

SERIAL 11002 RFP SHORT TERM DISABILITY ADMINISTRATOR

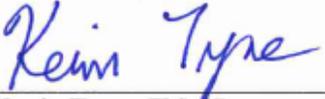
DATE OF LAST REVISION: November 02, 2016 CONTRACT END DATE: December 31, 2021

CONTRACT PERIOD THROUGH DECEMBER 31, ~~2016~~ 2021

TO: All Departments
FROM: **Office of Procurement Services**
SUBJECT: Contract for **SHORT TERM DISABILITY ADMINISTRATOR**

Attached to this letter is published an effective purchasing contract for products and/or services to be supplied to Maricopa County activities as awarded by Maricopa County on **November 16, 2011(Eff. 01/01/12)**.

All purchases of products and/or services listed on the attached pages of this letter are to be obtained from the vendor holding the contract. Individuals are responsible to the vendor for purchases made outside of contracts. The contract period is indicated above.



Kevin Tyne, Chief Procurement Officer
Office of Procurement Services

SD/mm
Attach

Copy to: **Office of Procurement Services**
Chris Bradley, Department of Business Strategies and Health Care Programs
Meg Blankenship, Department of Business Strategies and Health Care Programs

(Please remove Serial 04007-S from your contract notebooks)



This Contract is entered into this 16th day of November, 2011 by and between Maricopa County (“County”), a political subdivision of the State of Arizona, and Sedgwick Claims Management Services, Inc., an Illinois corporation (“Contractor”) for the purchase of Employee Short Term Disability Administrative Services.

1.0 CONTRACT TERM:

- 1.1 This Contract is for a term of Five (5) years, beginning on the 1st day of January, 2012 and ending the 31st day of December, ~~2016~~ 2021.
- 1.2 The County may, at its option and with the agreement of the Contractor, renew the term of this Contract for additional terms up to a maximum of Five (5) years, (or at the County’s sole discretion, extend the contract on a month-to-month bases for a maximum of six (6) months after expiration). The County shall notify the Contractor in writing of its intent to extend the Contract term at least thirty (30) calendar days prior to the expiration of the original contract term, or any additional term thereafter.

2.0 FEE ADJUSTMENTS:

Any request for a fee adjustments must be submitted sixty (60) days prior to the current Contract expiration date. Requests for adjustment in cost of labor and/or materials must be supported by appropriate documentation. If County agrees to the adjusted fee, County shall issue written approval of the change. The reasonableness of the request will be determined by comparing the request with the (Consumer Price Index) or by performing a market survey. In no case can renewal fees exceed the Cap fees in Exhibit A

3.0 AVAILABILITY OF FUNDS:

- 3.1 The provisions of this Contract relating to payment for services shall become effective when funds assigned for the purpose of compensating the Contractor as herein provided are actually available to County for disbursement. The County shall be the sole judge and authority in determining the availability of funds under this Contract. County shall keep the Contractor fully informed as to the availability of funds.
- 3.2 If any action is taken by any state agency, Federal department or any other agency or instrumentality to suspend, decrease, or terminate its fiscal obligations under, or in connection with, this Contract, County may amend, suspend, decrease, or terminate its obligations under, or in connection with, this Contract. In the event of termination, County shall be liable for payment only for services rendered prior to the effective date of the termination, provided that such services are performed in accordance with the provisions of this Contract. County shall give written notice of the effective date of any suspension, amendment, or termination under this Section, at least ten (10) days in advance. Contractor’s obligations under this Contract are suspended during any period of underfunding in which Contractor’s fees are not paid or any required loss funding is not made available.

4.0 DUTIES:

- 4.1 The Contractor shall perform all duties stated in Exhibit “B”, or as otherwise directed in writing by the Procurement Officer.

5.0 TERMS and CONDITIONS:

5.1 INDEMNIFICATION

- 5.1.1 To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless County, its agents, representatives, officers, directors, officials, and employees from and against all claims, damages, losses and expenses, including, but not limited to, attorney fees, court costs, expert witness fees, and the cost of appellate proceedings, relating to, arising out of, or alleged to have resulted from the negligent acts, errors, omissions, mistakes or malfeasance by the Contractor relating to the performance of this Contract. Contractor's duty to defend, indemnify and hold harmless County, its agents, representatives, officers, directors, officials, and employees shall arise in connection with any claim, damage, loss or expense that is caused by any negligent acts, errors, omissions or mistakes in the performance of this Contract by the Contractor, as well as any person or entity for whose acts, errors, omissions, mistakes or malfeasance Contractor may be legally liable.
- 5.1.2 The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.
- 5.1.3 The scope of this indemnification does not extend to the sole negligence of County.

5.2 INSURANCE REQUIREMENTS:

- 5.2.1 **Contractor, at Contractor's own expense, shall purchase and maintain the herein stipulated minimum insurance from a company or companies duly licensed by the State of Arizona and possessing a current A.M. Best, Inc. rating of B++. In lieu of State of Arizona licensing, the stipulated insurance may be purchased from a company or companies, which are authorized to do business in the State of Arizona, provided that said insurance companies meet the approval of County. The form of any insurance policies and forms must be acceptable to County.**
- 5.2.2 All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted. Failure to do so may, at the sole discretion of County, constitute a material breach of this Contract.
- 5.2.3 Contractor's insurance shall be primary insurance as respects County, and any insurance or self-insurance maintained by County shall not contribute to it.
- 5.2.4 Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect the County's right to the scope and intent of the INDEMNITY, including defense, pursuant to paragraph 5.1.1 of this Contract.
- 5.2.5 The insurance policies may provide coverage that contains deductibles or self-insured retentions. Such deductible and/or self-insured retentions shall not be applicable with respect to the coverage provided to County under such policies. Contractor shall be solely responsible for the deductible and/or self-insured retention.
- 5.2.6 County reserves the right to request and to receive, within 10 working days, certified copies of any or all of the herein required insurance certificates. County shall not be obligated to review policies and/or endorsements or to advise Contractor of any deficiencies in such policies and endorsements, and such receipt shall not relieve Contractor from, or be deemed a waiver of County's right to insist on strict fulfillment of Contractor's obligations under this Contract.

5.2.7 The insurance policies required by this Contract, except Workers' Compensation, and Errors and Omissions, shall name County, its agents, representatives, officers, directors, officials and employees as Additional Insureds.

5.2.8 The policies required hereunder, except Workers' Compensation, and Errors and Omissions, shall contain a waiver of transfer of rights of recovery (subrogation) against County, its agents, representatives, officers, directors, officials and employees for any claims arising out of Contractor's work or service.

5.2.9 Commercial General Liability.

Commercial General Liability insurance and, if necessary, Commercial Umbrella insurance with a limit of not less than \$2,000,000 for each occurrence, \$4,000,000 Products/Completed Operations Aggregate, and \$4,000,000 General Aggregate Limit. The policy shall include coverage for premises liability, bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage, and shall not contain any provisions which would serve to limit third party action over claims. There shall be no endorsement or modifications of the CGL limiting the scope of coverage for liability arising from explosion, collapse, or underground property damage.

5.2.10 Automobile Liability.

Commercial/Business Automobile Liability insurance and, if necessary, Commercial Umbrella insurance with a combined single limit for bodily injury and property damage of not less than \$1,000,000 each occurrence with respect to any of the Contractor's owned, hired, and non-owned vehicles assigned to or used in performance of the Contractor's work or services or use or maintenance of the Premises under this Contract.

5.2.11 Workers' Compensation.

5.2.11.1 Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services under this Contract; and Employer's Liability insurance of not less than \$1,000,000 for each accident, \$1,000,000 disease for each employee, and \$1,000,000 disease policy limit.

5.2.11.2 Contractor waives all rights against County and its agents, officers, directors and employees for recovery of damages to the extent these damages are covered by the Workers' Compensation and Employer's Liability or commercial umbrella liability insurance obtained by Contractor pursuant to this Contract.

5.2.12 Errors and Omissions Insurance.

Errors and Omissions insurance and, if necessary, Commercial Umbrella insurance, which will insure and provide coverage for errors or omissions of the Contractor, with limits of no less than \$1,000,000 for each claim.

5.2.13 Certificates of Insurance.

5.2.13.1 Prior to commencing work or services under this Contract, Contractor shall have insurance certificates issued and furnished to the County by its brokers as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall identify this contract number and title.

5.2.13.2 Prior to commencing work or services under this Contract, Contractor shall have insurance in effect as required by the Contract in the form provided by the County, issued by Contractor's insurer(s) as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall be made available to the County with ten (10) business days of request. BY SIGNING THE AGREEMENT PAGE THE CONTRACTOR AGREES TO THIS REQUIREMENT AND FAILURE TO MEET THIS REQUIREMENT WILL RESULT IN CANCELLATION OF CONTRACT.

5.2.13.3 In the event any insurance policy (ies) required by this Contract is (are) written on a "claims made" basis, coverage shall extend for two (2) years past completion and acceptance of Contractor's work or services and as evidenced by annual Certificates of Insurance.

5.2.13.4 If a policy does expire during the life of the Contract, a renewal certificate must be sent to County fifteen (15) days prior to the expiration date or as soon as Sedgwick receives the renewal certificate.

5.2.14 Cancellation and Expiration Notice.

Insurance required herein shall not be permitted to expire, be canceled, or materially changed without thirty (30) days prior written notice to the County.

5.3 WARRANTY OF SERVICES:

5.3.1 The Contractor warrants that all services provided hereunder will conform to the requirements of the Contract, including all descriptions, specifications and attachments made a part of this Contract. County's acceptance of services or goods provided by the Contractor shall not relieve the Contractor from its obligations under this warranty.

5.3.2 In addition to its other remedies, County may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all the provisions of this Contract in the manner and to the same extent as services originally furnished hereunder.

5.4 INSPECTION OF SERVICES:

5.4.1 The Contractor shall provide and maintain an inspection system acceptable to County covering the services under this Contract. Complete records of all inspection work performed by the Contractor shall be maintained and made available to County during contract performance and for as long afterwards as the Contract requires.

5.4.2 County has the right to inspect and test all services called for by the Contract, to the extent practicable at all times and places during the term of the Contract. County shall perform inspections and tests in a manner that will not unduly delay the work.

5.4.3 If any of the services do not conform with Contract requirements, County may require the Contractor to perform the services again in conformity with Contract requirements, at no increase in Contract amount. When the defects in services cannot be corrected by re-performance, County may:

5.4.3.1 Require the Contractor to take necessary action to ensure that future performance conforms to Contract requirements; and

5.4.3.2 Reduce the Contract price to reflect the reduced value of the services performed.

5.4.4 If the Contractor fails to promptly perform the services again or to take the necessary action to ensure future performance in conformity with Contract requirements, County may:

5.4.4.1 By Contract or otherwise, perform the services and charge to the Contractor any cost incurred by County that is directly related to the performance of such service; or

5.4.4.2 Terminate the Contract for default.

5.5 NOTICES:

All notices given pursuant to the terms of this Contract shall be addressed to:

For County:
Maricopa County
Office of Procurement Services
Attn: Director of Purchasing
320 West Lincoln Street
Phoenix, Arizona 85003-2494

For Contractor:
Sedgwick Claims Management Services, Inc.
Attn: Legal Department
1100 Ridgeway Loop Rd.
Memphis, TN 38120

5.6 REQUIREMENTS CONTRACT:

5.6.1 Contractor signifies its understanding and agreement by signing this document that this Contract is a requirements contract. This Contract does not guarantee any purchases will be made (minimum or maximum). Orders will only be placed when County identifies a need and issues a purchase order or a written notice to proceed.

5.6.2 County reserves the right to cancel purchase orders or notice to proceed within a reasonable period of time after issuance. Should a purchase order or notice to proceed be canceled, the County agrees to reimburse the Contractor for actual and documented costs incurred by the Contractor. The County will not reimburse the Contractor for any avoidable costs incurred after receipt of cancellation, or for lost profits, or shipment of product or performance of services prior to issuance of a purchase order or notice to proceed.

5.7 TERMINATION FOR CONVENIENCE:

The County reserves the right to terminate the Contract, in whole or in part at any time, when in the best interests of the County without penalty or recourse. Upon receipt of the written notice, the Contractor shall immediately stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the County. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the County upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

5.8 TERMINATION FOR DEFAULT:

5.8.1 In addition to the rights reserved in the Contract, the County may terminate the Contract, in whole or in part, due to the failure of the Contractor to comply with any material term or condition of the Contract, to acquire and maintain all required insurance policies,

bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

5.8.2 Upon termination under this paragraph, all goods, materials, documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the County on demand.

5.8.3 The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

5.8.4 The Contractor may terminate the Contract, for to the failure of the County to comply with any material term or condition of the Contract, including but not limited to the failure to timely replenish the STD benefit checking account, or for the failure to timely and/or fully pay the Contractor the per claim fees or expenses. Prior to termination, the Contractor shall give the County thirty (30) days notice of the Contractor's intent to terminate the Contract, to include notice of the basis of the default, if at the end of the thirty (30) days notice period the County has not acted to cure the default, the Contract shall be terminated.

5.9 STATUTORY RIGHT OF CANCELLATION FOR CONFLICT OF INTEREST:

Notice is given that pursuant to A.R.S. §38-511 the County may cancel this Contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or consultant to any other party of the Contract with respect to the subject matter of the Contract. Additionally, pursuant to A.R.S §38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the Contract

5.10 OFFSET FOR DAMAGES;

In addition to all other remedies at law or equity, either party may offset from any money due to the other party any amounts that party owes to the other party for damages resulting from breach or deficiencies in performance under this contract.

5.11 ADDITIONS/DELETIONS OF SERVICE:

The County reserves the right, upon written agreement with Contractor, to add and/or delete products and/or services provided under this Contract. If a requirement is deleted, payment to the Contractor will be reduced proportionately to the amount of service reduced in accordance with the proposal price. If additional services and/or products are required from this Contract, prices for such additions will be negotiated between the Contractor and the County.

5.12 RELATIONSHIPS:

In the performance of the services described herein, the Contractor shall act solely as an independent contractor, and nothing herein or implied herein shall at any time be construed as to create the relationship of employer and employee, partnership, or joint venture between the District and the Contractor.

5.13 SUBCONTRACTING:

The Contractor may not assign this Contract or subcontract to another party for performance of the terms and conditions hereof without the written consent of the County. All correspondence authorizing subcontracting must reference the Proposal Serial Number and identify the job project.

5.14 AMENDMENTS:

All amendments to this Contract shall be in writing and approved/signed by both parties. Maricopa County **Office of Procurement Services** shall be responsible for approving all amendments for Maricopa County.

5.15 ACCESS TO AND RETENTION OF RECORDS FOR THE PURPOSE OF AUDIT AND/OR OTHER REVIEW:

5.15.1 In accordance with section MCI 367 of the Maricopa County Procurement Code the Contractor agrees to retain all books, records, accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract for six (6) years after final payment or until after the resolution of any audit questions which could be more than six (6) years, whichever is latest. The County, Federal or State auditors and any other persons duly authorized by the Department shall have full access to, and the right to examine, copy and make use of, any and all said materials.

5.15.2 If the Contractor's books, records, accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract are not sufficient to support and document that requested services were provided, the Contractor shall reimburse Maricopa County for the services not so adequately supported and documented.

5.16 AUDIT DISALLOWANCES:

If at any time, County determines that a cost for which payment has been made is a disallowed cost, such as overpayment, County shall notify the Contractor in writing of the disallowance. County shall also state the means of correction, which may be but shall not be limited to, if undisputed by Contractor, adjustment of any future claim submitted by the Contractor by the amount of the disallowance, or to require repayment of the disallowed amount by the Contractor.

5.17 ALTERNATIVE DISPUTE RESOLUTION:

5.17.1 After the exhaustion of the administrative remedies provided in the Maricopa County Procurement Code, any contract dispute in this matter is subject to compulsory arbitration. Provided the parties participate in the arbitration in good faith, such arbitration is not binding and the parties are entitled to pursue the matter in state or federal court sitting in Maricopa County for a de novo determination on the law and facts. If the parties cannot agree on an arbitrator, each party will designate an arbitrator and those two arbitrators will agree on a third arbitrator. The three arbitrators will then serve as a panel to consider the arbitration. The parties will be equally responsible for the compensation for the arbitrator(s). The hearing, evidence, and procedure will be in accordance with Rule 74 of the Arizona Rules of Civil Procedure. Within ten (10) days of the completion of the hearing the arbitrator(s) shall:

5.17.1.1 Render a decision;

5.17.1.2 Notify the parties that the exhibits are available for retrieval; and

5.17.1.3 Notify the parties of the decision in writing (a letter to the parties or their counsel shall suffice).

5.17.2 Within ten (10) days of the notice of decision, either party may submit to the arbitrator(s) a proposed form of award or other final disposition, including any form of award for attorneys' fees and costs. Within five (5) days of receipt of the foregoing, the opposing party may file objections. Within ten (10) days of receipt of any objections, the arbitrator(s) shall pass upon the objections and prepare a signed award or other final disposition and mail copies to all parties or their counsel.

5.17.3 Any party which has appeared and participated in good faith in the arbitration proceedings may appeal from the award or other final disposition by filing an action in the state or federal court sitting in Maricopa County within twenty (20) days after date of

the award or other final disposition. Unless such action is dismissed for failure to prosecute, such action will make the award or other final disposition of the arbitrator(s) a nullity.

5.18 SEVERABILITY:

The invalidity, in whole or in part, of any provision of this Contract shall not void or affect the validity of any other provision of this Contract.

5.19 RIGHTS IN DATA:

The County shall own have the use of all data and reports (generated exclusively for the County) resulting from this Contract without additional cost or other restriction except as provided by law. Each party shall supply to the other party, upon request, any available information that is relevant to this Contract and to the performance hereunder.

5.20 INTEGRATION:

This Contract represents the entire and integrated agreement between the parties and supersedes all prior negotiations, proposals, communications, understandings, representations, or agreements, whether oral or written, express or implied.

5.21 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §41-4401 AND FEDERAL IMMIGRATION LAWS AND REGULATIONS:

5.21.1 By entering into the Contract, the Contractor warrants compliance with the Immigration and Nationality Act (INA using e-verify) and all other federal immigration laws and regulations related to the immigration status of its employees and A.R.S. §23-214(A). The contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract. The Contractor and its subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the Immigration Reform and Control Act of 1986, as amended from time to time, for all employees performing work under the Contract and verify employee compliance using the E-verify system and shall keep a record of the verification for the duration of the employee's employment or at least three years, whichever is longer. I-9 forms are available for download at USCIS.GOV.

5.21.2 The County retains the legal right to inspect contractor and subcontractor employee documents performing work under this Contract to verify compliance with paragraph 5.21.1 of this Section. Contractor and subcontractor shall be given reasonable notice of the County's intent to inspect and shall make the documents available at the time and date specified. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County will consider this a material breach of the contract and may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.

~~5.22 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §§35-391.06 AND 35-393.06 BUSINESS RELATIONS WITH SUDAN AND IRAN:~~

~~5.22.1 The Respondent shall procure all permits, insurance, licenses and pay the charges and fees necessary and incidental to the lawful conduct of his/her business, and as necessary complete any required certification requirements, required by any and all governmental or non-governmental entities as mandated to maintain compliance with and in good standing for all permits and/or licenses. The Respondent shall keep fully informed of existing and future trade or industry requirements, Federal, State and Local laws, ordinances, and regulations which in any manner affect the fulfillment of a Contract and~~

~~shall comply with the same. Contractor shall immediately notify both Office of Procurement Services and the using agency of any and all changes concerning permits, insurance or licenses.~~

~~5.22.2 The County may request verification of compliance for any contractor or subcontractor performing work under the Contract. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.~~

5.23 CONTRACTOR LICENSE REQUIREMENT:

5.23.1 The Respondent shall procure all permits, insurance, licenses and pay the charges and fees necessary and incidental to the lawful conduct of his/her business, and as necessary complete any required certification requirements, required by any and all governmental or non-governmental entities as mandated to maintain compliance with and in good standing for all permits and/or licenses. The Respondent shall keep fully informed of existing and future trade or industry requirements, Federal, State and Local laws, ordinances, and regulations which in any manner affect the fulfillment of a Contract and shall comply with the same. Contractor shall immediately notify both **Office of Procurement Services** and the using agency of any and all changes concerning permits, insurance or licenses.

5.23.2 Respondents furnishing finished products, materials or articles of merchandise that will require installation or attachment as part of the Contract, shall possess any licenses required. A Respondent is not relieved of its obligation to possess the required licenses by subcontracting of the labor portion of the Contract. Respondents are advised to contact the Arizona Registrar of Contractors, Chief of Licensing, at (602) 542-1525 to ascertain licensing requirements for a particular contract. Respondents shall identify which license(s), if any, the Registrar of Contractors requires for performance of the Contract.

5.24 CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

5.24.1 The undersigned (authorized official signing for the Contractor) certifies to the best of his or her knowledge and belief, that the Contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

5.24.1.1 are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

5.24.1.2 have not within 3-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

5.24.1.3 are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

5.24.1.4 have not within a 3-year period preceding this Contract had one or more public transaction (Federal, State or local) terminated for cause of default.

5.24.2 Should the Contractor not be able to provide this certification, an explanation as to why should be attached to the Contract.

5.24.3 The Contractor agrees to include, without modification, this clause in all lower tier covered transactions (i.e. transactions with subcontractors) and in all solicitations for lower tier covered transactions related to this Contract.

5.25 GOVERNING LAW:

This Contract shall be governed by the laws of the state of Arizona. Venue for any actions or lawsuits involving this Contract will be in Maricopa County Superior Court or in the United States District Court for the District of Arizona, sitting in Phoenix, Arizona

5.26 ORDER OF PRECEDENCE:

In the event of a conflict in the provisions of this Contract and Contractor's license agreement, if applicable, the terms of this Contract shall prevail.

5.27 INFLUENCE

As prescribed in MC1-1202 of the Maricopa County Procurement Code, any effort to influence an employee or agent to breach the Maricopa County Ethical Code of Conduct or any ethical conduct may be grounds for Disbarment or Suspension under MC1-902.

An attempt to influence includes, but is not limited to:

5.27.1 **A Person offering or providing a gratuity, gift, tip, present, donation, money, entertainment or educational passes or tickets, or any type valuable contribution or subsidy,**

5.27.2 **That is offered or given with the intent to influence a decision, obtain a contract, garner favorable treatment, or gain favorable consideration of any kind.**

If a Person attempts to influence any employee or agent of Maricopa County, the Chief Procurement Officer, or his designee, reserves the right to seek any remedy provided by the Maricopa County Procurement Code, any remedy in equity or in the law, or any remedy provided by this contract.

5.28 ISRAEL BOYCOTT:

By signing this Contract, the Contractor certifies that they are in compliance with Article 9, Arizona Revised Statutes Section 35-393 et seq.

5.29 INCORPORATION OF DOCUMENTS:

The following are to be attached to and made part of this Contract:

5.29.1 Exhibit A, Pricing;

5.29.2 Exhibit B, Scope of Work;

5.29.3 Exhibit B-1 (Vendor Response Questionnaire)

5.29.4 Exhibit B-2 (Claims Processing System Response)

IN WITNESS WHEREOF, this Contract is executed on the date set forth above.

SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.



AUTHORIZED SIGNATURE

STEPHEN R. HURLEY, VICE PRESIDENT

PRINTED NAME AND TITLE

1100 RIDGEWAY LOOP ROAD, MEMPHIS, TN 38120

ADDRESS

DATE

MARICOPA COUNTY

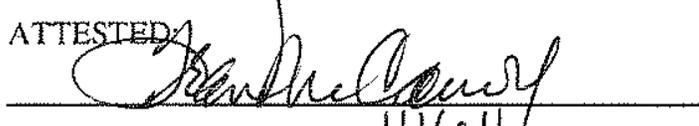


DEC 02 2011

CHAIRMAN, BOARD OF SUPERVISORS

DATE

ATTESTED



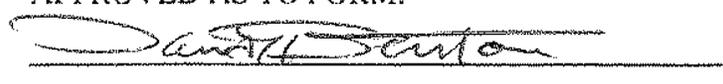
DEC 02 2011

CLERK OF THE BOARD

111611

DATE

APPROVED AS TO FORM:



Dec 1 2011

LEGAL COUNSEL

DATE

EXHIBIT A
PRICING

SERIAL 11002-RFP

PRICING SHEET NIGP CODE 95861

BIDDER NAME: Segwick CMS

F.I.D./VENDOR #: W00008582X

BIDDER ADDRESS: 1100 Ridgeway Loop Road, Memphis, TN 38120

P.O. ADDRESS: PO Box 5076, Memphis, TN 38101

BIDDER PHONE #: 818-222-3026

BIDDER FAX #: 800-495-39303

COMPANY WEB SITE: www.sedgwickcms.com/calabasas

COMPANY CONTACT (REP): Jason Rubinstein

E-MAIL ADDRESS (REP): jason.rubinstein@sedgwickcms.com

PAYMENT TERMS: NET 30 X

1.0 PRICING:					
1.1	Short Term Disability Administration: Rates				
	Rate Guarantee			Rate Guarantee	
	Year 1 (1/1/2012 - 12/31/2012)	Year 2 (1/1/2013 - 12/31/2013)	Year 3 (1/1/2014 - 12/31/2014)	Year 4 (1/1/2015 - 12/31/2015)	Year 5 (1/1/2016 - 12/31/2016)
<i>PRICING</i>					
<u>ASO</u>					
1.1.1 Monthly Retainer Fee	\$515	\$515	\$530	\$530	\$545
1.1.2 Initial Adjudication Per Claim (APPLIES TO DENIALS ONLY)	\$176	\$176	\$176	\$176	\$183
1.1.3-Charge Per Approved Claim (INCLUDES ADJUDICATION AND ALL PROCESSING FEES)	\$325	\$325	\$333	\$333	\$341
1.1.4 Charge for drafting benefit document/booklet	\$0	\$0	\$0	\$0	\$0
1.1.5 Charge for printing benefit document/booklet (assume initial order of 15,000 copies)	\$4,425	\$4,425	\$4,602	\$4,602	\$4,786

SERIAL 11002-RFP

	Year 6 (1/1/2017 - 12/31/201)	Year 7 (1/1/2018 - 12/31/2018)	Year 8 (1/1/2019 - 12/31/2019)	Year 9 (1/1/2020 - 12/31/2020)	Year 10 (1/1/2021 - 12/31/2021)
ASO (each % reflects an additional increase over the prior year fee)					
1.1.1 Monthly Retainer Fee	\$572 5%	\$599 5%	\$628 5%	\$659 5%	\$691 5%
1.1.2 Initial Adjudication Per Claim (APPLIES TO DENIALS ONLY)	\$192 5%	\$201 5%	\$211 5%	\$211 5%	\$231 5%
1.1.3-Charge Per Approved Claim (INCLUDES ADJUDICATION AND ALL PROCESSING FEES)	\$358 5%	\$375 5%	\$393 5%	\$412 5%	\$432 5%
1.1.4 Charge for drafting benefit document/booklet	0%	0%	0%	0%	0%
1.1.5 Charge for printing benefit document/booklet (assume initial order of 15,000 copies)	\$5,020 5%	\$5,265 5%	\$5,522 5%	\$5,791 5%	\$6,074 5%

Renewal Terms:	During the renewal guarantee period, Sedgwick CMS reserves the right to renegotiate rates if: (1) The number of participating lives or claim volume changes by more than 10% by line of coverage, positive or negative, to be reviewed on a quarterly basis, (2) There is a material change in the plan of benefits initiated by Maricopa County or by legislative or regulatory action.
Items included in quoted fees:	* Intake and customer service * Eligibility & advice to pay interfaces with weekly updates
Items not included in quoted fees:	Additional interfaces to DCMS requiring custom programming (i.e., HRIS/Job Row Update, Custom Employee Time, Organizational Hierarchy Feed,) Third party pass through expenses SPD assistance Sedgwick CMS does not contemplate any revisions to the DCMS system currently used to administer the Maricopa program. Should we implement technology, system or hardware changes during the life of the multi-year contact, we will partner with Maricopa County to ensure that the execution of such changes is successful and results in a positive impact to the program
Pass through expenses:	The claim fees agreed to shall include all costs incurred by Sedgwick CMS in handling claims submitted, except those costs performed by third party vendors and referred to as "pass through expenses." These expenses will be billed to Maricopa County when incurred. Common Disability Pass through Expenses: * IME/FCE – average cost \$700 but actual costs vary by type of service * Vocational evaluations – average cost \$700 * SIU services * Collection agency services – based on vendor schedule * Physician advisory services - average \$200/review * ADP check cutting services
Life of contract:	Sedgwick CMS will administer all claims received during the contract for the per claim fee. Claims open at contract termination will either be transferred to the new administrator or handled by Sedgwick CMS for an additional annual fee.
File storage:	The County is responsible for storage of claim files closed at the time that Sedgwick CMS begins claims administration.

EXHIBIT B
SCOPE OF WORK

1.0 INTENT:

It is the intent of this contract is to provide for a single contractor to administer, on an Administrative Services Only contract, the Short Term Disability Benefits plan for Maricopa County employees.

2.0 SCOPE OF WORK:

2.1 Program Outline

2.1.1 Eligibility

- All regular status active employees who meet benefit 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 Short-Term Disability (STD) coverage. Contract employees may be eligible for benefits based on the terms of their contract.
- Coverage Effective Date
- Coverage for new employees begins on the first calendar day of the month following their date of hire.
- All other coverage is elected during the annual Open Enrollment process and becomes effective at the beginning of the next plan year.
- Enrollment into the Short-Term Disability Plan is not allowed at the time of a qualified status change, except for a return from active duty military leave.

2.2 MANDATORY CONTRACTOR'S QUALIFICATIONS

Confirm your acceptance of each item. Explain non- or partial compliance.

- 2.2.1 The Contractor shall maintain eligibility by receiving eligibility data on a weekly basis via a HIPAA compliant file generated from the County's Benefit Administrator, ADP. Cost for eligibility data initial feed and maintenance shall be disclosed in the rate proposal.
Confirmed
- 2.2.2 Data received electronically from ADP shall be applied to the Contractor's enrollment/claims payment system and shall generate an exception report back to ADP. The Contractor shall work with ADP to resolve all data exceptions within 7 calendar days.
Confirmed
- 2.2.3 In an emergency enrollment situation, the Contractor shall do a haste enrollment at the direction of ADP.
Confirmed
- 2.2.4 Contractor must accept subscriber identification number (nine digits) as defined by the County. A subscriber identification number could be either: an employee identification number, social security number or an alternative identification number.
Confirm
- 2.2.5 Contractor shall maintain and update an electronic database in order to administer claim payments, maintain complete history, and report to the County.
Confirmed
- 2.2.6 Contractor shall maintain and update procedures and computer software needed to receive and process all benefit claims according to the Plan and all current and future regulations.
Confirmed

- 2.2.7 Contractor shall provide an annual SAS 70 type II audit report.
Confirmed
- 2.2.8 Contractor shall maintain a general ledger in accordance with the County's specifications reflecting deposits to and disbursements from the Plan's claims account(s), if an ASO contract is selected.
Confirmed
- 2.2.9 Contractor shall provide an online and a telephonic claims filing process.
Confirmed
- 2.2.10 Contractor shall assist the claimant in obtaining medical records if the claimant has not provided such records within 2 calendar days from the claims filing date.
Confirmed
- 2.2.11 Contractor shall electronically notify departmental contact persons to obtain required employer information related to a disability claim.
Confirmed
- 2.2.12 Contractor shall be able to perform/coordinate Independent Medical Exams (IMEs) when they are indicated or when requested by the County.
Confirmed
- 2.2.13 Contractor shall assess each claim and identify those anticipated to become long-term disability claims. When such claims are identified, the Contractor shall work with the Arizona State Retirement System's long-term disability carrier to transition the claimant from short-term to long-term disability with minimal payment disruption.
Confirmed
- 2.2.14 Contractor shall provide online or telephonic access to self-service capabilities where the participant can inquire about his/her claim through an IVR or secure Web site.
Confirmed
- 2.2.15 Contractor shall pay claims on a weekly basis.
Confirmed
- 2.2.16 Contractor shall have a process in place to recover any overpayments, regardless of their cause.
Confirmed
- 2.2.17 Contractor shall provide the County with online inquiry access via the Contractor's Web site where enrollment and claims payment information and standard reports can be viewed. The County prefers to be able to run ad hoc reports via the Contractor's Web site.
Confirmed
- 2.2.18 Contractor shall set up the account structure for eligibility and reporting as follows: Level 1: Paygroups: Exempt, Non-Exempt and No FLSA. Level 2 Employee Class: Contract Part-time benefits, Contract full-time benefits, Classified, Unclassified, Judicial Classified, Judicial Unclassified, Sworn Law Enforcement, Court Commissioner, Superior Court Judge, Elected Official, Appointed with Leave, and Appointed without Leave. Level 3: Active, Leave, Paid leave, and Suspended. Contractor shall conduct an annual Maricopa County specific customer service satisfaction survey and provide the County with results and an action plan to improve any areas of dissatisfaction.

Confirmed with exceptions - Sedgwick CMS can provide account structure reporting if the information is included in the Eligibility File.

- 2.2.19 Contractor shall provide customer service via a toll-free telephone number that is staffed with live customer service representatives from at least 8:00 a.m. to 6:00 p.m. MST to assist participants with questions regarding their claims. Contractor shall provide an interpreter service, as needed, to assist non-English speaking enrollees. Customer service representatives shall have the ability to view information regarding eligibility and claims, and be trained to explain claims denials, reason for pending claims status, and claims payment calculations.

Confirmed with exceptions - Claim denial explanations are provided by the Disability Specialist assigned to the employee's claim not by the customer service representatives.

- 2.2.20 Contractor shall have a continuous quality improvement program and provide a description of their quality improvement efforts on an annual basis.
Confirmed
- 2.2.21 Contractor shall provide a return to work program and provide program results on an annual basis.
Confirmed
- 2.2.22 Contractor shall work with the County's behavioral health contractor for enrollees filing a claim for a primary mental health diagnosis. The Contractor shall notify the behavioral health contractor who will conduct a disability assessment and ensure the enrollee is in treatment with an appropriate mental health provider.
Confirmed
- 2.2.23 Contractor shall provide (at no extra cost) fully trained staff to participate during the County's Open Enrollment presentations, New Employee Orientation (minimum of three hours per month), and County Departmental meetings, as needed.
Confirmed
- 2.2.24 Contractor shall handle first and second level claim appeals.
Confirmed
- 2.2.25 Contractor shall produce all collateral materials in both English and Spanish.
Confirmed
- 2.2.26 After the first quarter of program implementation (July 1 through September 30), Contractor shall conduct a self-audit based upon mutually agreed upon criteria for the purpose of assessing system set-up. The results from this audit shall be due by the following November 15.

Confirmed with exceptions - As Sedgwick CMS is the incumbent there will not be an implementation.

- 2.2.27 Contractor shall participate in joint operations meetings with other external vendors, and will share data according to mutually agreed upon guidelines and confidentiality agreements.
Confirmed
- 2.2.28 Contractor shall partner with other County external vendors to help achieve desired program outcomes.
Confirmed
- 2.2.29 Contractor shall correspond with the Employee Benefits Division on customer issues by using the County's Customer Relationship Management (CRM) system. Contractor shall agree to purchase at least one license to this system at the approximate cost of \$20 per month.
Confirmed

2.3 Implementation and Ongoing Requirements

2.3.1 To properly implement the Short-Term Disability plan, the successful Contractor will be required to provide a qualified implementation team and comprehensive project plan.

2.4 Reporting Requirements (minimum)

Contractor shall provide the following reports to the County in Excel or CSV format. All reports are due by the 15th calendar day following the reporting period and must be County-specific. Please include a sample of each report. If you cannot provide a report The County is requesting, indicate so and state whether you are willing to create it for the County at no extra cost. Reports, where applicable, shall be produced according to the 3-Level account structure as described in the Mandatory Qualifications section 2.2. If ad hoc reporting

2.4.1 Claim Reports

2.4.1.1 Claims Status Summary, including employee name, County Identification Number, date of disability, open/closed/pended status, amount paid, benefit amount, offsets, reserve, expected duration, and date and reason for benefit termination

- 2.4.1.2 Dollars Paid Quarterly Comparison
- 2.4.1.3 Claims Incidence Quarterly Comparison
- 2.4.1.4 Distribution of Claims by Age
- 2.4.1.5 Number of claims grouped by tenure with the County
- 2.4.1.6 Distribution of Claims by Diagnostic Category, including comparison to industry and book-of-business averages
- 2.4.1.7 Duration Comparison by Diagnostic Category, including comparison to industry and book-of-business averages
- 2.4.1.8 Top Ranking Diagnoses by Incidence and Cost
- 2.4.1.9 STD Repeater Report (number of claims and dollars paid, grouped by number of claims per claimant)
- 2.4.1.10 Quarterly claims turnaround time report, which shows the average time between disability date and claim report date
- 2.4.1.11 Number of appeals, reasons, and outcomes each quarter
- 2.4.1.12 Number of claims received by month
- 2.4.2 Financial Reports
 - 2.4.2.1 Monthly paid check listing
 - 2.4.2.2 Monthly outstanding checks listing
 - 2.4.2.3 Monthly fund transfers and amounts, and bank reconciliation
 - 2.4.2.4 Monthly claims payment and fees paid report
 - 2.4.2.5 Adjustments, including voids and stop pays
 - 2.4.2.6 Matrix of claims by month incurred and month paid

This Matrix is not currently provided. We will add this report without an additional charge.
- 2.4.3 Service Reports
 - 2.4.3.1 Results from internal audit procedures
 - 2.4.3.2 Average speed of answer by Customer Service Representatives
 - 2.4.3.3 Average abandonment rate of calls received by Customer Service Department
- 2.4.4 Contractor shall maintain and operate an electronic claims and customer service call tracking and call recording systems that maintains all information regarding:

All calls to the dedicated Maricopa intake/customer service phone number are tracked but they are not recorded.

 - 2.4.4.1 Customer service calls and all contacts made by a claimant

- 2.4.4.2 Dates and information about the nature of the contact
- 2.4.4.3 Claim specific information including approval, denial, and payment.

2.5 County Rights and Obligations

The County, upon awarding a contract, assumes responsibility for the following actions

- 2.5.1 Distribute announcement of new contractor, plan design, and administrative requirements.
- 2.5.2 Review and approve all communications materials to employees including, but not limited to, plan document, summary plan description, forms, booklets, newsletters, and letters prior to printing and distribution.
- 2.5.3 Approve all on-site visits by the Contractor's personnel to any County department or location prior to the scheduled visit.
- 2.5.4 The County will allow the Contractor to audit the County's records for valid business reasons to verify accounting of fee payments with proper notification.
- 2.5.5 Perform the enrollment function for the Short-term Disability benefit plan electronically via the ADP Benefit Administration system.
- 2.5.6 Issuing reimbursement for cleared checks on a weekly basis.

2.6 Administering the STD Plan:

- 2.6.1 In addition to the requirements above, the administrative services to be provided by the Contractor to the Plan shall include the following:
 - 2.6.1.1 Creating and maintaining claims files.
 - 2.6.1.2 Evaluating claims to determine if they have been properly filed and advising claimants in meeting the requirements for additional information.
 - 2.6.1.3 Determining disability.
 - 2.6.1.4 Computing the benefits due in accordance with the current benefit plan document
 - 2.6.1.5 Issuing drafts to the claimant.
 - 2.6.1.6 Discussing claims, where appropriate, with physicians and other providers of service.
 - 2.6.1.7 Applying claims control procedures necessary for the effective administration of the Plan.
 - 2.6.1.8 Reconciling issued and cleared checks, including prompt weekly reimbursement of any required funds in the event of an account deficit.
 - 2.6.1.9 Preparing a monthly numerical and alphabetical register of drafts issued. The register should include the check or draft number, employee name, claimant name, payee name, amount of check or draft, the date incurred and the date paid.
 - 2.6.1.10 Investigating claims that appear to be suspicious or fraudulent.

- 2.6.1.11 Preparing, printing, and distributing administrative forms required for the successful operation of the Plan.
- 2.6.2 Paying claims accurately and timely. Accuracy is defined as paying the correct benefit for the correct duration in 99% of claims. In the case of denials, 100% of claims must be denied for appropriate and documented reasons. A claim is paid timely when it is paid or denied within seven calendar days of receipt of all necessary information.
 - 2.6.2.1 Providing rehabilitation assistance at no charge to the employee.
 - 2.6.2.2 Notifying claimants of delayed claim payments that are caused by an error or omission in claim payment documentation.
 - 2.6.2.3 Establishing quality assurance standards and control mechanisms
 - 2.6.2.4 Printing checks or drafts and corresponding explanations of benefits.
 - 2.6.2.5 Responding within 2 business days following any inquiry from the County benefits personnel regarding the status or disposition of a claim.
 - 2.6.2.6 Preparing responses to participant appeals.
 - 2.6.2.7 Providing data required for government reporting.
- 2.7 Underwriting Requirements:
 - 2.7.1 Not-to-exceed renewal rate caps shall be due 360 days prior to the contract renewal dates for years six, seven, eight, nine and ten. Final rates shall be due 180 days prior to the contract renewal date.
 - 2.7.2 The County will self-administer the payment of fees. All fees will be paid based upon the County's enrollment counts.
 - 2.7.3 The County reserves the right to audit the contractor's claims processing, payment, and enrollment records with reasonable notice.
 - 2.7.4 The contractor acknowledges the County's right to select the auditors, and further agrees to cooperate fully with such auditors and waive all fees associated with providing access to the County's claim records, including use of the contractor's staff time to assist in the audit. The audits may include, but not be limited to:
 - 2.7.4.1 Determinations of any mathematical errors in computation.
 - 2.7.4.2 Determinations that only eligible insured's have had claims approved.
 - 2.7.4.3 Review of turnaround time in claim processing.

The audits may be conducted during the policy period and/or upon completion of the policy period and/or following submission of the final policy report by the contractor at the discretion of the County.

Additionally, the contractor may be requested to provide periodic eligibility lists or files to the County or its Benefits Administrator at no charge in order to reconcile participants' eligibility.

If, at any time, the County has a reasonable belief that it is being systematically overcharged or double-billed under the contract, or that any other significant accounting irregularities exist, the County may conduct or hire an agent to conduct an audit of the

Contractor's books and records with respect to this Contract. Such audit shall be undertaken at contractor's expense.

- 2.7.5 The County may correct legitimate administrative errors and is the final determinant of when such errors have occurred. The County shall be the final determinant for all eligibility issues.
- 2.7.6 In determining any person's rights to benefits under the Plan, contractor shall rely upon eligibility information furnished by the County.
- 2.7.7 The policy or contract's rate change date and anniversary will fall on January 1st. The County reserves the right to annually negotiate benefit modifications it considers in its best interest. Fees may be modified for such changes subject to mutual good faith negotiation on the value of such changes. By mutual agreement of the parties, the anniversary date of the contract may be changed to coincide with the County's fiscal year.
- 2.7.8 The County maintains the rights to accept, reject, or cancel the contract of a contractor at any time following 30 days written notice, if there is a significant change, in the County's opinion, in the contractor's operation of the plan, including but not limited to, satisfaction with customer service, quality of the plan, satisfaction by the County's employees benefits staff.
- 2.7.9 The contractor shall have the capability to accept electronic transfer of funds.
- 2.7.10 The contractor shall be responsible for drafting, production and distribution, subject to County review and approval, of all communication materials and administrative forms in both English and Spanish. Such services may be subcontracted. Such documents shall be produced in sufficient quantities to meet the County's needs for existing and future employees. Quantities may be reduced, subject to County approval, for all documents available on-line. However, the County will make the final determination as to the number of hard copy documents needed on hand at any point in time. Successful contractor will implement Maricopa County in a mutually agreed upon timely fashion and accomplish the following tasks:
 - 2.7.10.1 Setting up the account structure and corresponding subgroups
 - 2.7.10.2 Setting up the plan design
 - 2.7.10.3 Establishing the claims edits and/or business rules
 - 2.7.10.4 Transaction procedures are implemented correctly
 - 2.7.10.5 Accurate member correspondence and reporting

2.8 USAGE REPORT:

The Contractor shall furnish the County a quarterly usage report delineating the acquisition activity governed by the Contract. The format of the report shall be approved by the County and shall disclose the quantity and dollar value of each contract item by individual unit.

EXHIBIT B-1
QUESTIONNAIRE

~~Please complete each item completely and in the order shown. Clear reference to readily accessible back-up material (e.g., plan documents, reports, charts, etc.) is acceptable. Incomplete or inaccurate answers may result in the disqualification of the proposal. Answers should be inserted directly below question.~~

~~1.0 — Ownership~~

~~1.1 — Who is the owner of the company?~~

~~Sedgwick CMS is privately owned and is a 100% owned subsidiary of a parent company whose ultimate shareholders are Stone Point Capital LLC and Hellman & Friedman LLC. We have been operational since 1969. Our corporate address is 1100 Ridgeway Loop Road, Memphis, TN 38120.~~

~~1.2 — Do you have any plans to merge, sell, or otherwise change (e.g., change management contracts or personnel) your current organization structure? If yes, please explain.~~

~~No.~~

~~1.3 — Financial Analysis Questionnaire. Answers may be considered proprietary.~~

~~1.3.1 — Identify your company's fiscal year date.~~

~~Sedgwick CMS' fiscal year date is December 31st.~~

~~1.3.2 — Provide your two most recent audited financial reports that are usually given to stockholders. These reports should include a Balance Sheet, Income Statement, and Statement of Changes in Financial Position.~~

~~Sedgwick CMS is a privately held organization. Therefore, we do not release certain financial information. We have included copies of our two most recent Financial Report & Outlooks in the appendix.~~

~~1.3.3 — Please indicate your financial ratings for the following:~~

~~1.3.3.1 — Standard and Poor's~~

~~B+ — 01/2011~~

~~1.3.3.2 — Moody's~~

~~B1 — 1st Lien & Revolver — 12/2010 B3 — 2nd Lien — 12/2010
B2 — Family Rating — 12/2010~~

~~1.3.3.3 — A.M. Best~~

~~Not rated~~

~~2.0 — Account Management~~

~~2.1 — Provide a biography of the account manager who would be the primary contact for the County's benefits staff. Provide biographies of any other members who will have routine interaction with the County's benefits staff.~~

~~*Jenny Merrithew, Vice President, Operations Director, Calabasas*~~

Jenny is responsible for the overall management of Sedgwick Claims Management Service's California Disability and Leave of Absence Operations. She joined Sedgwick CMS in June 2010 after holding key management positions with disability insurance carriers including 18 years with UnumProvident and CIGNA. Jenny has extensive experience in FMLA, STD, and LTD claims management. Jenny has a BA from California State University, Long Beach and an MBA from Pepperdine University.

Jason Rubinstein, Account Manager

Jason's primary responsibilities include: client communication, project management, problem solving, coordination of renewals, and participation at health fairs and open enrollment meetings. He has been an Account Manager with Sedgwick CMS since 2004. Prior to joining Sedgwick CMS, Jason worked for Balboa Insurance Group as an Account Manager for the Property and Casualty Insurance Department. He also worked at Aetna, Inc. for eight years as an Account Manager. Jason has extensive experience managing public sector programs including the disability and disability pension programs for the County of Los Angeles and the County of Riverside. He has been Maricopa County's Account Manager for the past five years. Jason attended the California State University, Northridge, where he obtained a BS in Health Education and has earned his CPDM designation.

Lance Tomci, Operations Manager

As the leader of the Maricopa County STD claims administration team, Lance is responsible for monitoring the quality of each team member's work. He has hiring and training responsibilities and oversight of his team's adherence to the Maricopa performance guarantees and Sedgwick CMS best practices. Lance joined Sedgwick CMS as a Claims Manager in November 2006. He has been Maricopa County's Operation Manager for the past year. Lance obtained his BA degree in 1994 from California State University, Northridge.

Ellen Boyle, Claims Supervisor

Ellen supervises a Short Term Disability team which handles mandated state voluntary plans, ERISA plans, County plans, and paid family leave plans. She is responsible for reviewing claims, denials, benefit calculations and mentoring the Disability Specialists.

Ellen has 25 years of experience in self insured health and disability claims. She began with Sedgwick CMS 13 years ago working as a Disability Specialist. Ellen was promoted to supervisor in 2001. Previously, she worked for Provident Insurance as an intake specialist for psychiatric claims and has also worked in health and life claims for Insurance Company of America, New York Life and Principal Financial Group. Ellen has been supervising the Maricopa County claims team for the past year.

Irene Fradkin, Disability Specialist

Irene manages the complex and medical opportunity claims for Maricopa County's program. These types of claims are complicated in nature and require aggressive case management. Irene has been with Sedgwick CMS for more than 11 years and has over 35 years of insurance experience.

Irene has been managing Maricopa's STD claims for over six (6) years. She has excellent customer service skills and is often recognized in Claimant Surveys for her helpful and positive attitude. Because of her extensive knowledge of the Maricopa program she is called on to help train other team members on Maricopa County's claim process and culture.

Susan Koslov, Disability Specialist

Susan manages the fast track claims for Maricopa County's program. These types of claims are where the primary diagnosis has a set duration (for example, normal pregnancies and cesarean deliveries). Susan has been with Sedgwick CMS for more than seven (7) years and has been managing Maricopa's STD claims for the past six months.

2.2 — Please describe an ideal mix of skills between the County and your organization that will ensure a successful implementation and ongoing account management.

As incumbent, there will not be an implementation. The major roles and responsibilities of the account manager position are as follows:

- Coordinating, providing, and interpreting program related data and information in order to gauge results and guide the program in the proper strategic direction. This information includes, but is not limited to, claims financial outcomes, managed care results, predictive modeling, claims productivity statistics, and appropriate benchmarking for each respective area.
- Continual monitoring of industry, legislative, and peer program initiatives for potential application to the Maricopa County program.
- Frequent meetings and/or conference calls with Maricopa County to review individual cases and to discuss trends, as appropriate.
- Internal project management in areas such as Information Technology, Managed Care, and Staffing.
- Being Maricopa County's advocate in communicating and resolving any potential service and/or claim related issues.
- Assisting in ongoing evaluations of our office for Maricopa County's program to ensure the consistency of service and adherence of Maricopa County's special service requirements.

Within Sedgwick CMS, Account Management is focused on providing product delivery and results management customized to each client's program. This approach involves focusing on common objectives, acting as a strategic advisor, being an advocate in resolving issues, assisting with on going evaluation of the program, and ensuring adherence to a client's special service instructions. We use several methods to gauge our effectiveness in Account Management with the main two being: 1) The collection, review, and follow up as required on Account Management Client Satisfaction Surveys; and 2) Consistent communication between our clients and the account managers including quarterly meetings and performance measurements. In addition, we provide frequent training to our account managers and also provide feedback to them during their performance review process.

2.3 — Will you establish a dedicated claims unit to service Maricopa County?

No. Our claims department is organized in designated teams and going forward we will continue to engage the same management and team members that have provided excellent service to the Maricopa County program over the past six (6) years.

2.4 — Do the short term disability examiners process other lines of business?

No. We have found that the skill sets are different for each service type such as Short Term Disability management, Long Term Disability management, and Leave Administration. By using STD Disability Specialists, we are able to better focus our training and performance measurement efforts for STD programs.

3.0 Technology

3.1 What is the name of your short term disability claims payment system?

Sedgwick CMS' proprietary claim management system is called DCMS — Disability Claim Management System.

3.2 Is your system fully integrated? Please provide a high level schematic of your short term disability claims payment system.

Yes. Please see the Claim System schematic in the appendix.

3.3 Do you plan any revisions in your claims systems or system hardware? If yes, please describe them and the timing of the changes

We do not contemplate any revisions to DCMS, the system currently used to administer the Maricopa program. Should we implement technology, system, or hardware changes during the life of the multi year contact, we will partner with Maricopa County to ensure that the execution of such changes is successful and results in a positive impact to the program.

3.4 How many other employer groups submit their eligibility to your organization using data extracted from ADP's Benefit Administration system (WinFlex)?

The Calabasas Office currently receives two client's eligibility files from ADP.

4.0 Customer Service

4.1 Where is the customer service center that would handle The County's account?

Sedgwick CMS' customer service center is located at 24025 Park Sorrento, Suite 200, Calabasas, CA 91302-4007.

4.2 What are the hours of operation of the customer service center?

Employees can call a unique toll free number assigned to Maricopa County. Our customer service hours are 5:00AM to 5:00PM PST, Monday through Friday during which a "live person" answers the calls. After hours, employees may call our Interactive Voice Response (IVR) system, which will allow the caller to obtain current claim facts such as claim status, the next payment date, amount of the payment, and the expected return to work date housed in our claim system.

4.3 What is your staffing ratio of customer service representative to members?

For STD, our current ratio is one customer service representative (CSR) per 17,000 covered employees.

4.4 How many members does the customer service center currently service?

Approximately 430,000 covered lives for Short Term Disability and 565,000 for Long Term Disability.

4.5 Will additional staff be added to the customer service center to accommodate our account?

Not specifically due to the County. We add staff based on projected call volumes for all accounts.

4.6 Describe the structure of your organization (include customer services, claims processing, provider relations, eligibility, account management, billing).

~~We have included an organizational chart for the Calabasas claim center in the appendix. This includes the members of the Claims administration, information technology, billing and account management staff in the Calabasas claims office who service the Maricopa account. Legal, contract pricing, and strategic planning support is provide through our headquarter resources in Memphis, Tennessee.~~

~~4.7 How many bilingual customer service representatives are employed?~~

~~We currently have eleven (11) bilingual customer service representatives in our Calabasas Service Center. Sedgwick CMS has bilingual customer service representatives in all major claim centers throughout the country. Also, our customer service representatives use AT&T Language Line services for additional and off hours support.~~

~~4.8 Will there be specific bilingual customer service representatives dedicated to Maricopa County?~~

~~No specific customer service representatives are dedicated to the Maricopa program. However, callers needing a bilingual representative can be promptly routed to a bilingual service representative by our Interactive Voice Response (IVR) system.~~

~~4.9 List the specific functions of the customer service department.~~

~~Sedgwick CMS customer service department intakes new claims and leave requests from employees, authorized representatives, supervisors, and employer representatives. The department provides information on existing claims, answers frequently asked questions, receives missing information, and instructs the caller on claim filing procedures. Our Customer Services Representatives also receive attending physician certifications and extensions over the telephone.~~

~~4.10 Will you provide a dedicated customer service team to handle inquiries related to the County's plans?~~

~~All inquiries related to the County's plan are escalated by the service representative to the Disability Specialists assigned to the Maricopa County program.~~

~~4.11 Describe your customer service tracking and call recording systems and reporting capabilities~~

~~We use Lucent Technologies Definity Enterprise Communications Server, which is a digital voice, video and data communications system utilizing Time Division Multiplexing technology. This portion of the system is available to all employees. Supplementing the Definity Server for our call center requirements is Answersoft's Sixth Sense software, which permits us to automate CSR workflow throughout the life span of a claimant transaction.~~

~~Sixth Sense permits us to obtain real time data on call loads thus permitting timely management action. Lucent Technologies Conversant Interactive Voice Response System and a combination of Davox and Answersoft's Computer Telephone Integration technology permit real time updates to the Interactive Voice Response System. The software provides graphical user interfaces for setting rules that define, tailor and automate customer specific call flows. This enhanced system is available to all call center employees and client contact personnel.~~

~~Lucent Technologies Definity system enables high level Computer Telephony Integration to enhance the capabilities of our Disability Claim Management System's (DCMS) intake and reporting processes. The CSR receives client specific prompts (using Automatic Number Identification) on intake questions, can record scratch pad notes into DCMS and can record and retain voice portions of calls for supervisory review and action.~~

~~We are able to record and track all aspects of call transactions including 'hang time'; abandonment rates, and 'talk time'. Further, this customer specific data is stored for retrieval and downloading upon request.~~

4.12 Provide sample client specific reports generated from your customer service tracking system.

Please see our Sample Reports in the appendix.

4.13 Provide a copy of your most recent customer satisfaction survey instrument.

Please see our customer satisfaction survey reports in the appendix.

4.14 Provide examples of three recent changes implemented as a result of customer satisfaction surveys. Please explain how the outcome has changed.

Three recent changes were implemented as a result of the customer satisfaction survey results:

~~Disability Specialist Response Time~~—Previously, a Claims Assistant would call the claimant within 24 business hours to explain the disability process and obtain any missing claim information. Once Sedgwick compiled a complete claim, the claim was assigned to the Disability Specialist. Now, the Disability Specialist assigned to the claim is the first person the employee will speak to after he/she files a claim. This has resulted in less confusion about who the claimant should contact for future questions.

~~Script Updates~~—Clarifications and additions were made to the intake script in order to improve the initial conversation with the employees during the claim intake and provide more information to the caller.

~~Frequently Asked Questions~~—After getting feedback that callers were asking for more specific information about the claim process, a FAQ sheet was created to ensure we are providing consistent answers to the employees' most important and frequently asked questions.

4.15 What is the average hold time for a member to speak with a customer service representative during peak times? During non-peak times?

~~Our objective is for all incoming calls during business hours to be answered by a Customer Service Representative on average within 45 seconds. Our average speed of answer during the first six (6) months of 2011 was 15 seconds. Sedgwick CMS does not track these measurements specifically during peak or non-peak times.~~

4.16 What is your call abandonment rate at the customer service center during peak times? During non-peak times?

~~The Customer Service Department's abandonment rate objective is less than 5%. During the first six (6) months of 2011, we averaged a 1.05% abandonment rate. Sedgwick CMS does not track these measurements specifically during peak or non-peak times.~~

4.17 Provide your customer service center metrics for the last three months.

~~Our average speed of answer for the last three (3) months is 26 seconds and our abandonment rate is 0.92%.~~

4.18 Do you have an online tool where the County can check the status of customer service issues or member appeals? Provide a link to a demonstration website.

Yes, our web site address is www.sedgwickcms.com/calabasas.

- Click on "I am an Employer"
- Enter the user ID and password

- Then click on any of the links in the middle of the page below "Leave Status"
- Click on Advance Search to Filter by the Appeal Codes.

5.0 Billing Process

5.1 Describe the mechanics of establishing the Administrative Services Only arrangement, including:

5.1.1 Timing of claim/check cash demand, charge to client/Maricopa County bank account, and bank funds float, if any

Maricopa County's STD benefit checking account is currently owned by Sedgwick CMS. It is an escrowed account which means that Maricopa County pre funds the account (currently with \$100,000 minimum balance). Each Thursday evening, Sedgwick CMS creates a Funding Invoice and Client Funding Report, listing all checks that have been produced and credited from the prior Thursday through Wednesday. Replenishment of the checking account from Maricopa is due on the following Monday.

5.1.2 If self funded, are funds withdrawn from the account when checks are drawn or cashed? In other words, who benefits from the float between those two dates?

No one benefits, as the checking account is in a non interest bearing checking account.

5.1.3 Minimum bank balance or initial deposits

Because there is an existing banking relationship, no additional deposit is required. The minimum bank balance is currently \$100,000, which is an average of four weeks of benefit payments.

5.1.4 Bank(s) required or recommended

None required. We recommend the existing banking relationship.

5.1.5 Methods of fund transfer to be used

Our preferred method is for the funds to be transferred through Electronic Fund Transfer (EFT).

5.1.6 Other banking requirements or regular or special service charges

We don't anticipate any other charges but it does depend on the final specifications and expected activity.

5.1.7 Include a copy of a sample banking arrangement

Please see answer 5.1.1 for a description of the current banking arrangement.

5.2 Describe your billing process (frequency, due dates, grace period, late payment procedures, interest penalties, etc.) and system for monthly fees and claims reimbursement.

Per Claim Fees: At the end of each month, we query our claim system to capture the number of new claims received and the number of claims denied during the month. The per claim rates are applied and the monthly invoice is created and sent to Maricopa.

Plan expenses: Plan expenses are billed as they are incurred. The invoices are emailed during the first business week of the new month for fees/bills incurred during the previous month. Payment of invoices is due within 30 days of the invoice date.

5.3 Provide a sample monthly invoice.

Please see the Sample Invoice in the appendix.

5.4 — Describe your self billed process.

Please see answer to question 5.1.1 for self billed process.

6.0 — Benefit Provisions

6.1 — Can you administer the current plan of benefits without modification?

Yes.

6.2 — If you cannot administer the current plan of benefits, explain the changes you would require and the reason for them.

Not applicable.

6.3 — Describe any plan design recommendations that the County should consider and how these impact the financial and return to work outcomes.

We have no recommendations at this time but as in the past, at our quarterly meetings, we will continue to include recommendations for changes based on review of the Program's quarterly results.

6.4 — Include a detailed description of any services or materials that would be excluded under your program.

Plan expenses are billed as incurred and are not included in the fees paid to Sedgwick CMS. These include but are not limited to: medical record fees, independent medical exams, functional capacity evaluations, peer reviews, and field case management.

6.5 — Do you have an online tool where the County can review the benefit plan as it is loaded in your system?

No.

7.0 — Implementation/Enrollments

7.1 — Provide a detailed implementation plan outlining tasks, dates, roles and responsibilities, assuming a July 1, 2012 effective date.

7.2 — Indicate additional implementation costs not already included in your fees.

7.3 — Describe your preferred method of communicating the new plan to The County's employees.

7.4 — Include sample implementation and ongoing communication materials.

Will you do initial and ongoing direct mailings to employees' homes? If yes, describe the cost associated with the initial and ongoing direct mailings? Is this cost included in your rates?

7.5 — If you will not provide direct mailing to employees' homes, how will communication materials be distributed?

7.6 — To what extent can your communication materials be customized?

7.7 — Confirm that the cost of customizing communication materials is included in your quoted rates.

7.8 — Provide a copy of enrollment materials that the County would be able to include in their enrollment material for new hires.

7.9 — What materials are sent to an employee upon selection of your short term disability plan?

7.10 — Confirm that the cost of printing and distributing the new enrollee materials is included in your quoted rates.

7.11 — Confirm that you will provide draft plan documents and evidence of coverage booklets to the County in electronic format

7.12 — If you will agree to provide draft plan documents and evidence of coverage booklets to the County will there be any charge to the County for these documents (describe).

7.13 — Please describe the process you will use to assure takeover claims already in payment and initial review and adjudication.

~~7.14 Describe the level of responsibility and resource commitment you will require of The County and their current STD administrator during implementation.~~

~~As Sedgwick CMS is the incumbent administrator, the transition processes described in 7.1-7.14 are not applicable.~~

~~8.0 References from clients who have/had short term disability coverage with your company~~

~~8.1 How many employer groups and members are enrolled with your plan in Arizona?~~

~~Sedgwick CMS provides the Long Term Disability benefit plan management to all of the employer groups in the Arizona State Retirement System.~~

~~8.2 How many public sector employer groups are enrolled with your plan in Arizona?~~

~~Sedgwick CMS provides claims administration services for self insured employers who have designed their own plan. For example, Sedgwick CMS is the Long Term Disability benefit plan management to all of the employer groups in the Arizona State Retirement System.~~

~~8.3 Provide a representative list of at least five current Arizona clients (Attachment C) for which you provide ASO or fully insured short term disability administration, including the number of covered employees, length of time that they have been contracted, and a contact name and phone number. Provide three employer groups who have terminated within the last 2 years.~~

~~Please see Attachment C for our references. The Arizona State Retirement System is the only other Sedgwick CMS client headquartered in Arizona. We have 25 other clients with employees in Arizona for whom we provide Short Term Disability claims administration services.~~

~~We have no Arizona employer groups who have terminated our service during the past two years.~~

~~8.4 Indicate the number of clients you have in the following categories that are administered in the same geographic location as The County:~~

~~8.4.1 Fewer than 1,000 employees~~

~~0~~

~~8.4.2 1,000-5,000 employees~~

~~0~~

~~8.4.3 5,000 or more employees~~

~~1 ASRS has 212,000 employees~~

~~9.0 Claims Processing~~

~~9.1 At what geographic location will claims be processed?~~

~~Claims will be processed from Sedgwick CMS' regional claim center in Calabasas, CA.~~

~~9.2 What is your targeted turnaround time for processing a clean claim from the time that it is received in your mailroom?~~

~~Our target turnaround time for processing a clean claim is within three (3) business days of the date received.~~

~~9.3 What is your actual average turnaround time in the claims processing center that will process the County's claims?~~

During the first six (6) months of 2011, our average claim turnaround time for first decision for Maricopa County was 1.6 workdays.

~~9.4 Describe your claims facilities and procedures, including:~~

~~9.4.1 The percentage of short term disability claims undergoing review prior to payment and subsequent to payment.~~

~~All of our claims are reviewed prior to payment.~~

~~9.4.2 Training program for claim adjusters.~~

~~A newly hired Disability Specialist will receive 90 days of in-house training. During the training, the Disability Specialist will work with the Training and Development Specialist, will assume a caseload, and will be tested on their core competencies for claim handling. They complete a Medical Terminology course instructed by a Registered Nurse. Also, they will receive daily mentoring from their supervisor when they first join the team and are subject to 100% review of claim decision until released from review by their supervisor.~~

~~9.4.3 Steps and procedures used in claim administration, starting with the original claim submission.~~

~~The initial application for Short Term Disability benefits requests begins with a visit to www.sedgwickems.com/calabasas or with a brief phone call by the disabled employee to Maricopa County's dedicated toll free Customer Service number, (800) 599-7797. The caller is greeted by our Interactive Voice Response (IVR) system, which provides 24/7 status on existing claims, the ability to connect with a Spanish-speaking operator, or direct access to the Customer Service team during regular business hours.~~

~~A member of the Customer Service Team will ask the employee (or the employee will input directly into the web screens) a series of questions including demographic information, and physician information as well as questions regarding the cause of the disability and any other income sources.~~

~~This information is immediately entered into our Disability Claims Management System (DCMS) during the call.~~

~~When the initial claim is filed, DCMS automatically checks the eligibility file supplied by the employer and uploads eligibility information, including the employee's salary, date of hire and hours worked. This ensures that accurate employee information is immediately available for review.~~

~~The employee is also advised to have the treating physician call the toll free number to provide the Attending Physician's Statement of Disability. Specific Maricopa County closing scripts are used to advise the employee regarding the next steps in the disability process. Upon receipt and entry of the employee claim information, DCMS automatically produces a Claim Confirmation and Employee Release Statement and a Right of Reimbursement Form, which are sent to the employee immediately along with a cover letter that explains the Disability claim process. Employees are advised to verify the information on the form, sign the release statement and Right of Reimbursement form, and return them immediately. Sedgwick CMS will follow up in seven (7) business days if these items are not received and guides the employee on their next steps.~~

~~Sedgwick CMS's intake department will initiate the physician call out procedure if the physician does not phone in within two (2) business days of the initial claim intake. The physician is contacted and the information is obtained over the phone.~~

If the physician prefers, a Physician's Statement is faxed and a diary is created to follow up every two days. If the form is not received by the third follow up, the employee is contacted and asked to phone the physician to prompt receipt of the required information. Follow up continues with both employee and physician until the information is received.

Sedgwick CMS will verify the employee's plan coverage from the eligibility file provided by Maricopa County. The Disability Specialist will confirm from the employee and physician data the following information:

- The last day worked
- The first day of disability for STD plan purposes
- The dates of the waiting period
- The dates of any late reporting penalty
- The dates of any period of authorized STD benefits

Adjudication and Case Management

Once the Employee's Statement, Employment Verification, and Attending Physician's Statement have been received, the Disability Specialist will compare all three parts to ensure that all of the information is consistent (i.e. the dates of disability and return to work are the same, the description of the disabling condition, etc.). The Disability Specialist will also check to see if any party has mentioned if the claim is work related. If the claim is work related, the Disability Specialist will follow the procedures as described below in our Worker's Compensation Cordination paragraph.

The claim will then be automatically triaged into one of three categories using triggers set in our system. Our claim system has an internal triaging program that automatically establishes proper ownership through the initial diagnosis reported on the claim.

A *Fast Track* claim would consist of claims where the primary diagnosis is either normal pregnancy or a surgical procedure, and the duration requested is within our duration guidelines. These claims are routine in nature, provided the diagnosis remains the same and within duration guidelines, require no duration management.

The Disability Specialist will ensure appropriate offsets are taken and the payments are accurate and issued timely.

A *Complex* claim consists of claims where the primary diagnosis has been determined to be more complex in nature with a wide variation in possible duration and may be complicated by co-morbidities (i.e. sprains/strains, osteoarthritis, hypertension, and coronary artery disease). In addition to confirming offsets and ensuring accurate payments, the Disability Specialist is responsible for managing the duration of the claim.

A *Medical Opportunity* claim consists of claims where the primary diagnosis has been determined to be the most problematic or requires the analysis of more complex clinical findings in order to assess function. These claims need immediate intervention and aggressive case management, (i.e. mental nervous, multiple sclerosis, migraines, asthma, pregnancy complications, and chronic fatigue). The RN case manager is responsible for management of the duration of the claim.

Administrative actions to support correct and timely payments on these claims are handled by the Disability Specialist.

If the claim falls into the *Fast Track* category and the claim is extended beyond our duration guidelines, DCMS will automatically reevaluate the claim category and notify the appropriate Disability Specialist of the need to reassign the claim to either the Complex or Medical opportunity claim type.

If the claim is determined to be *Complex*, the Disability Specialist will review the medical evidence and determine whether the claim is payable and for how long. A case summary and action plan is documented in the Case Management screens. If needed, additional medical records will be requested to support initial or on-going disability. Benefits may be held pending receipt of the information. Depending on the type of information needed, the request may be in the form of a phone conversation with the physician, or a faxed request for chart notes to the physician's office. When the medical information is received, the Disability Specialist will review it and determine if benefits are payable. If the information received is questionable or does not support a finding of continued disability, the Disability Specialist can refer the claim to the RN Case Manager or a Physician Consultant for review. Independent Medical Evaluations and Functional Capacity Evaluations may be requested as needed. If the evidence does not support disability, benefits are terminated.

If the claim falls into the *Medical Opportunity* category, it is assigned to a Registered Nurse (RN) Case Manager for duration management. The RN will review the claim, document a case summary and action plan, and determine whether benefits can be initiated based on the information on file. The RN will contact the physician in order to discuss the condition, determine treatment, and obtain restrictions. If the physician will not discuss the case on the phone, medical records will be requested via fax. *Medical Opportunity* claims normally require an in depth analysis of test results as well as clinical examinations in order to establish disability. Each time a request for additional benefits is received, the RN will review the case, update the action plan, and determine whether additional evidence is needed. Benefits are terminated if the objective medical evidence does not support a finding of disability.

Sedgwick CMS's case management services, including our *Transitional Return to Work Program* have proven successful as we use a combination of Functional Capacity Evaluations, Independent Medical Evaluations, and field based intervention when cost effective. In addition to duration management, each claim must be monitored for payment accuracy. Information provided by the employee is reviewed to determine whether there are other sources of income that must be offset from Plan benefits. If the employee indicates another source of income, contact is made to obtain the amount of income and begin date.

In work related cases, the Disability Specialist will contact the workers' compensation vendor in order to obtain status and payment information for offsets. If the workers' compensation claim is delayed, a lien is filed and benefits initiated if evidence supports the claim (provided the employee has signed a Right of Reimbursement Form). A diary is created in DCMS to follow up with the Workers' Compensation vendor for the claim decision. If the employee alleges a third party injury, a Right of Reimbursement Form is required as well as information regarding the accident and any attorney involvement. A lien is filed with the attorney. A diary is created in DCMS to follow up with the employee for the third party settlement.

Transitional Return to Work

While new claims are being reviewed, Sedgwick CMS's system automatically identifies claims using preset triggers (for example: medical certification which exceed two months duration, certification is beyond our duration guidelines, or the employee has been released to a part time work release) to flag claims that have a

~~Return to Work (RTW) management opportunity.~~

~~If an employee is identified as a potential Transitional Return to Work (TRTW) candidate, the system will automatically notify the Sedgwick CMS RTW Coordinator of the claim. The RTW Coordinator will then review the file to determine that the referral was appropriate and that the claim will benefit from their intervention. If the claim is not a TRTW candidate, the system will notify the Disability Specialist to continue the claims process.~~

~~The first step in the TRTW process involves the RTW Coordinator contacting the employee to explain the program and ascertain their level of interest. When the employee expresses an interest in the program, the RTW Coordinator contacts the medical provider to obtain authorization for the participation in the program and to obtain information regarding any necessary medical restrictions or need for workplace accommodations. An employee may return to work when a medical release is completed by the treating provider and returned to Sedgwick CMS. The RTW Coordinator then contacts the employee and their supervisor to identify suitable work, which meets the employee's medical restrictions as well as the needs of the individual Maricopa County department.~~

~~If appropriate transitional work is available, the RTW Coordinator interfaces with the employee and their supervisor to ensure successful performance of the work. Some employees may be medically eligible for return to work, but may still be unable to work his/her normal hours. The TRTW program allows the employee to return to work and build up the hours worked at medically prescribed intervals, until he/she is able to return to their regular schedule. For a employee needing light duty during the transitional period, the program could involve some pre disability duties or different duties, if available. The choice and combination of tasks is made in consultation with the supervisor and associate, consistent with medical guidelines, so that the duties do not adversely affect the employee's disability.~~

~~If the employee is unable to return to work to his/her regular occupation due to permanent work restrictions or because of Maricopa County's inability to accommodate the job modifications, the employee will continue on full disability until the claim reaches maximum benefit, or the employee is no longer disabled. If the employee is unable to return to his/her pre disability job after a reasonable trial of transitional duty, the RTW Coordinator investigates to determine if a temporary job accommodation can become a permanent accommodation or if an alternate job with Maricopa County is possible. Following a successful completion of the TRTW program, the RTW Coordinator will follow up with the employee for a period of 60 days to ensure that he/she remains employed and to assist with any questions or possible accommodations that may be needed. A detailed quarterly TRTW report is sent to Maricopa County's Benefits Department. The report includes all employees in the program, along with the results of each encounter and the total disability duration saved.~~

~~Initial Calculation of Benefits~~

~~Upon completion of the data evaluation and eligibility determination, the Disability Specialist is prepared to initiate the payment calculation. At this point, the Disability Specialist verifies the other benefit information already entered into the system — WC benefits, rehabilitation, third party awards, and any other income replacement benefits. The Disability Specialist will continue to monitor the receipt of these other sources throughout the life of the claim. Due to the breadth and flexibility of our payment system, the Disability Specialist can focus on ensuring all related information has been received and entered into the database.~~

~~Once the payment cycle is started, the system will automatically calculate the appropriate offsets and taxes from information entered by the CSR and Disability~~

Specialist. If the Disability Specialist is unsure of the accuracy of information, they can utilize the PREVIEW function in the system to calculate the exact amounts that will be issued on the check and Explanation of Benefits without actually producing a payment. After reviewing the previewed payment, and determining that the results are satisfactory, the Disability Specialist can finalize the payment sequence.

Sedgwick CMS's payment system will accurately compute the claim payment, including the withholding of the appropriate federal and state withholding taxes based on the employee's W 4 status. DCMS also allows Sedgwick CMS to take Elective Deductions from the disability benefit checks to avoid having your internal staff send reminder letters and collect checks to continue coverage. The explanation of benefits section will describe in detail the gross to net calculations.

In the event of denial, the Disability Specialist also prepares a detailed letter to explain the specific reason for benefit denial. Included in the letter are the employee's appeal rights and procedures to file an appeal.

9.4.4 The use and role of medical consultants in reviewing questionable claims.

Sedgwick CMS works with Network Medical Review (NMR) and Medical Evaluation Specialists (MES) for Physician advisor/peer related services. Physician advisors are engaged when clarifying medical information is required with the treatment provider, as part of the Utilization Review Accreditation Commission (URAC) utilization review program and to assist with clarifying functionality associated with the return to work process. We have found significant benefit from using physician advisors working directly with our clinicians and treatment providers. This includes ensuring timely medical treatment within treatment guidelines and avoidance of unnecessary independent medical examiners. Like our claims staff and clinicians, the physicians also engage the providers in the Stay At Work/Return To Work (SAW/RTW) American College of Occupational and Environmental Medicine (ACOEM) RTW guideline discussion supporting full functional restoration and appropriate review of functional capability as part of the return to work process.

9.4.5 Measures taken to prevent fraud by your own employees related to claims processing and claim/draft control.

The Oracle Relational Database Management software that we use handles all internal data integrity. Access to the database itself is tightly controlled, and users can only access those screens that they have been given explicit permission to use. Similarly, various access levels (view, insert, update, and delete) for each database table has also been explicitly defined for each user. Users can only see or change data in the tables that they legitimately use. Lastly, only the IS Dept can make changes to the production screens and programs. The system contains hundreds of built-in edits to reduce data input errors.

In addition to the safeguards and protocols mentioned above, we seek outside expert review of our system integrity in the form of annual SAS 70 Audits. The most recent SAS 70 audit found Sedgwick CMS's security measures to be appropriate.

In the DCMS system, there is a separation of duties. Input, claim approval, and check disbursement duties have been separated to the extent that three separate individuals must be involved to issue a check.

DCMS contains many edits and cross references to prevent data from becoming invalid. In general, our database is designed to store key fields in only one place, so that if the value is changed, it will immediately be "seen" throughout the system. As an example, the Social Security number is stored only on the claim record. Our tax reports, which display payment information corresponding to a single Social Security number, will always show the current Social Security number. In contrast, if we stored the Social Security number on each check (as some other systems do)

~~then it would be very easy for the Social Security number on the claim and checks tables to get “out of sync” whenever a change was made.~~

~~9.4.6 — Measures taken to prevent fraud by claimants.~~

~~In addition to the security measures mentioned in 10.4.5, we request Physician’s State Board License numbers for each claim and we review each claim on an individual basis, assessing the objective medical evidence in the file to determine if it supports the claimant’s disability based on the Plan definition. We look for cases that have diagnoses that are often highly abused due to the self reported nature of symptoms, such as mental health conditions, soft tissue injuries, fibromyalgia, and chronic fatigue syndrome. Nurse case managers are assigned these specific types of claims from the onset for clinical evaluation and management. Our nurses establish direct contact with the treating physician, documenting objective versus subjective complaints, restrictions or limitations, as well as determining if the treatment is appropriate. Duration expectations are discussed with the physician.~~

~~9.4.7 — Your procedures for detecting duplicate payments or overpayments and recovering such amounts from employees.~~

~~Our system does not allow duplicate payments or payments for duplicate benefit periods.~~

~~9.4.8 — Steps taken to verify continuance of disability.~~

~~Please see 10.4.3.~~

~~9.5 — Are you willing to provide documentation of all Maricopa County case specific internal audit results to the County?~~

~~We will provide the results of our Total Performance Management (TPM) audits on a quarterly basis. We do not provide case specific information.~~

~~9.6 — If you will provide documentation of all case specific internal audits to the County, how often will this documentation be provided?~~

~~A summary of the TPM audits are provided to Maricopa County on a quarterly basis.~~

~~9.7 — Please describe your charges for managing the claims. This should include the initial adjudication determination (approval and/or denial) and ongoing claims management fees.~~

~~Please see the Pricing Worksheet on Attachment A.~~

~~9.8 — Explain your member appeal procedures for level one and two~~

~~When an appeal is filed, the appeal request and claim file are assigned to the Sedgwick National Appeal Unit. Within five (5) business days of receipt of the appeal the assigned Appeal Specialist issues a letter to the claimant acknowledging receipt of the appeal and explaining the review timeframes. All appeal determinations are made by an independent reviewer (Appeal Specialist) who had not previously been involved in the initial claim decision and is not the subordinate of the individual or team responsible for the initial decision.~~

~~The Appeal Specialist conducts an initial review of the file including any new submitted evidence (medical records, MRI reports, x rays, etc.). If deemed necessary, additional information will be requested from the employee or their attending physicians. After the case file is complete, the Appeal Specialist will make a determination to either approve the claim or uphold the initial decision. A letter of the decision is sent to the employee. If the decision is to uphold the denial, the letter contains the reason for the denial, the plan~~

~~provision on which it is based, statement of the employee's right to review (on request and at no charge) relevant documents. If an internal rule, protocol, or similar criterion was used in making the decision, a description of the rule, protocol, or similar criterion or notice that a copy will be provided free of charge, and a statement of the claimant's right to a second appeal.~~

~~Appeal decisions must be made within 60 days of receipt unless delayed due to matters beyond the control of Sedgwick CMS. In the case of a delay, a letter is issued to the claimant in advance of the sixty (60) days explaining the reason for delay and when a decision may be expected. All decisions must be made within one hundred and twenty (120) days. In the case where information is outstanding from the employee, the time for the review is tolled until the information is received. The employee is notified of this in the request for information.~~

~~The second appeal will be conducted by a different Appeal Specialist than the person making the first level appeal decision. The procedures and claim workup follow the same format described above for the first level.~~

~~9.9 Will you provide claim investigation services and legal counsel for disputed claims locally (in Arizona)? Describe the scope of such services. Will they be provided by internal staff or subcontracted?~~

~~We provide subcontracted claim investigation services. These range from field case management to surveillance. With the County's approval, we will set up the individual investigative services and incorporate these findings in our claim determination. We do not provide legal counsel for disputed claims~~

~~9.10 Will you establish a dedicated claims unit to service Maricopa County?~~

~~Our Disability Specialists have been assigned and trained to service the Maricopa County account in a team atmosphere. This claims administration team will continue to operate under the same management team that supervises other public sectors Short Term Disability accounts. We have not established a specific dedicated team for Maricopa County.~~

~~9.11 Are other lines of business processed by the short term disability examiners?~~

~~No.~~

~~9.12 Please describe your procedure for determining if a valid disability has occurred.~~

~~Please see our answer to 10.4.3. to understand the process for determining if a claim is valid.~~

~~9.13 Describe your rehabilitation and return to work capabilities for STD recipients.~~

~~STD claims are evaluated for both the Transitional Return to Work Program and Sedgwick CMS's Vocational Rehabilitation Program. Transitional Return to Work is described in 10.4.3. Our Vocational Rehabilitation Program goal is to return an employee with a disability to gainful employment in a job that is medically appropriate. The proper use of vocational rehabilitation services takes into account the claimant's aptitudes, interests, and transferable skills.~~

~~The successfully rehabilitated worker benefits physically, psychologically, financially, and socially.~~

~~A key component to successful rehabilitation is early intervention. Claims are screened for rehabilitation potential within the first six months of disability.~~

~~The Disability Specialists review claims using the following screening criteria:~~

- ~~Claimant's Age~~—Rehabilitation success rates are often inversely correlated with an employee's age.
- ~~Disability Duration~~—Early intervention is important to rehabilitation efforts. It is important to initiate rehabilitation activities before a claimant adapts his/her lifestyle to the disability.
- ~~Claimant Attitude~~—Good rehabilitation outcomes tend to be coupled with positive claimant attitudes and motivation to return to work.
- ~~Financial Status~~—Claimants with financial incentives to continue working often make good rehabilitation candidates.
- ~~Educational Background~~—Claimants with strong educational backgrounds, including a college education, tend to be good rehabilitation candidates.
- ~~Employer Attitude~~—Employers that foster supportive return to employment environments are more amenable to successful outcomes.
- ~~Disability Diagnosis~~—Certain diagnoses have higher rehabilitation success rates.

~~Claims are screened for rehabilitation potential within the first six months of disability and each time a medical review is conducted using the criteria noted above. A claimant does not need to meet all criteria to be considered for a referral. Individuals meeting a majority of the criteria are referred by the Disability Specialist or Nurse Case Manager to a Rehabilitation Specialist for review.~~

~~Components of Sedgwick CMS's Vocational Rehabilitation Program include:~~

- ~~vocational rehabilitation assessment by a Sedgwick CMS Rehabilitation Specialist~~
- ~~referral to a qualified rehabilitation vendor in the claimant's geographic area~~
- ~~development of an appropriate rehabilitation plan, and~~
- ~~close monitoring and management of the plan to control time frames and cost while ensuring successful completion of the plan.~~

~~Following receipt of a rehabilitation referral, the Rehabilitation Specialist will review the file to determine the claimant's educational/training background and medical restrictions. If needed, the treating physician will be contacted for clarification of the claimant's current medical status. A Functional Capacity Evaluation may also be requested.~~

~~If the medical facts of the case support the potential for rehabilitation, the claimant will be contacted for a phone interview to determine whether he/she is a feasible candidate. If the claimant is a feasible candidate, the Rehabilitation Specialist will first investigate the possibility of a return to work at Maricopa County. If it is determined that modified or alternate work is not available with the County and retraining will be needed, the case is referred to an outside rehabilitation vendor.~~

~~The outside rehabilitation vendor reviews referral information, including the medical file, and conducts an evaluation to determine the most appropriate way to return the claimant to gainful employment. The vocational evaluation begins with an initial interview of the claimant. The rehabilitation counselor may continue the evaluation with one or more of the following:~~

- ~~a functional capacity evaluation (if one has not been done previously) or~~
- ~~extended work evaluation~~
- ~~psychometric testing~~
- ~~transferable skills analysis~~
- ~~labor market research~~

- ~~vocational exploration; ergonomic assessment; job site analysis~~
- ~~investigation of various training programs (on the job training versus formal educational programs)~~

~~The rehabilitation professional uses all information acquired to develop a vocational plan that allows the employee to return to the competitive workplace in the quickest, most cost-effective manner. Following approval of the rehabilitation plan by Sedgwick CMS and the employer, the Sedgwick CMS Rehabilitation Specialist monitors progress of the Rehabilitation Plan through regular telephone calls and review of written status reports.~~

~~9.14 Describe how claims data and reporting can be viewed on line.~~

~~Sedgwick CMS launched our website www.sedgwickems.com/calabasas in 2001 as a resource center for Employers, Employees, and Physicians. The site gives the employee and the employer access to claims information 24/7. When a Maricopa County employee first visits the website, they will be asked to register with a user ID of at least 5 characters, and a password consisting of characters and numbers at least 6 characters long. Passwords are never displayed on the website, and are encrypted in the database tables, along with the Social Security Numbers. Claimants are only allowed access to their individual claims.~~

~~Once registered, the claimant can explore:~~

- ~~Claims status~~
- ~~Payment history and payment details~~
- ~~Explanation of the claims extension process~~
- ~~Download forms (Claim form, Authorized release statement, extension forms, etc.)~~
- ~~Browse frequently asked questions~~
- ~~Check on documents received at Sedgwick CMS~~
- ~~E mail questions to our e customer service representative~~
- ~~Educate themselves about their condition using the health resources and links~~
- ~~STD claimants can file claims 24/7~~

~~Maricopa County's internal benefits staff is also able to benefit greatly from the resources available on the site. Each representative will need to register and be given access restrictions based on division, site location, and job title, as determined by the County. The employer is able to:~~

- ~~View employees' claim status (what's missing, and needed), claim history and estimated return to work dates~~
- ~~Generate and download ad-hoc activity reports for their location by Plan number, Work location, and business unit as needed~~
- ~~Download employee claim forms~~
- ~~Enter Employer Notes for the Disability Specialist~~

~~Please see the Sample Reports in the appendix to view the online reporting screen.~~

~~9.15 Provide a web address to view sample reports.~~

~~www.sedgwickems.com/calabasas~~

~~10.1 Describe your process for handling eligibility exceptions.~~

~~Each new eligibility file is a complete file that overrides the previous file. Employee information provided directly to Sedgwick CMS will update our records. We can provide these exceptions in a weekly file to ADP.~~

~~10.2 State your average turnaround time for loading eligibility files received from the County's Benefit Administrator.~~

~~Within four hours.~~

~~11.0 Communications~~

~~11.1 Provide a sample of all your collaterals in English and Spanish?~~

~~Please refer to the Collaterals in the appendix.~~

~~11.2 Are your collaterals available to the County electronically in a PDF file format?~~

~~Yes.~~

~~11.3 Describe your Internet capabilities for this product.~~

~~Our capabilities are described in the answer to 10.14.~~

~~12.0 Reporting~~

~~12.1 Do you have a query tool available where the County can generate ad hoc reports?~~

~~Yes.~~

~~12.2 Are ad hoc reports available from the Contractor upon the County's request and if so, is there an additional charge?~~

~~Many ad hoc reports are available at no additional cost. The cost for ad hoc reports depends on the complexity of the report. Most requests do not require additional programming. If they do require programming, our programming fees are \$150 per hour.~~

~~12.3 Provide samples of your standard reports.~~

~~Please see the Screen Shots in the appendix.~~

~~13.0 Rating/Financials~~

~~13.1 Describe in detail the funding arrangement you are proposing.~~

~~As a third party administrator, we manage self-funded plans exclusively. We have described the funding process in section 5.1.1~~

~~13.2 It is the intent of The County to determine the method by which your renewal rates will be calculated prior to entering into a contract. Describe your renewal calculation procedure in detail.~~

~~This applies mainly to insurance contracts. For administrative services only, Sedgwick CMS will review changes to the cost of providing services to Maricopa and adjust the fees accordingly. Our rates will not increase greater than 5% annually. Renewal rates are calculated on a per claim basis. We take the number of claims and multiply it by an annual per claim rate. The per claim rates are subject to increase annually at the contract anniversary date based on percentages that are mutually agreed upon by~~

~~Maricopa County and Sedgwick CMS. The proposed annual percentage increases are defined in the pricing attachment of this RFP document.~~

~~13.3 Are the renewal procedures guaranteed with respect to the County contract?~~

~~Yes.~~

~~13.4 How long are your renewal procedures guaranteed?~~

~~Renewal procedures are guaranteed for the life of the contract.~~

~~13.5 How, if at all, will the initial renewal methodology differ from subsequent renewals?~~

~~The methodology does not differ.~~

~~13.6 Describe the financial obligations of the County in the event of contract termination for incurred but unpaid claims.~~

~~As the Maricopa County is self insured, the County's financial obligations are those specified in the Plan.~~

~~13.7 Is your current claim system capable of sending EFTs (electronic funds transfers) for payments directly to a claimant's bank account?~~

~~We currently offer this service only for Long Term Disability plans where the benefit payments can be expected to last for much longer period of time~~

EXHIBIT B-1 (REVISED 11-1-16)**QUESTIONNAIRE**

Please complete each item completely and in the order shown. Clear reference to readily accessible back-up material (e.g., plan documents, reports, charts, etc.) is acceptable. Incomplete or inaccurate answers may result in the disqualification of the proposal. Answers should be inserted directly below question.

1.0 Ownership

1.1 Who is the owner of the company?

Sedgwick CMS is privately owned and is a 100% owned subsidiary of a parent company whose ultimate shareholders are KKR & Co. L.P. Stone Point Capital LLC and certain management investors are minority shareholders.. We have been operational since 1969. Our corporate address is 1100 Ridgeway Loop Road, Memphis, TN 38120.

1.2 Do you have any plans to merge, sell, or otherwise change (e.g., change management contracts or personnel) your current organization structure? If yes, please explain.

No.

1.3 Financial Analysis Questionnaire. Answers may be considered proprietary.

1.3.1 Identify your company's fiscal year date.

Sedgwick CMS' fiscal year date is December 31st.

1.3.2 Provide your two most recent audited financial reports that are usually given to stockholders. These reports should include a Balance Sheet, Income Statement, and Statement of Changes in Financial Position.

Sedgwick is privately owned and is a 100% owned subsidiary whose ultimate parent company is Sedgwick, Inc. and whose ultimate majority shareholder is KKR & Co. L.P. Stone Point Capital LLC and certain management investors are minority shareholders. Sedgwick is an independent TPA, not affiliated with any broker, insurance carrier, or related services vendor.

1.3.3 Please indicate your financial ratings for the following:

1.3.3.1 Standard and Poor's

B — 04/05/2016

1.3.3.2 Moody's

B2 – Family Rating – 12/2010B3 – 04/05/2016

1.3.3.3 A.M. Best

Not rated

2.0 Account Management

2.1 Provide a biography of the account manager who would be the primary contact for the County's benefits staff. Provide biographies of any other members who will have routine interaction with the County's benefits staff.

Jenny Merrithew Deborah Chiccoa, Assitant Vice President, Operations Director, Calabasas

Deborah Chiccoa has been with Sedgwick 21 years. She started her career as an examiner and promoted several times to her current position as AVP, Operations & Client Services. Deborah is currently responsible for the operations of accounts in a wide variety of industries, including finance, manufacturing, government, food service and temporary agencies.

Deborah holds a Bachelor's degree in Liberal Studies and a Master's in Humanities from California State University - Northridge. She also holds certificates in Certified Professional in Disability Management (CPDM), Workers' Compensation Claims Associate (WCCA), and a Certificate in Management Development

Jason Rubinstein, Account Manager

Jason's primary responsibilities include: client communication, project management, problem solving, coordination of renewals, and participation at health fairs and open enrollment meetings. He has been an Account Manager with Sedgwick CMS since 2004. . Prior to joining Sedgwick CMS, Jason worked for Balboa Insurance Group as an Account Manager for the Property and Casualty Insurance Department. He also worked at Aetna, Inc. for eight years as an Account Manager. Jason has extensive experience managing public sector programs including the disability and disability pension programs for the County of Los Angeles and the County of Riverside. He has been Maricopa County's Account Manager for the past ten years. Jason attended the California State University, Northridge, where he obtained a BS in Health Education and has earned his CPDM designation.

Lance Tomei Vondradee Courtenay, Operations Manager

As the leader of the Maricopa County STD claims administration team, Vondradee is responsible for monitoring the quality of each team member's work. She has hiring and training responsibilities and oversight of his team's adherence to the Maricopa performance guarantees and Sedgwick CMS best practices. Vondradee joined Sedgwick CMS as a Claims Manager in September 2006. She has been Maricopa County's Operation Manager for the past four years.

Ellen Boyle, Claims Supervisor

Ellen supervises a Short Term Disability team which handles mandated state voluntary plans, ERISA plans, County plans, and paid family leave plans. She is responsible for reviewing claims, denials, benefit calculations and mentoring the Disability Specialists.

Ellen has 30 years of experience in self insured health and disability claims. She began with Sedgwick CMS 18 years ago working as a Disability Specialist. Ellen was promoted to supervisor in 2001. Previously, she worked for Provident Insurance as an intake specialist for psychiatric claims and has also worked in health and life claims for Insurance Company of America, New York Life and Principal Financial Group. Ellen has been supervising the Maricopa County claims team for the past year.

Irene Fradkin, Disability Specialist

Irene manages the complex and medical opportunity claims for Maricopa County's program. These types of claims are complicated in nature and require aggressive case management. Irene has been with Sedgwick CMS for more than 16 years and has over 35 years of insurance experience.

Irene has been managing Maricopa's STD claims for over 11 years. She has excellent customer service skills and is often recognized in Claimant Surveys for her helpful and positive attitude. Because of her extensive knowledge of the Maricopa program she is called on to help train other team members on Maricopa County's claim process and culture.

Susan Koslov, Disability Specialist

Susan manages the fast track claims for Maricopa County's program. These types of claims are where the primary diagnosis has a set duration (for example, normal pregnancies and cesarean deliveries). Susan has been with Sedgwick CMS for more than twelve years and has been managing Maricopa's STD claims for the past six years.

2.2 Please describe an ideal mix of skills between the County and your organization that will ensure a successful implementation and ongoing account management.

As incumbent, there will not be an implementation. The major roles and responsibilities of the account manager position are as follows:

- Coordinating, providing, and interpreting program related data and information in order to gauge results and guide the program in the proper strategic direction. This information includes, but is not limited to, claims financial outcomes, managed care results, predictive modeling, claims productivity statistics, and appropriate benchmarking for each respective area.
- Continual monitoring of industry, legislative, and peer program initiatives for potential application to the Maricopa County program.
- Frequent meetings and/or conference calls with Maricopa County to review individual cases and to discuss trends, as appropriate.
- Internal project management in areas such as Information Technology, Managed Care, and Staffing.
- Being Maricopa County's advocate in communicating and resolving any potential service and/or claim related issues.
- Assisting in ongoing evaluations of our office for Maricopa County's program to ensure the consistency of service and adherence of Maricopa County's special service requirements.

Within Sedgwick CMS, Account Management is focused on providing product delivery and results management customized to each client's program. This approach involves focusing on common objectives, acting as a strategic advisor, being an advocate in resolving issues, assisting with on-going evaluation of the program, and ensuring adherence to a client's special service instructions. We use several methods to gauge our effectiveness in Account Management with the main two being: 1) The collection, review, and follow up as required on Account Management Client Satisfaction Surveys; and 2) Consistent communication between our clients and the account managers including quarterly meetings and performance measurements. In addition, we provide frequent training to our account managers and also provide feedback to them during their performance review process.

2.3 Will you establish a dedicated claims unit to service Maricopa County?

No. Our claims department is organized in designated teams and going forward we will continue to engage the same management and team members that have provided excellent service to the Maricopa County program over the past eleven years.

2.4 Do the short-term disability examiners process other lines of business?

No. We have found that the skill sets are different for each service type such as Short-Term Disability management, Long-Term Disability management, and Leave Administration. By using STD Disability Specialists, we are able to better focus our training and performance measurement efforts for STD programs.

3.0 **Technology**

3.1 **What is the name of your short-term disability claims payment system?**

Sedgwick CMS' proprietary claim management system is called DCMS – Disability Claim Management System.

3.2 **Is your system fully integrated? Please provide a high-level schematic of your short-term disability claims payment system.**

Yes. Please see the Claim System schematic in the appendix.

3.3 **Do you plan any revisions in your claims systems or system hardware? If yes, please describe them and the timing of the changes**

We do not contemplate any revisions to DCMS, the system currently used to administer the Maricopa program. Should we implement technology, system, or hardware changes during the life of the multi-year contact, we will partner with Maricopa County to ensure that the execution of such changes is successful and results in a positive impact to the program.

3.4 **How many other employer groups submit their eligibility to your organization using data extracted from ADP's Benefit Administration system (WinFlex)?**

The Calabasas Office currently receives two client's eligibility files from ADP.

4.0 **Customer Service**

4.1 **Where is the customer service center that would handle The County's account?**

Sedgwick CMS' customer service center is located at 8521 Fallbrook Ave, Suite 250, West Hills, CA 91304

4.2 **What are the hours of operation of the customer service center?**

Employees can call a unique toll-free number assigned to Maricopa County. Our customer service hours are 5:00AM to 5:00PM PST, Monday through Friday during which a "live person" answers the calls. After hours, employees may call our Interactive Voice Response (IVR) system, which will allow the caller to obtain current claim facts such as claim status, the next payment date, amount of the payment, and the expected return to work date housed in our claim system.

4.3 **What is your staffing ratio of customer service representative to members?**

For STD, our current ratio is one customer service representative (CSR) per 17,000 covered employees.

4.4 **How many members does the customer service center currently service?**

Approximately 430,000 covered lives for Short-Term Disability and 565,000 for Long-Term Disability.

4.5 **Will additional staff be added to the customer service center to accommodate our account?**

Not specifically due to the County. We add staff based on projected call volumes for all accounts.

4.6 **Describe the structure of your organization (include customer services, claims processing, provider relations, eligibility, account management, billing).**

We have included an organizational chart for the Calabasas claim center in the appendix. This includes the members of the Claims administration, information technology, billing and account

management staff in the Calabasas claims office who service the Maricopa account. Legal, contract pricing, and strategic planning support is provide through our headquarter resources in Memphis, Tennessee.

4.7 How many bilingual customer service representatives are employed?

We currently have eleven (11) bilingual customer service representatives in our Calabasas Service Center. Sedgwick CMS has bilingual customer service representatives in all major claim centers throughout the country. Also, our customer service representatives use AT&T Language Line services for additional and off hours support.

4.8 Will there be specific bilingual customer service representatives dedicated to Maricopa County?

No specific customer service representatives are dedicated to the Maricopa program. However, callers needing a bilingual representative can be promptly routed to a bilingual service representative by our Interactive Voice Response (IVR) system.

4.9 List the specific functions of the customer service department.

Sedgwick CMS customer service department intakes new claims and leave requests from employees, authorized representatives, supervisors, and employer representatives. The department provides information on existing claims, answers frequently asked questions, receives missing information, and instructs the caller on claim filing procedures. Our Customer Services Representatives also receive attending physician certifications and extensions over the telephone.

4.10 Will you provide a dedicated customer service team to handle inquiries related to the County's plans?

All inquiries related to the County's plan are escalated by the service representative to the Disability Specialists assigned to the Maricopa County program.

4.11 Describe your customer service tracking and call recording systems and reporting capabilities

We use Lucent Technologies Definity Enterprise Communications Server, which is a digital voice, video and data communications system utilizing Time Division Multiplexing technology. This portion of the system is available to all employees. Supplementing the Definity Server for our call center requirements is Answersoft's Sixth Sense software, which permits us to automate CSR workflow throughout the life span of a claimant transaction.

Sixth Sense permits us to obtain real time data on call loads thus permitting timely management action. Lucent Technologies Conversant Interactive Voice Response System and a combination of Davox and Answersoft's Computer Telephone Integration technology permit real-time updates to the Interactive Voice Response System. The software provides graphical user interfaces for setting rules that define, tailor and automate customer specific call flows. This enhanced system is available to all call center employees and client contact personnel.

Lucent Technologies Definity system enables high-level Computer-Telephony Integration to enhance the capabilities of our Disability Claim Management System's (DCMS) intake and reporting processes. The CSR receives client specific prompts (using Automatic Number Identification) on intake questions, can record scratch pad notes into DCMS and can record and retain voice portions of calls for supervisory review and action.

We are able to record and track all aspects of call transactions including 'hang time'; abandonment rates, and 'talk time'. Further, this customer specific data is stored for retrieval and downloading upon request.

- 4.12 **Provide sample client specific reports generated from your customer service tracking system.**

Please see our Sample Reports in the appendix.

- 4.13 **Provide a copy of your most recent customer satisfaction survey instrument.**

Please see our customer satisfaction survey reports in the appendix.

- 4.14 **Provide examples of three recent changes implemented as a result of customer satisfaction surveys. Please explain how the outcome has changed.**

Three recent changes were implemented as a result of the customer satisfaction survey results:

Disability Specialist Response Time – Previously, a Claims Assistant would call the claimant within 24 business hours to explain the disability process and obtain any missing claim information. Once Sedgwick compiled a complete claim, the claim was assigned to the Disability Specialist. Now, the Disability Specialist assigned to the claim is the first person the employee will speak to after he/she files a claim. This has resulted in less confusion about who the claimant should contact for future questions.

Script Updates – Clarifications and additions were made to the intake script in order to improve the initial conversation with the employees during the claim intake and provide more information to the caller.

Frequently Asked Questions – After getting feedback that callers were asking for more specific information about the claim process, a FAQ sheet was created to ensure we are providing consistent answers to the employees' most important and frequently asked questions.

- 4.15 **What is the average hold time for a member to speak with a customer service representative during peak times? During non-peak times?**

Our objective is for all incoming calls during business hours to be answered by a Customer Service Representative on average within 45 seconds. Our average speed of answer during the first six (6) months of 2011 was 15 seconds. Sedgwick CMS does not track these measurements specifically during peak or non-peak times.

- 4.16 **What is your call abandonment rate at the customer service center during peak times? During non-peak times?**

The Customer Service Department's abandonment rate objective is less than 5%. During the first six (6) months of 2011, we averaged a 1.05% abandonment rate. Sedgwick CMS does not track these measurements specifically during peak or non-peak times.

- 4.17 **Provide your customer service center metrics for the last three months.**

Our average speed of answer for the last three (3) months is 26 seconds and our abandonment rate is 0.92%.

- 4.18 **Do you have an online tool where the County can check the status of customer service issues or member appeals? Provide a link to a demonstration website.**

Yes, our web site address is www.sedgwickcms.com.

- Click on "I am an Employer"
- Enter the user ID and password
- Then click on any of the links in the middle of the page below "Leave Status"
- Click on Advance Search to Filter by the Appeal Codes.

5.0 **Billing Process**

5.1 **Describe the mechanics of establishing the Administrative Services Only arrangement, including:**

5.1.1 **Timing of claim/check cash demand, charge to client/Maricopa County bank account, and bank funds float, if any**

Maricopa County's STD benefit checking account is currently owned by Sedgwick CMS. It is an escrowed account which means that Maricopa County pre-funds the account (currently with \$100,000 minimum balance). Each Thursday evening, Sedgwick CMS creates a Funding Invoice and Client Funding Report, listing all checks that have been produced and credited from the prior Thursday through Wednesday. Replenishment of the checking account from Maricopa is due on the following Monday.

5.1.2 **If self-funded, are funds withdrawn from the account when checks are drawn or cashed? In other words, who benefits from the float between those two dates?**

No one benefits, as the checking account is in a non-interest bearing checking account.

5.1.3 **Minimum bank balance or initial deposits**

Because there is an existing banking relationship, no additional deposit is required. The minimum bank balance is currently \$100,000, which is an average of four weeks of benefit payments.

5.1.4 **Bank(s) required or recommended**

None required. We recommend the existing banking relationship.

5.1.5 **Methods of fund transfer to be used**

Our preferred method is for the funds to be transferred through Electronic Fund Transfer (EFT).

5.1.6 **Other banking requirements or regular or special service charges**

We don't anticipate any other charges but it does depend on the final specifications and expected activity.

5.1.7 **Include a copy of a sample banking arrangement**

Please see answer 5.1.1 for a description of the current banking arrangement.

5.2 **Describe your billing process (frequency, due dates, grace period, late payment procedures, interest penalties, etc.) and system for monthly fees and claims reimbursement.**

Per Claim Fees: At the end of each month, we query our claim system to capture the number of new claims received and the number of claims denied during the month. The per claim rates are applied and the monthly invoice is created and sent to Maricopa.

Plan expenses: Plan expenses are billed as they are incurred. The invoices are emailed during the first business week of the new month for fees/bills incurred during the previous month. Payment of invoices is due within 30 days of the invoice date.

5.3 **Provide a sample monthly invoice.**

Please see the Sample Invoice in the appendix.

5.4 **Describe your self-billed process.**

Please see answer to question 5.1.1 for self-billed process.

6.0 **Benefit Provisions**

6.1 **Can you administer the current plan of benefits without modification?**

Yes.

6.2 **If you cannot administer the current plan of benefits, explain the changes you would require and the reason for them.**

Not applicable.

6.3 **Describe any plan design recommendations that the County should consider and how these impact the financial and return-to-work outcomes.**

We have no recommendations at this time but as in the past, at our quarterly meetings, we will continue to include recommendations for changes based on review of the Program's quarterly results.

6.4 **Include a detailed description of any services or materials that would be excluded under your program.**

Plan expenses are billed as incurred and are not included in the fees paid to Sedgwick CMS. These include but are not limited to: medical record fees, independent medical exams, functional capacity evaluations, peer reviews, and field case management.

6.5 **Do you have an online tool where the County can review the benefit plan as it is loaded in your system?**

No.

7.0 **Implementation/Enrollments**

7.1 **Provide a detailed implementation plan outlining tasks, dates, roles and responsibilities, assuming a July 1, 2012 effective date.**

7.2 **Indicate additional implementation costs not already included in your fees.**

7.3 **Describe your preferred method of communicating the new plan to The County's employees.**

7.4 **Include sample implementation and ongoing communication materials.**

Will you do initial and ongoing direct mailings to employees' homes? If yes, describe the cost associated with the initial and ongoing direct mailings? Is this cost included in your rates?

7.5 **If you will not provide direct mailing to employees' homes, how will communication materials be distributed?**

7.6 **To what extent can your communication materials be customized?**

7.7 **Confirm that the cost of customizing communication materials is included in your quoted rates.**

7.8 **Provide a copy of enrollment materials that the County would be able to include in their enrollment material for new hires.**

7.9 **What materials are sent to an employee upon selection of your short-term disability plan?**

7.10 **Confirm that the cost of printing and distributing the new enrollee materials is included in your quoted rates.**

7.11 **Confirm that you will provide draft plan documents and evidence of coverage booklets to the County in electronic format**

7.12 **If you will agree to provide draft plan documents and evidence of coverage booklets to the County will there be any charge to the County for these documents (describe).**

7.13 **Please describe the process you will use to assure takeover claims already in payment and initial review and adjudication.**

7.14 **Describe the level of responsibility and resource commitment you will require of The County and their current STD administrator during implementation.**

As Sedgwick CMS is the incumbent administrator, the transition processes described in 7.1 – 7.14 are not applicable.

8.0 **References from clients who have/had short-term disability coverage with your company**

8.1 **How many employer groups and members are enrolled with your plan in Arizona?**

Sedgwick CMS provides the Long-Term Disability benefit plan management to all of the employer groups in the Arizona State Retirement System.

8.2 **How many public sector employer groups are enrolled with your plan in Arizona?**

Sedgwick CMS provides claims administration services for self insured employers who have designed their own plan. For example, Sedgwick CMS is the Long-Term Disability benefit plan management to all of the employer groups in the Arizona State Retirement System.

8.3 **Provide a representative list of at least five current Arizona clients (Attachment C) for which you provide ASO or fully insured short-term disability administration, including the number of covered employees, length of time that they have been contracted, and a contact name and phone number. Provide three employer groups who have terminated within the last 2 years.**

Please see Attachment C for our references. The Arizona State Retirement System is the only other Sedgwick CMS client headquartered in Arizona. We have 25 other clients with employees in Arizona for whom we provide Short-Term Disability claims administration services.

We have no Arizona employer groups who have terminated our service during the past two years.

8.4 **Indicate the number of clients you have in the following categories that are administered in the same geographic location as The County:**

8.4.1 **Fewer than 1,000 employees**

0

8.4.2 **1,000 – 5,000 employees**

0

8.4.3 **5,000 or more employees**

9.0 **Claims Processing**

9.1 **At what geographic location will claims be processed?**

Claims will be processed from Sedgwick CMS' regional claim center in West Hills, CA.

9.2 **What is your targeted turnaround time for processing a clean claim from the time that it is received in your mailroom?**

Our target turnaround time for processing a clean claim is within three (3) business days of the date received.

9.3 **What is your actual average turnaround time in the claims processing center that will process the County's claims?**

During the first six (6) months of 2011, our average claim turnaround time for first decision for Maricopa County was 1.6 workdays.

9.4 **Describe your claims facilities and procedures, including:**

9.4.1 **The percentage of short-term disability claims undergoing review prior to payment and subsequent to payment.**

All of our claims are reviewed prior to payment.

9.4.2 **Training program for claim adjusters.**

A newly hired Disability Specialist will receive 90 days of in-house training. During the training, the Disability Specialist will work with the Training and Development Specialist, will assume a caseload, and will be tested on their core competencies for claim handling. They complete a Medical Terminology course instructed by a Registered Nurse. Also, they will receive daily mentoring from their supervisor when they first join the team and are subject to 100% review of claim decision until released from review by their supervisor.

9.4.3 **Steps and procedures used in claim administration, starting with the original claim submission.**

The initial application for Short-Term Disability benefits requests begins with a visit to www.sedgwickcms.com/calabasas or with a brief phone call by the disabled employee to Maricopa County's dedicated toll free Customer Service number, (800) 599-7797. The caller is greeted by our Interactive Voice Response (IVR) system, which provides 24/7 status on existing claims, the ability to connect with a Spanish-speaking operator, or direct access to the Customer Service team during regular business hours.

A member of the Customer Service Team will ask the employee (or the employee will input directly into the web screens) a series of questions including demographic information, and physician information as well as questions regarding the cause of the disability and any other income sources.

This information is immediately entered into our Disability Claims Management System (DCMS) during the call.

When the initial claim is filed, DCMS automatically checks the eligibility file supplied by the employer and uploads eligibility information, including the employee's salary, date of hire and hours worked. This ensures that accurate employee information is immediately available for review.

The employee is also advised to have the treating physician call the toll free number to provide the Attending Physician's Statement of Disability. Specific Maricopa County closing scripts are used to advise the employee regarding the next steps in the disability process. Upon receipt and entry of the employee claim information, DCMS automatically produces a Claim Confirmation and Employee Release Statement and a Right of Reimbursement Form, which are sent to the employee immediately along with a cover letter that explains the Disability claim process. Employees are advised to verify the information on the form, sign the release statement and Right of Reimbursement form, and return them immediately. Sedgwick CMS will follow up in seven (7) business days if these items are not received and guides the employee on their next steps.

Sedgwick CMS's intake department will initiate the physician call out procedure if the physician does not phone in within two (2) business days of the initial claim intake. The physician is contacted and the information is obtained over the phone. If the physician prefers, a Physician's Statement is faxed and a diary is created to follow up every two days. If the form is not received by the third follow up, the employee is contacted and asked to phone the physician to prompt receipt of the required information. Follow up continues with both employee and physician until the information is received.

Sedgwick CMS will verify the employee's plan coverage from the eligibility file provided by Maricopa County. The Disability Specialist will confirm from the employee and physician data the following information:

- The last day worked
- The first day of disability for STD plan purposes
- The dates of the waiting period
- The dates of any late reporting penalty
- The dates of any period of authorized STD benefits

Adjudication and Case Management

Once the Employee's Statement, Employment Verification, and Attending Physician's Statement have been received, the Disability Specialist will compare all three parts to ensure that all of the information is consistent (i.e. the dates of disability and return to work are the same, the description of the disabling condition, etc.). The Disability Specialist will also check to see if any party has mentioned if the claim is work related. If the claim is work related, the Disability Specialist will follow the procedures as described below in our Worker's Compensation Coordination paragraph.

The claim will then be automatically triaged into one of three categories using triggers set in our system. Our claim system has an internal triaging program that automatically establishes proper ownership through the initial diagnosis reported on the claim.

A *Fast Track* claim would consist of claims where the primary diagnosis is either normal pregnancy or a surgical procedure, and the duration requested is within our duration guidelines. These claims are routine in nature, provided the diagnosis remains the same and within duration guidelines, require no duration management.

The Disability Specialist will ensure appropriate offsets are taken and the payments are accurate and issued timely.

A *Complex* claim consists of claims where the primary diagnosis has been determined to be more complex in nature with a wide variation in possible duration and may be complicated by co-morbidities (i.e. sprains/strains, osteoarthritis, hypertension, and coronary artery disease). In addition to confirming offsets and ensuring accurate payments, the Disability Specialist is responsible for managing the duration of the claim.

A *Medical Opportunity* claim consists of claims where the primary diagnosis has been determined to be the most problematic or requires the analysis of more complex clinical findings in order to assess function. These claims need immediate intervention and aggressive case management, (i.e. mental nervous, multiple sclerosis, migraines, asthma, pregnancy complications, and chronic fatigue). The RN case manager is responsible for management of the duration of the claim.

Administrative actions to support correct and timely payments on these claims are handled by the Disability Specialist.

If the claim falls into the *Fast Track* category and the claim is extended beyond our duration guidelines, DCMS will automatically reevaluate the claim category and notify the appropriate Disability Specialist of the need to reassign the claim to either the Complex or Medical opportunity claim type.

If the claim is determined to be *Complex*, the Disability Specialist will review the medical evidence and determine whether the claim is payable and for how long. A case summary and action plan is documented in the Case Management screens. If needed,

additional medical records will be requested to support initial or on-going disability. Benefits may be held pending receipt of the information. Depending on the type of information needed, the request may be in the form of a phone conversation with the physician, or a faxed request for chart notes to the physician's office. When the medical information is received, the Disability Specialist will review it and determine if benefits are payable. If the information received is questionable or does not support a finding of continued disability, the Disability Specialist can refer the claim to the RN Case Manager or a Physician Consultant for review. Independent Medical Evaluations and Functional Capacity Evaluations may be requested as needed. If the evidence does not support disability, benefits are terminated.

If the claim falls into the *Medical Opportunity* category, it is assigned to a Registered Nurse (RN) Case Manager for duration management. The RN will review the claim, document a case summary and action plan, and determine whether benefits can be initiated based on the information on file. The RN will contact the physician in order to discuss the condition, determine treatment, and obtain restrictions. If the physician will not discuss the case on the phone, medical records will be requested via fax. *Medical Opportunity* claims normally require an in-depth analysis of test results as well as clinical examinations in order to establish disability. Each time a request for additional benefits is received, the RN will review the case, update the action plan, and determine whether additional evidence is needed. Benefits are terminated if the objective medical evidence does not support a finding of disability.

Sedgwick CMS's case management services, including our *Transitional Return-to-Work Program* have proven successful as we use a combination of Functional Capacity Evaluations, Independent Medical Evaluations, and field-based intervention when cost effective. In addition to duration management, each claim must be monitored for payment accuracy. Information provided by the employee is reviewed to determine whether there are other sources of income that must be offset from Plan benefits. If the employee indicates another source of income, contact is made to obtain the amount of income and begin date.

In work-related cases, the Disability Specialist will contact the workers' compensation vendor in order to obtain status and payment information for offsets. If the workers' compensation claim is delayed, a lien is filed and benefits initiated if evidence supports the claim (provided the employee has signed a Right of Reimbursement Form). A diary is created in DCMS to follow up with the Workers' Compensation vendor for the claim decision. If the employee alleges a third party injury, a Right of Reimbursement Form is required as well as information regarding the accident and any attorney involvement. A lien is filed with the attorney. A diary is created in DCMS to follow up with the employee for the third party settlement.

Transitional Return to Work

While new claims are being reviewed, Sedgwick CMS's system automatically identifies claims using preset triggers (for example: medical certification which exceed two months duration, certification is beyond our duration guidelines, or the employee has been released to a part time work release) to flag claims that have a Return to Work (RTW) management opportunity.

If an employee is identified as a potential Transitional Return to Work (TRTW) candidate, the system will automatically notify the Sedgwick CMS RTW Coordinator of the claim. The RTW Coordinator will then review the file to determine that the referral was appropriate and that the claim will benefit from their intervention. If the claim is not a TRTW candidate, the system will notify the Disability Specialist to continue the claims process.

The first step in the TRTW process involves the RTW Coordinator contacting the employee to explain the program and ascertain their level of interest. When the

employee expresses an interest in the program, the RTW Coordinator contacts the medical provider to obtain authorization for the participation in the program and to obtain information regarding any necessary medical restrictions or need for workplace accommodations. An employee may return to work when a medical release is completed by the treating provider and returned to Sedgwick CMS. The RTW Coordinator then contacts the employee and their supervisor to identify suitable work, which meets the employee's medical restrictions as well as the needs of the individual Maricopa County department.

If appropriate transitional work is available, the RTW Coordinator interfaces with the employee and their supervisor to ensure successful performance of the work. Some employees may be medically eligible for return to work, but may still be unable to work his/her normal hours. The TRTW program allows the employee to return to work and build up the hours worked at medically prescribed intervals, until he/she is able to return to their regular schedule. For an employee needing light duty during the transitional period, the program could involve some pre-disability duties or different duties, if available. The choice and combination of tasks is made in consultation with the supervisor and associate, consistent with medical guidelines, so that the duties do not adversely affect the employee's disability.

If the employee is unable to return to work to his/her regular occupation due to permanent work restrictions or because of Maricopa County's inability to accommodate the job modifications, the employee will continue on full disability until the claim reaches maximum benefit, or the employee is no longer disabled. If the employee is unable to return to his/her pre-disability job after a reasonable trial of transitional duty, the RTW Coordinator investigates to determine if a temporary job accommodation can become a permanent accommodation or if an alternate job with Maricopa County is possible. Following a successful completion of the TRTW program, the RTW Coordinator will follow up with the employee for a period of 60 days to ensure that he/she remains employed and to assist with any questions or possible accommodations that may be needed. A detailed quarterly TRTW report is sent to Maricopa County's Benefits Department. The report includes all employees in the program, along with the results of each encounter and the total disability duration saved.

Initial Calculation of Benefits

Upon completion of the data evaluation and eligibility determination, the Disability Specialist is prepared to initiate the payment calculation. At this point, the Disability Specialist verifies the other benefit information already entered into the system — WC benefits, rehabilitation, third party awards, and any other income replacement benefits. The Disability Specialist will continue to monitor the receipt of these other sources throughout the life of the claim. Due to the breadth and flexibility of our payment system, the Disability Specialist can focus on ensuring all related information has been received and entered into the database.

Once the payment cycle is started, the system will automatically calculate the appropriate offsets and taxes from information entered by the CSR and Disability Specialist. If the Disability Specialist is unsure of the accuracy of information, they can utilize the PREVIEW function in the system to calculate the exact amounts that will be issued on the check and Explanation of Benefits without actually producing a payment. After reviewing the previewed payment, and determining that the results are satisfactory, the Disability Specialist can finalize the payment sequence.

Sedgwick CMS's payment system will accurately compute the claim payment, including the withholding of the appropriate federal and state withholding taxes based on the employee's W-4 status. DCMS also allows Sedgwick CMS to take Elective Deductions from the disability benefit checks to avoid having your internal staff send reminder letters and collect checks to continue coverage. The explanation of benefits section will describe in detail the gross to net calculations.

In the event of denial, the Disability Specialist also prepares a detailed letter to explain the specific reason for benefit denial. Included in the letter are the employee's appeal rights and procedures to file an appeal.

9.4.4 The use and role of medical consultants in reviewing questionable claims.

Sedgwick CMS works with Network Medical Review (NMR) and Medical Evaluation Specialists (MES) for Physician advisor/peer related services. Physician advisors are engaged when clarifying medical information is required with the treatment provider, as part of the Utilization Review Accreditation Commission (URAC) utilization review program and to assist with clarifying functionality associated with the return to work process. We have found significant benefit from using physician advisors working directly with our clinicians and treatment providers. This includes ensuring timely medical treatment within treatment guidelines and avoidance of unnecessary independent medical examiners. Like our claims staff and clinicians, the physicians also engage the providers in the Stay At Work/Return To Work (SAW/RTW) American College of Occupational and Environmental Medicine (ACOEM) RTW guideline discussion supporting full functional restoration and appropriate review of functional capability as part of the return to work process.

9.4.5 Measures taken to prevent fraud by your own employees related to claims processing and claim/draft control.

The Oracle Relational Database Management software that we use handles all internal data integrity. Access to the database itself is tightly controlled, and users can only access those screens that they have been given explicit permission to use. Similarly, various access levels (view, insert, update, and delete) for each database table has also been explicitly defined for each user. Users can only see or change data in the tables that they legitimately use. Lastly, only the IS Dept can make changes to the production screens and programs. The system contains hundreds of built-in edits to reduce data input errors.

In addition to the safeguards and protocols mentioned above, we seek outside expert review of our system integrity in the form of annual SAS 70 Audits. The most recent SAS 70 audit found Sedgwick CMS's security measures to be appropriate.

In the DCMS system, there is a separation of duties. Input, claim approval, and check disbursement duties have been separated to the extent that three separate individuals must be involved to issue a check.

DCMS contains many edits and cross-references to prevent data from becoming invalid. In general, our database is designed to store key fields in only one place, so that if the value is changed, it will immediately be "seen" throughout the system. As an example, the Social Security number is stored only on the claim record. Our tax reports, which display payment information corresponding to a single Social Security number, will always show the current Social Security number. In contrast, if we stored the Social Security number on each check (as some other systems do) then it would be very easy for the Social Security number on the claim and checks tables to get "out of sync" whenever a change was made.

9.4.6 Measures taken to prevent fraud by claimants.

In addition to the security measures mentioned in 10.4.5, we request Physician's State Board License numbers for each claim and we review each claim on an individual basis, assessing the objective medical evidence in the file to determine if it supports the claimant's disability based on the Plan definition. We look for cases that have diagnoses that are often highly abused due to the self-reported nature of symptoms, such as mental health conditions, soft tissue injuries, fibromyalgia, and chronic fatigue syndrome. Nurse case managers are assigned these specific types of claims from the onset for clinical evaluation and management. Our nurses establish direct contact with the treating

physician, documenting objective verses subjective complaints, restrictions or limitations, as well as determining if the treatment is appropriate. Duration expectations are discussed with the physician.

9.4.7 Your procedures for detecting duplicate payments or overpayments and recovering such amounts from employees.

Our system does not allow duplicate payments or payments for duplicate benefit periods.

9.4.8 Steps taken to verify continuance of disability.

Please see 10.4.3.

9.5 Are you willing to provide documentation of all Maricopa County case-specific internal audit results to the County?

We will provide the results of our Total Performance Management (TPM) audits on a quarterly basis. We do not provide case-specific information.

9.6 If you will provide documentation of all case specific internal audits to the County, how often will this documentation be provided?

A summary of the TPM audits are provided to Maricopa County on a quarterly basis.

9.7 Please describe your charges for managing the claims. This should include the initial adjudication determination (approval and/or denial) and ongoing claims management fees.

Please see the Pricing Worksheet on Attachment A.

9.8 Explain your member appeal procedures for level one and two

When an appeal is filed, the appeal request and claim file are assigned to the Sedgwick National Appeal Unit. Within five (5) business days of receipt of the appeal the assigned Appeal Specialist issues a letter to the claimant acknowledging receipt of the appeal and explaining the review timeframes. All appeal determinations are made by an independent reviewer (Appeal Specialist) who had not previously been involved in the initial claim decision and is not the subordinate of the individual or team responsible for the initial decision.

The Appeal Specialist conducts an initial review of the file including any new submitted evidence (medical records, MRI reports, x-rays, etc.). If deemed necessary, additional information will be requested from the employee or their attending physicians. After the case file is complete, the Appeal Specialist will make a determination to either approve the claim or uphold the initial decision. A letter of the decision is sent to the employee. If the decision is to uphold the denial, the letter contains the reason for the denial, the plan provision on which it is based, statement of the employee's right to review (on request and at no charge) relevant documents. If an internal rule, protocol, or similar criterion was used in making the decision, a description of the rule, protocol, or similar criterion or notice that a copy will be provided free of charge, and a statement of the claimant's right to a second appeal.

Appeal decisions must be made within 60 days of receipt unless delayed due to matters beyond the control of Sedgwick CMS. In the case of a delay, a letter is issued to the claimant in advance of the sixty (60) days explaining the reason for delay and when a decision may be expected. All decisions must be made within one hundred and twenty (120) days. In the case where information is outstanding from the employee, the time for the review is tolled until the information is received. The employee is notified of this in the request for information.

The second appeal will be conducted by a different Appeal Specialist than the person making the first level appeal decision. The procedures and claim workup follow the same format described above for the first level.

9.9 **Will you provide claim investigation services and legal counsel for disputed claims locally (in Arizona)? Describe the scope of such services. Will they be provided by internal staff or subcontracted?**

We provide subcontracted claim investigation services. These range from field case management to surveillance. With the County's approval, we will set up the individual investigative services and incorporate these findings in our claim determination. We do not provide legal counsel for disputed claims

9.10 **Will you establish a dedicated claims unit to service Maricopa County?**

Our Disability Specialists have been assigned and trained to service the Maricopa County account in a team atmosphere. This claims administration team will continue to operate under the same management team that supervises other public sectors Short Term Disability accounts. We have not established a specific dedicated team for Maricopa County.

9.11 **Are other lines of business processed by the short-term disability examiners?**

No.

9.12 **Please describe your procedure for determining if a valid disability has occurred.**

Please see our answer to 10.4.3. to understand the process for determining if a claim is valid.

9.13 **Describe your rehabilitation and return-to work capabilities for STD recipients.**

STD claims are evaluated for both the Transitional Return to Work Program and Sedgwick CMS's Vocational Rehabilitation Program. Transitional Return to Work is described in 10.4.3. Our Vocational Rehabilitation Program goal is to return an employee with a disability to gainful employment in a job that is medically appropriate. The proper use of vocational rehabilitation services takes into account the claimant's aptitudes, interests, and transferable skills.

The successfully rehabilitated worker benefits physically, psychologically, financially, and socially.

A key component to successful rehabilitation is early intervention. Claims are screened for rehabilitation potential within the first six months of disability.

The Disability Specialists review claims using the following screening criteria:

- Claimant's Age – Rehabilitation success rates are often inversely correlated with an employee's age.
- Disability Duration - Early intervention is important to rehabilitation efforts. It is important to initiate rehabilitation activities before a claimant adapts his/her lifestyle to the disability.
- Claimant Attitude – Good rehabilitation outcomes tend to be coupled with positive claimant attitudes and motivation to return to work.
- Financial Status – Claimants with financial incentives to continue working often make good rehabilitation candidates.
- Educational Background – Claimants with strong educational backgrounds, including a college education, tend to be good rehabilitation candidates.
- Employer Attitude -- Employers that foster supportive return to employment environments are more amenable to successful outcomes.
- Disability Diagnosis – Certain diagnoses have higher rehabilitation success rates.

Claims are screened for rehabilitation potential within the first six months of disability and each time a medical review is conducted using the criteria noted above. A claimant does not need to meet all criteria to be considered for a referral. Individuals meeting a majority of the criteria are referred by the Disability Specialist or Nurse Case Manager to a Rehabilitation Specialist for review.

Components of Sedgwick CMS's Vocational Rehabilitation Program include:

- vocational rehabilitation assessment by a Sedgwick CMS Rehabilitation Specialist
- referral to a qualified rehabilitation vendor in the claimant's geographic area
- development of an appropriate rehabilitation plan, and
- close monitoring and management of the plan to control time frames and cost while ensuring successful completion of the plan.

Following receipt of a rehabilitation referral, the Rehabilitation Specialist will review the file to determine the claimant's educational/training background and medical restrictions. If needed, the treating physician will be contacted for clarification of the claimant's current medical status. A Functional Capacity Evaluation may also be requested.

If the medical facts of the case support the potential for rehabilitation, the claimant will be contacted for a phone interview to determine whether he/she is a feasible candidate. If the claimant is a feasible candidate, the Rehabilitation Specialist will first investigate the possibility of a return-to-work at Maricopa County. If it is determined that modified or alternate work is not available with the County and retraining will be needed, the case is referred to an outside rehabilitation vendor.

The outside rehabilitation vendor reviews referral information, including the medical file, and conducts an evaluation to determine the most appropriate way to return the claimant to gainful employment. The vocational evaluation begins with an initial interview of the claimant. The rehabilitation counselor may continue the evaluation with one or more of the following:

- a functional capacity evaluation (if one has not been done previously) or
- extended work evaluation
- psychometric testing
- transferable skills analysis
- labor market research
- vocational exploration; ergonomic assessment; job site analysis
- investigation of various training programs (on-the-job training versus formal educational programs)

The rehabilitation professional uses all information acquired to develop a vocational plan that allows the employee to return to the competitive workplace in the quickest, most cost-effective manner. Following approval of the rehabilitation plan by Sedgwick CMS and the employer, the Sedgwick CMS Rehabilitation Specialist monitors progress of the Rehabilitation Plan through regular telephone calls and review of written status reports.

9.14 **Describe how claims data and reporting can be viewed on-line.**

Sedgwick CMS launched our website www.sedgwickcms.com/calabasas in 2001 as a resource center for Employers, Employees, and Physicians. The site gives the employee and the employer access to claims information 24/7. When a Maricopa County employee first visits the website, they will be asked to register with a user ID of at least 5 characters, and a password consisting of characters and numbers at least 6 characters long. Passwords are never displayed on the website, and are encrypted in the database tables, along with the Social Security Numbers. Claimants are

only allowed access to their individual claims.

Once registered, the claimant can explore:

- Claims status
- Payment history and payment details
- Explanation of the claims extension process
- Download forms (Claim form, Authorized release statement, extension forms, etc.)
- Browse frequently asked questions
- Check on documents received at Sedgwick CMS
- E-mail questions to our e-customer service representative
- Educate themselves about their condition using the health resources and links
- STD claimants can file claims 24/7

Maricopa County's internal benefits staff is also able to benefit greatly from the resources available on the site. Each representative will need to register and be given access restrictions based on division, site location, and job title, as determined by the County. The employer is able to:

- View employees' claim status (what's missing, and needed), claim history and estimated return to work dates
- Generate and download ad-hoc activity reports for their location by Plan number, Work location, and business unit as needed
- Download employee claim forms
- Enter Employer Notes for the Disability Specialist

Please see the Sample Reports in the appendix to view the online reporting screen.

9.15 **Provide a web address to view sample reports.**

www.sedgwickcms.com

10 **Eligibility**

10.1 **Describe your process for handling eligibility exceptions.**

Each new eligibility file is a complete file that overrides the previous file. Employee information provided directly to Sedgwick CMS will update our records. We can provide these exceptions in a weekly file to ADP.

10.2 **State your average turnaround time for loading eligibility files received from the County's Benefit Administrator.**

Within four hours.

11 **Communications**

11.1 **Provide a sample of all your collaterals in English and Spanish?**

Please refer to the Collaterals in the appendix.

11.2 **Are your collaterals available to the County electronically in a PDF file format?**

Yes.

11.3 **Describe your Internet capabilities for this product.**

Our capabilities are described in the answer to 10.14.

12 **Reporting**

12.1 **Do you have a query tool available where the County can generate ad hoc reports?**

Yes.

12.2 **Are ad hoc reports available from the Contractor upon the County's request and if so, is there an additional charge?**

Many ad hoc reports are available at no additional cost. The cost for ad hoc reports depends on the complexity of the report. Most requests do not require additional programming. If they do require programming, our programming fees are \$150 per hour.

12.3 **Provide samples of your standard reports.**

Please see the Screen Shots in the appendix.

13 **Rating/Financials**

13.1 **Describe in detail the funding arrangement you are proposing.**

As a third party administrator, we manage self-funded plans exclusively. We have described the funding process in section 5.1.1

13.2 **It is the intent of The County to determine the method by which your renewal rates will be calculated prior to entering into a contract. Describe your renewal calculation procedure in detail.**

This applies mainly to insurance contracts. For administrative services only, Sedgwick CMS will review changes to the cost of providing services to Maricopa and adjust the fees accordingly. Our rates will not increase greater than 5% annually.

Renewal rates are calculated on a per-claim basis. We take the number of claims and multiply it by an annual per-claim rate. The per-claim rates are subject to increase annually at the contract anniversary date based on percentages that are mutually agreed upon by Maricopa County and Sedgwick CMS. The proposed annual percentage increases are defined in the pricing attachment of this RFP document.

13.3 **Are the renewal procedures guaranteed with respect to the County contract?**

Yes.

13.4 **How long are your renewal procedures guaranteed?**

Renewal procedures are guaranteed for the life of the contract.

13.5 **How, if at all, will the initial renewal methodology differ from subsequent renewals?**

The methodology does not differ.

13.6 **Describe the financial obligations of the County in the event of contract termination for incurred but unpaid claims.**

As the Maricopa County is self-insured, the County's financial obligations are those specified in the Plan.

13.7 **Is your current claim system capable of sending EFTs (electronic funds transfers) for payments directly to a claimant's bank account?**

We currently offer this service only for Long Term Disability plans where the benefit payments can be expected to last for much longer period of time

EXHIBIT B-2
STD CLAIM PROCESSING SYSTEM

THIS COMPLETED ATTACHMENT MUST BE SUBMITTED AS PART OF YOUR PROPOSAL.

Indicate below what data is kept in computer-accessible form and is used by the examiner or computer to process routine STD claims. Note: Respond only with respect to the system to be used in processing claims for Maricopa County. Please use the following definitions for the columns shown below:

- (1) = The data item under consideration.
- (2) = The data item is kept in computer-accessible form and is accessed electronically by the computer in order to process the claim.
- (3) = The examiner obtains the data item manually and enters it into the computer in order to process the claim.
- (4) = The data item is not accessed electronically by the computer; instead, the examiner obtains and uses the data manually in order to process the claim although other parts of the process may be computerized.
- (5) = The data is not used to process a claim.

(1)	(2)	(3)	(4)	(5)
<u>Data</u>	<u>Computer Accessed</u>	<u>Examiner Accessed</u>	<u>Used Manually</u>	<u>Not Used</u>
Employee eligibility files	X			
Current plan provisions	X			
Prior provisions of plan	X			
EOB explanatory paragraphs	X			
Individual claim histories	X			
Diagnosis	X	X		
Prognosis	X	X		

If your processing system is computerized, provide the name of the software and the firm who developed it below:

Our technology system, Disability Claims Management System (DCMS), is the best in the industry. The system is proprietary and based on the Oracle RDBMS system. DCMS was designed singularly for the purpose of assisting staff in managing disability episodes. Our DCMS offers totally integrated decision support tools for all types of plans through this single system. The system provides full disability payroll taxation support, including the collection, reporting, and depositing of tax withholdings.

Our claims intake process is enhanced by the Lucent Technologies' Definity Enterprise Communications System which combines sophisticated the County specific call routing with state of the art call data capturing and reporting capabilities. All data entered by a CSR into our DCMS is routed automatically to the Disability Specialist. Our DCMS system contains hundreds of automatic, built-in edits to ensure that the claims data is as error free as possible. Sedgwick CMS has developed a unique Interactive Voice Response (IVR) system. The IVRS enables the claimant to conveniently obtain complete information about the status of his or her claim as well as to obtain Sedgwick CMS's address and fax number, 24 hours a day, seven days a week.

The County's supervisory and Human Resource staff use the IVR to obtain claim status information. The system is very user-friendly and provides clear, concise information on the current status of each benefit plan claim type – statutory, STD, and LTD. We can also load workers' compensation claim data for lost time claims status as well, if the information is made available from the current administrator(s). Our system also contains on-line proprietary duration guidelines for all ICD9-CM codes.

SEDGWICK CMS, 1100 RIDGEWAY LOOP ROAD #200, MEMPHIS, TN 38120

PRICING SHEET: NIGP CODE 95337

Vendor Number: ~~2011001320-0~~ **VC0000003563**

Certificates of Insurance Required

Contract Period: To cover the period ending **December 31, 2016 2021.**