBLE EMPLOYEE

For purposes of this article, Eligible Employee means:

(a) A benefitted standard hour Employee who is (i) initially hired after July 19, 2012, (ii) ineligible to participate in SDCERS, and (iii) in a bargaining unit represented by the San Diego City Firefighters, International Association of Fire Fighters Local 145; the San Diego Municipal Employees' Association; the American Federation of State, County and Municipal Employees, AFL-CIO, Local 127; the International Brotherhood of Teamsters, Local 911; or the Deputy City Attorneys Association.

(b) An Unrepresented Employee, defined as an Employee who is either an elected officer or is not represented by any of the City's recognized employee organizations, who (i) is not a sworn police officer, (ii) is initially hired after July 19, 2012, and (iii) is ineligible to participate in SDCERS.

(c) A police recruit who is initially hired by the *City* after June 30, 2013, but only while the police recruit is participating in the *City's* Police Academy and is ineligible to participate in the San Diego City Employees' Retirement System.

(d) An Elected Officer who is initially hired or initially assumes office after July 19, 2012 and is therefore ineligible to participate in SDCERS.

6.4 COMMENCEMENT OF PARTICIPATION

Each individual who is an Eligible Employee on the Effective Date or who became disabled or died on or after July 20, 2012, will become a Participant on the Effective Date. Each individual who becomes an Eligible Employee after the Effective Date will become a Participant when he or she becomes an Eligible Employee.

6.5 TRANSITION TO PERMANENT DEATH AND DISABILITY BENEFIT PLAN

The City and its affected Recognized Employee Organizations (REOs) agree to meet and confer over the transition from this interim death and disability plan to a permanent City of San Diego Death and Disability Benefit Plan upon the earlier of the occurrence of the following events:

(a) the date a court of competent jurisdiction, following exhaustion of all appeals, issues a final order or decision declaring Proposition B to be unlawful or invalid, in whole or in part; or

(b) the date a court of competent jurisdiction, following the exhaustion of all appeals, issues a final order or decision declaring Proposition B to be lawfully adopted.

The interim death and disability benefits provided under this article are purely voluntary on behalf of the City. Neither the establishment of this article nor any future amendment, nor the payment of any benefits, gives any person a legal or equitable right against the City, unless that right is specified in this article or conferred by affirmative action of the Plan Administrator or the City in accordance with the terms and provisions of this article. No action by the City with respect to this article gives any Eligible Employee or Participant the right to continued City employment. All Participants remain subject to discharge to the same extent as though this article had not been established.

6.6 INDUSTRIAL DISABILITY BENEFIT

A Participant will receive an interim annual industrial disability benefit paid bi-weekly regardless of his or her age or years of service in the tax-free amount of 50% of the Participant's Final Compensation (as defined under Municipal Code section 24.0103), if the Participant is permanently incapacitated for the performance of his or her usual and customary duty and that incapacity:

(a) is a result of an injury or disease arising out of or in the course and scope of his or her employment as determined by the California Workers Compensation Appeals Board (WCAB) whose decision on causation shall be final and binding and in accordance with WCAB rules (if the WCAB does not make such a determination, for whatever reason, the Claims Administrator will decide the issue subject to the Appeals Process (6.23(f));

(b) renders his or her separation from City employment necessary;

(c) did not arise from:

(1) a Preexisting Medical Condition, which means a medical condition that occurred or existed before the Participant became a Participant, or

(2) a nervous or mental disorder; and

(d) was not caused by willful misconduct, malicious violation of the law, or intemperate use of alcohol or drugs as determined by the WCAB (if the WCAB does not make such a determination, for whatever reason, the Claims Administrator will decide the issue subject to the Appeals Process (6.23(f)).

For the sake of clarity, Final Compensation means the average of a Participant's three highest years of Base Compensation (as defined under Municipal Code section 24.0103) while a City employee. Payment of the benefit under this article will cease upon the effective date of the permanent City of San Diego Death and Disability Benefit Plan, the death of the Participant, or the date the City determines the Participant is no longer disabled under the terms of the Plan, whichever is earlier.

6.7 NON-INDUSTRIAL DISABILITY BENEFIT

A Participant will receive an interim annual non-industrial disability benefit paid biweekly regardless of his or her age or years of service in the amount of 33 1/3% of the Participant's Final Compensation (as defined under Municipal Code section 24.0103), if the Participant is permanently incapacitated from the performance of his or her usual and customary duty and that incapacity:

(a) is not a result of an injury or disease arising out of and in the course of his or her employment;

(b) renders his or her separation from City employment necessary; and

(c) was not caused by willful misconduct, malicious violation of the law, or the intemperate use of alcohol or drugs.

For the sake of clarity, Final Compensation means the average of a Participant's three highest years of Base Compensation (as defined under Municipal Code section 24.0103) while a City employee. Payment of the benefit under this article will cease upon the effective date of the permanent City of San Diego Death and Disability Benefit Plan, the death of the Participant, or the date the City determines the Participant is no longer disabled under the terms of the Plan, whichever is earlier.

6.8 COST OF LIVING ADJUSTMENT

Effective every July 1, the Plan Administrator will adjust each Participant's interim disability benefit by the lesser of:

(a) the percentage annual change in the Bureau of Labor Statistics Consumer Price Index, United States – All items for the preceding calendar year, rounded to the nearest tenth of a percent, or

(b) 2%;

provided, however, that no decrease will reduce any Participant's disability benefit below the benefit in effect on the Effective Date of his or her interim disability benefit.

6.9 REIMBURSEMENT OBLIGATION AND SUBROGATION RIGHTS

The City has the right to recover and subrogate from and against Third Parties or persons, as well as their agents or insurers, any payments made under this article of the Plan.

6.10 DISABILITY EFFECTIVE DATE

Any interim disability award under this article will be effective on the Disability Effective Date, which is the day after the Participant's City employment terminates due to the Participant's incapacity. Payment of any disability award under this article will commence within 30 days after the Claims Administrator or Plan Administrator, as the case may be, approves the award.

6.11 DISABILITY AFFIDAVIT

(a) Any Participant who is receiving an interim industrial or non-industrial disability benefit under this article of the Plan must annually file an affidavit of condition of disability with the Plan Administrator in the form prescribed by the Plan Administrator.

(b) The Plan Administrator will provide an affidavit to each Participant receiving a disability benefit under this article of the Plan each year during the month of his or her birthday or as needed at the Plan Administrator's discretion. The Participant must return the affidavit within thirty 30 days of when the affidavit is mailed. If the completed affidavit is not received from the Participant within 30 days, the Plan Administrator will follow-up with the Participant to determine why he or she has failed to comply.

(c) If, after reasonable follow-up by the Plan Administrator, the Participant fails to return the affidavit, the Plan Administrator may temporarily

suspend the Participant's interim disability benefit until such time as he or she complies.

(d) The Plan Administrator may prescribe additional rules and regulations for an annual filing of an affidavit of condition of disability subject to meet and confer.

6.12 PERIODIC PHYSICAL EXAMS FOR DISABLED PARTICIPANTS

(a) The Plan Administrator may order any Participant who is receiving an interim industrial or non-industrial disability benefit under this article of the Plan to be examined annually by one or more licensed physicians for the purpose of confirming the individual's continuing eligibility for disability benefits, and may at any time order the Participant to active duty, in which case payment of the disability allowance will cease.

(b) The Plan Administrator may prescribe rules and regulations for periodic physical examinations subject to meet and confer.

6.13 ACTIVE EMPLOYEE DEATH BENEFIT

(a) Under this article, the Plan will pay the interim active (non-industrial) death benefit to a Participant's Beneficiary, who is defined as any person or entity entitled to receive a benefit under this article at the time of the Participant's death, if:

(1) the Participant dies:

(A) while in active City service (on the City payroll and not on a leave of absence);

(B) while absent on military service;

(C) within four months of terminating City employment because the Participant's position was abolished; or

(D) while incapacitated from the performance of his or her duties, if the incapacity was continuous from when the Participant terminated City employment until his or her death; and

(2) an industrial death benefit is not payable.

(b) The interim active death benefit is a lump sum equal to one month of pay for each year of service credit, not to exceed 50% of the Participant's Final Compensation (as defined under Municipal Code section 24.0103). For

the sake of clarity, Final Compensation means the average of a Participant's three highest years of Base Compensation (as defined under Municipal Code section 24.0103) while a City employee.

6.14 INDUSTRIAL DEATH BENEFIT

(a) Under this article, the Plan will pay the interim industrial death benefit, instead of the active employee death benefit, to a Participant's Surviving Spouse, who is defined as the Participant's spouse or registered domestic partner at the time of the Participant's death, or if none, the Surviving Minor Children, who are defined as a Participant's children under the age of 18 at the time of the Participant's death, if, in addition to satisfying the requirements in section 6.11(a) the Participant:

(1) dies from industrial causes, as determined in accordance with the procedures set forth under the California Labor Code, Workers' Compensation Division; and

(2) either:

(A) has a Surviving Spouse who is named as the Participant's Beneficiary when the Participant dies, or

(B) the Participant has one or more Surviving Minor Children when he or she dies.

(b) If the Participant has a Surviving Spouse who is the Participant's Beneficiary when he or she dies, under this article the Plan will pay an interim annual death benefit paid bi-weekly to the Surviving Spouse equal to 50% of the Participant's Final Compensation (as defined under Municipal Code section 24.0103), beginning with the month that includes the Participant's death and continuing under this article until the effective date of the permanent City of San Diego Death and Disability Benefit Plan or the death of the Surviving Spouse, whichever is earlier. If the Participant does not have a Surviving Spouse, but has one or more Surviving Minor Children, when the Participant dies, under this article the Plan will pay an interim annual death benefit paid bi-weekly, in equal shares, to the Surviving Minor Children, equal to 50% of the Participant's Final Compensation (as defined under Municipal Code section 24.0103), beginning with the month that includes the Participant's death, until each Surviving Minor Child reaches age 18 or until the effective date of the permanent City of San Diego Death and Disability Benefit Plan, whichever is earlier. For the sake of clarity, Final Compensation means the average of a Participant's three years of Base Compensation (as defined under Municipal code section 24.0103) while a City employee.

(c) If, when the Participant dies, it has not yet been determined under the California Labor Code, Workers' Compensation Division, whether the Participant died from industrial causes, under this article the Plan may pay the interim active death benefit to the Participant's Beneficiary. If it is subsequently determined under the California Labor Code, Workers' Compensation Division, that the Participant died from industrial causes, and there is a qualifying Surviving Spouse or one or more Surviving Minor Children, under this article the Plan will pay the interim industrial death benefit reduced by the amount of the active death benefit paid to the Participant's Surviving Spouse, or, if none, Surviving Minor Children. The Surviving Spouse or Surviving Minor Children will not be paid an interim industrial death benefit until the accumulation of the benefit fully offsets the lump sum amount paid for the active death benefit. The benefit will cease on the effective date of the permanent City of San Diego Death and Disability Plan or the death of the Surviving Spouse or surviving Minor children, whichever is earlier.

(d) One Hundred Percent (100%) Continuance Survivor Benefit

(1) The payment of a 100% continuance survivor benefit may be authorized by the Plan under this subsection (d) when a Participant receiving an industrial disability benefit dies; and

(2) The Surviving Spouse or Surviving Minor Children of such a deceased Participant makes a written application to the Plan Administrator for an award of this benefit; and

(3) The Surviving Spouse or Surviving Minor Children demonstrate, by clear and convincing evidence, that the Participant's death was the direct result of the disability for which the Participant was receiving a benefit under this article. For the avoidance of doubt, the same monthly benefit the Participant was receiving at death will be payable to the Participant's Surviving Spouse or Surviving Minor Children provided the conditions set forth above in this subsection (d) are satisfied. The benefit will cease on the effective date of the permanent City of San Diego Death and Disability Plan or the death of the Surviving Spouse or surviving Minor children, whichever is earlier.

6.15 BENEFICIARY DESIGNATION

The Participant's designated beneficiary under the City of San Diego Supplemental Pension Savings Plan H is the Participant's Beneficiary entitled to receive any death benefits payable under this article of the Plan on account of the Participant's death.

6.16 BENEFICIARY NOT DESIGNATED

(a) Under this article, the Plan will pay all amounts due because of the death of a Participant as provided in subdivision (b) of this section if the Participant’s estate would not be probated if no amounts were due from this article of the Plan and:

(1) the Participant did not name a Beneficiary,

(2) there is no living named Beneficiary,

(3) after reasonable efforts, the Plan Administrator is unable to locate the named Beneficiary, or

(4) the Beneficiar*y* is the Participant’*s* estate.

(b) Payment will be made, in the following order, to the Participant’s:

(1) Surviving Spouse,

(2) children,

(3) parents,

(4) siblings, or

(5) next of kin.

(c) Under this article, the Plan will not make any payment under this section to persons in any group listed in subpart (b) if there are living persons in any earlier group on the date of payment.

(d) Under this article, the Plan will not make any payment under this section without first receiving from each payee an affidavit in compliance with the California Probate Code permitting a decedent’s successor to collect non probate assets.

6.17 PAYMENT TO FUNERAL DIRECTOR

The Plan Administrator may pay any of the amount due from this article of the Plan because of the death of a Participant to the funeral director who conducted the funeral, or to the person or organization that paid the funeral expenses, if:

(1) the Participant did not name a Beneficiary,

(2) there is no living named Beneficiary,

(3) the Plan Administrator is unable to locate the named Beneficiary, or

(4) the Beneficiary is the Participant's estate; and

no person in any of the groups listed in Section 6.14(b) has survived the Participant.

(a) Payment under this section will not exceed the actual cost of the funeral or the portion of that cost paid by the person or organization to the funeral director, as shown by the funeral director's sworn itemized statement and by any other documents required by the Plan Administrator.

(b) Payment under this section will fully discharge the Plan for the amount paid.

6.18 UNIFORM SIMULTANEOUS DEATH ACT

California law regarding the distribution of estates under the Uniform Simultaneous Death Act governs payments made by this article of the Plan because of the death of a Participant or Beneficiary. In applying the Uniform Simultaneous Death Act to benefits paid to a Beneficiary, benefits under this article of the Plan will have the same status as benefits under insurance policies.

6.19 CONTINUED HEALTH COVERAGE

A Safety Member's Surviving Spouse or Surviving Minor Child who is eligible for the industrial death benefit is entitled to continued health coverage as provided in California Labor Code section 4856. Under that section, if a Safety Participant who is a firefighter or a peace officer and:

(a) is killed in the performance of his or her duty, or

(b) dies as a result of an accident or injury caused by external violence or physical force incurred in the performance of his or her duty, the City must continue providing health benefits to the deceased Participant's Surviving Spouse under the same terms and conditions provided prior to the death, or prior to the accident or injury that caused the death, until the Surviving Spouse is Medicare eligible. Upon Medicare eligibility, the City will pay the Medicare Part B premium for the Surviving Spouse's life. Surviving Minor Children will continue to receive benefits under the coverage provided the Surviving Spouse or, if there is no Surviving Spouse, until the age of 26 years. However, pursuant to section 4856 of the Labor Code, the Surviving Spouse may not add the new spouse or

stepchildren as family members under the continued health benefits coverage of the Surviving Spouse.

6.20 RETIREE DEATH BENEFIT

Under this article, the Plan will pay a $2,000 death benefit to the designated Beneficiary of a Participant who has received a disability benefit under this article of the Plan. If there is no designated *Beneficiary*, the benefit will be paid according to Sections 6.14 or 6.15, whichever is applicable.

6.21 PLAN ADMINISTRATOR

For purposes of this article only, the Plan Administrator is the City's Risk Management Director. The Plan Administrator has the exclusive discretion and authority to (a) establish rules, forms, and procedures for the Plan's administration; (b) to construe and interpret this article of the Plan in good faith and in a manner consistent with the Plan's purpose; and (c) to decide any and all questions of fact, interpretation, definition, computation, or administration arising in connection with the operation of this article of the Plan, including, but not limited to, the eligibility to participate in the Plan and amount of benefits paid under this article of the Plan. The Plan Administrator may delegate to any other person or organizations any of his or her powers and duties. The rules, interpretations, computations, and other good faith actions of the Plan Administrator will be binding and conclusive on all persons.

6.22 CLAIMS ADMINISTRATOR

For purposes of this article only, the Claims Administrator is the Plan Administrator, or a third party designated by the Plan Administrator to determine claims for benefits under this article.

For purposes of this article only, the Appeals Committee is the Committee responsible for reviewing and deciding appeals of denied claims. The Appeals Committee is comprised of the City's Human Resources Director, the City's Risk Management Director and a representative of a *City* safety REO, a representative of a *City* non-safety REO and a designee from the Independent Budget Analyst's Office. The REO representative may not be a member of the same REO as the Claimant.

6.23 CLAIMS PROCEDURES

The following claims procedures apply only to claims for interim death and disability benefits filed under this article:

(a) Filing a Claim

A claim for benefits is not filed until all of the documents prescribed by the Claims Administrator for benefit application are completed, signed and filed with the Claims Administrator. All required documentation for

disability claims must be completed, signed and filed with the Claims Administrator within 60 days of filing the initial claim or the claim will be denied. A claim for benefits must include sufficient evidence to enable the Claims Administrator to determine whether the Participant has met the Plan's requirements for a disability benefit. For purposes of this section, "Claimant" means a Participant, Beneficiary or, where applicable, his or her authorized representative, who has filed a claim for benefits under this article of Plan.

(b) Time Limit for Filing a Claim

A Claimant must, at the time and manner prescribed by the Claims Administrator, file a claim for disability benefits with the Claims Administrator:

(1) while the Participant is in active service (on the *City* payroll and not on a leave of absence) or on long-term disability;

(2) within four months of discontinuance of active service; or

(3) within three years of discontinuing active service if the Participant establishes that he or she was continuously physically or mentally incapacitated from the performance of duty from that date until he or she applied for disability benefits.

A claim for disability benefits filed more than three years after a Participant discontinues active service will be deemed denied. The Claimant will then be permitted to appeal the denial in accordance with the Appeals Procedure described in section 6.23(f).

(c) Benefit Claim Determinations

(1) Upon the Claimant's timely filing of a claim as described in sub-sections (a) and (b) of this section, the Claims Administrator will review and evaluate the claim to ensure that disability benefits are paid only to those who are legally authorized to receive those ben-efits.

(2) During the review and evaluation process the Claims Administrator may in the exercise of good faith:

(A) request additional supporting information from the Claimant;

(B) require that the Claimant submit to one or more independent medical examination(s) on any medical condition covered or raised by the claim;

(C) conduct an independent review of the Claimant's files and records; or

(D) inquire into or investigate Claimant's relevant habits or conduct.

(3) The Claimant must cooperate with the Claims Administrator's reasonable review and evaluation conducted in good faith by providing any relevant information requested and by submitting to one or more independent medical examinations requested by the Claims Administrator. Claimant's refusal to provide any relevant information requested or to submit to an independent medical examination is grounds for denial of the claim without further evaluation.

(d) <u>Decision on Claims</u>

(1) The Claims Administrator will make its determination regarding a claim within 45 days of receipt by the Plan. The Claims Administrator may, however, extend this decision-making period for an additional 30 days for reasons beyond the control of the Claims Administrator. The Claims Administrator will notify the Claimant of the extension prior to the end of the 45-day period. If, after extending the time period for the first 30-day period, the Claims Administrator determines that it will still be unable, for reasons beyond the control of the Claims Administrator, to make decision within the extension period, the Claims Administrator may extend decision making for a second 30-day period.

(2) Appropriate notice must be provided to the Claimant before the end of the first 45 days and again before the end of each succeeding 30-day period. This notice will explain the circumstances requiring the extension and the date the Claims Administrator expects to render a decision to the Claimant. It will explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues. The Claimant will have 45 days from the date of receipt of the Claims Administrator's notice to provide the information required.

(3) If the Claims Administrator determines that a preponderance of the evidence supports the claim, it will approve the claim. In that case, benefit payments will begin within 30 days thereafter.

(e) Denial of Claims

If any claim for benefits is denied in whole or in part (an "adverse benefit determination"), the Claims Administrator must notify the Claimant, in writing, of the denial of the claim, and of the Claimant's appeal rights. The notice will state:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information the necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary

(4) A description of the Plan'*s* review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under California Code of Civil Procedure section 1094.5 following an adverse benefit determination on review.

(5) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

(C) a disability determination made by the Social Security Administration regarding the Claimant and presented by the Claimant to the Plan.

(6) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to the Claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(7) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(8) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(f) Appeals Procedure

(1) When a Claimant receives a notice of an adverse benefit determination, the Claimant may request a review of the decision. The request must be in writing and must be filed within 180 days following receipt of the notice. The Claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The Claims Administrator will give the Claimant an opportunity to choose to have his/her appeal heard in front of an Adjudicator from either JAMS or Judicate West.

(2) The review shall take 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. The review will not afford deference to the initial adverse benefit determination and will be considered by the Appeals Committee, whose members did not make the initial adverse determination. Upon request, and at no expense to the Claimant, the Appeals Committee will convene a meeting, with at least 30-days advance notice to the Claimant, so that the Claimant’s appeal may be heard. Claimant will be given the opportunity and sufficient time at Claimant’s own expense to present his or her appeal in person whether *in pro per* or through a representative and will be given the opportunity and sufficient time to present the testimony of lay or expert witnesses.

(3) If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Appeals Committee shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

(4) If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to the Claimant, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow the Claimant time to respond.

(5) Before the Appeals Committee issues an adverse benefit determination on review that is based on a new or additional rationale, the Claimant must be provided a copy of the rationale at no cost to the Claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the Claimant time to respond.

(6) The Claimant will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, or, if a hearing is requested, within 60 days after the hearing is closed, unless special circumstances require an extension of time for processing. In such a case, the Claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the Claimant of the determination on review no later than 90 days after receipt of the request for review.

(g) Notice of Adverse Benefit Determination on Review

The Plan Administrator shall provide written notification to the Claimant or his authorized representative. If the initial adverse benefit determination is upheld on review, the notice will include:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

(4) A statement of Claimant's right to bring a civil action under California Code of Civil Procedure section 1094.5 and, if the Plan imposes a contractual limitations period that applies to Claimant's right to bring such an action, a statement to that effect which includes the calendar date on which such limitation expires on the claim.

(5) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

(B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

(C) a disability determination made by the Social Security Administration regarding the Claimant and presented by the Claimant to the Plan.

(6) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(7) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(h) Relevant Documents

For purposes of these procedures, a document, record, or other information shall be considered relevant to a claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option.

(i) Exhaustion of Remedies

No legal action for benefits under the Plan may be brought until the Claimant has exhausted all remedies available under this claims procedure.

(j) Limitations Period on Claims

Any legal action related to a claim for benefits must be filed within one year from the date on which the Appeals Committee provides notice that the Claimant's appeal has been denied or after all remedies under this claims procedure have otherwise been exhausted, regardless of any state or federal statutes establishing provisions related to limitations of actions.

6.24 NO VESTED RIGHTS

Participants and their Beneficiaries have no vested rights to the interim death and disability benefits provided under this article. The City will terminate eligibility for and payment of benefits under this article upon the effective date of the permanent City of San Diego Death and Disability Plan. At such time, the City will amend the Plan by resolution of the City Council to remove this Article VI. For the sake of clarity, any death or disability benefit payments being made to Participants or Beneficiaries under this article will immediately cease upon the effective date of the permanent City of San Diego Death and Disability Benefit Plan. No further payments will be made under this article, but will instead be made under the permanent City of San Diego Death and Disability Benefit Plan. Participants and Beneficiaries will also no longer be eligible for awards of

benefits under this article after the effective date of the permanent City of San Diego Death and Disability Benefit Plan.

6.25 BENEFIT PAYMENTS UNDER OTHER PLAN PROVISIONS

If a Participant is eligible to receive a benefit both under this article and another provision of the Plan, the benefit provided under the other Plan provision will be paid to the Participant. If eligibility for payment of the benefit under the other Plan provision ceases for any reason, the benefit under this article will then be payable to the Participant, provided the Participant meets the eligibility requirements of this article at the time benefit payments cease under the other Plan provision. Under no circumstances will simultaneous benefit payments be made to a Participant under this article and another Plan provision.

6.26 SUNSET PROVISION

Notwithstanding any other provision in the Plan except as provided in Section 6.24 above, this article of the Plan will terminate on December 31, 2022 unless it is mutually agreed in writing to extend the termination provision to a later date by the City and the applicable REOs.