Maricopa County Group Short-Term Disability Plan Description

Revised July 2022

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PLAN DESCRIPTION

What is short-term disability (STD)?

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

Who is eligible to purchase STD coverage?

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

When can I enroll?

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

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

Once an election is made, no changes will be allowed for any reason during the Plan Year except when you are called to or return from active duty or are included in a reduction in the workforce.

When does coverage become effective?

Coverage for new hires or newly eligible employees becomes effective on the first day of the month following their date of hire/benefits eligibility date.

Coverage for eligible employees enrolling during Open Enrollment becomes effective the first day of the new plan year.

Exception to when coverage begins

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

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

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

Is there a pre-existing condition limitation?

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

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

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

Are there any conditions excluded from coverage?

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

What benefit coverage amount can I elect?

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

- **40% of Weekly Salary**
- **50% of Weekly Salary**
- **60% of Weekly Salary**

How much are the benefit premiums?

The benefit premiums for this coverage are 100% employee paid. . The total cost of your coverage under this Plan depends on the benefit coverage amount you choose and your annual base salary. Please refer to the 'Contribution Costs' section to calculate your contribution rate. Contributions are post-tax, meaning that you pay taxes on the contribution amount, and if you qualify for the benefit, your benefit coverage amount is not taxable income when received.

What is the Maximum Benefit Duration Period?

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

Is there an Elimination Period before payments begin?

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

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

During the Elimination Period when you are not receiving Disability Benefits, you are required to use sick leave during your absence from work. If you do not have enough sick leave to cover the entire Elimination Period, you must use available vacation time. If you do not have sufficient vacation time, you will be unpaid. You cannot be paid vacation, sick leave, parental leave, donated leave or regular pay for the same period for which you are receiving Disability Benefits. After the Elimination Period is exhausted, you may request to use some, all or none of your vacation leave before you start receiving Disability Benefits. However, you **may not** use vacation **to supplement** your STD payment. Any overpayment that results in receiving both payments must be repaid.

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

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

What are my STD benefits for pregnancy?

The standard STD benefit for pregnancy is six weeks for a vaginal delivery without complications and eight weeks for a caesarian delivery. This six- or eight-week period begins with the date of delivery. Your STD benefits will begin on the first day of Hospitalization, or day of birth if not hospitalized. The STD plan also covers complications that require the employee to be off work pre- and post-delivery. Refer to the 'Pre-Existing Condition' section for more details.

What happens to my other benefits while I am receiving Disability Benefits?

If you are receiving short-term disability benefits as an active employee, you are considered to be on an unpaid leave of absence and you remain responsible for the employee portion of the premium contribution for each benefit plan in which you are currently enrolled. To pay for your other benefits while you are on STD, the premium amount due for each plan will go into an arrears balance to be paid later. When you return to work, you will pay back the premium owed by having a premium amount that is up to double the amount per period per plan deducted each paycheck until the amount owed is recovered. If you do not return to work, you will be billed for the premiums due.

There is a maximum amount of time in which active benefits will continue. The Benefits Continuation Policy defines the maximum period of benefits continuation, per leave type, with an employee responsible for only the Employee portion of the insurance premium, while on an approved unpaid leave of absence. The maximum period is tracked in a rolling 12-month period. Benefits will terminate on the final day of the month following the maximum benefits continuation period.

The benefits continuation period depends on the type of approved leave an employee is on:

- While on an approved unpaid leave of absence under the Family Medical Leave Act (FMLA), benefits will continue through the duration of the approved FMLA period.
- While on an approved unpaid Military Leave of absence, benefits will continue for up to 12 months.
- Any other leave that is not an approved FMLA or Military Leave of absence will be considered Non-FMLA and benefits will continue for up to a **maximum of 4 pay periods**.

Visit the Benefit Continuation Policy for additional information.

What happens if I terminate employment or change to a non-benefits eligible status while receiving Disability Benefits?

Once you are approved to receive Disability Benefits, those payments will continue for the duration of the approved period without interruption up to the maximum 26-week benefit duration period even if you terminate employment or change to a non-benefits eligible status while receiving Disability Benefits.

What to expect if I need to submit a claim

Your STD benefits are intended to help support you while you are unable to work. The claim management process used by the claim administrator is based on the type of injury or illness and on the expected length of time away from work due to the injury or illness. The claim administrator will work with you to understand your specific needs and help you with the disability claim approval process.

How do I submit a claim?

Claims can be filed in two ways: via the Internet at **mySedgwick** (24 hours a day, seven days a week) or by phone toll-free at 1-800-599-7797. Representatives are available to take your call 6 AM.- 6 PM Mountain Standard Time, Monday through Friday.

When must I submit a claim?

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

Who will review my claim?

Once the claim administrator receives your claim request (including all three parts: employee, employer and attending physician's statement), you will be assigned a disability benefits specialist who will handle your claim. This individual who is trained in disability management will evaluate and pay the claim in accordance with the Plan and will begin working with you toward your recovery and return-to-work goals as appropriate.

Is anyone else involved in the review process?

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

Participation in any case management program that the claim administrator determines to be beneficial to your return to work is required for your continued eligibility.

When will a decision be made about my claim?

With some conditions, such as standard maternity leave or recovery following a routine surgery, your benefits may begin almost immediately after the Elimination Period concludes, provided all three parts of the claim are completed timely.

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

DISABILITY

When do Disability Benefits become payable?

The claim administrator approves payment of a weekly benefit for covered conditions after the end of the benefit Elimination Period and only when you and your Physician or Mental Health Professional provide documentation that you:

1. Are disabled due to illness or injury, and
2. Are under appropriate treatment and care of a Physician or Mental Health Professional.

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

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

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

How are claims paid?

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

Your STD check will be mailed to the address you provided when you filed your claim, or you have the option to set up direct deposit. Direct deposit instructions are provided after your claim is filed.

What constitutes proof of claim?

For a claim to be processed, the claim administrator must receive your claim for benefits (with all required forms completed and signed), as well as sufficient objective medical evidence in support of your claim. Such evidence may consist of records from your doctor or Mental Health Professional, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the Regular Care and treatment of a Physician or Mental Health Professional. In the absence of such proof, the claim administrator may elect to suspend benefits until such proof is received.

Your disability must be supported by current objective medical evidence. You must be under the continuous care of a qualified Physician or Mental Health Professional, with a course of treatment that is appropriate for your condition.

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

You must give the claim administrator proof of continued disability and regular treatment by a Physician or a Mental Health Professional within 45 days of the date the claim administrator requests such proof.

Are Disability Benefits taxable?

Your Disability Benefits are not considered taxable income because you pay the premium contribution with post-tax dollars.

What conditions must be met for Disability Benefits to continue?

You will be paid a weekly benefit for a covered condition so long as you remain disabled and are under the appropriate treatment and care of a Physician or Mental Health Professional. You will not be paid longer than described in the ‘What is the Maximum Benefit Duration Period?’ section.

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

The claim administrator may require that you be examined as often as is reasonable, at the Plan’s expense, by an independent Physician or Mental Health Professional of the administrator’s choice. You may also be required to be interviewed by an authorized claim administrator representative. If you fail to comply with such a request, the result will be an interruption in or termination of benefits. Benefits may also be terminated if the results of the independent examination determine that you are not disabled under the definition of ‘Disability.’ See the ‘Terms and Definitions’ section.

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

Participation in any case management program that the claim administrator determines to be beneficial to your return to work is required for your continued eligibility. Participating in the case management program means following the recommended treatment plan and attending the required appointments.

How do I estimate my benefit payment?

To calculate the amount of your weekly benefit, multiply your weekly base salary by the percentage of the benefit coverage amount you elected (i.e. 40, 50, or 60%) and deduct any 'Other Income Benefits' you are receiving that offset your benefit from this Plan. Refer to the 'What are Other Income Benefits?' section for more information.

If you are disabled for a partial week, divide your estimated weekly benefit payment by seven and multiply by the number of approved disabled days in the week.

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

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

If there is a transitional duty assignment available that meets your medical restrictions and for which you are qualified, you will be required to participate in transitional duty in order to continue receiving Disability Benefits. Any needed or requested accommodations under the Americans with Disabilities Act (ADA) will be subject to the Act and the County's ADA policy, HR2429.

What is the Transitional Duty – Return to Work Process?

When released by your healthcare provider to return to work partial days and/or with restrictions, the claim administrator will communicate this return-to-work information to your Human Resources liaison. Your Human Resources liaison will coordinate exploring possible transitional duty assignment with your Manager or Supervisor and will communicate this information to you. In the event you are approved for transitional duty assignment, your Human Resources liaison will be requested to communicate this and your transitional duty work schedule (i.e., number of hours worked per day per week) to the claims administrator for the purposes of calculating your partial disability benefit payment.

How do I estimate my STD benefits if I am working in a transitional duty assignment?

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

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

Pre-disability gross wages for 40 hours =	$800
($20/hour) STD Benefit Level	60%
Standard STD Benefit (60% level)	$480 ($800 x 60%)
Part-time Gross Wages	$400 ($20 x 20 hours)
Standard STD Plus Part-Time Wages	$880 ($480 + $400)
80% of Pre-disability Gross Wages	$640 ($800 x 80%)
Partial disability benefit	$240 ($640 - $400)

In this example, the STD benefit plus gross part-time earnings cannot exceed 80% of pre-disability gross wages or $640.Thus, the STD benefit must be reduced from $480 to $240.

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

What happens if I am out of work for a long time?

If your claim is or becomes long term and you are covered under the ASRS, you may want to apply for long-term disability. Contact your Human Resources liaison for more information.

What are Other Income Benefits?

Unless prohibited by applicable law, 'Other Income Benefits' offset the amount of your STD payment. You are responsible for reporting the receipt of other income immediately upon receipt to the claim administrator. If it is discovered after the fact that an offset should have occurred and did not, you will be required to pay back an amount equal to the offset amount. Other Income Benefits include, but are not limited to, the following:

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

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

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

If no period is given for the lump sum, you are responsible for paying the Plan an amount equal to the full amount of the lump sum received or the full amount of Disability Benefits received, whichever is less.

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

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

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

GENERAL EXCLUSIONS

What disabilities are not covered?

This plan will not provide payments for any Disability Benefits if:

1. You are not under the direct and Regular Care of a Physician or Mental Health Professional and are not receiving Medical Treatment as defined in the 'Terms and Definitions' section;
2. You participate in a felony and become disabled because of such participation;
3. You are confined in any penal or correctional institution because of a conviction for a criminal or other public offense;
4. Your injuries are sustained while you are on a personal leave of absence without pay, excluding jury duty and vacations (see 'Active Employment' in the 'Terms and Definitions' section).
5. Your Physician or Mental Health Professional is unable to provide a valid diagnosis. Symptoms such as pain, lethargy, and fatigue do not constitute a valid diagnosis.
6. You have cosmetic or elective surgery, except surgery made necessary by accidental injury incurred while covered under the plan;
7. You have an injury, sickness or pregnancy for which you receive, or a prudent person would have received Medical Treatment within the 90 calendar days before the date your coverage under the STD plan became effective. This exception does not apply to disability commencing after a plan participant has been covered under the plan for a period of 12 continuous months or has been treatment-free for three months, whichever comes first.
8. You are on an approved Military Leave of Absence. Short-Term Disability coverage terminates on the day in which military leave commences. You must contact the Employee Benefits and Wellness Division to reinstate Short-Term Disability within 30 days of return to work from Military Leave.

TERMINATION

When does coverage terminate?

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

1. The date your Employer discontinues the Plan;
2. The last day of the month for which the premium was paid;
3. The last day of the month in which your employment ends (if you are disabled on or before the date you cease to be an employee and would otherwise be entitled to benefits for that disability, benefits will be payable as though coverage had not terminated. Benefits under this extension will be payable only if the disability continues without interruption);

How will I be notified about the decision regarding my disability claim?

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

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

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

What happens if I disagree with the claim administrator's decision on my claim?

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

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

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

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

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

If this does not satisfactorily resolve your claim, you should send a letter to the claim administrator at:
Sedgwick
Attn: Director of Claims
P.O. Box 9830
Calabasas, CA 91372
within 20 calendar days of the receipt of the appeal denial. Your 2nd and final written appeal must include your statement of the general nature of the appeal; a copy of the denial letter; a statement of the factual circumstances giving rise to the appeal, a summary of the action already taken prior to filing the final appeal and a statement as to the remedy you seek to resolve the final appeal.

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

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

Employee Benefits may ask that you put your complaint in writing. A Benefits Representative will work with the administrator and you to resolve your service issue.

PREMIUM COSTS

Short-Term Disability (STD) Plan

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

Short-Term Disability Premium Calculation Example

	Multiplier
40%	0.18%
50%	0.29%
60%	0.55%

Annual Base Salary:$25,000	40% Option	50% Option	60% Option
Multiplier	0.0018	0.0029	0.0055
Annual Premium	$45.00	$72.50	$137.50
Deductions Per Year	26	26	26
Per Pay Period Premium (Per Pay Period Salary x Per Pay Period Multiplier)	$1.73	$2.79	$5.29

TERMS AND DEFINITIONS

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

Active Employment means you must currently be working:

- For your Employer in regular status and paid regular earnings,
- At least the minimum number of hours to be eligible for coverage, and

Note: Employees working under specific employment contracts may or may not be eligible for certain benefits based on the terms of their contract.

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

Disability and **Disabled** mean that because of illness or injury you cannot perform each of the essential functions of your Regular Occupation and you are not working in any occupation. Furthermore, you are not considered disabled unless you are under the Regular Care and Medical Treatment of a Physician or Mental Health Professional who is practicing within the scope of his/her license or certification during the entire period of disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PLAN CONTACT INFORMATION

Name of the plan

Maricopa County Group Short-Term Disability Plan (the Plan) or (STD Plan)
Group Number 435000

Name and address of Employer/payroll coordinator

Maricopa County
301 W. Jefferson St., Suite 820
Phoenix, Arizona 85003

Who pays for the plan?

Participating employees pay the cost of this plan.

Plan Sponsor/Plan Administrator

Maricopa County
Employee Benefits and Wellness Division
301 W. Jefferson St., 8th Floor
Phoenix, AZ 85003

Phone: (602) 506-1010
Fax: (602) 506-2354
Email: Benefits@maricopa.gov

Agent for service of legal process

See Plan Administrator section above.

Claim administrator

Sedgwick
PO Box 14648
Lexington, KY 40512-4648

Customer service telephone number: (800) 599-7797
Fax number: (855) 800-5116