Maricopa County
Group Short-Term Disability
Plan Description

Effective July 1, 2013

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PLAN DESCRIPTION

What is short-term disability (STD)?

Short-term disability (STD) is a plan that replaces a portion of your weekly salary, depending on the level of coverage elected, while you are disabled. Refer to the 'Terms and Definitions' section for the definitions of 'Disability' and 'Disabled.' This plan does not provide coverage if you are unable to work due to the disability of an immediate family member. Participation in this Plan is voluntary and does not provide job protection.

Who is eligible to purchase STD coverage?

All regular status active employees who meet benefits eligibility criteria as defined by Maricopa County (except some contract employees as specified below) and are normally scheduled to work at least 20 hours per week are eligible to purchase STD coverage. Employees working under specific contracts may or may not be eligible for certain benefits based on the terms of their contract.

When can you enroll?

If you are eligible to purchase STD coverage, you can enroll online within 30 calendar days of your hire date or within 30 calendar days of attaining benefits eligibility (e.g., going from temporary to regular status). Other Family Status Changes unrelated to attaining benefits eligibility do not qualify you for enrollment into the STD plan such as marriage, divorce, etc.

If you do not elect STD coverage within the time frames listed above, you will not be able to elect coverage until the next benefits Open Enrollment period.

Once an election is made, no changes will be allowed for any reason during the plan year (July 1-June 30) except when you are called to or return from active duty or are included in a reduction in the workforce.

When does coverage begin?

Coverage for new hires or newly-eligible employees begins on the first day of the third pay period following their date of hire/benefits eligibility date. Coverage for employees attaining benefit-eligible status due to a qualifying event begins on the event date of attaining benefit eligibility status but no sooner than a new hire effective date. As specified in the 'When can you enroll?' section, a completed online Family Status Change must be submitted within specified time frames through the Benefit Enrollment System.

Coverage for eligible employees enrolling during Open Enrollment becomes effective July 1st following the Open Enrollment period.

Exception to when coverage begins

If you are not actively at work on the effective date your initial STD coverage would otherwise begin, your coverage will become effective when you return to active duty.

If your initial effective date falls on a weekend, holiday or any day that is not a scheduled workday, you will be covered if:

- You were actively at work on your last scheduled workday, and
- You were able to perform all your job duties had the effective date been a regularly scheduled workday

Is there a pre-existing condition limitation?

If you have a disability for which you received treatment (including diagnostic services and/or prescription drugs) within 90 calendar days before your coverage became effective or for which a prudent person would have received treatment, no benefits will be payable for that condition until you have been treatment-free for three months or covered by the STD plan for 12 months.

Note: When you increase your benefit level during Open Enrollment, the increased benefit level is subject to the pre-existing condition limitation. The increased benefit level will not be paid until it has been determined that the presenting disability is not pre-existing.

Example: If you previously elected the 50% benefit, and during an Open Enrollment period you changed your election to the 60% benefit, the difference between the 50% and the 60% benefit is subject to the pre-existing condition criteria. If you filed a claim with a disability date in the new plan year, the disabling condition would be reviewed to determine if it is pre-existing during the past 12 months. If so, your claim would be paid at the 50% level.

Are there any conditions excluded from coverage?

Certain conditions are excluded from coverage. Refer to the 'General Exclusions' section for details.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect one of the following benefit levels. The maximum benefit is $2,000 per week:

- **40% of weekly salary**
- **50% of weekly salary**
- **60% of weekly salary**

Note: If your weekly disability payment will be at the $2,000 per week maximum, you may be enrolling in a coverage level with a higher multiplier than necessary. Refer to the STD Calculator on the Employee Benefits Home page to determine the most cost-effective coverage level.

What is weekly salary?

Weekly salary is the amount of annual base salary (including Management Professional Assignment pay), divided by 52, that is paid to you by your employer as of the date of your disability.

How much are the benefit premiums?

The benefit premiums for this coverage are paid entirely by you through 24 payroll deductions. The total cost of your coverage under this Plan depends on the benefit coverage amount you choose and your annual base salary. Please refer to the 'Contribution Costs' section to calculate your contribution rate. Contributions are post-taxed, meaning that you pay taxes on the contribution amount, and if you qualify for the benefit, your benefit coverage amount is not taxable when received.

What is the maximum benefit duration period?

The benefit duration period is a maximum of 26 weeks beginning with the date of onset of your disability. Refer to the 'Is there an elimination period before payments begin?' section for information on how the 26-week duration period is calculated.

Is there an elimination period before payments begin?

There is a two-week elimination period (14 consecutive calendar days) from the onset date of your disability before you begin to receive STD payments, unless you become hospitalized during the elimination period. If you are hospitalized during the elimination period, your STD benefits will begin on the first day of hospitalization.

The elimination period is part of the 26-week Maximum Benefit Duration Period.

During the elimination period in which you are not receiving STD payments, you are required to use sick leave during your absence from work. If you do not have enough sick leave to cover the entire elimination period, you must use available vacation time. If you do not have sufficient vacation time, you will be placed on Leave Without Pay.

You cannot be paid vacation, sick leave or regular pay or receive donated leave for the same time period for which you are receiving STD payments. After the elimination period is exhausted, you may request to

use some, all or none of your vacation leave before you start receiving STD payments. However, you may not use vacation to supplement your STD payment. Any overpayment that results in receiving both payments must be repaid.

If you do not notify Sedgwick CMS (Sedgwick) during your initial interview or via the online application process of your intention to save your vacation time, it will be treated as an offset to your STD benefit and will have the effect of reducing the number of weeks of your STD benefit.

If you return to work for less than 30 consecutive or intermittent working days, those days count toward the 26-week Maximum Benefit Duration Period. Likewise, if you come back to work on a part-time basis and receive the return to work incentive benefit, those days count toward the 26-week Maximum Benefit Duration Period.

What are my STD benefits for pregnancy?

The standard STD benefit for pregnancy is six weeks for a vaginal delivery without complications and eight weeks for a caesarian delivery. This six or eight week time period begins with the date of delivery and includes a two-week elimination period. If you are hospitalized during the elimination period, your STD benefits will begin on the first day of hospitalization. The STD plan also covers complications that require the employee to be off work prior to delivery. Refer to the 'Pre- Existing Condition' section for more details.

What happens to your other benefits while you are receiving short-term disability benefits?

If you are receiving short-term disability benefits as an active employee, you are considered to be on an unpaid leave of absence and you remain responsible for the employee portion of the premium for each benefit plan in which you are currently enrolled. To pay for your other benefits while you are on STD, you may prepay the total amount due before the start of your leave or you may be permitted to allow the premium amount due for each plan to go into arrears each pay period. When you return to work, you will pay back the premium owed by having an additional per pay period premium deducted in addition to the current premium until the amount owed is recovered. If you do not return to work, you will be billed for the premiums due.

Your basic life coverage will continue in force while you are on an approved unpaid leave of absence, except for active duty military leave.

If you do not want to continue your benefits coverage while on your unpaid leave, you must revoke it by completing an online Family Status Change through the Benefit Enrollment System within 30 calendar days of the date your unpaid leave of absence begins. However, your STD coverage may not be revoked, except when you are called to active duty or are included in a reduction in the workforce. If you revoked your benefits, you must complete an online Family Status Change within 30 days of your return to work to resume your benefits.

What happens if you terminate employment or change to a non-benefits eligible status while receiving disability benefits?

STD benefit payments will continue through the time you are determined to meet the STD eligibility criteria without interruption up to the maximum 26-week benefit duration period even if you terminate employment or change to a non-benefits eligible status while receiving disability benefits.

What to expect if you need to submit a claim

Your STD benefits are intended to help support you while you are unable to work. The claims management process used by the claims administrator is based on the types of injuries or illnesses you might encounter and on the expected length of your time away from work due to the injury or illness. Disability benefits specialists will work with you to understand your specific needs and help you in getting your disability claim approved as you move through the stages of disability and on to recovery.

The claims administrator is committed to providing you with specialized expertise and responsive service, whether for a planned absence or with assistance after a disabling accident or illness.

If you are disabled due to a mental health diagnosis, the claims administrator will work with the behavioral health vendor to ensure you have a disability assessment, are receiving care by a mental health professional, and that you are assigned a care coordinator who will regularly work with you, the claims administrator and your mental health provider on your treatment plan and your return-to-work goals.

How do you submit a claim?

Claims can be filed in two ways: via the Internet at **www.sedgwickcms.com** (24 hours a day, seven days a week) or by phone toll-free at 1-800-599-7797. Representatives are available to take your call 5 AM.- 5 PM PST, Monday through Friday.

When must you submit a claim?

If you want to receive benefits with as little break in pay as possible, you should submit your claim to Sedgwick no later than 21 calendar days after your disability starts. However, your claim must be submitted no more than one year after the date your disability begins. Claims submitted beyond that date will be denied due to late filing.

Who will review your claim?

Once the claims administrator receives your claim request (including all three parts: employee, employer and attending physician's statement), you will be provided with direct access to a disability benefits specialist who will personally handle your claim. This special contact, an individual trained in disability management, will evaluate the full nature of your disability and the potential length of your time away from work, will arrange payment of the STD benefits, and will begin working with you toward your recovery and return-to-work goals as appropriate.

Is anyone else involved in the review process?

When appropriate, your disability benefits specialist will call your employer and your attending physician to better understand your condition and your potential for recovery. The claims administrator's physicians, nurses, case managers, and vocational rehabilitation consultants support the disability benefits specialists and may also be in touch with your doctor. These professionals may review the medical, occupational and rehabilitative information for your claim.

Additionally, if your claim is related to a mental health diagnosis, your disability benefits specialist will refer you to the Magellan Disability Management Support program for a disability assessment. You will be assigned a care coordinator who will also work with you, your mental health professional, and the claims administrator regarding your treatment plan and your return-to-work goals.

Participation in any case management program that Sedgwick, in its role as the third party administrator of the STD benefit, determines to be beneficial to your return to work is required for your continued eligibility.

When will a decision be made about your claim?

Once all three portions of your claim are completed and submitted to the claims administrator, your claim will be assigned to a disability benefits specialist. With some conditions, such as standard maternity leave or recovery following a routine surgery, your benefits may begin almost immediately after the elimination period concludes.

If your medical condition is more complicated, the claims administrator may require additional medical information to better understand your claim. In any event, once the disability benefits specialist has received all necessary information, a decision will be made within four business days.

For claims with a mental health diagnosis, you will be referred for a disability assessment with the

Magellan Disability Management Support program. Depending on how quickly the administrator receives the additional information, your benefit determination could take longer. The claims administrator's goal is to always provide a decision as quickly as possible. Your prompt response to requests for information about your claim will help the claims administrator to serve you better and help ensure that you receive payments in a timely manner.

DISABILITY

When do disability benefits become payable?

The claims administrator (refer to the ''Plan Contact Information'' section) approves payment of a weekly benefit for covered conditions after the end of the benefit elimination period and only when you and your physician or mental health professional provide documentation that you:

1. Are disabled due to illness or injury, and
2. Are under appropriate treatment and care of a physician or mental health professional.

An approval notice indicating the length of time for which disability payments have been approved will be sent to you. If you continue to be disabled after the disability end date on your approval notice, you must submit additional documentation of your continued disability to the claims administrator for review. Please note that the approval notice is the only notice you will receive with the disability end date. It is your responsibility to continue to communicate with your disability benefits specialist in the event your disability continues past this date. Failure to provide additional information of your continued disability in a timely manner will result in your benefits being delayed or cancelled.

Refer to the 'Terms and Definitions' section for the definition of 'Disabled.'

Please note that certain conditions are excluded from coverage. Refer to the 'General Exclusions' section for details.

When are claims paid?

When the claims administrator receives satisfactory proof of your claim, and your claim for disability benefits is approved, benefits payable under the plan will be paid weekly during any period that you remain disabled under the terms of the plan.

Your STD check will be mailed to the address you provided when you filed your claim.

It is important that your department have your current address and telephone number while you are on a leave of absence in the event that information must be communicated to you. Please contact your Human Resources Liaison or the Employee Records Unit of the Human Resources Department to update your information in the Payroll/Records system.

What constitutes proof of claim?

In order for a claim to be processed, the claims administrator must receive your application for benefits (with all required forms completed and signed), as well as sufficient objective medical evidence in support of your claim. Such evidence may consist of records from your doctor or mental health professional, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the regular care and treatment of a physician or mental health professional. In the absence of such proof, the claims administrator may elect to suspend benefits until such proof is received.

Your disability must be supported by current objective medical evidence. You must be under the continuous care of a qualified physician or mental health professional, with a course of treatment that is appropriate for your condition.

If your doctor cannot substantiate your disability by objective findings, you may be required to see a doctor selected by the claims administrator for an independent evaluation. Failure to cooperate with such requests will result in a denial or termination of benefits.

You must give the claims administrator proof of continued disability and regular treatment by a

physician or a mental health professional within 45 days of the date the claims administrator requests such proof.

Are STD payments taxable?

Your STD payments are not taxable because you pay the premium with post-tax dollars.

What conditions must be met for benefit payments to continue?

You will be paid a weekly benefit for a covered condition so long as you remain disabled and are under the appropriate treatment and care of a physician or mental health professional. You will not be paid longer than described in the 'What is the maximum benefit duration period?' section.

If you continue to be disabled past the time period listed on your approval letter, you must submit additional documentation of your continued disability to the claims administrator for review. Failure to provide such information in a timely manner will result in your benefits being delayed

The claims administrator may require that you be examined as often as is reasonable, at the plan's expense, by an independent physician/specialist, mental health professional, or vocational expert of the administrator's choice. You may also be required to be interviewed by an authorized claims administrator representative. If you fail to comply with such a request, the result will be an interruption in or termination of benefits. Benefits may also be terminated if the results of the independent examination determine that you are not disabled under the definition of 'Disability.' See the 'Terms and Definitions' section.

Additionally, if you are eligible to apply for long-term disability benefits, you will be required to apply for and accept payment of long-term disability benefits through the Arizona State Retirement System (ASRS).

Participation in any case management program that Sedgwick, in its role as the third party administrator of the STD benefit, determines to be beneficial to your return to work is required for your continued eligibility. Participating in the case management program means following the recommended treatment plan and attending the required appointments.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your weekly salary by the percentage of the benefit coverage amount you elected and deduct any 'Other Income Benefits' you are receiving that offset your benefit from this plan. Refer to the 'What are Other Income Benefits?' section for more information.

Benefits payable for less than one weekly period will be paid to you at the rate of one-seventh of the STD benefit amount for each day of total disability.

What happens if I can only return to work part-time or with other restrictions?

Maricopa County understands that a disability can cause you hardship. The County wants to help you reduce that hardship by providing you with an incentive to return to work as soon as you are able. You may not be able to return full time or perform all the essential functions of your position initially. However, the County will work with you and your doctor to determine if you are able to participate in transitional duty prior to returning to full duty (working your usual schedule and performing all your pre-disability job functions) or if other accommodations can be made for you. Sedgwick will continue to support your recovery by continuing to pay a portion of your STD benefit, within certain limits, in addition to your part- time earnings if you are approved for transitional duty.

To continue receiving STD benefits, if there is an assignment available that meets your medical restrictions and for which you are qualified, you are required to participate in transitional duty; otherwise,

your STD benefits may cease altogether.

If your leave is covered under the Family Medical Leave Act (FMLA), you can choose to decline a transitional duty assignment, but you will not receive STD benefits. In that case, you will be required by the County to exhaust any remaining Sick Leave, followed by any Vacation accruals for any remaining FMLA leave entitlement covering your absence from work. Following exhaustion of leave accruals, you may be eligible for donated leave. In the absence of donated leave, you will be placed on Leave without Pay until the conclusion of your FMLA leave entitlement.

If, however, you are not covered under the FMLA and have been released to return to work by your health care provider with restrictions that the County can accommodate, the County will require you to return to work. Failure to return to work under these circumstances may result in dismissal from your employment.

How will your STD benefits be calculated if you are working in a transitional assignment?

When you add your gross part-time earnings to your weekly STD benefit, the total is limited to the lesser of your regular STD benefit or 80% of your pre-disability gross earnings. If your weekly STD benefit and your gross earnings exceed 80% of your pre-disability earnings, then your STD benefit will be reduced so that the total amount of gross wages and the STD benefit equals 80% of your pre-disability wage.

EXAMPLE: An employee who normally works a 40-hour week is on STD. The doctor releases the employee to return to work part-time, no more than 20 hours per week.

Pre-disability gross wages for 40 hours =	$480
($12/hour) STD Benefit Level	60%
Standard STD Benefit	$288 ($480 x 60%)
Part-time Gross Wages	$240 ($12 x 20 hours)
80% of Pre-disability Gross Wages	$384 ($480 x 80%)
Part-time Gross Wages	($240) + STD Benefit ($288) = $528
$528 exceeds 80% of pre-disability wages	($384)

Because the STD benefit plus gross part-time earnings ($528) cannot exceed 80% of the pre-disability wage ($384), the STD benefit is reduced from $288 to $144 ($240 [part-time earnings] - $384 [80% of pre-disability wages]).

The return-to-work incentive will begin with the first day you return to part-time work. It will continue for a period of up to 21 weeks elapsed time unless you stop working part-time and are totally disabled (your full disability benefit will continue in that case) or until you are no longer disabled, whichever occurs first. Once you begin to receive the return to work incentive benefit, the 21-week period will continue to count down until 21 weeks have elapsed. Intermittent periods of total disability or partial disability under the return to work incentive will count toward the total 21-week return-to-work incentive benefit period. This 21-week period cannot exceed the total Maximum Benefit Duration Period.

What happens if you are out of work for a long time?

If your claim is or becomes long term and you are covered under the ASRS, the claims administrator will advise you to apply for long-term disability. The claims administrator will make this contact after you have been off work for 90 days and it appears that your disability will continue for more than an additional 90 days.

What are Other Income Benefits?

Unless prohibited by applicable law, ‘Other Income Benefits’ offset the amount of your STD payment. You are responsible to report the receipt of other income immediately upon receipt to the claims payer. If it is discovered after the fact that an offset that should have occurred did not, you will be required to pay back the money owed. Other Income Benefits include, but are not limited to, the following:

1. Applicable amounts provided under any Workers' Compensation law (including pay continuation program)
    a. Transitional Duty
    b. Supplemental Pay Program (Workers' Compensation coordination)
2. Any benefits you are eligible to receive because of your disability under the Social Security Act or similar plan or act. If benefits from these programs are denied for any reason (except your non- insured status), you will be required to appeal the denial to the full extent permitted. You will continue to be considered eligible to receive STD benefits until all appeal processes are exhausted.
3. **Note**: If Social Security Disability payments are received retroactively to cover a period of time during which you were covered and paid benefits from the STD plan, you are liable and responsible to pay the plan an amount equal to the retroactive amount received from the corresponding period or the amount of disability benefits received, whichever is less.
4. Any benefits you are eligible to receive under any plan or provision providing periodic payments for disability or providing benefits for loss of time or income to which your employer, union, trade or professional organization directly or indirectly sponsored or contributed.
5. Any benefits received from any Salary Continuation Plan, including, but not limited to, workers' compensation income protection, sick leave, vacation, or donated leave.
6. Any salary received while on a transitional assignment with Maricopa County (amount of STD benefits may be reduced in accordance with the return-to-work incentive, if applicable, as described above)

What happens if you receive a lump sum payment from Other Income Benefits?

If a lump sum payment is received retroactively to cover a period of time during which you were covered and paid benefits from the STD plan, you are liable and responsible to pay the plan an amount equal to the retroactive amount received from the corresponding period or the amount of disability benefits received, whichever is less.

If no time period is given for the lump sum, you are liable and responsible to pay the plan an amount equal to the full amount of the lump sum received or the full amount of disability benefits received, whichever is less.

What happens if I return to work and become disabled again?

If you are disabled, return to work and become disabled again due to the same or related cause, the second disability will be considered a continuation of the first period of disability, as long as you returned to work for less than 30 consecutive calendar days.

If your second disability is unrelated to the first, or if you returned to work for 30 or more consecutive calendar days, the second period of disability will be considered a separate claim, and a new elimination period must be satisfied before benefits will become payable.

GENERAL EXCLUSIONS

What disabilities are not covered?

This plan will not provide payments for any disability benefits if:

1. You are not under the direct and regular care of a licensed physician or mental health professional and are not receiving medical treatment as defined in the 'Terms and Definitions' section;
2. You participate in a felony and become disabled as a result of such participation;
3. You are confined in any penal or correctional institution as a result of a conviction for a criminal or other public offense;
4. Your disability is the result of a war or act of war, unless you are a United States expatriate or on

temporary assignment in a war area on employer business or you are in the military service of any country which is at war;

5. Your injuries are sustained while you are on a personal leave of absence without pay, excluding jury duty and vacations (see 'Active Employment' in the 'Terms and Definitions' section).
6. Your physician is unable to provide a valid diagnosis. Symptoms such as pain and fatigue do not constitute a valid diagnosis.
7. You have cosmetic or elective surgery, except surgery made necessary by accidental injury incurred while covered under the plan;
8. You have an injury, sickness or pregnancy for which you receive, or a prudent person would have received medical treatment within the three months before the date of your coverage under the STD program. This exception does not apply to disability commencing after a plan participant has been covered under the plan for a period of 12 continuous months, unless the benefit coverage level increased.

TERMINATION

When does coverage terminate?

You cease to be covered **on the earliest of** the following dates:

1. The date your employer discontinues the plan,
2. The date you retire under any normal retirement plan or your employer's retirement plan,
3. The date you cease to be an employee.
4. The date of your death,
5. The last day of the pay period for which premium was paid,
6. The last day of the pay period in which your employment ends unless you are disabled on or before the date you cease to be an employee and would otherwise be entitled to benefits for that disability. In that situation, benefits will be payable as though coverage had not terminated. Benefits under this extension will be payable only if the disability continues without interruption.
7. The date you are determined to be no longer disabled;
8. The end of the plan's maximum benefit duration period including any partial benefit payment periods.

How will you be notified about the decision regarding your disability application?

The claims administrator will advise you of a decision within four business days of receipt of your complete claim information for disability benefits. In the event your claim is denied, you will receive a written notice from the claims administrator, which will include:

1. The specific reason(s) for the denial, with reference to those plan provisions on which the denial is based;
2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and
3. An explanation of the steps to be taken if you or your authorized representative wishes to have the decision reviewed.

Note: If the claims administrator does not respond to your claim within the time limits set forth above, you should contact the claims administrator to request a status on your application.

What happens if you disagree with the claims administrator's decision on your claim?

The claims process is designed to ensure that your claim receives a thorough, fair and objective evaluation. In addition, numerous safeguards are in place throughout the process to ensure the integrity of the decisions that result from the administrator's evaluation. If benefits are determined as not payable either in whole or in part, you may appeal the decision by requesting a separate, impartial review from the claims administrator.

You or your authorized representative may appeal a denied claim within 60 calendar days after you receive the claims administrator's notice of denial. You have the right to:

1. Submit a written request for review to the claims administrator at:
   Sedgwick, CMS
   Attn: Claims Manager
   P.O. Box 9830
   Calabasas, CA 91372-0830
2. Review pertinent documents; and
3. Submit issues, comments and additional supporting documentation, in writing, to the claims administrator.

The claims administrator will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review will be made no later than 60 calendar days following the claims administrator's receipt of your written request for review, unless an extension is required due to special circumstances. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision will be made no later than 120 calendar days following receipt of your request for review.

The decision of the claims administrator is the final decision. The final decision on review will be furnished in writing to you and will include the reasons for the decision with reference to those plan provisions upon which the final decision is based.

If this does not satisfactorily resolve your claim, you should send a letter to the Sedgwick Director of Claims, P.O. Box 9830, Calabasas, CA 91372 within 20 calendar days of the receipt of the appeal denial. Your written appeal must include your statement of the general nature of the appeal; a copy of the denial letter; a statement of the factual circumstances giving rise to the appeal, a summary of the action already taken prior to filing the appeal and a statement as to the remedy you seek to resolve the appeal.

How do you resolve a service issue with the claims administrator?

If you are having a service issue with the claims administrator that you are unable to resolve by contacting the administrator, you may file a formal complaint through the Employee Benefits Division. Refer to the 'Plan Contact Information' section of this booklet for contact information.

Employee Benefits will ask that you put your complaint in writing. The Benefits Analyst will work with the administrator to resolve your service issue.

PREMIUM COSTS

Short-Term Disability (STD) Plan

100% Paid by Employee
$2,000 weekly maximum benefit

Short-Term Disability Premium Calculation Example

	Multiplier
40%	0.2677%
50%	0.3785%
60%	0.5908%

Annual Base Salary: $25,000	40% Option	50% Option	60% Option
Multiplier	0.002677	0.003785	0.005908
Annual Premium	$66.93	$94.63	$147.70
Deductions Per Year	24	24	24
Per Pay Period Premium (Per Pay Period Salary x Per Pay Period Multiplier)	$2.79	$3.94	$6.15

TERMS AND DEFINITIONS

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows.

Active Employment means you must currently be working:

- For your employer in regular status and paid regular earnings,
- At least the minimum number of hours to be eligible for coverage, and
- At your employer's usual place of business or a location to which your employer's business requires you to travel.

Note: Employees working under specific contracts may or may not be eligible for certain benefits based on the terms of their contract. Each appointing authority, in conjunction with the Compensation Division, determines if contract employees are benefits-eligible.

Complications of Pregnancy refers to that part of the pregnancy during which abnormal conditions or concurrent disease significantly affects the pregnancy's usual medical management. A complication may exist 1) during the pregnancy, 2) during the delivery or 3) after the delivery. Complications of pregnancy do not include an elective cesarean section.

Disability and **Disabled** mean that because of illness or injury you cannot perform each of the essential functions of your regular occupation and you are not working in any occupation. Furthermore, you are not considered disabled or under a disability unless you are under the regular care and medical treatment of a licensed physician or mental health professional who is practicing within the scope of his/her license or certification during the entire period of disability.

Disability Benefits means money that is paid as a weekly benefit when your claim has been approved.

Elimination Period means 14 consecutive calendar days from the date of onset of your disability during which time no STD benefits are payable.

Employer means Maricopa County and includes any department, division, subsidiary or affiliated company named in the plan.

Gross Weekly Benefit means the disability benefit amount before any reduction or offset for other income benefits and earnings.

Hospitalization means a registered bed patient in a Hospital upon the recommendation of a physician for at least a twenty-four (24) hour period of time, or any part thereof for which the employee is charged a full day's rate for room and board.

Illness means sickness, disease or other medical conditions including pregnancy or mental health conditions. The disability resulting from the illness must begin while you are covered under the plan.

Injury means bodily injury resulting directly from an accident and independently of all other causes. The disability resulting from the injury must begin while you are covered under the plan.

Maximum Benefit Duration Period means benefits will continue up to a maximum of 26 weeks beginning with your date of disability, which includes the benefit elimination period and any partial disability payment periods or intermittent periods of work where you do not return to work for more than 30 consecutive days at 100% of the job's regular hours.

Medical Treatment means that you have consulted, or received the advice of — including advice given during a routine examination — a licensed medical or dental practitioner or mental health professional. It also includes situations in which you have received medical, dental or mental health care, treatment or services, including taking drugs, medication, insulin or similar substances.

Mental Health Professional means a person (other than you, your spouse, child, brother, sister or your parent or the parent of your spouse) who is operating within the scope of his/her license and is a:
Licensed psychiatrist;
Licensed clinical psychologist, or
Licensed masters level mental health clinician/therapist, such as a social worker or counselor.

Net Weekly Benefit means the disability benefit amount after any reduction or offset for other income benefits and earnings.

Partial Disability and **Partially Disabled** mean that because of illness or injury you are unable to perform all the essential functions of your regular occupation on a full-time basis, and you are performing at least one of the essential functions of your regular occupation or another occupation on a part-time or full-time basis.

Physician means a person (other than you, your spouse, child, brother, sister or parent, or parent of your spouse) who is:

- Operating within the scope of his/her medical license; and is either
- Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- Has a doctoral degree in psychology (PhD or Psy.D) and whose primary practice is treating patients; or who is legally qualified as a medical practitioner according to the laws and regulations of the governing jurisdiction.

Regular Care means you personally visit a physician or mental health professional as frequently as is medically required according to generally accepted medical standards to effectively manage and treat your disabling condition(s); and you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards for your disabling condition(s) from a physician or mental health professional whose specialty or experience is the most appropriate for your disabling condition(s).

Regular Occupation means the occupation and job tasks as defined under the essential job functions section of the Maricopa County personnel job requisition in place at the time your disability began.

You and **Your** means the employee.

Weekly Salary means the amount of regular weekly salary or wages (excluding Special Work Assignment pay and including Management Professional Assignment pay) paid by your employer as of the date of your disability. Weekly salary is calculated by dividing annual salary by 52 weeks.

PLAN CONTACT INFORMATION

Name of the plan

Maricopa County Short-Term Disability Plan
Group Number 435000

Name and address of employer/payroll coordinator

Maricopa County
301 W. Jefferson St., Suite 3200
Phoenix, Arizona 85003

Who pays for the plan?

Participating employees pay the cost of this plan.

Plan sponsor/plan administrator

Maricopa County
Employee Benefits Division
301 W. Jefferson St,, Suite 3200
Phoenix, AZ 85003

Agent for service of legal process

See Plan administrator section above.

Claims administrator

Sedgwick, CMS P.O.
Box 9830
Calabasas, CA 91372-0830

Customer service telephone number: (800) 599-7797
Fax number: (818) 591-7664

Employee Benefits

Maricopa County
Employee Benefits Division
301 W. Jefferson St., Ste. 3200
Phoenix, AZ 85003

Phone: (602) 506-1010
Fax: (602) 506-2354

BenefitsService@mail.maricopa.gov

www.maricopa.gov/benefits