STATE EMPLOYEE BENEFITS AND WORKERS' COMP: 2015 UPDATE

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By

Valerie A. Johnson
Copeley Johnson & Groninger PLLC
Durham, North Carolina
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I. INTRODUCTION[2]

Although the interaction between the state employee benefits system and the workers' compensation system has some points of friction that have been the source of litigation,[3] as a general rule, the two systems fit together fairly neatly. This paper provides a broad overview of the benefits available to state employees from the State and discusses how the receipt of workers' compensation benefits would affect these benefits. Finally, it discusses how the careful structuring of settlements can mitigate or avoid offsets of workers' compensation benefits against benefits from the State.

II. STATE WORKERS' COMPENSATION PROGRAM ADMINISTRATION

The State of North Carolina is self-insured for workers' compensation. Prior to 1996, the State's workers' compensation program was self-administered by each state agency. Presently only the Department of Transportation self-administers its program. The workers' compensation programs of the other agencies are administered by Sedgwick.

The 1995 General Assembly established a three-year pilot program using an outside third party administrator in an effort to reduce the cost of claims filed by state employees. Key Risk Management Services was selected as the third party administrator for the pilot program. In late 1998, Key Risk was awarded a contract to administer the State's workers' compensation programs for up to 63 months beginning April 1, 1999, in exchange for a fee for each claim handled. Following the contract expiration in 2004, the process was re-opened for proposals and bidding. Key Risk was again selected as administrator. Its contract was extended in 2007 and came to an end

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[1] Narendra Ghosh of Patterson Harkavy LLP updated of the latest edition of this paper.

[2] An earlier edition of this paper was submitted for review to the Teachers' and State Employees' Retirement System of North Carolina in order to ensure its accuracy. We were informed that, based on the advice of the Attorney General's Office, the Retirement System would not give an opinion regarding whether the information contained in this paper was accurate.

[3] See, e.g., Estes v. North Carolina State University, 89 N.C. App. 55, 365 S.E.2d 160 (1988), appeal after remand 102 N.C. App. 52, 401 S.E.2d 384 (1991).

in June 2009.

In 2009, Corvel was awarded the contract, and began operating as the third party administrator in July 2009. Corvel's original three-year contract was subsequently extended. In 2015, Sedgwick was awarded the contract and became the third party administrator for a term of three years.

The workers' compensation programs for the county and city boards of education are the responsibility of the State's Board of Education. N.C.G.S. § 115C-337(a). Sedgwick was awarded the contract to serve as the administrator for workers' compensation for employees of the State's Department of Public Instruction and local school systems for three years beginning in July 2015.[4]

III. STATE EMPLOYEE ELIGIBILITY FOR BENEFITS

All North Carolina state government employees are eligible to receive workers' compensation, including all agency and university employees and officers, state elected officials, and members of the General Assembly. In addition, part-time and temporary employees of the State, in addition to full-time employees, may receive workers' compensation. N.C.G.S. § 97-2(3); North Carolina Office of State Personnel, State Personnel Manual [hereinafter "Personnel Manual"], § 6, at 38, 43.[5]

A more limited number of employees are covered by the benefits administered by the Teachers' and State Employees' Retirement System of North Carolina ("TSERS"), which administers short and long-term disability benefit plans and a retirement benefit plan. To be a member of the Teachers' and State Employees' Retirement System, an employee must be: a permanent full-time teacher or employee of a state-supported board of education or community college, or a permanent employee of the State or its agencies and work at least 30 hours per week for 9 months a year. N.C.G.S. § 135-3(1), 135-1(10), (25). Coverage under the plan ends once an employee terminates employment with the State, withdraws accumulated contributions, or dies. N.C.G.S. § 135-3(3).

IV. RELATIONSHIP BETWEEN STATE EMPLOYEE BENEFITS AND THE WORKERS' COMPENSATION SYSTEM

A. Legal Waiting Period

[4] Sedgwick's proposal to administer this program, which includes a detailed description of its claims administration process, is attached as Appendix A.

[5] Relevant excerpts of the State Personnel Manual, Section 6 are attached to this paper as Appendix B. The Office of State Personnel's workers' compensation handbook for employees is attached as Appendix C. These documents may be obtained online at www.osp.state.nc.us.

State employees who suffer an injury on the job or contract an occupational disease are expected to apply for workers' compensation benefits.[6] Personnel Manual § 6, at 39. Like non-state employees, state employees have a seven-day waiting period before they become eligible to obtain workers' compensation benefits. N.C.G.S. § 97-28. During this time, some employees will be able to receive their normal pay by taking accrued sick or vacation leave.

Employees who miss work because of their disability and have accrued sick or vacation leave can, but are not required, to use this leave to receive their normal salary during the waiting period. N.C.G.S. § 135-104; Personnel Manual § 6, at 44. Under the workers' compensation system, these workers will later be paid at the usual workers' compensation weekly rate for this period of time if the period of disability lasts more than twenty-one days. N.C.G.S. § 97-28. The amount of workers' compensation later paid for this period is not offset against the amount paid for sick or vacation leave. However, the sick or vacation time used will still be considered used and no longer available to the employee. Personnel Manual § 6, at 44.

Employees who have no accrued sick or vacation leave or elect not to use accrued leave will not be paid during the seven-day waiting period for workers' compensation benefits. Id. If the disability lasts more than twenty-one days, the workers' compensation system would then pay the normal workers' compensation benefit due for this period of time. Id.

B. Receipt of Workers' Compensation Benefits Following the Waiting Period

Once the waiting period has expired, state employees eligible for workers' compensation benefits are required to draw them and go on "workers' compensation leave." Personnel Manual § 6, at 38, 43. In addition, these employees may be able to receive wage replacement benefits from: 1) accrued vacation and sick leave; 2) the State's short-term disability plan; 3) the State's long-term disability plan; and 4) the State's retirement plan. Whether workers' compensation benefits will be offset against these benefits will depend on the type of state benefit and the type of workers' compensation benefit at issue.

While on "workers' compensation leave," an employee continues to accumulate vacation and sick leave which is credited to the employee's account for use upon return to work. Personnel Manual § 6, at 45.

1. Accrued vacation and sick leave and return to work

[6] Certain categories of employees, including law enforcement officers injured due to the special risks of their emploiyment and teachers injured by an act of violence, will not draw periodic workers' compensation benefits during the first one or two years of disability. These employees are covered by special statutory provisions that ensure that they will receive a full salary during these years. See infra at Part IV.C.

Employees who receive workers' compensation benefits and who miss work as a result of their disability are eligible to use accrued vacation or sick leave to supplement their workers' compensation benefits.[7] Personnel Manual § 6, at 44. An employee's workers' compensation benefits will generally amount to two-thirds of his or her regular salary subject to a maximum cap.[8] Under the State's supplemental income program, the employee can use a set amount of earned vacation leave or sick leave each week in accordance with a schedule published each year by the Office of State Personnel. Personnel Manual § 6, at 44. The schedule sets out the amount of vacation and sick leave that may be used each week in order roughly to approximate the employee's pre-injury income.

The supplemental income program is not available to employees who have no accrued vacation or sick leave. By the same token, it is not available to employees whose employment is terminated because they will not be able to return to their jobs; these employees are paid their accumulated vacation and sick leave (including leave accumulated only during the first twelve months of workers' compensation leave) in a lump sum. Finally, this program is not available to those who are placed in a light duty job that pays less than their normal salaries. Personnel Manual § 6, at 44-45.

The state Personnel Manual specifically addresses the treatment of employees who have been released to return to work. Prior to "maximum medical improvement," if unable to perform the original position, the employee is to be placed in temporary limited work "suitable to the employee's capacity which is both meaningful and productive and advantageous to the employee and the agency." Personnel Manual § 6, at 41-42.

At maximum medical improvement, if able, the employee is to be returned to the original or equivalent position. If not able to perform such work, the state agency is to attempt to place the employee in another suitable position which is mutually advantageous and "is both meaningful and productive." If a suitable position is unavailable, the employee is to be given the first suitable vacancy and receive “work placement efforts.” Personnel Manual § 6, at 42. The state agency is to "request stop payment of compensation and implement dismissal procedures" when the employee is at maximum medical improvement and "refuses suitable employment in keeping with the employee's capacity." Personnel Manual § 6, at 42.

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[7] Employees eligible for workers' compensation benefits may not draw accrued vacation or sick leave pay in lieu of accepting benefits. Employees eligible for workers' compensation benefits are required to draw workers' compensation benefits and may use accrued vacation and sick leave only to supplement these benefits. State Personnel Manual, § 6, at 44.

[8] As of January 1, 2015, the maximum weekly rate of compensation was $920.00 for injuries occurring after that date. The maximum weekly rate for injuries occurring after January 1, 2016, is $944.00.

2. Short-term disability plan

The State provides a short-term disability plan for disabled[9] employees who meet eligibility requirements.[10] The short-term disability plan begins to pay benefits following a 60-day waiting period. N.C.G.S. § 135-104(a). After that time, disabled employees receive benefits for 365 days, although they may also receive an additional 365 days of benefits if the State's Medical Board determines that they will likely be able to return to work during that period. N.C.G.S. § 135-105(b), (g).

Short term disability benefits are offset dollar-for-dollar by periodic workers' compensation benefits for temporary partial or temporary or permanent total disability.[11] N.C.G.S. § 135-105(c); Benefits Pamphlet, at 34. The short-term disability plan provides that employees will receive approximately 50 percent of their pre-injury weekly pay.[12] Because workers' compensation benefits generally provide two-thirds of an

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[9] By statute, disability is defined as: "[t]he mental or physical incapacity for the further performance of duty of a participant or beneficiary; provided that such incapacity was not the result of terrorist activity, active participation in a riot, committing or attempting to commit a felony, or intentionally self-inflicted injury." N.C.G.S. § 135-101(6). The Trustees of the Retirement System require that an employee be incapacitated only in the performance of his or her usual occupation. Teachers' and State Employees' Retirement Handbook Revised January 2015, entitled, "Your Retirement Benefits" [hereinafter "Benefits Pamphlet"], at 33. (This publication is online at https://www.nctreasurer.com/ret/Benefits%20Handbooks/TSERShandbook.pdf.)

[10] To be eligible for short-term disability benefits, employees must: 1) have at least one year of contributing membership service in the Retirement System earned within 36 calendar months preceding the disability; 2) be found to be mentally or physically disabled for the further performance of their usual occupation; and 3) have had the disability continuously and incurred at the time of active employment. N.C.G.S. § 135-105(a); Benefits Pamphlet, at 33. There is no requirement that an application for short-term disability by filed by any particular time.

[11] Workers' compensation benefits for a "permanent partial disability rating" do not offset short-term disability benefits. N.C.G.S. § 135-101(21). See infra at 6. In addition, social security benefits do not offset short-term disability benefits. Benefits Pamphlet, at 34. A 1994 amendment provides for the offset from short-term and long-term disability benefits of "any monthly payments from the federal Veterans Administration, any other federal agency, or any payments made [for disability from National Guard Service] to which the participant may be entitled on account of the same disability." N.C.G.S. §§ 135-105(c), -106(b) (emphasis added). The Retirement System, however, does not apply this amendment to offset social security benefits from short-term disability. The legislative history and preexisting offset of social security from long-term disability benefits support the Retirement System's view that this language was enacted as authority to offset only government payments to veterans on account of the same disability for which the participant is receiving disability benefits. Benefits Pamphlet, at 34-35; Sess. Laws 1993 (Reg. Sess., 1994), ch. 769, secs. 7.30(s)-(v).

[12] Under the disability plan, an employee's monthly short-term benefit will equal 50

employee's average weekly earnings, usually the workers' compensation benefits will completely offset the short-term disability plan's benefits.[13]

The workers' compensation lawyer should be aware of two features relating to the offset. First, even if an employee will draw only minimal benefits from the disability plan because of the offset, it may still be in the employee's interest to apply and qualify for short-term disability benefits. Those employees who are paid any monthly benefits under the short-term disability plan will earn retirement credits for the time they receive these benefits. N.C.G.S. § 135-4(y). In contrast, workers who receive solely workers' compensation do not automatically earn retirement credits and must, instead, buy them for a lump sum payment shared between the employee and employer. N.C.G.S. § 135-4(r); Personnel Manual § 6, at 46.[14]

Second, although periodic workers' compensation benefits for all total disability under N.C.G.S. § 97-29 and for partial disability based on wage loss under N.C.G.S. § 97-30 are offset from short-term disability benefits, compensation for a permanent partial disability rating pursuant to N.C.G.S. § 97-31 is not offset. N.C.G.S. § 135-101(21); N.C.G.S. § 135-105(c); Benefits Pamphlet, at 34. Consequently, at the time an employee who is partially disabled reaches maximum medical improvement, it may be to his or her advantage to accept compensation based on a rating under N.C.G.S. §97-31 rather than to continue receiving benefits based on wage loss under N.C.G.S. §97-30 in order to avoid the offset. See Gupton v. Builders Transport, 320 N.C. 38, 357 S.E.2d 674 (1987).

3. Long-term disability plan

Following the cessation of short-term disability benefits, eligible disabled state employees may receive benefits from the State's long-term disability plan.[15] N.C.G.S. §

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percent of 1/12th of his or her annual base rate of compensation prior to the beginning of the short-term benefit period, plus 50 percent of 1/12th of his or her annual longevity payment, if any, to a maximum of $3,000 per month. N.C.G.S. § 135-105(c); Benefits Pamphlet, at 33.

[13] Highly-paid employees may be an exception to this general rule. These employees will receive less than two-thirds of their regular pay because of the maximum weekly rate on workers' compensation benefits. Depending on their salary, these employees' benefits under the disability plan may not be completely offset by workers' compensation, as the maximum rate payable for benefits under the disability plan is higher than that paid for workers' compensation benefits.

[14] Employees whose short-term disability benefits are completely offset by workers' compensation will not earn retirement credits, as the statute requires that an employee be both "eligible for" and "paid" disability plan benefits to earn retirement credits for that month. N.C.G.S. § 135-4(y) (emphasis added).

[15] Employees are eligible to receive long-term disability benefits for as long as they remain disabled until they are eligible for unreduced service retirement. N.C.G.S. § 135-106(b). Employees are eligible for long-term disability benefits if they: 1) have at

135-106(a). Eligibility for these benefits, however, is conditioned on the termination of state employment. In the absence of an application for long term disability, the disabled employee will be able to continue on "workers' compensation leave" until the state agency employer determines that circumstances justify termination on the basis of "unavailability." Personnel Manual § 11, at 6-7.[16] An employee on "workers'

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least five years of contributing membership service in a retirement system earned within 96 calendar months prior to the end of the short-term disability period; 2) apply to receive long-term benefits within 180 days after the end of the short-term disability, salary continuation payments, or monthly workers' compensation payment (excluding payments for ratings for permanent partial disability), whichever occurs later; 3) are certified mentally or physically incapacitated for further performance of duty by the medical board, where the disability has been continuous, is likely to be permanent, and is incurred at the time of active employment; and (4) terminate their employment as a state employee. N.C.G.S. § 135-106(a); Benefits Pamphlet, at 34.

[16] See supra at 4, for discussion of treatment of employees released to work. The policy for "separation due to unavailability when leave is exhausted" provides:

> An employee may be separated on the basis of unavailability when the employee becomes or remains unavailable for work after all applicable leave credits have been exhausted and agency management does not grant a leave without pay, or does not extend a leave without pay period, for reasons deemed sufficient by the agency. Such reasons include, but are not limited to, lack of suitable temporary assistance, criticality of the position, budgetary constraints, etc.
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> …
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> Prior to separation, the employing agency shall notify the employee in writing of the proposed separation, the efforts undertaken to avoid separation and why the efforts were unsuccessful. The employing agency must also give the employee a letter of separation stating the specific reasons for the separation and setting forth the employee's right of appeal. The burden of proof on the agency in the event of a grievance is not just cause, as that term exists in G.S. 126-35. Rather, the agency's burden is to prove that the employee was unavailable, that reasonable efforts were undertaken to avoid separation, and the reason the efforts were unsuccessful.
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> Involuntary separation pursuant to the policy may be grieved or appealed. The employing agency must also give the employee a letter of separation stating the specific reasons for the separation and setting forth the employee's right of appeal. The burden of proof on the agency in the event of a grievance is not just cause, as that term exists in G.S. 126-35. Rather, the agency's burden is to prove that the employee was unavailable, that the agency considered the employee's proposed accommodations for the unavailability and were unable to make the proposed accommodations or other reasonable accommodations.
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> Agencies should make efforts to place an employee when the employee

compensation leave", therefore, will want to consider whether he or she should delay applying for these benefits in order to retain the option of returning to work. A 365-day extension for benefits under the short term disability plan is available in these circumstances if the State's Medical Board determines that the disability continues to be temporary and the employee will likely return to work during the extended period. N.C.G.S. § 135-105(b), (g).

As with short term disability benefits, there is a dollar-for-dollar offset against long-term disability benefits of weekly workers' compensation benefits for temporary partial disability under N.C.G.S. § 97-30 or for temporary or permanent total disability under N.C.G.S. § 97-29. N.C.G.S. § 135-101(21), N.C.G.S. § 135-106(b); Benefits Pamphlet, at 34.[17] During the first 36 months of long-term disability, the monthly long-term benefit will equal approximately 65 percent of the employee's salary,[18] offset by applicable workers' compensation or any social security disability or retirement benefits the employee "may be entitled" to receive, whether or not he or she elects to receive the retirement benefit.[19] N.C.G.S. § 135-106(b).

The July 2007 amendment to the long-term disability provision altered the benefits scheme after the first 36 months of benefits. For employees who have not

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becomes available, if the employee desires, consistent with other employment priorities and rights. However, there is no mandatory requirement placed on an agency to secure an employee, separated under this policy, a position in any agency.

[17] In David v. N.C. Department of Correction, I.C. 606302 (Full Comm'n Nov. 29, 2000), a divided Full Commission ruled that the Department of Correction was entitled to a "dollar for dollar credit" for the long term disability payments received by the employee. In her dissent, Commissioner Ballance pointed out that the Retirement System, not the agency, gets the credit in these circumstances.

[18] By statute, the employee will receive 65 percent of 1/12th of the annual base rate of compensation prior to the beginning of the short-term benefit, plus 65 percent of 1/12th of the annual longevity payment, if any, to a maximum of $3,900 per month. N.C.G.S. § 135-106(b); Benefit Pamphlet, at 34.

[19] Accordingly, the long-term benefit will be offset by the amount of the reduced social security retirement benefit of any employee age 62 or older, whether or not the employee applies for these benefits. The long-term benefit, however, will not be offset by the amount of a social security disability benefit during the first 36 months unless the employee has actually been awarded these benefits. An employee who is totally disabled and insured under the social security system is entitled to receive social security benefits following a five-month waiting period. Employees age 65 and older, and who are insured under the system, are entitled to receive full social security retirement benefits. Disabled employees between 62 and 65 years of age have a choice between receiving social security disability or reduced social security retirement benefits. The age at which an employee is entitled to the full social security retirement benefit increases incrementally for employees born after 1937 until it is age 67 for employees born in 1960.

vested benefits as of July 31, 2007 (i.e. they did not have 5 years of service), long-term benefits cease after 36 months unless the employee has been approved and is in receipt of primary Social Security disability benefits. N.C.G.S. § 135-106(b); Session Law 2007-325 §§ 2, 4; Benefit Pamphlet, at 35. The long-term benefit is then reduced by an amount equal to the awarded social security disability benefit. Id.[20] For employees who have vested benefits as of July 31, 2007, long-term benefits continue after 36 months, but are reduced by an amount equal to the social security disability benefit to which the worker would have been entitled had he or she been awarded social security disability benefits. N.C.G.S. § 135-106(b); Session Law 2007-325 § 4; Benefit Pamphlet, at 35. As with short-term disability benefits, long-term disability benefits will, therefore, generally be largely offset by workers' compensation and social security benefits.[21] However, an employee eligible for long-term disability will automatically receive the $10.00 minimum payment per month from the long-term disability plan, regardless of the amount of other benefits received. Id.

The present practice of the Board of Trustees of the Retirement System is to limit the offset for workers' compensation to the net amount after reduction for attorney's fees deducted and paid by the state agency directly to the employee's attorney. See Hunt v. N.C. State Univ., I.C. No. 839851, at Conclusion #4 (Dep. Comm'r Feb. 28, 2006) ("Defendants' credit for said disability benefits is reduced by the amount necessary to provide counsel for Plaintiff with an attorney's fee of 25% of the indemnity benefits due Plaintiff."), rev'd on other grounds by I.C. No. 839851 (Full Comm'n Apr. 13, 2007). This practice is consistent with the decisions of the North Carolina Court of Appeals on the treatment of attorney's fees paid by social security claimants. The Court of Appeals has held that the offset for social security disability benefits is limited to the net benefit amount after deduction of the beneficiary's attorneys' fees. Willoughby v. Board of Trustees, 121 N.C. App. 444, 466 S.E.2d 285 (1996); Smith v. Board of Trustees, 122 N.C. App. 631, 471 S.E.2d 121 (1996). The court reasoned that the beneficiary was not "entitled" within the meaning of N.C.G.S. § 135-106(b) to the amount statutorily reserved and paid directly by the Social Security Administration to the beneficiary's attorney as fees. The court, however, drew a distinction between the attorneys' fees paid directly to the attorney and the costs which the beneficiary reimbursed to his attorney. The offset thus was not reduced by the expenses the beneficiary reimbursed to his attorney. Willoughby v. Board of

[20] If the long-term benefit ceases after 36 months, the benefit may later be restored retroactively to the date of cessation, however, if the Social Security Administration "grants a retroactive approval" for the disability benefit with a "benefit effective date" within the first 36 months of the long-term disability period. Id.

[21] Highly-paid employees may be an exception to this general rule. These employees will receive less than two-thirds of their regular pay because of the statutory cap on workers' compensation benefits. Depending on their salary, these employees' benefits under the disability plan may not be completely offset by workers' compensation benefits as the maximum rate payable for benefits under the disability plan is significantly higher than that paid for workers' compensation benefits.

Trustees.[22]

The same features relevant to a workers' compensation lawyer with respect to short-term disability benefits are also relevant with respect to long-term disability benefits. First, as with short-term disability, it may be in the employee's interest to apply and qualify for long-term disability even if, due to the workers' compensation offset, he or she will receive only the $10.00 minimum monthly payment. Those employees who do so will earn retirement credits for the time they receive even this minimal amount of disability benefits. N.C.G.S. §135-4(y). Employees who receive solely workers' compensation do not automatically earn retirement credits and must, instead, buy them for a lump sum payment shared between the employee and employer. N.C.G.S. §135-4(r).

Second, although the Teachers and State Employees' Retirement System offsets workers' compensation periodic benefits for total disability pursuant to N.C.G.S. § 97-29 and for partial disability based on wage loss pursuant to N.C.G.S. § 97-30, it does not offset benefits for permanent partial disability based on acceptance of a rating pursuant to N.C.G.S. § 97-31. N.C.G.S. §§ 135-101(21), 135-106(b); Benefits Pamphlet, at 34. Consequently, at the time an employee who is partially disabled reaches maximum medical improvement, it may be to his or her advantage to accept compensation based on a rating under N.C.G.S. §97-31 rather than receive benefits based on wage loss under N.C.G.S. §97-30 in order to avoid the offset. See Gupton v. Builders Transport, 320 N.C. 38, 357 S.E.2d 674 (1987).

4. State Employees' Retirement Plan

The receipt of workers' compensation benefits has no effect on the amount of retirement benefits received. Once an employee becomes eligible for unreduced retirement benefits,[23] benefits from the State's long-term disability plan will cease.

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[22] The Court of Appeals also concluded in Smith v. Board of Trustees that widow's insurance benefits under the Social Security Act are "separate and different from social security disability benefits" and accordingly are not subject to offset from the long-term disability benefit under N.C.G.S. § 135-106(b).

[23] Workers' compensation benefits have no effect on unreduced retirement benefits and reduced early retirement benefits. An employee who is not a law enforcement officer is eligible for unreduced benefits after: 1) he or she reaches age 65 and completes 5 years of creditable service; or 2) he or she reaches age 60 and completes 25 years of creditable service; or 3) he or she completes 30 years of creditable service at any age. A law enforcement officer is eligible for unreduced retirement benefits after: 1) he or she reaches age 55 and completes 5 years of creditable service; or 2) he or she completes 30 years of creditable service. An employee who is not a law enforcement officer is eligible for reduced early retirement benefits after: 1) he or she reaches age 50 and completes 20 years of creditable service; or 2) he or she reaches age 60 and completes five years of service. A law enforcement officer is eligible for reduced early retirement benefits after he or she reaches age 50 and completes 15 years of creditable

N.C.G.S. §135-106(b).

5. Local Government Employees' Retirement System

Employees of counties and cities and other local governmental units are covered by the Local Government Employees' Retirement System ("LGERS") if their employer has agreed to participate. N.C.G.S. § 128-23. Workers' compensation benefits also have no effect on pension benefits of local government employees participating in the State's retirement system.

A local government employee is entitled to a disability retirement benefit if permanently disabled from performing his or her job after five years of creditable service or at any time if a law enforcement officer, fireman or rescue squad worker disabled from an accident in the performance of duties. N.C.G.S. § 128-27(c).[24] This disability retirement benefit is unlike anything in the current State Employees' system and should be examined carefully if applicable. For example, some local governmental employees may be excluded from social security taxes and coverage on government earnings, thus making the receipt of the disability retirement benefit crucial for qualified disabled employees.

Following the Court of Appeals decision in Cox v. City of Winston-Salem, 157 N.C. App. 228, 578 S.E. 2d 669 (2003), the Commission denied a credit to the public employer for disability retirement benefits paid under the Local Government Employees' Retirement System because the benefits were the result of joint employee/employer contributions. Cox v. City of Winston-Salem, I.C. 910497 (April 5, 2004).

Note that credit from other Retirement Systems, such as TSERS, may be counted along with credit in LGERS in order to determine eligibility for benefits. Creditable service also can be transferred between LGERS and TSERS. But, only creditable service in LGERS is used in computing the amount of benefits in LGERS. LGERS Pamphlet, at 8.

6. The *Faulkenbury* Decision

The previous discussion of the state disability program applies only to employees who retired after January 1, 1988. A different system applied to employees who retired before that date, when the present short term and long term disability programs did not exist. Before January 1, 1988, disabled employees who qualified received "disability retirement" benefits from the State. Unlike the payments from the present short and

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service. N.C.G.S. § 135-5(b16).

[24] Local Governmental Employees' Retirement Handbook Revised January 2015, entitled, "Your Retirement Benefits" [hereinafter "LGERS Pamphlet"], at 7. (This publication is online at https://www.nctreasurer.com/ret/Benefits%20Handbooks/LGERShandbook.pdf.)

long-term disability programs, these retirement payments were not offset by workers' compensation or social security benefits.

As a result of the Supreme Court's decision in Faulkenbury v. Teachers' & State Employees' Retirement System, 345 N.C. 683, 483 S.E.2d 422 (1997), the option to accept "disability retirement benefits" in lieu of short term and long term disability benefits still exists for employees (a) who have five years of membership service and thus were vested in the State Retirement System on January 1, 1988 and (b) who become disabled following this date. These employees may elect to receive a "disability retirement" benefit with no offset for workers' compensation or social security in lieu of the present short and long term disability plan benefits. The "disability retirement" normally will yield more generous benefits and thus usually should be selected by qualified employees. Since this is not always true, however, an individual assessment -- including income tax considerations -- is required. It may be more advantageous, for example, for an employee to select benefits under the Disability Income Plan when there is limited life expectancy because of the life insurance available under this plan or when disability occurs close to age 65.

The Retirement System provides employees qualified to make this election with a comparison of the benefits payable under the present long term disability plan and "disability retirement" under the Faulkenbury decision.[25]

C. Special Salary Continuation Plan For Law Enforcement Officers And Other Designated Positions

The State provides a special salary continuation plan for law enforcement officers and specific other employees[26] who are disabled in the course of their official

[25] The Retirement Systems' standard letter explaining the alternatives is attached as Appendix D.

[26] § 143-166.13. Persons entitled to benefits under Article.

(a) The following persons who are subject to the Criminal Justice Training and Standards Act are entitled to benefits under this Article:

(1) State Government Security Officers, Department of Administration;
(2) State Correctional Officers, Department of Corrections;
(3) State Probation and Parole Officers, Department of Corrections;
(4) Sworn State Law-Enforcement Officers with the power of arrest, Department of Corrections;
(5) Alcohol Law-Enforcement Agents, Department of Crime Control and Public Safety;
(6) State Highway Patrol Officers, Department of Crime Control and Public Safety;
(7) General Assembly Special Police, General Assembly;
(8) Sworn State Law-Enforcement Officers with the power of arrest, Department of Human Resources;
(9) Juvenile Justice Officers, Department of Juvenile Justice and

duties. N.C.G.S. § 143-166.14.[27] However, in 2014, the plan was modified to add the requirement that disability result from an injury "proximately caused by the heightened risk and special hazards directly related to the violent nature of the eligible person's official duties." Id. (emphasis added); see S.L. 2014-100, § 35.12(a). This change applies to all injuries occurring on or after October 1, 2014. S.L. 2014-100, § 35.12(b).

Under this plan, covered employees will receive their full salary for a period of two years from the date the employee is incapacitated. Id. A special provision for teachers and other employees of state educational institutions injured in an act of violence provides them their full salary for up to one year. N.C.G.S. § 115C-338(a), (b). During the time these provisions apply, employees will be ineligible to receive workers' compensation for total or partial disability based on wage loss under N.C.G.S. § 97-29 and § 97-30. N.C.G.S. §§ 143-166.16, 115C-338(b). However, they are eligible to receive all other benefits under the Workers' Compensation Act, including

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Delinquency Prevention;

(10) Insurance Investigators, Department of Insurance;

(11) State Bureau of Investigation Officers and Agents, Department of Justice;

(12) Director and Assistant Director, License and Theft Enforcement Section, Division of Motor Vehicles, Department of Transportation;

(13) Members of License and Theft Enforcement Section, Division of Motor Vehicles, Department o Transportation, designated by the Commissioner of Motor Vehicles as either "inspectors" or uniformed weigh station personnel;

(14) Utilities Commission Transportation Inspectors and Special Investigators;

(15) North Carolina Ports Authority Police, Department of Commerce;

(16) Sworn State Law-Enforcement Officers with the power of arrest, Department of Environment, Health, and Natural Resources;

(17) Sworn State Law-Enforcement Officers with the power of arrest, Department of Crime Control and Public Safety;

(18) Sworn State Law-Enforcement Officers with the power of arrest, Department of Revenue;

(19) Sworn State Law-Enforcement Officers with the power of arrest, University System.

(b) The following persons are entitled to benefits under this Article regardless of whether they are subject to the Criminal Justice Training and Standards Act:

(1) Driver License Examiners injured by accident arising out of and in the course of giving a road test, Division of Motor Vehicles, Department of Transportation.

(2) Employees of the Department of Correction injured by a direct and deliberate act of an offender supervised by the Department or while performing supervisory duties over offenders which place the employees at risk of such injury.

[27] Note that deputy sheriffs are not included within this plan.

compensation for a permanent partial disability rating pursuant to N.C.G.S. §97-31. Id. At the end of this period of time, these employees will be treated like other state employees, and will be subject to all provisions of the North Carolina Workers' Compensation Act.[28] N.C.G.S. § 143-166.14, 143-166.16. The statutory scheme thus may favor acceptance of a permanent partial disability rating under N.C.G.S. §97-31 where an employee is partially disabled, as benefits under that section may be available whereas the benefits under §97-30 may not be awarded during the salary replacement period.

V. SETTLEMENT OF WORKERS' COMPENSATION CLAIMS

A. Offset of Benefits

The existence of the offset for workers' compensation total and partial benefits based on wage loss against the State's short- and long-term disability benefits introduces a notable anomaly for the workers' compensation lawyer. Presently, the Board of Trustees of the Retirement System will not impose the offset to final settlement agreements or "clinchers", as it views payments under such agreements as a compromise of a disputed claim and something other than "disability income benefits under the North Carolina Workers' Compensation Act." N.C.G.S. § 135-101(21).[29] The consequence of this treatment of clincher agreements is that, where the worker qualifies for disability benefits under the State's plan, it may be exceedingly advantageous for him or her to enter into a clincher agreement. Because the offset would be avoided following the clincher, the employee's total monthly benefit would remain the same and the employee would, besides, receive the payment from the clincher agreement. Thus, even clinchers that give the employee significantly less than the present value of the expected workers' compensation benefits may be in the employee's interest.

It is important to note that the policy of the Board of Trustees may be subject to change concerning the imposition of the offset. The practitioner should be aware that reliance on the present policy could result in a reduced recovery in the future. Care should be taken to ameliorate the potential danger with language concerning the categorization of the lump sum in the compromise settlement agreement.

The financial incentive to enter a clincher is less the closer the employee is to

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[28]Employees covered by the law enforcement salary replacement program will have two years following the end of the period in which salary is paid to file their workers' compensation claim. N.C.G.S. §§ 143-166.16, 97-24. This statute provides that the state department head shall determine the "cause of the incapacity and to what extent the claimant may be assigned to" alternative work. The decision of the department head is filed with the North Carolina Industrial Commission and becomes final unless the claimant within 30 days files a request for hearing before the Commission. N.C.G.S. §§ 143-166.18 - 166.19.

[29]The "no offset" policy was confirmed with the Retirement Systems in November 2007.

attaining an unreduced service retirement, as long-term disability benefits would cease once an employee becomes eligible for retirement, although workers' compensation benefits would continue.

B. The State Comprehensive Major Medical Plan

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan ("State Health Plan") has a right to recover excess payments made to any persons, insurance companies or other organizations. N.C.G.S. §135-48.37(b). However, those rights were significantly expanded by the passage of a statutory provision effective July 1, 2004, and amended on August 27, 2006, establishing a right of subrogation, a right of first recovery against liable third parties, and a lien on damages recovered by the third party.[30] The plan has contracted with an outside company in order to facilitate recovery of such payment.[31]

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[30] N.C.G.S. § 135-48.37. Liability of third person; right of subrogation; right of first recovery:

(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18.2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery against any third party who was overpaid. If the Plan recovers damages from a liable third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a liable third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for not more than the value of claims paid related to the liability of the third party, on any damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney, and the attorney shall disburse proceeds

The State Health Plan has advised that the primary purpose of the statute was to allow recovery of payments in tort claims. While the language of the statute mirrors that of tort actions ("damages" and "liable third party"), full consideration of the potential implications to workers' compensation claimants has not been made. However, in the event that the Plan should seek subrogation in a settled workers' compensation claim, the provisions of N.C.G.S. § 97-17 should apply.

Further, it should be noted that an issue exists regarding whether the State Employee's health plan covers work-related injuries following a final settlement. The State Health Plan specifically excludes charges "for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges." N.C.G.S. § 135-48.52.(2). Accordingly, the employee's lawyer should consider whether specific provision should be made at the time of settlement for coverage for future medical expenses.

The attorneys in the Workers' Compensation and Tort Claims Section of the North Carolina Attorney General's Office work with these issues daily. They can be consulted regarding the proper way to structure clincher agreements to address medical insurance issues and avoid offsets.

VI. CONCLUSION

With careful attention to the relevant statutes, regulations, and provisions of the benefit plans available to state employees, the workers' compensation attorney can structure an employee's benefits under the various applicable plans to maximize the benefits received by the employee.

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pursuant to this section.

[31] Information concerning subrogation is attached as Appendix E.

sedgwick

Response to Request for Proposal

RFP No. DPI 40-PC00117-15

Prepared by Sedgwick | January 2015

Letter of Transmittal

January 23, 2015

Ms. Joni Robbins
Section Chief of Procurement and Contract
NC Department of Public Instruction
301 N. Wilmington Street
Raleigh, NC 27601

Re: RFP # DPI 40-PC00117-15, Workers' Compensation Insurance, North Carolina Department of Public Instruction, Date issued December 16, 2014

Conflict of interest statement

Sedgwick and its representatives have received no assistance in preparing the response from any current or former employee of the state of North Carolina whose duties are relate(d) to this RFP and no member of our team or immediate family has any financial interest in the outcome of this RFP. No member of Sedgwick or any employee is related by blood or marriage to an agency employee or resides with an agency employee.

Dear Ms. Robbins:

On behalf of Sedgwick Claims Management Services, Inc. (Sedgwick), I would like to personally thank you for the invitation to once again participate in the North Carolina Department of Public Instruction's (DPI) request for proposal for third-party claims administration and managed care services (RFP: # DPI 40-PC00117-15, Workers' Compensation Insurance). We have thoroughly reviewed all of the RFP materials and prepared our proposal to illustrate our understanding, expertise and creative program alternatives focused on bringing your claims administration and delivery of care for your injured employees to higher levels of success.

Change is a constant in the dynamic, ever-evolving risk management and third-party administrator (TPA) world. We understand that DPI is looking for even more cost savings and program enhancements for your overall program spend as well as better care for your injured employees.

The Sedgwick organization has also undergone significant growth and change in just one year since we last met in Raleigh. We have been very successful with new client relationships, expanded services to existing clients and a strategic acquisition of VeriClaim, which filled our void to provide global property and field case management solutions for our clients.

We welcome the opportunity and challenge of a new business partnership and believe we can positively impact your total cost of risk through achieving your goals and developing new initiatives as this program evolves.

Sedgwick is a privately owned, independent company without any insurance company and/or brokerage affiliation. Sedgwick owns and operates all core claims operations and leverages fully integrated ancillary partnerships to provide a single source, comprehensive array of claims, risk and technology services.

In our RFP response and in our actions, we will demonstrate to DPI our ability to lead the process and meet each of your objectives as detailed in the RFP. Our approach is to form a true partnership with DPI, and all strategic service providers, with the consultation and flexibility to inspire a better program for your organization. We maintain a clear focus on achieving the best outcomes by integrating a quality system defined by your needs, by providing advanced analytical capabilities to identify cost drivers, and designing program management services to ensure excellence.

We look forward to sharing our technological advancements, program management strategies and, most of all, our custom program delivery success with DPI.

We have the highest caliber of professionals in third-party administration, proven elite program success and a dedication to quality. Should you have any questions concerning this RFP, please feel free to contact us at your convenience.

Please note that the following addendums have been received, and the required acknowledgement documentation is attached:

- Addendum 1 — dated December 18, 2014 (Updated RFP bid number)
- Addendum 2 — dated December 18, 2014 (Corrected workers' compensation schedule of dates pages 6)
- Addendum 3 — dated January 16, 2015 (Written questions and answers)

Sedgwick colleague to contact for clarification inquiries:

Rick Ackerman
Sedgwick Claims Management Services, Inc.
Senior Vice President, Business Development
1100 Ridgeway Loop Road
Memphis, Tennessee 38120
rick.ackerman@sedgwick.com
770.901.3111
404.580.8638 (cell)

Sedgwick colleague designated to contractually obligate and to negotiate the contract:

Robert Peterson
Sedgwick Claims Management Services, Inc.
Chief Marketing Officer
1100 Ridgeway Loop Road
Memphis, Tennessee 38120
robert.peterson@sedgwick.com
901.415.7526
901.484.0799 (cell)

Thank you for considering Sedgwick.

Sincerely,

Robert Peterson
Sedgwick Claims Management Services, Inc.
Chief Marketing Officer

Table of Contents

Proposal Summary

Sedgwick is happy to respond to the North Carolina Department of Public Instruction's (DPI) request for proposal for third-party claims administration and managed care. We are responding to three of the four RFP components — third-party services, pharmacy services and other medical services. Whether DPI selects Sedgwick as a single source solution or chooses an external partnership model, we are dedicated to providing superior customer service and maintaining strong quality controls. The bottom line as a strategic partner for DPI is that we, and all associated partners, work closely with you to achieve your five initial goals:

- Quality care and service to injured employees, maximize savings and reduce program costs
- Ensure a seamless transition of services to injured employees and LEAs
- Aggressive administration and management of claims
- Return to work focus
- Claim closure

Sedgwick has more than four decades of experience serving the nation's most prominent organizations and largest public entities for workers' compensation, multiline liability, first- and third-party property, short-term disability, long-term disability and FMLA/leave of absence administration. Our 12,000 colleagues in 275 offices in the U.S., Canada and the U.K. are focused on our corporate mission to be the premier third-party administrator (TPA) in the industry. As the largest TPA in the country, we handle more than 2.8 million claims annually and have fiduciary responsibility for claim payments totaling almost $12 billion annually.

Key points of our proposed solution for DPI include:

At Sedgwick, we understand the unique environment and technical intricacies of exposures facing public entities. We partner with more than 150 public entity programs across the United States representing more than 11% of our total annual revenue. Our large public entity practice has experience handling public schools, cities, counties, states, university systems, transportation divisions and energy departments nationwide. The graphic below highlights just a select few of our public entity clients.

At Sedgwick, delivering the services that each client needs is what we do.

Sedgwick has an extensive presence in North Carolina with two offices and more than 155 colleagues. The DPI dedicated workers' compensation and clinical team will be located in Raleigh, North Carolina, as requested in this RFP. Our real estate group, led by Linda Lagesse, has evaluated the real estate market in the Raleigh area, and we have options available for desired locations. Our local resources in the state of North Carolina, coupled with our national implementation team assigned to this project, will be focused on ensuring a smooth transition to coordinate all of the critical aspects of this program startup (training and recruiting, banking, IT development and support, etc.).

We have identified qualified colleagues from our southeast operations team to fill some of the key implementation, claims and clinical roles on your program. Additionally, we will post jobs internally, recruit locally in the Raleigh market and, most importantly, evaluate re-badging your current claims staff. Our experience shows that a staffing strategy that considers a balance of current claims staff members and experienced Sedgwick colleagues will produce a team ready to service the program from the start as well as provide long-term stability.

Sedgwick's seamless implementation process

Sedgwick leads the industry in transition management and we are accustomed to and understand the complex nature of complicated program transitions. Rest assured that our dedicated implementation personnel armed with our detailed project plan will be more than capable of ensuring a smooth and seamless transition. This transition process begins as early as the development stage, when we engage in discovery sessions and set the program design features.

Typical activities would include visits to our office facilities, meetings with our key operational and management personnel, and firsthand demonstration of our systems platform.

Once an award has been offered, Sedgwick then initiates our comprehensive implementation procedures. We assign an implementation project manager (Debora Mayes as listed in this RFP response) to coordinate the transition process. A detailed project plan will be finalized, which will identify the key deliverables, action items and due dates to meet the expectations of DPI. The transition process will begin with an initial implementation team meeting involving all responsible parties from Sedgwick, DPI and external vendors, if applicable. The implementation team members will be responsible for their individual area of expertise as it relates to this transition (i.e., technology, recruiting, training, orientation, banking, etc.). Ongoing management of the project plan and communication of the progress will be handled through a series of conference calls and meetings.

Sedgwick's workers' compensation claims process

It is simple to report a claim with Sedgwick through our internal contact center organization — headquartered in Memphis, Tennessee — supporting toll-free claim intake 24 hours a day, seven days a week. Based upon our understanding of the RFP, intake will occur using our direct Web entry through our viaOne intake module, an online reporting tool that allows DPI to enter claims over a secure Internet connection. This would include capturing information required for your split-funding process. We often work with pre-filled information provided by a human resource data feed from our customers. Use of this feed requires further discussion with the client before implementation.

Once a workers' compensation claim is reported, a team lead in your Sedgwick dedicated claims unit in Raleigh, North Carolina, will review the claim and determine if there are any red flags, subrogation opportunities or special requirements based on the reported information. The team lead will then assign the claim to an examiner based upon the complexity of the claim and dedication/designation requirements with instructions, where appropriate.

The specific investigative process by line of coverage is outlined below.

- Claims that are reported as incident only claims are simply set up within JURIS, but no further investigation is performed.
- Medical only claims may include a one-point contact to the employer depending on the completeness of the information reported or if questions are present based upon the information presented. Medical bills and reports are continuously reviewed upon receipt to ensure there are no inconsistencies with the reported mechanism of injury and the injury itself as well as to ensure appropriate treatment protocols, etc.
- Indemnity claims require a minimum three-point contact with the claimant, employer and medical provider. Additional contacts may be necessary based upon the details of the accident, presence of witnesses, potential for subrogation, etc. When appropriate, recorded statements or on-site investigations will be obtained. Medical information will continue to be reviewed for appropriateness of treatment and other actions on a continual basis.

Claims will be indexed as agreed to with DPI, but our best practice is that at a minimum, all indemnity level claims are indexed and charged to the file as a pass-through cost. Sedgwick has a dedicated special investigations unit (SIU) that assists examiners in vetting potential fraud when it is suspected to have occurred. Our SIU uses various tools, including social media searches, to help the examiner fully explore any and all red flags. Sedgwick employs a team approach with multiple resources to ensure benefits are only paid when they are due.

Medical management — streamlined approach supporting employee health

Sedgwick is at the forefront of leading an innovative approach to medical management for workers' compensation and creating a holistic healthcare program. Recognizing the complexity of work-related injuries, and the factors influencing claims outcomes, Sedgwick has designed a strategic clinical program. Using predictive analytics to drive outcomes — and applying proactive, acuity-based case management — claims are referred to the appropriate resource. And, our experienced clinicians have the tools necessary to move claims forward.

Sedgwick has also created unique clinical tools to support claims resolution, such as real-time, live nurse chat for the injured employee, access to behavioral health experts to address psycho-social barriers or issues and escalation thresholds for proactive intervention when high-cost or high-risk claims are identified. The strategic clinical program is structured to ensure an ongoing progression toward claim resolution is occurring — a unique approach, with real outcomes.

Sedgwick's medical management approach offers a combination of in-house and private-labeled solutions, including clinical consultation/nurse triage, return to work (RTW) case management services, catastrophic case management, field case management, utilization review (UR), pharmacy UR, complex pharmacy management, medical bill review, provider network solutions and data management.

Building a customized PPO network with quality providers

Sedgwick's ability to create superior networks with high-performing physicians goes beyond the traditional network penetration model that balances quality care with cost control and delivers a positive employee experience. We developed a proprietary provider benchmarking tool that scores providers to determine those physicians with knowledge of occupational injuries and proactive RTW strategies. We will use this tool and our analysis of DPI's provider utilization patterns to recommend the best network makeup for DPI to match the 115 LEA jurisdictions in the state of North Carolina.

Sedgwick uses objective measurements of healthcare provider performance based on our clients' claims outcomes. Our claims data analysis identifies providers who demonstrate positive outcomes. Providers are ranked on a 1–5 scale, with five indicating the best performance.

Our ability to manage and direct care has allowed our clients to have most of their claims treated with high-scoring providers. DPI employees will have plenty of access to these top-performing providers. Sedgwick completed a study that evaluated the outcomes on claims based on the score of the physician providing initial treatment on the claim. The study found that initial medical care provided by a top-performing medical provider results in shorter claim duration, less incurred cost, faster RTW and lower litigation rates.

Benefits include:

- Claim duration — 40% faster claims resolution
- Incurred total — 68% lower with top-performing medical providers
- Faster RTW/lower indemnity: Average lost time days — 73% lower for claims in which initial care was with a top-performing medical provider and incurred indemnity — 79% lower
- Claims with litigation were two times higher when care was provided by lower-scoring physicians versus the top-scored medical providers
- Incurred medical — 62% lower with top-performing medical providers
- Incurred expense — 61% lower with top-performing medical providers
- 36% of the claims in which initial care was provided by a lower-scoring provider resulted in surgery, as opposed to 18% with higher-scoring providers

During implementation Sedgwick will analyze your current provider makeup and develop a strategy for reducing the use of low-scoring or providers without score to help DPI achieve best-in-class outcomes. Sedgwick's provider benchmarking and search tool ensures that our clients have access to healthcare providers that drive the best results for injured employees in every location and for every specialty and injury. Sedgwick developed the outcomes-based direction of care approach to increase healthcare quality and savings through the use of providers with superior outcomes.

Sedgwick uses objective measurements of healthcare provider performance on Sedgwick claims. In the Sedgwick solution, claims are measured by analyzing the following outcomes factors:

- Claim duration and costs
- Average lost work time and transitional duty days
- Incidence rate of litigation
- Recidivism rate (claims reopening)
- Dates of medical service and billed and paid dollars with explanation of reimbursement codes
- Diagnosis and treatment codes

Targeted clinical intervention

Sedgwick uses predictive modeling to develop a sophisticated nurse case management referral process that can replace or supplement the standard, logic-based triggers traditionally deployed for referrals. The model uses DPI's experience to guide the examiner to refer claims with the potential for high exposure to a nurse.

Teamwork is essential in resolving complex claims and medical issues. Nurse case managers, RTW specialists and examiners have real-time access to all claim information through JURIS, which expedites the process for referring and communicating critical information and moving the claim forward to resolution as well as avoiding redundancies and duplicative efforts. Additionally, diaries synchronize to coordinate discussions around strategy discussions, action planning and targeted intervention protocols.

Sedgwick's integrated bill review process is efficient

Our medical bill review is fully integrated into the claims management process, which ensures prompt and accurate bill processing against real-time claims data. Our ability to locate a bill at any point in the bill review and payment process is a differentiator in the industry. And our dedicated bill review customer service center is available to our customers, medical providers or injured employees to advise them of the bill status. Medical providers also have direct access to both a mobile application as well as an online tool, viaOne express, to check bill payment status.

Our medical bill review system is continually updated to adjust bills to the most current and accurate prices for all state fee schedules, applicable state rules and regulations, usual and customary (UCR) reductions, PPO reductions, UR treatment plans and clinical edits. National correct coding initiatives (NCCI) and clinical edits are also embedded into the system, which allow for proper identification of unbundled, up-coded or inappropriate services. The synchronization of Sedgwick UR decisions into the bill review system ensures that only authorized treatment is ultimately paid to the medical provider. Additionally, automated red flags will alert Sedgwick to transmit bills to senior bill reviewers, bill review nurses, examiners or other colleagues who augment the system to validate that the treatment and payment amount are related to and authorized for the work-related injury.

At Sedgwick, our results set us apart in the industry, and outcomes reporting is clearly defined by the reduction reason. Medical bills are reduced to fee schedule or UCR amount before the PPO contracted fees application. Often, our competition charges percentage of savings fees beginning at the provider billed amount, which increases customer fees.

Sedgwick's integrated pharmacy management services

Sedgwick partners with Helios for pharmacy benefit management (PBM) services. The Sedgwick PBM program combines automated claim-specific formulary and utilization edits, clinical review programs and aggressive workers' compensation discounted contracting of major chains. Sedgwick clinicians and claims examiners benefit from integration of formulary management, authorization alerts and adverse drug trends notifications within our system, allowing seamless access to off-formulary claims and promoting tight management of pharmaceuticals. The end result benefits the health and welfare of the injured employee and achieves better RTW outcomes.

A primary goal in supporting your injured employees is to ensure that receive their prescribed medications without delay or paying out of pocket. The Sedgwick first fill program establishes a pre-authorized limited formulary for common workers' compensation medications at the time of injury. The first fill program information is provided to the injured employee by their supervisor or via the Sedgwick medical card emailed to the employee. The first fill authorization is effective for 30 days, for a 10-day supply or $250 of medication. The Sedgwick pharmacy benefit management partner assumes financial risk for the medication if the injury is deemed non-compensable.

Adjudicating the DPI workers' compensation pharmacy benefits on JURIS and through our PBM's national workers' compensation retail network allows for improved timeliness of pharmacy management at a claim level; flexibility to customize our clinical, trend and utilization service specific for the DPI; and improved network penetration across third-party billing solutions and physician dispensing clinics.

The Sedgwick PBM solution integrates key players in the workers' compensation pharmacy distribution system such as Concentra, U.S. Healthworks, third-party billers, dispensing physician groups, compounding pharmacies and multiple mail-order pharmacies.

Our solutions include specialty network arrangements, automated re-indexing and out-of-network conversion.

Our highly customized pharmacy benefit management solutions also feature:

- Injury specific formulary — drug formulary is aligned with the diagnosis for maximum utilization control.
- Acute and chronic based formulary — formulary enhancements occur throughout the life of the claim to best manage drug utilization at acute and chronic stages.
- Authorization alerts — claims examiners receive email notification when a drug is outside of the formulary and requires claims examiner review and approval before it is filled at the retail pharmacy.
- Home delivery — qualifying claims are identified through claims data eligibility provided through our electronic interfaces with the pharmacy benefit management partners.
- Out-of-network bill review — out-of-network bills are electronically routed to our pharmacy benefit management partners to increase savings.
- Step therapy — point-of-sale system edits alert the dispensing pharmacist of the opportunity for lower-cost alternatives and to communicate the need for physician outreach.
- Drug trend alerts — trend management notification that interfaces with the JURIS claims system for claims examiner notification of adverse drug utilization trends.

There are more than 60,000 participating pharmacies and physician clinics and medical providers in the Sedgwick PBM. Last year, Sedgwick built a dedicated team of pharmacy UR nurses and hired a pain management and rehabilitation physician to lead the team. Sedgwick's pharmacy solutions include point-of-sale intervention and a complex pharmacy program. The complex pharmacy program targets complex claims in which health, safety and cost concerns drive the need to evaluate and develop alternative treatment. The pharmacy clinical review program combines enhanced formulary management at the point-of-sale with adverse trend alert notifications to provide greater ability to manage medication concerns and long-term clinical and/or financial impacts on a claim.

All pharmacy scripts are subject to a formulary when an injured employee or patient attempts to fill his or her prescription at the pharmacy. The medication will automatically process and fill at the pharmacy if it is on the formulary. However, if the medication is not indicated to treat the injury type, it will block at the pharmacy and require authorization before the pharmacy will dispense the medication. Sedgwick has identified high-risk medications that are routed to the pharmacy nursing team as part of our UR best practices. In 2013, our clients experienced a 12:1 return on investment through our point-of-sale pharmacy interventions. All UR decisions are visible in the claims files to support uniform follow-up actions and communication across our claims management teams, nurse case managers and bill reviewers.

Split-funding — a special banking requirement we understand

Sedgwick understands the unique requirement and complexities associated with DPI's split-funding process. Rest assured that Sedgwick, as the industry's leading and largest third-party administrator, is ready and capable of working with you to execute a process and workflow that contemplates the daily communication and activities associated with funding the losses from multiple funding sources.

In our RFP response, we will demonstrate to DPI our ability to meet each of your objectives detailed in the RFP. Our approach is to form a true partnership with DPI, providing the consultation and flexibility to inspire a better program for your organization. We maintain a clear focus on achieving the best outcomes by integrating a quality system defined by your needs; advanced analytical capabilities to identify cost drivers; and program management services designed to ensure excellence. We look forward to sharing our technological advancements, program management strategies, and, most of all, our custom program delivery success with DPI. We have the highest caliber of professionals in third-party administration, proven elite program success and a dedication to quality.

Solicitation RFP No. DPI 40-PC00117-15 workers' compensation Insurance

Vendor: Sedgwick Claims Management Services, Inc.

THIS PAGE IS TO BE FILLED OUT AND RETURNED WITH YOUR PROPOSAL. FAILURE TO DO SO MAY SUBJECT YOUR PROPOSAL TO REJECTION.

ATTENTION

Federal Employer Identification Number or alternate identification number (e.g., Social Security Number) is used for internal processing, including bid tabulation.

Enter ID number here: 36-2685608

Pursuant to N.C.G.S. 132-1.10(b) this identification number shall not be released to the public.

This page will be removed and shredded, or otherwise kept confidential, before the procurement file is made available for public inspection.

EXECUTION OF PROPOSAL

By submitting this proposal, the potential contractor certifies the following:

This proposal is signed by an authorized representative of the firm.

It can obtain insurance certificates as required within 10 calendar days after notice of award.

The cost and availability of all equipment, materials, and supplies associated with performing the services described herein have been determined and included in the proposed cost.

All labor costs, direct and indirect, have been determined and included in the proposed cost.

The vendor has attended the conference/site visit and is aware of prevailing conditions associated with performing these services.

The vendor can and will provide the specified performance bond or alternate performance guarantee (if applicable).

The vendor has read and understands the conditions set forth in this RFP and agrees to them with no exceptions.

The vendor is registered in NC E-Procurement @ Your Service or agrees to register within two days after notification of contract award.

VENDOR: Sedgwick Claims Management Services, Inc.

ADDRESS: 1100 Ridgeway Loop Road

CITY, STATE, ZIP: Memphis, Tennessee 38120

TELEPHONE NUMBER: 901-415-7400 **FAX:** 901-415-7406

E-MAIL: Robert.Peterson@sedgwick.com

Principal Place of Business if different from above (See Attachment B):

N/A

Will any of the work under this contract be performed outside the United States? ☐ Yes ☐ No (If yes, describe in technical proposal.)

N.C.G.S. § 133-32 and Executive Order 24 prohibit the offer to, or acceptance by, any State Employee of any gift from anyone with a contract with the State, or from any person seeking to do business with the State. By execution of any response in this procurement, you attest, for your entire organization and its employees or agents that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

BY: _____ **TITLE:** Chief Marketing Officer **DATE:** January 23, 2015

(Signature)

Robert J. Peterson

(Printed name)

****

ACCEPTANCE OF PROPOSAL

(Department of Public Instruction)

BY: Robert J. Peterson **TITLE:** Chief Marketing Officer **DATE:** January 23, 2015

THIS PAGE MUST BE SIGNED AND INCLUDED IN YOUR PROPOSAL.

Unsigned proposals will not be considered.

RESTRICTIONS AND OTHER NOTICES TO VENDORS

8. **Vendors must indicate which RFP component(s) they are responding to by making an "X" in the Component Selection box below and include in their technical proposal response:**

Component	Selected
Third Party Services	X
Pharmacy Services	X
Other Medical Services	X
Other Services	

Example – a Vendor choosing to respond to RFP Third Party Services component only would complete the Component Selection box as follows:

Component	Selected
Third Party Services	X
Pharmacy Services	
Other Medical Services	
Other Services	

Example – a Vendor choosing to respond to all four (4) RFP components would complete the Component Selection box as follows:

Component	Selected
Third Party Services	X
Pharmacy Services	X
Other Medical Services	X
Other Services	X

Section II: Technical Requirements

DPI maintains the following objectives and goals for this RFP:

a. **Quality care and service to injured employees, maximize savings and reduce program costs.**

b. **Ensure a seamless transition of services to injured employees and LEAs.**

c. **Aggressive administration and management of claims.**

d. **Return-to-Work focus**

e. **Claim closure**

Vendors bidding on Sections II A and/or B must provide descriptive details on how it will meet the following RFP requirements. Vendors are welcome to submit additional comments and ideas that may facilitate attainment of DPI's expectations. Vendors bidding on services must specifically describe within their proposal the components of service and requirements addressed in each section on which the Vendor is bidding: Section II A and/or B.

Vendors bidding on TPA services may also include bids on any of the carve-out services. Vendor Proposals, both for TPA services and Carve-Out Services, shall be submitted in a form that, at the option of DPI, may be incorporated verbatim into a contract. All Proposals must be organized in the order in which the Technical Requirements are presented in this RFP. All proposals must contain a Table of Contents which cross-references the RFP requirements. Proposals not organized in the appropriate manner may be eliminated from consideration.

A. Technical Requirements of TPA

DPI will select a TPA to administer WC claims, offer a network of medical providers and perform bill review. The TPA will prepare checks for all payments made under the program. TPA must fully explain how their experience and services offered are relevant to the requirements of this RFP.

1.0 Minimum Requirements, Third Party Administration

Any Vendor responding to the Third Party Administration Services RFP component must meet the following minimum requirements. Vendors shall include a description of how the Vendor will comply with and meet each requirement stated below:

Third Party Administration Services – Minimum Requirements	
1	**Vendor must have at least five (5) years of experience providing Third Party Administrative services.** Sedgwick agrees to comply with this requirement. Sedgwick has been providing workers' compensation claims management services for more than 44 years, since 1971, and North Carolina public entities have been Sedgwick clients since 1971.

2	**TPA must offer the following: aggressive approaches to claims handling and administration; triage and/or early intervention of claims; bill review and a network of providers; robust electronic network for claims management and medical provider information; reporting capabilities for LEAs and DPI; subrogation services.**

Triage/clinical consultation

In 2013, 31% of callers were provided with self-care recommendations and did not require medical attention. Additionally clients experienced a 10% increase in network penetration.

The nurse triage/clinical consultation program offers DPI a one-call model.

Our registered nurses — available 24 hours a day, 365 days a year — provide a clinical assessment during the call. Self-care recommendations are made when appropriate. A follow-up survey call is made the next day with an option to speak with a nurse for medical follow up. Should medical care be required, the nurse will schedule the appointment during the call using our proprietary provider benchmarking and search tool. This connects the injured employee immediately with an in-network provider with proven quality outcomes for that particular injury type.

The end result is timely access to quality medical care for the injured employee and reductions in DPI's medical spend.

PPO network

Sedgwick recommends the use of our Occunet network with customization to provide exceptional coverage and ease of access to care.

Occunet is a long-standing, Sedgwick-owned PPO network that has solid penetration with first treating and specialty providers as well as medical facilities. The reach of this network is consistent with the needs and geographic reach of the North Carolina LEAs.

Additionally, Sedgwick has a dedicated network management team who can assist in customizing the network through the use of our nomination and credentialing process. This ensures that DPI has the flexibility to add providers that are well-known in their LEA location, have experience working with the workers' compensation patient, ensure timely RTW and have quality outcomes.

The network is exclusively used for workers' compensation and has an aggressive pricing structure.

Sedgwick's philosophy is to use providers with the best outcomes at the onset of the injury. Sedgwick was one of the first in the industry to create a quantitative methodology to measure the quality of care provided to injured employees, and to use that knowledge to build superior networks. When injured workers visit top-performing providers identified through our benchmarking program at the onset of their injury, clients have 40% shorter claim duration, 68% less incurred cost, 73% faster RTW and 46% lower litigation rates.

The five-star tool rates providers based on the following claims information:

- Claim duration and costs

- Average lost work time and transitional duty days
- Incidence rate of litigation
- Recidivism rate (claims reopening)

The Sedgwick five-star provider network will house all provider information for injured employee referral, and includes a five-star benchmarking system.

The Sedgwick five-star provider search tool, is designed to ensure access to quality healthcare providers who deliver the best results. Our five-star tool allows employers, injured employees, claims examiners and nurses to find in-network providers who understand the workers' compensation treatment philosophy and have best treatment outcomes.

The five-star provider benchmarking and search tool is accessed by DPI supervisors and injured employees by using our online portal. Results can be emailed or text messaged to the injured employee and includes contact information, turn-by-turn directions, pharmacy first fill information and UR contact numbers for the medical providers.

Sedgwick bill review

Our medical bill review is fully integrated into the claims management process, which ensures prompt and accurate bill processing against real-time claims data. Sedgwick's ability to locate a bill at any point in the bill review and payment process is a differentiator in the industry. And our dedicated bill review customer service center is available to our customers, medical providers or injured employees to advise them of the bill status. Medical providers also have direct access to both a mobile application as well as an online tool, viaOne express, to check bill payment status.

Our medical bill review system is continually updated to adjust bills to the most current and accurate prices for all state fee schedules, applicable state rules and regulations, usual and customary (UCR) reductions, PPO reductions, UR treatment plans and clinical edits. National correct coding initiatives (NCCI) and clinical edits are also embedded into the system, which allow for proper identification of unbundled, up-coded or inappropriate services. The synchronization of Sedgwick UR decisions into the bill review system, ensures that only authorized treatment is ultimately paid to the medical provider.

Additionally, automated red flags will alert Sedgwick to transmit bills to senior bill reviewers, bill review nurses, examiners or other colleagues, who augment the system to validate that the treatment and payment amount are related to, and authorized for the work-related injury.

At Sedgwick, our results set us apart in the industry, and outcomes reporting is clearly defined by the reduction reason. Medical bills are reduced to fee schedule or UCR amount, before the PPO contracted fees application. The integration between our medical bill review and claims management system ensures that UR treatment plans are matched to the medical bill received. Additionally we do not charge for duplicate bills or bills that are submitted for reconsideration.

Claim process

Whether new claims are reported from our contact center or directly from the client, the process is the same once it reaches Sedgwick. The data are loaded to

the JURIS national system, where it is validated and then routed to the appropriate servicing office based on the location identified for the claim. JURIS checks for and routes new transmissions every 20 minutes throughout the day so that new claims arrive in the servicing offices within an hour of their receipt by Sedgwick.

The new claim information is received into the JURIS system as an incident. After initial investigation and review of the information received, the examiner will convert the incident into a full-fledged claim. The examiner may then set reserves and schedule payments as necessary. If it is determined that the reported accident will not become a claim, it is left in incident status having no financial impact (no incurred value and no payments).

DPI will be assigned a dedicated toll-free number that is used to specifically identify DPI to the contact center customer service representatives (CSR). As calls are received via DPI's dedicated toll-free number, the call is answered using a DPI-defined greeting. Our Internet-based intake software, viaOne intake, guides the CSR to capture all of the specific information needed, as defined during our client implementation process.

During intake, the information is keyed into the intake application, which uploads to JURIS at 20-minute intervals. All information stored in the JURIS system can be viewed in real-time through use of the viaOne suite of services. Sedgwick is able to produce the Employer's First Report of Injury for all U.S. states. These reports are filed with the state either via paper or electronically, depending upon the requirements of the state. Additionally, we have the capability of sending copies of the Employer's First Report of Injury to an intricate distribution of client destinations via email, fax or U.S. mail.

All information necessary for the intake process is available in an online help system maintained by the contact center. Additionally, the contact center's customer service representatives have access to the JURIS claims management system through the viaOne suite of services. We have included a workers' compensation flowchart in the appendix.

Claim investigation

Once a workers' compensation claim is reported, a team lead will review the claim and determine if there are any red flags, subrogation opportunities, or special requirements based upon the reported information. The team lead will then assign the claim to an examiner based upon the complexity of the claim and dedication/designation requirements with instructions where appropriate.

The specific investigative process by claim type is outlined below and is subject to change based on DPI requirements.

- Claims that are reported as incident only claims are simply set up within JURIS but no further investigation is performed.
- Medical only claims may include a one-point contact to the employer depending upon the completeness of the information reported or if questions are present based upon the information presented. Medical bills and reports are continuously reviewed upon receipt to ensure there are no inconsistencies with the reported mechanism of injury and the injury itself as well as to ensure appropriate treatment protocols, etc.

- Indemnity claims require a minimum three-point contact with the claimant, employer and medical provider. Additional contacts may be necessary based upon the details of the accident, presence of witnesses, potential for subrogation, etc. When appropriate, recorded statements or on-site investigations will be obtained. Medical information will continue to be reviewed for appropriateness of treatment and other actions on a continual basis.

Claims will be indexed as agreed to with DPI, but our best practice is that at a minimum, all indemnity level claims are indexed.

Sedgwick has a dedicated special investigations unit (SIU) that assists examiners in vetting potential fraud when it is suspected to have occurred. Our SIU uses various tools, including social media searches, to help the examiner fully explore any and all red flags. Sedgwick employs a team approach with multiple resources to ensure benefits are only paid when they are due.

Electronic claims network

Sedgwick uses systems and technology to provide our claim professionals with the tools they need to efficiently and accurately manage DPI's claims as well as to provide DPI with easy access to real-time claim information. The core of our technology is our proprietary JURIS claims management system. Through JURIS, we provide our examiners with a structured, yet flexible, series of screens and routines that simplify the claim management process. DPI-specific instructions are stored online for easy access. DPI-specific data capturing and validation edits are consistently performed. In addition, JURIS provides our examiners with a comprehensive diary and file note capability to assist them in documenting files and maintaining schedules of future activities. In many cases, JURIS will automatically document critical activities with system-generated diaries and file notes.

JURIS uses extensive parameters to provide claim reporting flexibility. These parameters are used to depict DPI's various locations and organizational structure on the system and will allow us to capture the LEA as well as the specific school campus for detailed reporting to DPI. JURIS will use this vast hierarchy structure to create reports that will summarize claim information at any level corresponding to DPI's organization.

Throughout the claims management process, critical detailed claim related information is collected and stored. Making this information available to DPI is accomplished through our Web portal, viaOne. In addition to the many standard and client customized reports that are available, Sedgwick offers viaOne view to DPI, which gives them the ability to check the real-time status of specific claims, including images of all correspondence and medical information received. DPI can report incidents and claims through viaOne intake, create ad hoc inquiries or data extracts through viaOne query, and even manage their OSHA logs through viaOne OSHA.

Sedgwick offers viaOne customizable home page, available from viaOne view, our platform-independent, Web-based application for viewing and analyzing metric and DPI data. The dashboard capability allows DPI to expose key data in a dashboard-style view. Each dashboard/graphical report offers the ability to drill down to the individual claim level for review in viaOne view. User-defined threshold functionality on each dashboard provides customizable alerts when a key

performance indicator is exceeded.

Sedgwick data warehousing capabilities take the viaOne product to the next level by offering data integration services and a next-generation query tool. Through the data warehouse, DPI integrates claims data managed by other administrators and a variety of non-claim data (i.e., data from HR systems, surveys and exposures) that assists the user in reporting meaningful risk information. Our goal is to provide clients with a single look at their entire program rather than adding to the often-fragmented view that is created by multiple administrators and systems. viaOne analysis provides DPI with an extremely powerful environment for extracting, analyzing and building ad hoc reports in a single tool. Using point-and-click/drag-and-drop technology, clients create, view and drill into trends easily and effectively.

The viaOne alerts feature increases the value of claims information for DPI by expanding user-defined parameters for notification of new developments affecting individual claims and facilitating accelerated analysis of claim trends. viaOne alerts includes an extensive menu of information tracking points and comprehensive sequencing options. These capabilities enable you to establish an unlimited number of alert triggers based on factors such as claim duration, severity and processing status. You can also create alert nesting routines which integrate combinations of contingencies into a single alert trigger. Other functionalities include the delivery of email notifications, links to claim files associated with an alert and customization of the duration of the alert.

Reserves feature

Our reserves are set for each individual category-indemnity, medical and expense. We use all of the information gathered in the initial investigation to set the initial reserves. Our detailed reserve work sheet, which is contained online in our JURIS system, breaks the reserve into detailed categories within each major category, including temporary total disability, permanent total and partial disability and vocational rehabilitation. Examiners use the reserving work sheet embedded in JURIS as a tool in setting reserves, rather than a system-generated tool. Our experience has found that automatic reserving tools present inaccuracies and inconsistencies.

Reserve adjustments and histories are maintained in our JURIS claims system. In any reserve change, a note is made in JURIS of the reserve change and the reason for the change. Reserve calculations are documented in the claim file on an electronic reserve work sheet. Reserve worksheets and reserve history are maintained in our JURIS claims system.

Notes

JURIS provides a comprehensive file note capability. The notes recorded on a given claim accumulate chronologically beginning with the day a claim is opened. Besides the examiner's notes, the system also stores team lead, legal, nurse and other note categories. All notes are coded for easy viewing on any specific note category, or all notes can be viewed (or printed) chronologically providing a complete history of the claim. Nurse notes are interfaced to JURIS and coded by type. This electronic exchange of information between the nurse and examiner occurs five times per day. These notes are available to clients for viewing through our viaOne suite of services.

Additionally, clients with the proper security with online access through the viaOne Web portal have the ability to record notes on the individual claim files. When a client enters a note, the system will generate a diary to the examiner advising them to review the client created note. These notes are stored with the examiner's notes and are available to the examiner for review. Client notes are part of the claim file.

Reporting

Standard reporting options — by Sedgwick for DPI

The JURIS system provides a wide variety of standard reports, which can be generated at any level of DPI on a regular basis.

JURIS uses extensive parameters to provide claim reporting flexibility. These parameters are used to depict the client's various locations and organizational structure on the system. JURIS will use this vast hierarchy structure to create reports that will summarize claim information at any level corresponding to DPI's organization.

Standard month-end reports include: adjustment report, loss analysis I report, claim and expense report and transaction report.

Special reports include: accumulative loss analysis, lag report, allocation/transaction report , loss claim and experience report, cause code analysis report, loss analysis II, claim report, loss summary report, claim status history report, loss run summary report, claims log report, misc. client field report, cost range analysis report, pay-code analysis report, experience rating report, payment and reserve progression, hard copies by client report, repeaters list report, indemnity report, reserve change report, stewardship report and specific excess report, and many more.

There are no additional fees for standard reports, copies of which are included in the appendix.

viaOne reporting options — run by DPI

viaOne report

Other reporting capabilities include viaOne report and quick filters features. viaOne report provides easy access to a number of detail and summary reports. These pre-formatted reports use viaOne quick filters, allowing clients quick access to data for previously-defined sets of claims. DPI may choose certain selection criteria or user-defined fields and sort, sub-total and page break options specified to each report. These filters can be used to view claims matching defined criteria in viaOne customizable home page quick filter gadgets and viaOne report. Samples and descriptions of available reports can be found in the viaOne report sample book, included in the appendix.

viaOne query — ad hoc reporting

Additionally, through the viaOne Web portal, claim information is available for downloading to your internal systems for ad hoc reporting or analysis. The viaOne query module allows for the ad hoc selection of data elements to be extracted and for the ad hoc definition of the extraction criteria to be used. Data are available for reporting through the viaOne Web portal on a real-time basis.

	viaOne dashboard Sedgwick also offers the viaOne dashboard, an independent, Web-based graphical application, which allows DPI to customize and view metrics and KPI data for disability data. DPI can select which dashboard(s) to view and has the ability to set personal thresholds for each dashboard. **viaOne analysis** Sedgwick data warehousing capabilities take the viaOne product to the next level by offering data integration services and a next-generation query tool. Through the data warehouse, DPI integrates claims data managed by other administrators and a variety of non-claims data (i.e., data from HR systems, surveys and exposures) that assists the user in reporting meaningful risk information. Our goal is to provide DPI with a single look at your entire program rather than adding to the often-fragmented view that is created by multiple administrators and systems. viaOne analysis provides customers with an extremely powerful environment for extracting, analyzing, and building ad hoc reports in a single tool. Using point-and-click/drag-and-drop technology, customers create, view, and drill into trends easily and effectively. **Subrogation** Subrogation opportunities are identified during the initial investigation, and throughout the life of the claim, as additional information is obtained. The claim is flagged in our system and appropriate codes are entered. A subrogation review diary is automatically established and the system will generate subrogation review notices to the examiner and the team lead on the file. The pursuit of subrogation will be coordinated with the appropriate DPI representatives to determine the extent you want us to pursue this on your behalf and to assist in the determination of any waiver of subrogation or other contractual agreements that may exist. Sedgwick has developed a dedicated subrogation unit to increase the opportunity for return on investment for our client partners. This unit also provides the following benefits: • Use of staff experienced in recovery work • Ability to maximize our client partner's returns • Solid ongoing relationships with our client partners • Free up examiners to concentrate 100% on management of "mainstream" claims versus recovery claims, thereby maximizing efficiencies.
3	**TPA must confirm willingness to support and work with carve-out vendors in accordance with the requirements of this RFP. In the event that Vendor is selected for TPA, PPO, and Bill Review services and is not selected for a particular carve-out service, TPA shall use and enter into all necessary contractual agreements for TPA to obtain the carve-out services from the Carve-Out Vendor(s) selected by NCDPI and at the prices agreed upon by the Carve Out Vendor(s) and NCDPI. Further, TPA shall enter into all agreements and arrangements with Carve-Out Vendors that are necessary for it to obtain employee claims information and other information relating to services it requests from Carve-Out Vendors selected by NCDPI in a form and via an electronic transmittal format required by the TPA. Costs, if any,**

	relating to electronic transmittal agreements and/or arrangements shall be dictated by agreement(s) between TPA and individual Carve-Out Vendors. Sedgwick agrees to comply with this requirement. Setting Sedgwick apart is the comprehensive approach we take to provide a full range of in-house workers' compensations managed care services that are electronically integrated with our claims management software. This offers timely communication and collaboration with examiners, quality medical care and controlled medical costs. Sedgwick managed care programs: • Show year over year improvements of both indemnity and medical spend when clients use the Sedgwick model • Systems integration with our vendor partners streamlines referrals for services and billing and are incorporated in the claims file for application of UR and bill review • In the Sedgwick model, DPI is assured regulatory compliance and state reporting Sedgwick will work with DPI and vendors of their choosing to establish workflows for timely and streamlined communication of essential claim information. Should electronic interfacing be required, Sedgwick will assist DPI and its vendors and perform a full evaluation of technical needs, workflow options for the interface development and ongoing maintenance.
4	**TPA must comply with "Split-Funding" requirements including: modifying Form 19 to allow LEAs to make "Split-Funding" percentage entries.** Sedgwick agrees to comply with this requirement.
5	**TPA must collect split-funding payments from LFP. The TPA shall not request DPI to release a split-funded check until the TPA has received and deposited the LFP's payment into the DPI account. The TPA shall be responsible for and pay any penalties levied on DPI by NCIC due to late payment of claims.** Sedgwick agrees to comply with this requirement.
6	**TPA must comply with Procedures For Check Processing and Payments of Workers' Compensation Claims and Benefits. See Attachment E.** Sedgwick agrees to comply with this requirement.
7	**TPA must have a network currently in place to support the services outlined within this RFP. Proposing to establish a network before the contract date is not sufficient to meet requirements of this RFP.** Sedgwick agrees to comply with this requirement. Sedgwick owns the Occunet PPO serving North Carolina, Washington DC, Maryland, and Virginia. The current provider network matrix for the state of North Carolina for primary and tertiary networks is as follows: Occunet; Procura; Beech; IHP; Prime Health;and Interplan.

8	**TPA must have a network of medical providers for injured employees residing in all 115 NC LEAs. Please see Attachment M for a listing of NC LEAs.** The Sedgwick Occunet network and our multitiered approach to network customization will provide DPI with coverage is consistent with all geographic locations represented by the LEAs.
9	**TPA must have an efficient business rules based electronic WC claims system that can be utilized by all 3600 LEA school locations and DPI.** Sedgwick's claim system, as well as our bill review system, has the ability for business rules application, to properly address specific scenarios during the life of a claim. The Sedgwick implementation team will collaborate with DPI during the design phase of the program, to establish rules for DPI. This feature also allows for on-going evaluation and update of rules, as the program/claims mature or alter.
10	**TPA must provide a toll free phone number for WCAs and DPI to access staff and report claims.** Sedgwick agrees to comply with this requirement. Sedgwick's best practice is to use our internal contact center organization, headquartered in Memphis, Tennessee, supporting toll-free claim intake 24 hours a day, seven days a week.
11	**TPA must maintain disaster recovery procedures for claims, eligibility, billing and accounts receivable records, which include:** • **Documentation to support regulatory compliance and** • **Daily data back-ups.** We have a complete information technology disaster recovery plan (IT-DRP) that is tested twice annually. In addition, a full business continuity plan is in place for operational recovery in the event of a disaster or loss. As part of a larger business continuity plan that coordinates business office and information technology protocols, Sedgwick has developed an IT-DRP to document-specific actions and procedures that are to be executed in response to a disruption to the primary application systems at the Little Rock, Arkansas, data center. The IT-DRP is maintained within an offsite-housed database to allow for easy updates and modifications and is maintained, updated and tested by Sedgwick's outsourced technology infrastructure vendor, Fidelity Information Services (FIS). FIS' disaster recovery testing and reporting is measured by contractual service level agreements. A coordinated but separate plan for operational recovery is also stored in this database and is updated by national operations within Sedgwick. The plan is put into action by official declaration from one of the plan-identified Sedgwick leadership team. All business critical systems are backed up at least daily; back-ups are stored offsite in secured data storage facilities. Sedgwick contracts with FIS for site recovery. Additionally, back-up offices are designated for each of our field offices. In the event of a business interruption to a field office requiring implementation of our business continuity plan, telephone calls and critical claims activity can be re-

	routed to the designated back-up office or to an alternative site. Sedgwick can also use secure Web-based applications, VPN connections and Citrix servers to provide our colleagues access to business critical applications from alternate sites with Internet connectivity following a business interruption. This allows for a great degree of flexibility in recovering from business interruptions to our field offices. In the event of a disaster declaration, base and core systems are the first to be restored and are done so within 48 hours of the disaster declaration. This is the recovery time objective (RTO). Base and core systems will be restored to the data state that existed no greater than 24 hours before the event occurrence, which constitutes our recovery point objective (RPO).
12	**TPA must provide 5 references. Other NC state agencies preferred. See Attachment C.** Sedgwick agrees to comply with this requirement.

2.0 Administration of Claims by TPA

TPA shall administer claims in accordance with the NC Workers' Compensation Act, NCGS Chapter 97. DPI receives 6,000 to 8,000 new claims per year. Approximately 1,500 open indemnity and 2500 medical claims will be transferred.

Sedgwick agrees to comply with this requirement.

Split-Funding Process

On the Employer's Report of Employee's Injury or Occupational Disease, NCIC Form 19, the TPA must modify their electronic form to allow an entry from the LEA/WCA to enter the percentage of "split-funding." It is the LEA's/WCA's responsibility to enter the correct percentage of "split-funding" on the Form 19. The TPA must work directly with each LFP to collect the payments due from local funds. The selected TPA must provide adequate documentation to LFPs for prompt payments into the WC Fund. It is the responsibility of the TPA to ensure that local funds are transferred into the WC Fund to cover the local portion of the "split-funded" check release request--- before any payments made to injured workers, medical providers or other service providers. The TPA must not request DPI to release a split-funded check until the TPA has received and deposited the LFP's payment into the DPI account. TPA shall be responsible for and pay any penalties levied on DPI by NCIC due to late payment of claims. "Split-funded" changes/corrections made by the LEA/WCA will be accepted effective the date of notice to the TPA and approved by DPI. Changes to "split-funding" made by the LEA/WCA will not be made retroactively.

We will capture the allocations between DPI and the LEA using client-defined fields that are captured at intake, allowing us to report this on the Form 19 as well as it being a reportable data field within JURIS, our proprietary claims system. If DPI adopts our standard practice, a copy of this form would be disseminated to the workers' compensation administrator at the LEA and to DPI as confirmation of the allocation provided.

2.1 Claims Administration

Vendor shall describe how it will provide the following required services:

a. Claim intake process.

Sedgwick's best practice is to use our internal contact center organization, headquartered in Memphis, Tennessee, supporting toll-free claim intake 24 hours a day, seven days a week. Our contact center operations receive new reports for all lines of business and clients have the option of using multiple reporting channels, including voice and direct Web entry through our viaOne intake module, an online reporting tool that allows DPI to enter their claims over a secure Internet connection. We often work with pre-filled information provided by a human resource data feed from our customers. Use of this feed requires further discussion with the client before implementation. Our service center operations are staffed with trained customer service representatives who are employees of Sedgwick.

b. Claim investigation process, including 3-point investigation and recording.

Once a workers' compensation claim is reported, a team lead will review the claim and determine if there are any red flags, subrogation opportunities or special requirements based upon the reported information. The team lead will then assign the claim to an examiner based upon the complexity of the claim and dedication/designation requirements with instructions where appropriate.

Indemnity claims require a minimum three-point contact with the claimant, employer and medical provider. Additional contacts may be necessary based upon the details of the accident, presence of witnesses, potential for subrogation, etc. When appropriate, recorded statements or on-site investigations will be obtained. Medical information will continue to be reviewed for appropriateness of treatment and other actions on a continual basis.

Claims will be indexed as agreed to with DPI, but our best practice is that at a minimum, all indemnity level claims are indexed.

Sedgwick has a dedicated SIU that assists examiners in vetting potential fraud when it is suspected to have occurred. Our SIU uses various tools, including social media searches, to help the examiner fully explore any and all red flags. Sedgwick employs a team approach with multiple resources to ensure benefits are only paid when they are due.

c. Claim management cycle.

Our approach to claims management is simple. Work aggressively utilizing first class resources while partnering DPI to secure a fast, fair and equitable claim conclusion. The examiner is charged with the overall management of the claim. They are the gatekeeper in ensuring benefits are paid appropriately and the appropriate techniques are deployed to secure the best outcome. The examiner will work closely with our managed care colleagues and the treating physician to provide reasonable and necessary care resulting in the employee's recovery and return to work. The team lead is involved to help the examiner and provide needed coaching and mentoring. This claims team is focused on securing the best possible outcome for DPI.

d. Subrogation process.

Subrogation opportunities are identified during the initial investigation and throughout the life of the claim as additional information is obtained. The claim is flagged in our system and appropriate codes (the claims examiner needs to be flagged or coded "in" subrogation on the main JURIS screen) are entered. Written communication/notice to the identified third-party will be sent within five business days of the knowledge. A subrogation review diary is automatically established and the system will generate subrogation review notices to the examiner and the team lead on the file at a minimum of every 90 calendar days unless the claim is in litigation — those diaries are set at a minimum of every

60 calendar days. The pursuit of subrogation will be coordinated with the appropriate DPI representatives to determine the extent you want us to pursue this on your behalf and to assist in the determination of any waiver of subrogation or other contractual agreements that may exist.

Our workers' compensation claim examiners are trained on the second injury fund process in the states where they handle claims and ensure that the appropriate submissions are sent and follow up occurs.

e. Method for establishing reserves.

We establish loss reserves on each claim, for each line of coverage, based on the probable outcome of the claim. Appropriate initial reserves are established on all new claims based on information available at the time of file creation and are subsequently reviewed and recalculated as developments occur that impact the total incurred. Our reserves are set for each individual category: indemnity, medical and expense.

The examiner uses of the information gathered in the initial investigation to project DPI's financial exposure and set the initial reserves. Our detailed reserve work sheet, which is contained online in our JURIS system, breaks the reserve into detailed categories within each major category, including temporary total disability, permanent total and partial disability, and vocational rehabilitation. Expense reserves are calculated based upon the anticipated investigative costs to take the claim to resolution.

Timing of reserves is critical. It is Sedgwick's best practice to allow up to five days of receipt of the claim to set a fact base reserve. Most of our reserves, however, are set within the first two days of the opening of the claim.

If additional information is received that would necessitate a reserve change, the examiner must effectuate the change and document the rationale within five business days. It is the job of each examiner to review the propriety of file reserves each time they touch the file and to make adjustments as supported by the facts and new information that may have been obtained since the last review that impacts the value of the claim. Reserves are reviewed formally and are documented in the file at minimum every 90 days following the initial reserve.

Our end-to-end quality process ensures that our claims examiners follow our best practices relative to reserving as well as any special client requirements. The claims team leads are charged with reviewing reserves when looking at the claim files. In addition, our quality managers assess both the claims examiner and team lead.

Limited medical and expense payments can be made on a closed claim. Once this threshold is exceeded the examiner will be required to reopen the file and set an appropriate reserve. No indemnity payments can be made on a closed file.

Performance 360®

At Sedgwick, we are continually expanding our services and looking for ways to enhance the overall quality and value we bring to our clients. By evaluating what we do and how we do it, we can improve claims outcomes and be better prepared to assist clients as their businesses evolve.

It is with this philosophy in mind that we embark on our next evolutionary step to improve best practices and ultimately impact the quality of our processes and claim file outcomes. By modifying daily activities involved in quality control and compliance, we can enhance the claims services we provide — ultimately improving results for our clients.

Our Performance 360 quality program takes a holistic approach to every step of the claims process including compliance auditing at key times in the claims cycle, implementing score carding and reinforcing our performance goals with the appropriate training and communication to ensure

colleagues understand outcomes expectations. Embedded in the program is a continual performance review process to make ongoing enhancements and to ensure we are delivering the best possible services to our clients.

During the implementation process, Sedgwick will establish the specific procedures to ensure that DPI is appropriately involved in the process. The JURIS system establishes automatic email notifications of reserve changes at levels specified during the implementation process.

f. Determination of medical treatment by an adjuster.

During the implementation Sedgwick will review three years of DPI claims history and together with DPI will develop business rules and electronic triggers that are embedded in our electronic claims system, JURIS. This level of customization allows DPI to set guidelines that will trigger the referral for case management and medical treatment.

Examiners and case managers use Official Disability Guidelines (ODG) to determine claim eligibility and justification for recommendations and referrals. The clinician selects the appropriate guideline by determining the purpose of their role in the process. If the claim is complex, it may require a complex review of several guidelines to arrive at the appropriate recommendation. If the issue is simply a best practice duration guideline or an identification of potential complications for a given diagnosis ODG, MDA or Milliman will be accessed. The guidelines are diagnosis-specific and require additional clinical information for the clinician to appropriately make recommendations and referrals.

Physician advisors are required to deny any treatment requests that fall outside the treatment plan guidelines. Sedgwick has established a physician advisor network, to access board certified specialists who not only review the clinical documentation, but also have peer-to-peer discussion with the treating physician. This action is in an attempt to gain consensus and share best practice while recommending an alternative treatment plan.

- Physician advisors are URAC accredited under independent review organization.
- These physicians are well qualified, free from conflict of interest and capable of addressing issues of medical necessity and experimental treatments.

In the Sedgwick strategic clinical design, the nurse case manager and examiner work as partners in returning the injured employee to work and claim resolution. Nurse case managers have a real-time link with examiners through our JURIS electronic claims management system. This expedites the process for referring and communicating critical information and moving the claim forward to resolution. Our physicians are available for in-house consultation and may be sought through the Sedgwick physician advisor network.

g. Return to Work focus.

Claims examiners and case managers aggressively manage RTW options beginning with the first notice of lost work time and continue to seek options for RTW throughout the life of the claim. They will work with DPI, the injured employee and the treating physician to discuss all transitional and full duty RTW options.

Our RTW program strives to restore the injured worker to full function while following the American College of Occupational and Environmental Medicine (ACOEM) stay at work (SAW) and RTW guidelines. Official disability durations embedded in our electronic claims management system allow our examiners and case managers to track RTW status on every case.

We provide the injured employee and medical treatment provider with the estimated RTW date for transitional and full duty. This has been very successful for our integrated disability and workers' compensation clients.

Through our managed care solutions and use of our highly rated in-network providers, clients see 73% faster RTW rates.

Return to work specialists

Unique to Sedgwick are our RTW specialists who evaluate DPI's RTW program along with the culture of the organization. They tailor their approach to your industry and location, developing a plan that will provide an array of RTW options. As an example, our RTW specialists can design creative light and modified-duty assignments with local nonprofit organizations meeting the need of the local community, the injured employee and our client alike. As a best practice, we hire certified rehabilitation counselors (CRCs) in these positions.

Vocational rehabilitation counselors

Recognizing RTW barriers and engaging a vocational rehabilitation counselor at the workplace can significantly impact a claim and can often help close the claim faster. For injuries that require vocational rehabilitation, Sedgwick deploys a master's degree level vocational counselor.

The vocational rehabilitation counselor can use multiple assessment tools and techniques to develop a RTW plan for the injured employee that is in line with limitations defined by the medical provider. These assessment tools include, but are not limited to, job analysis, job placement, job modification, labor market surveys, transferable skills analysis and vocational evaluation and testing. This aggressive approach quickly defines barriers to full RTW and together with our client and injured worker, an action plan can be developed for job modification, job placement or retraining.

h. Process when claimant reaches MMI.

The treating physician is engaged for evaluation of maximum medical improvement when the case manager identifies a plateau has been reached in medical treatment. Upon confirmation of MMI with the physician, Sedgwick reviews this determination to ensure that it makes sense based on ODG guidelines and the objective medical findings.

If needed, Sedgwick will engage our clinical team, physician advisors or an independent medical examiner to ensure that the MMI determination makes sense and that no additional healing or increase in functionality is anticipated. If necessary, the injured worker will participate in a functional capacity evaluation to ensure the final MMI status and work restrictions, if identified by the treatment provider, are appropriate. MMI status will then be relayed to DPI as it relates to RTW and Sedgwick's claim resolution process will commence.

i. Claims with multiple injuries.

All injuries and diagnoses are logged in the claims management system, both in coding areas and through documentation provided during the claims investigations. Sedgwick claims examiners and nurses also document any co-morbidities identified during discussions with the injured employee, employer representative and treating physicians. Relatedness of all medical conditions and injuries to the injury on the job is evaluated during the initial and continuing claims investigations.

MMI can only occur when all body parts have reached their maximum healing. Ensuring that each body part is addressed throughout the life of the claim and in concert with each other is essential to ensuring maximum medical improvement is reached. Our examiners and clinical team are trained to address each area of injury individually to ensure full resolution of all issues but also to ultimately resolve the entire claim with a holistic approach to maximum medical improvement.

ODG guidelines help to guide our colleagues in the interplay of additional injuries or comorbidities to allow for reasonable expectations as it relates to full healing. Sedgwick examiners will keep DPI up to date on the resolution of parts of the injury and provide the status on the anticipated full resolution of the entire work related claim.

2.2 Information Services

Vendor shall describe how it will provide the following required services:

a. Electronic claims management system.

Sedgwick uses systems and technology to provide our claim professionals with the tools they need to efficiently and accurately manage DPI's claims as well as to provide you with easy access to real-time claim information. The core of our technology is our proprietary JURIS claims management system. Through JURIS, we provide our examiners with a structured, yet flexible, series of screens and routines that simplify the claim management process. DPI-specific instructions are stored online for easy access. DPI-specific data capturing and validation edits are consistently performed. In addition, JURIS provides our examiners with a comprehensive diary and file note capability to assist them in documenting files and maintaining schedules of future activities. In many cases, JURIS will automatically document critical activities with system-generated diaries and file notes.

JURIS uses extensive parameters to provide client claim reporting flexibility. These parameters are used to depict DPI's various locations and organizational structure on the system. JURIS will use this vast hierarchy structure to create reports that will summarize claim information at any level corresponding to your organization.

Throughout the claims management process, critical detailed claim related information is collected and stored. Making this information available to DPI is accomplished through our Web portal, viaOne. In addition to the many standard and client customized reports that are available, Sedgwick offers viaOne view, which gives you the ability to "look over the shoulder" of our examiners and check the real-time status of specific claims. You can report incidents and claims through viaOne intake, create ad hoc inquiries or data extracts through viaOne query, and even manage their OSHA logs through viaOne OSHA.

Sedgwick offers viaOne customizable home page, available from viaOne view, our platform-independent, Web-based application for viewing and analyzing metric and DPI data. The dashboard capability allows DPI to expose key data in a dashboard-style view. Each dashboard/graphical report offers the ability to drill down to the individual claim level for review in viaOne view.

User-defined threshold functionality on each dashboard provides customizable alerts when a key performance indicator is exceeded.

Additional reporting capabilities include viaOne report and quick filters features. viaOne report provides easy access to a number of detail and summary reports. These pre-formatted reports use viaOne quick filters, allowing clients quick access to data for previously-defined sets of claims. DPI may choose certain selection criteria, user-defined fields and sort, sub-total and page break options specified to each report. Through viaOne quick filters, you can create filters based on defined sets of claims information. These filters can be used to view claims matching defined criteria in viaOne customizable home page quick filter gadgets and viaOne report.

Sedgwick data warehousing capabilities take the viaOne product to the next level by offering data integration services and a next-generation query tool. Through the data warehouse, DPI integrates claims data managed by other administrators and a variety of non-claim data (i.e., data from HR systems, surveys and exposures) that assists the user in reporting meaningful risk information. Our goal is to provide you with a single look at your entire program rather than adding to the often-fragmented view that is created by multiple administrators and systems. viaOne analysis provides clients with an extremely powerful environment for extracting, analyzing and building ad hoc reports in a single tool. Using point-and-click/drag-and-drop technology, DPI creates, views and drills into trends easily and effectively.

The viaOne alerts feature increases the value of claims information by expanding user-defined parameters for notification of new developments affecting individual claims and facilitating accelerated analysis of claim trends. viaOne alerts includes an extensive menu of information tracking points and comprehensive sequencing options. These capabilities enable you to establish an unlimited number of alert triggers based on factors such as claim duration, severity and processing status. You can also create alert nesting routines which integrate combinations of contingencies into a single alert trigger. This feature is available for all JURIS-supported lines of business including workers' compensation, disability and liability claims management activities. Other functionalities include the delivery of email notifications, links to claim files associated with an alert, and customization of the duration of the alert.

b. System capabilities to provide electronic data to/from DPI and LEAs.

We regularly provide data to RMIS vendors, clients and carriers by tape or electronic transmission. This is done at daily, weekly, monthly, quarterly and yearly intervals as well as upon request. Data files can be produced containing complete history of payment, reserve changes and notes as well as claim summary data. Monthly activity tapes are also available providing the same information. Any requirements outside the scope of our normal layout would be customized and subject to fees. Pricing for custom interfaces is included in the pricing section.

If it is our standard layout, then we have no issues with being able to provide data on the takeover date. If there is customization, then we will have to work with DPI to further refine the requirements and develop a timeline for completion. A copy of our data interface documentation, which outlines all current data elements, is included in the appendix.

Our claims management system, JURIS, is a fully integrated N-Tier system for managing claims in a multiline environment. The system is developed and maintained utilizing the Progress 4GL graphical Application Development Environment (ADE) and Progress Relational database Management System (RDBMS). The JURIS client software operates in current Windows® standard operating systems, including Windows. The backend processing is hosted in a UNIX® (AIX) environment.

Sedgwick's proprietary JURIS application has an extensive number of real-time and batch level edits and data validations incorporated throughout our operational workflows. In addition, our standard interface procedures use header and trailer records to ensure completion of all data processing for interface exports and loads. Other common QA practices include the utilization of control totals to verify proper processing and cross-validation of transactional reports to ensure month-end balancing has successfully occurred.

viaOne is the name of Sedgwick's customer-facing system for view access to the JURIS claims system. viaOne uses SSL-encrypted, roles-based login security to view a real-time data twin of the JURIS data environment hosted on an Oracle database.

c. Electronic capabilities of Form 19; including capturing split-funding requirements.

As stated earlier, we have the ability of adding questions regarding the "split-funding" into the intake script so that information is captured in our JURIS claims adjudication system and in addition, would be provided back to the identified individual as a part of the reporting package including the Form 19. By making this information mandatory at intake, the data are transferred into client-defined fields in JURIS and is available to the examiner from the time of initial review.

d. System capabilities for claims history, adjuster notes, return-to-work, status of MMI/transitional duty, payments, employees with multiple claims, reporting capabilities.

Our claim system provides for preprogrammed claim status reports. We use these reports for customers who require written status reports at regular intervals, usually quarterly, for serious or complex cases. These reports provide our customers with the most recent claim examiner, team lead and medical management notes, along with reserve, payment and excess information. We recommend development of a cumulative report, which could be issued by work location or state that would provide updated claim information in a condensed format.

JURIS provides a comprehensive file note capability. The notes recorded on a given claim accumulate chronologically beginning with the day a claim is opened. Besides the examiner's notes, the system also stores team lead, legal, nurse and other note categories. All notes are coded for easy viewing on any specific note category, or all notes can be viewed (or printed) chronologically providing a complete history of the claim. Nurse notes are interfaced to JURIS and coded by type. This electronic exchange of information between the nurse and examiner occurs five times per day. These notes are available to clients for viewing through our viaOne suite of services.

Additionally, clients with the proper security with online access through the viaOne Web portal have the ability to record notes on the individual claim files. When a client enters a note, the system will generate a diary to the examiner advising them to review the client created note. These notes are stored with the examiner's notes and are available to the examiner for review. Client notes are part of the claim file.

The JURIS system stores, displays and can report both lost work days and restricted duty days and is calendar-based.

Lost work days are calculated in one of two ways, depending on need. Either they are calculated based on benefit payments issued for a specific number of days or they are calculated based on an approved benefit period entered and maintained by an examiner in JURIS. Restricted duty days are calculated from the same benefit status records that may be used to calculate lost work days, also entered and maintained by the examiner. JURIS records both the estimated and actual RTW dates, as well as client approval of these dates.

The work status report lists the work status details of claimants that meet selected criteria and the duration of each work status. This report varies from the work status days report in that it only shows the number of days for listed work status records on the claim that fall within the requested period — no days before the requested period are included. It is useful for evaluating employee RTW patterns and identifying locations that are complying with accommodations and RTW programs. Please refer to the work status report sample in the reporting sample book in the appendix.

The payment history screen displays consolidated payment/check information for the selected claim. This screen also provides access to individual allocation details for specific payments/checks through the allocation edit screen as well as access to the deductibles, payment detail, receivables, totals and reschedule utility screens.

This screen only displays the total paid for the current claim. If allocations associated with other claimants are tied to the same payment, this information will appear on each claimant's payment detail screen accessed through their payment history screen. The existence of allocations tied to other claimants is shown on the payment detail screen. You may view all allocations associated with one payment by check number in the banking utility's payment history screen.

e. Access to your claims system.

Our client partners access their data through an Internet-based system, viaOne. To access viaOne, DPI will need either Internet Explorer 9.0 128 bit (or higher), Safari 5.0 (or higher), Mozilla Firefox 3.5 (or higher), or Google Chrome. viaOne uses SSL encrypted, roles-based login security to view a real-time data twin of the JURIS data environment hosted on an Oracle database.

f. System capabilities to report paid and reserve financial information.

The claim and expense report provides our clients with detailed claims information for all open claims at each level of the corporate structure, and lists closed claims with current activity during the month. The report provides current period financials, as well as total incurred, future reserves and paid to date amounts. It also tracks new claims and closures for the period and contains important recovery financials broken out into the appropriate categories. The claim and expense report also provides summary financial and claim count data at each level of the clients' structure. Since this report can become quite large, a table of contents is available to provide quick location look-up.

The payment history screen, available for selection from the financial menu in viaOne view, provides a detailed list of all payments issued for a claim, with the ability to search for payments by pay code, payee, document number or a range of dates. Our standard reporting criteria reports financials on a gross total incurred basis, meaning that refunds and voids reduce the total incurred but recoveries, such as subrogation do not.

g. Reporting capabilities that will facilitate DPI in the claims settlement and or case review process.

Standard reporting options – by Sedgwick for DPI

The JURIS system provides a wide variety of standard reports, which can be generated at any level of DPI on a regular basis.

JURIS uses extensive parameters to provide client claim reporting flexibility. These parameters are used to depict DPI's various locations and organizational structure on the system. JURIS will use this vast hierarchy structure to create reports that will summarize claim information at any level corresponding to your organization. Standard month-end reports include: adjustment report, loss analysis I report, claim and expense report and transaction report.

Special reports include: accumulative loss analysis, lag report, allocation/transaction report , loss claim and experience report, cause code analysis report, loss analysis II, claim report, loss summary report, claim status history report, loss run summary report, claims log report, misc. client field report, cost range analysis report, pay-code analysis report, experience rating report, payment and reserve progression, hard copies by client report, repeaters list report, indemnity report, reserve change report, stewardship report and specific excess report, and many more. There are no additional fees for standard reports, copies of which are included in the appendix.

viaOne reporting options — run by DPI

viaOne report

Other reporting capabilities include viaOne report and quick filters features. viaOne report provides easy access to a number of detail and summary reports. These pre-formatted reports utilize viaOne quick filters, allowing you quick access to data for previously-defined sets of claims. DPI may choose certain selection criteria or user-defined fields and sort, sub-total and page break options specified to each report. These filters can be used to view claims matching defined criteria in viaOne customizable home page quick filter gadgets and viaOne report. Samples and descriptions of available reports can be found in the viaOne report sample book, included in the appendix.

viaOne query — ad hoc reporting

Additionally, through the viaOne Web portal, claim information is available for downloading toyour internal systems for ad hoc reporting or analysis. The viaOne query module allows for the ad hoc selection of data elements to be extracted and for the ad hoc definition of the extraction criteria to be used. Data are available for reporting through the viaOne Web portal on a real-time basis.

viaOne dashboard

Sedgwick also offers the viaOne dashboard, an independent, Web-based graphical application, which allows DPI to customize and view metrics and KPI data for disability data. You can select which dashboard(s) to view and has the ability to set personal thresholds for each dashboard.

viaOne analysis

Sedgwick data warehousing capabilities take the viaOne product to the next level by offering customers data integration services and a next-generation query tool. Through the data warehouse, DPI integrates claims data managed by other administrators and a variety of non-claims data (i.e., data from HR systems, surveys and exposures) that assists the user in reporting meaningful risk information. Our goal is to provide a single look at your entire program rather than adding to the often-fragmented view that is created by multiple administrators and systems. viaOne analysis provides customers with an extremely powerful environment for extracting, analyzing, and building ad hoc reports in a single tool. Using point-and-click/drag-and-drop technology, customers create, view and drill into trends easily and effectively.

Sedgwick examiners can access client service instructions directly from the JURIS system. Client service instructions provide immediate access to critical client servicing requirements and links to additional resources on the Sedgwick intranet site. Examiners receive automatic notification when changes are made to the client service instructions, upon login to the JURIS system.

h. OSHA reporting capabilities. (Include any additional charge for this function in pricing as separate item).

Sedgwick provides flexible OSHA recordkeeping solutions. DPI has the option to select one of three levels of service to suit you preferences through our viaOne OSHA proprietary application. The system is able to generate standard reports such as the OSHA 300, 300A, 301 and Sharps logs as well as other reports such as DART and BLS surveys.

Our three service levels include:

- For level I clients, Sedgwick provides initial and ongoing demographic data updates to the application. The client retains responsibility for other recordkeeping decisions including time tracking, privacy case designation and recordability.
- Level II adds a module that eliminates the need for clients to track time. viaOne OSHA populates days away, restricted and job transfer days. Other recordkeeping decisions continue to remain with the client.
- With level III Sedgwick's trained OSHA analysts assume responsibility for all recordkeeping updates including time tracking, recordability, injury type designation and privacy. Services include evaluation of data based on OSHA guidelines and work status records, in addition to basic demographic information and special OSHA fields that are loaded into the system several times each day.

Pricing for our services varies depending on the level selected. Before purchasing OSHA services, we encourage you to participate in a demo of the application to determine which level best meets your needs.

i. Reporting capabilities to track all payments made from the WC Fund.

Our payment detail spreadsheet report provides detailed payment information based on criteria specified by the requestor in .csv format. The report can be requested for specific clients or bank accounts.

2.3 Operation and Services

Vendor shall describe how it will provide the following required services:

a. TPA operations, ownership and expertise in TPA services.

The name of our firm is Sedgwick Claims Management Services, Inc. or Sedgwick. We became a corporation December 22, 1969 in the state of Illinois. 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. Our corporate office is located at 1100 Ridgeway Loop Road, Memphis, Tennessee 38120.

Sedgwick is the industry preferred TPA for sophisticated, large employers seeking a customized claims management solution. We have more than four decades of experience serving the nation's most prominent organizations for national workers' compensation, multiline liability, first- and third-party property, short-term disability, long-term disability and FMLA/leave of absence administration. We handle over 2.8 million claims annually and have fiduciary responsibility for claim payments almost $12 billion annually. We are ranked as the largest TPA in the country handling self-insured and alternatively funded claims administration programs.

Sedgwick is an independent, investor owned TPA, without any insurance company and/or brokerage affiliation. Sedgwick's more than 12,000 colleagues in 275 offices in the United States, Canada and the United Kingdom are focused on our corporate mission to be the premier TPA in the industry. We operate in a fully transparent environment, maintain SOC1, Type II certification (formerly referred to as SAS70, Type II certification), and provide state-of-the-art, fully-secured systems technology.

Sedgwick owns and operates all core claims operations and leverages fully integrated ancillary partnerships to provide a single source, comprehensive array of claims, risk and technology services. *Business Insurance* has recognized Sedgwick for being the largest and one of the best TPAs based on customer service, quality, innovation and value.

b. Locations of each operational and account management facility that will be utilized to support the program. Include the approximate number of staff for each location. DPI prefers TPA adjusting staff to be located in Raleigh, NC.

We propose handling the DPI account from our Raleigh, North Carolina, servicing office. Our proposed staffing for the DPI program is listed in the table below:

Position	Estimated staffing required
Claims examiner (LT)	10.00
Claims associate (MO)	7.00
Claims team lead	3.00
Claims assistant	2.00

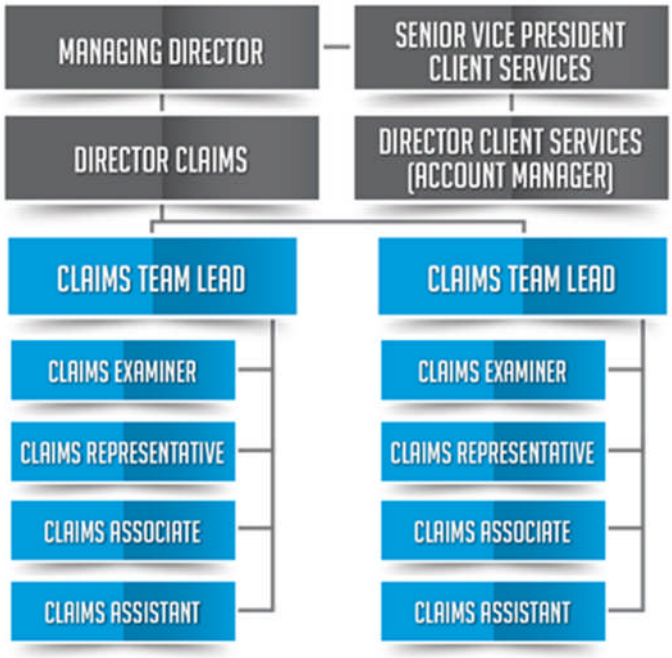
OSS coordinator	0.50
Data quality analyst	1.00
Director claims	0.50
Director client services	1.00
Total estimated staffing	**25.00**

c. Organizational chart of key executives and operations leaders, include biographies.

We have included Sedgwick organizational charts in the appendix. Sedgwick has a world-class, stable management team with more than 240 years of combined industry experience. Our senior executive team includes the following:

David North	President and Chief Executive Officer
Steven Penman	Chief Operating Officer
Jay Potter	Chief financial officer
Jason Hood	Chief Legal Officer
Terri Browne	Chief People Officer
Bradley Johnson	EVP, Operational Strategy and Shared Services
Elizabeth Demaret	Chief Customer Relationship Officer
Robert Peterson	Chief Marketing Officer
Don Sloan	EVP, Director of Managed Care
Darryl Hammann	EVP, Disability Operations
Scott Rogers	Executive Director, Casualty Operations
Jim Ryan	Executive Director, Casualty Operations

The following organizational chart illustrates a typical claim department structure. Staffing models vary by Sedgwick office and by client specific needs. The average ratio of examiners to team leads is 5:1, with one support person for every six to eight employees. This model will differ depending upon the size of the particular Sedgwick office.



We have provided bios for proposed staffing in the appendix.

d. For lost time and medical claims, address the following:

i. Will adjusters be 100% dedicated to the program?

DPI will have examiners dedicated to your program in the Raleigh office. Generally, examiners are assigned based on whether the claim is lost time or medical only, and this assignment does not change. However, if a medical only claim becomes a lost time, it is often transferred to a higher level examiner.

ii. Will supervisors be 100% dedicated to the program?

Based on our best practices staffing ratios, we expect three dedicated team leaders assigned to this program.

e. What is the average case load for medical & lost time adjusters? What will TPA propose as the total number of files assigned to staff under the DPI program?

Medical only caseloads average 300-350 per examiner. Lost time caseloads average 150-160 per examiner.

f. Claims management approach used to facilitate open claims to closure.

Sedgwick underscores the need to our examiners to aggressively manage the claims to effectuate settlement or closure as soon as appropriate. Our best practice model includes the examiner working in tandem with the clinical case manager on cases that may be impacted by clinical involvement. A claim may be medically managed from first report of injury through claim closure, using a cost-effective approach that combines medical expertise with the Sedgwick examiner's claim handling expertise to achieve the best possible result. The main concern is to maintain treatment standards that are known to be safe, effective and efficient, thereby ensuring the best possible medical outcome at the lowest possible cost for the entire treatment episode and initiation of RTW.

Client services works alongside the claims team to identify and deploy strategies for claims that are identified as having the propensity for becoming an aged claim.

It is Sedgwick's goal to use creative solutions to resolve claims before reaching this point. In the event a claim becomes "aged," the team will work aggressively to secure an equitable conclusion. Innovative settlement strategies, medication utilization control and stakeholder engagement are crucial in successfully mitigating aged claims.

g. Aspects of your service that potentially distinguish you from other competitors.

Sedgwick has differentiated itself from our competitors by offering a world of resources and expansive services that are unparalleled in the industry.

Many clients choose Sedgwick because they know we process more claims than any other TPA in North America, giving us the experience and insight to help them build optimal claims solutions. Sedgwick's more than 12,000 skilled colleagues in 275 offices manage claims quickly and efficiently. Our dedicated national practice groups include industry experts in workers' compensation, managed care, liability, disability and absence management ensure consistency within our organization, compliance with legal and regulatory requirements, and awareness among our clients and colleagues about emerging practices within our industry.

In addition to our experience and expertise, our technology solutions — JURIS and viaOne — give us and our clients the ability to manage the full spectrum of claims and productivity management solutions from property, casualty and disability to integrated services that make the administration process more efficient and effective. Our integrated solutions are strengthened by this common system platform that allows the client to capture and view organizational impact from every aspect. We continue to develop intuitive technology that allows us to give the client, the employee, and the examiner the information needed to create a more positive outcome.

At Sedgwick, we understand the unique environment and technical intricacies of exposures facing public entities. We partner with more than 150 public entity programs across the United States representing more than 11% of our total annual revenue. Our large public entity practice has experience handling public schools, cities, counties, states, university systems, transportation divisions and energy departments nationwide.

Listed below is a sampling of public entity clients we are fortunate enough to serve. Many have similar profiles and exposures to the DPI program.

At Sedgwick, delivering the services that each client needs is what we do while also reducing our clients' overall claims costs. Sedgwick managed care has developed unique strategies to be the industry leader in cost containment solutions. Our medical bill review program ensures that bills are reduced to the lowest possible fee schedule before any PPO discounts are applied as well as subsequent PPO fees. Also, there is no bill review fee for denied, duplicate or reconsideration bills, which is also a client advantage. Access to the top quality providers in North Carolina is crucial for obtaining the best claim outcomes, not just a PPO discount.

The Sedgwick provider benchmarking and search tool allows our customers, claims and clinical colleagues to find the best possible provider, based on scored claims data, at the click of a button. And, our best performing 3-, 4-, and 5-star providers have proven results in reducing loss costs. The development of our Sedgwick field case management network provides our customers and colleagues access to the best field case manager in an area without being confined to a single vendor network. Sedgwick service expectations and oversight also ensure best outcomes and quality assurance, and 2014 will provide field case management quality scoring, as we do in our provider network.

In 2013, Sedgwick made a significant investment in a pharmacy management program, unlike any other in the industry. A team of pharmacy specialty nurses, led by a medical director for pharmacy management has been established to aggressively manage the ongoing challenge of growing pharmacy costs in workers' compensation. Customized business rules, identify prescriptions out of formulary for point-of-sale review, evaluate medication requests against diagnosis and other medication for UR before prescriptions are filled. And, complex pharmacy management, identifies claims with adverse trends for full clinical oversight and round tabling between the prescribing physician, examiner and Sedgwick pharmacy medical director. Results in this program were 12:1 net return on investment nationwide.

h. How will you communicate, interact and coordinate activities with vendors chosen under this RFP's carve-out program.

We have a shared goal with our clients at Sedgwick, your success in reducing overall claims cost is our success. At the time of implementation, we will bring together subject matter experts that will work collaboratively with DPI and its vendor to discuss data and information sharing strategies and build workflows that provide timely communication, and meet regulatory requirements while supporting the cost containment strategy for DPI. Ongoing, we will work closely with all partners to insure the overall goals of the program are being met and all efforts are in concert to meet these goals.

Client service instructions embedded in the JURIS claims management system will allow claims examiners managing your claims to consistently and quickly identify any special handling requirements regarding vendors providing services specifically for DPI.

i. Describe you disaster recovery plan.

We have a complete information technology disaster recovery plan (IT-DRP) that is tested twice annually. In addition, a full business continuity plan is in place for operational recovery in the event of a disaster or loss.

As part of a larger business continuity plan that coordinates business office and information technology protocols, Sedgwick has developed an IT-DRP to document specific actions and procedures that are to be executed in response to a disruption to the primary application systems at the Little Rock data center. The IT-DRP is maintained within an offsite-housed database to allow for easy updates and modifications and is maintained, updated and tested by Sedgwick's outsourced technology infrastructure vendor, Fidelity Information Services (FIS). FIS' disaster recovery testing and reporting is measured by contractual service level agreements.

A coordinated but separate plan for operational recovery is also stored in this database and is updated by national operations within Sedgwick. The plan is put into action by official declaration from one of the plan-identified Sedgwick leadership team.

All business critical systems are backed up at least daily; back-ups are stored offsite in secured data storage facilities. Sedgwick contracts with FIS for site recovery.

Additionally, back-up offices are designated for each of our field offices. In the event of a business interruption to a field office requiring implementation of our business continuity plan, telephone calls and critical claims activity can be re-routed to the designated back-up office or to an alternative site. Sedgwick can also use secure Web-based applications, VPN connections and Citrix servers to provide our colleagues access to business critical applications from alternate sites with Internet connectivity following a business interruption. This allows for a great degree of flexibility in recovering from business interruptions to our field offices.

In the event of a disaster declaration, base and core systems are the first to be restored and are done so within 48 hours of the disaster declaration. This is the recovery time objective (RTO). Base and core systems will be restored to the data state that existed no greater than 24 hours before the event occurrence, which constitutes our recovery point objective (RPO).

j. Provide your most recent SAS 70 Audit.

The results of our most recent SOC1, Type II audit are included in the appendix.

k. Provide a copy of your Sarbanes Oxley Control Audit, if one is available.

Sedgwick undergoes an annual SOC1, Type II audit, which assists our clients in their compliance with the Sarbanes-Oxley Act as it focuses on general claim and computer controls related to the financial transactional services we provide. Sedgwick is a privately owned company and not subject to Sarbanes-Oxley.

3.0 Implementation

To satisfy the requirement of a seamless transition and an on-time implementation, the TPA must begin the execution of an implementation plan following the award of the contract. The Vendor must be able to successfully exchange eligibility files with the incumbent TPA.

Sedgwick leads the industry in transition management. Implementation is a dedicated discipline within Sedgwick, staffed by colleagues who are adept at managing the wide array of operations impacted by a change in TPAs. The team's only responsibility is to seamlessly transition clients. They direct resources from multiple departments within the organization to deliver a best-in-class program. This transition process begins as early as the development stage, when we engage in discovery sessions and set the program design features. Typical activities would include visits to our office facilities, meetings with our key operational and management personnel, and firsthand demonstration of our systems platform.

Once an award has been offered, Sedgwick then initiates our comprehensive implementation procedures. We will accomplish this by assigning Deborah Mayes as implementation project manager to coordinate the transition process. A detailed project plan will be developed which will identify the key deliverables, action items, and due dates to meet the expectations of DPI. The transition process will begin with an initial implementation team meeting involving all responsible parties from Sedgwick, DPI and external vendors, if applicable. The implementation team members will be responsible for their individual area of expertise as it relates to this transition, i.e. technology, recruiting, training, orientation, banking, managed care, etc.

Ongoing management of the project plan and communication of the progress will be handled through a series of conference calls and/or meetings. We are proposing Debbi Mayes for the senior project implementation manage and have included her bio in the appendix.

The TPA shall provide each of the following:

a. Project Manager and Project Team to support an on-time implementation with a 7/1/2015 contract commencement date.

Sedgwick agrees to comply with this requirement. We are proposing Debora Mayes for the senior project implementation manager. We have included her bio in the appendix. Also, a draft implementation project plan is included in the appendix.

b. Outline deliverables of this RFP as required for a go-live date of 7/1/2015.

Sedgwick agrees to comply with this requirement.

c. Details on how TPA will implement activities with chosen carve-out vendors.

We have a shared goal with our clients at Sedgwick — your success in reducing overall claims cost is our success.

At the time of implementation, we will bring together subject matter experts that will work collaboratively with DPI and its vendor to discuss data and information sharing strategies and build workflows that provide timely communication, and meet regulatory requirements while supporting the cost containment strategy for DPI.

Identification of work processes and system connectivity required to support seamless claims management with applicable vendor support will be detailed in the DPI-specific implementation plan upon identification of the vendors that will be used and confirmation of interface or process development needs.

3.1 Performance Requirements

The TPA shall:

a. Begin making benefit payments on lost time claims without a lapse in claimant's benefits.

b. Set up Disbursing bank accounts and check writing process that is tested and operational at least thirty (30) days before July 1, 2015. See Attachment E

c. Collect split-funding payments from LFPs. The Vendor shall not request DPI to release a split-funded check until the Vendor has received and deposited the LFP's payment into the DPI account. The Vendor shall be responsible for and pay any penalties levied on DPI by NCIC due to late payment of claims.

d. Make payments to all providers and employees within time constraints as required by the NCIC.

e. Provide access and guidance to any of the carve-out services provided by other chosen vendors.

f. Have an effective fiscal control system that ensures for accountability of claim payments. LEAs and DPI designated personnel must have access to the electronic system for filing claims, access to claim notes, and payment information. System capabilities must include full reconciliation of accounting for every transaction.

g. Have internal controls which ensures that (1) all claim files are accurately established, maintained and updated; (2) supporting documentation for cash disbursements and receipts are accurately and securely maintained; (3) confidentiality and security of claimant's claim and personal information.

h. Aggressively pursue subrogation, where applicable. Remittance of subrogated funds shall be directly to the NC Department of Public Instruction.

i. Prepare litigated claimant files for submission to the Attorney General's office. Including all necessary and required NCIC forms. Files prepared for the AG's office shall contain copies of all NCIC forms, medical records (separated by provider and in chronological order), attorney or employee correspondence, employee information, employee and witness statements, clincher worksheets and chronological log of claim history. This information shall be provided to the AG's office within 10 days of the receipt of a Form 33; within 3 days of receipt of a motion, and within 5 days of receipt of interrogatories.

j. Meet with DPI on a quarterly basis to discuss and report claim activities; including complex cases, return to work issues, claim expenditures, claim closures, caseload review and software updates.

k. Pursue Utilization Review only if approved by DPI or the NC Attorney General's office.

l. Provide a dedicated adjuster assigned to each LEA.

Sedgwick agrees to comply with this requirement.

3.2 Adjuster Requirements

The TPA's Adjusters shall:

a. Have working knowledge of NC General Statute Chapter 97, Workers' Compensation Act and applicable case law.

Sedgwick agrees to comply with this requirement. Each jurisdiction Sedgwick handles has a designated state expert. The state expert for North Carolina is charged with updating colleagues on recent statutory developments and maintains a portal page for colleague reference.

b. Have working knowledge of NC G.S. 115C-338 Salaries for Employees Injured during an Episode of Violence.

Sedgwick agrees to comply with this requirement. 115C-338 provides that any full-time employee in any educational institution supported by and under the control of the state is eligible to make a claim for benefits for injuries arising out of an episode of violence. The statute further provides that the claim must be filed with the board of education within one year after the occurrence giving rise to the alleged injury. The board of education then has 30 days after receipt of the claim within to decide whether and to what extent the employee is entitled to benefits under the statute and the board must transmit its written decision to the employee.

c. Have working knowledge of all necessary forms required by the NC Industrial Commission (NCIC).

Sedgwick agrees to comply with this requirement.

d. Work directly with, LEAs, DPI and NC State Attorney Generals' Office.

Sedgwick agrees to comply with this requirement.

e. Have working knowledge of the split-funding process.

Sedgwick agrees to comply with this requirement.

f. Have working knowledge of State benefits.

Sedgwick agrees to comply with this requirement.

g. Project Director/Supervisor will be assigned to the account and serve as the primary contact for DPI.

Sedgwick will assign an account manager to the DPI claims program as the single point-of-contact. This person will be managed by Rick Schroder, our vice president of client services. Overall, the account manager will disseminate client objectives to all functional and strategic areas of Sedgwick, involving claims administration, customer service, systems, communication and program analysis as needed. This single point of contact for our clients has yielded the best results and ensures that our clients' needs and program objectives are communicated properly.

Sedgwick will identify suitable candidates to fill the role of DPI account manager. We believe the selection process should be collaborative, providing DPI the opportunity to review bios and interview the candidates — then we can work together to select the most appropriate manager to meet DPI's unique needs. Sedgwick's account manager leads your program team in every aspect of service delivery, quality and ongoing improvements. Our corporate structure has been built specifically to empower these colleagues to do what is needed for our client partners. Specific responsibilities include:

- Accountability for all areas of contracts, staffing, ongoing education and administrative management.
- Leadership for our program team and creating strong partnerships with operations nationwide.
- Responsibility to resolve any service, quality or administrative opportunity working with internal and external stakeholders.
- Authority to make changes working with the DPI program team to all areas in order to achieve excellence in outcomes.
- Management and reporting on all program outcomes.
- Creating ongoing recommendations for program evolution working with Sedgwick resources.
- Organizing ongoing education with Sedgwick University for DPI colleagues.

Additionally, Sedgwick will identify a managed care client services director – Tracey Radford, vice president, who will support the overarching managed care program, and provide on-going program reviews, participate in the quarterly meetings, and attend annual stewardship meeting. Tracey is a registered nurse, who will add a great deal of value to the DPI program.

h. Have at least one year of documented working experience in the area of workers' compensation.

Sedgwick agrees to comply with this requirement. Rick Schroder has over 30 years of workers' compensation experience.

i. Have working knowledge of NCIC Rehabilitation Rules.

Sedgwick agrees to comply with this requirement.

j. Prepare a settlement evaluation for review by DPI and AG's office. Claim settlements in excess of $5,000 must be approved by the Section Chief, School Insurance.

Sedgwick agrees to comply with this requirement.

k. Advise DPI when a claimant has been released back to work or has reached MMI and LEA has not returned claimant back to work.

Sedgwick agrees to comply with this requirement.

l. Advise the AG's office when ordering of a Medicare Set Aside may be necessary. The AG's office has full authority over the MSA process and will direct the adjuster on when to order an MSA. MSAs will not be ordered without AG approval. AG office will select the MSA vendor.

Sedgwick agrees to comply with this requirement.

However, Sedgwick recommends that AG uses Sedgwick's internal Medicare compliance unit. Sedgwick has implemented an entire Medicare compliance unit providing services to our clients and examiners that address Medicare issues. The primary purpose of this unit is to assist in getting cases resolved, not just simply providing a service.

This unit provides Medicare set-asides, Medicare lien resolution and medical cost projections services for all workers' compensation and liability cases on a flat-fee basis. The unit is comprised of Sedgwick's nurses, examiners and an attorney so that all aspect of Medicare compliance can be addressed. This unit has a positive impact of effectively and cost-efficiently getting cases resolved and protecting our clients from further action from Medicare.

By using Sedgwick's internal Medicare compliance unit, our clients receive these benefits:

- **Free, sound advice.** If a case does need an MSA, we advise the examiner and do not charge the client.
- **Double-checking.** With every referral, our internal group reviews all aspects of Medicare compliance to make sure no Medicare-related issues were missed.
- **Complete security.** Client and claimant sensitive information does not leave the confines of Sedgwick. Also, Sedgwick is the only MSA provider that submits MSA to the government through secure, encrypted emails. The industry standard is to mail paper copies or unencrypted CDs.
- **Reduced work for the examiners.** Because our internal unit has access to the same claim systems as our examiners, we significantly reduce the amount of time an examiner has to spend dealing with Medicare issues. The examiners don't have to copy records or fill out length referral requests. Our examiners can devote more time to the other important issues related to the claim.
- **Complete transparency/frequent updates.** Part of our procedures is making sure our examiners and our clients know the status of their requests and referrals. Because we have access to JURIS, we place important status updates right in the notes section of JURIS, which the clients can review through viaOne. This minimizes the amount of time our clients and examiners have to follow up to determine the status of a referral and lets everyone know that we are moving the referral forward in the process.

In addition to the above, Sedgwick is also a founding member and on the steering committee for the Medicare Advocacy Recovery Coalition (MARC). As such, Sedgwick is committed to assisting our clients, through legislative measures, in obtaining some clarity and resolution to many of the difficult issues that are connected to Medicare compliance.

m. Notify the LEA within 3 days of when an employee has received confirmation from treating physician that the employee is able to Return To Work (RTW). The adjuster will aid LEA in the RTW process. The TPA is required to report an LEA's non-compliance of RTW to DPI within 5 days of non-compliance of an LEA's refusal to return an employee back to work.

Sedgwick agrees to comply with this requirement.

n. Participate in the settlement evaluation process and inform DPI and the AG's office in a timely manner of a settlement agreement. At the request of the AG's office, adjusters may be required to participate in mediations.

Sedgwick agrees to comply with this requirement.

3.3 Fiscal Services:

a. Check processing and payment of Workers' Compensation Claims.

i. The process for payment of claims shall be on a daily basis. See ATTACHMENT E for Procedure for Check Processing and Payment of Workers' Compensation Claims.

Sedgwick agrees to comply with this requirement.

ii. TPA is required to collect split-funded payments from LFP's. TPA shall not request DPI to release a split-funded check until the TPA has received and deposited the LFP's payment into the DPI account. TPA shall be responsible for and pay any penalties levied on DPI by NCIC due to late payment of claims.

Sedgwick agrees to comply with this requirement.

iii. DPI shall reimburse the TPA from the WC Fund for administrative charges as agreed upon, and based on a monthly invoice for services.

Sedgwick agrees to comply with this requirement.

b. Fiscal Management of Claims

i. TPA shall make payments to all providers and employees within time constraints required by the Workers' Compensation Act.

The accurate payment of indemnity benefits is one of the most important functions of a claims examiner. Sedgwick will:

- Initiate indemnity payments within 14 days of the onset of injury.
- Process subsequent checks on a timely basis.
- Schedule long-term payments in the system, which are then produced by the system as due.
- Payments required due to awards, judgments or orders are paid within five days of receipt.
- Pay all substantiated bills within 21 days from receipt. If the bill is not to be paid, we notify the vendor for the reason for nonpayment.

Sedgwick's JURIS claim system contains an application that allows our examiners to pay benefits in accordance with the work status entered. This helps guarantee accurate benefit payments but also supplies DPI with an outline of the work status history from claim creation to resolution. Our examiners maintain system automated benefit approval diaries throughout the life of the claim to ensure payments are made timely.

ii. TPA shall establish and maintain adequate internal controls to ensure that:

1. **All claim files are accurately established, maintained and updated.**
2. **Supporting documentation for each disbursements and receipts are accurately and securely maintained.**
3. **Confidentiality and security of claimant's claims and personal information.**

Sedgwick agrees to comply with this requirement. Sedgwick's claim system, JURIS, provides for internal control exception reports that assist the examiner in maintaining and updating the claim as required by North Carolina statutory requirements as well as DPI's own internal instructions and preferences. These are further reinforced by our JURIS smart panels that provide specific reminders to the examiner at specific claim milestones. All Sedgwick colleagues are required to take part in annual training regarding Sedgwick's policy and procedures relative to privacy and confidentiality. JURIS will edit information available to the user based on their need to know and security level. Sedgwick colleagues are required to take privacy training once annually and it is closely monitored for completion.

iii. TPA shall pursue subrogation, as applicable.

Sedgwick agrees to comply with this requirement.

3.4 Administration Fees

TPA shall comply with the following:

a. Complete Attachment G, TPA Cost Proposal of RFP.

b. The applicable Administration and related fees for claims shall be billed by invoice detailing the claims on an end of the month invoice basis via e-mail. DPI agrees to pay within thirty (30) days of receipt or approval, whichever is later, of said invoice by Account Administrator. Documentation to be provided by the Vendor on a monthly basis will include, at minimum: 1) employee name; 2) claim number; 3) date of accident; 4) date claim was opened; 5) claim type; 6) if conversion, previous claim type, new claim type and date of claim conversion. DPI reserves the right to dispute any and all charges before payment.

c. Transferred Claim Cost for the 3-year life of contract, shall be payable in three annual equal installments.

d. Telephonic Case Management Fees shall be billed to the claim file. Fees for services shall be billed in accordance with the split funding provisions of the RFP.

e. before providing Utilization Review and or Physician Consultation services, such services must be discussed with the Account Administrator. Fees for services shall be billed to the claim file and in accordance with the split funding provisions of the RFP.

f. Subrogation fees shall be billed to the claim file and in accordance with the split funding provisions of the RFP.

g. Payments to carve-out vendors for services rendered shall be billed to the claim file and in accordance with the split-funding provisions of the RFP.

Sedgwick agrees to comply with this requirement.

4.0 Preferred Provider Network

4.1 Overview and Expectations

DPI will award a contract to a TPA with an integrated network of quality providers within a workers' compensation PPO network. The network should meet appropriate access to care standards throughout the 100 counties in North Carolina for all provider types handling workers' compensation claims. The TPA should have a thorough credentialing methodology and strong provider relation teams. Finally, the TPA should demonstrate thoughtful leadership, innovation and collaboration in developing new programs and pilots.

4.2 Network

TPA shall describe each of the following:

a. Primary functions for network management/provider relations team(s);

The primary function of the network management team is to provide DPI with a best-in-class workers' compensation PPO network based on the North Carolina LEAs. Additionally, the network management team ensures all networks meet Sedgwick service instructions for quality, coverage and outcomes. The management team also engages with the networks relative to any regulatory compliance requirements, provider demographic validation and grievance processes. Sedgwick network partners allow for prompt scheduling and knowledge of workers' compensation treatment guidelines, and the network team ensures commitment to this requirement.

b. Approach for recruiting and selecting providers to participate in network;

Our network partners determine whether an applicant meets the minimum credentialing or qualification requirements according to primary or secondary source verification. Network providers must also cooperate in expediting the RTW of injured workers, consistent with sound medical judgment, and are committed contractually to participating with, utilizing, and adhering to our partners' medical utilization guidelines.

Credentialing criteria is designed to review whether prospective hospital/facilities, physicians, and ancillary providers adhere to the national URAC, NCQA and /or JCAHO (facilities) standards.

Each of the networks' selection criteria may vary but generally are based on the providers' ability to meet the following guidelines:

- Clinical experience in treating occupational injuries
- Willingness to work with nurse case managers
- Familiarity with workers' compensation reporting requirements imposed by the state, including special format and content
- Prompt initial treatment and follow up
- Timeliness in completing required medical reports
- Functional improvement treatment philosophy as it pertains to light duty and RTW programs
- Cooperation with the networks' utilization management staff
- Commitment to continuing education and training in the area of workers' compensation

c. Process for collaborating with providers to address issues related to WC treatments;

When issues are identified with providers in our network, the network management team works with our network partners to communicate and resolve the issues as quickly and efficiently as possible. Sedgwick is in constant communication with our network partners in order to achieve excellent outcomes and positive results for our clients. Sedgwick provides network provider outreach to address over-utilization of care, adverse or problematic prescribing practices and accuracy in reporting and billing for services.

d. Process for initiating and monitoring provider quality improvements;

Sedgwick approaches medical cost containment in a unique manner. Choosing a high quality, superior outcome medical provider is paramount for limiting medical costs while also providing the best quality care for DPI injured workers.

Sedgwick's provider benchmarking tool, which is threaded through all of our product service offerings, is integral to our managed care program. The online tool ensures that injured workers are consistently sent to medical providers who understand workers' compensation and have proven quality outcomes. The provider benchmarking tool uses our expansive claims database to rate providers using an outcome based rating system. We measure provider outcomes monthly using the following claims information:

- Claim duration and costs
- Average lost work time and transitional duty days
- Incidence rate of litigation
- Recidivism rate (claims reopening)

Our provider benchmarking and search tool ensures that DPI injured workers have access to quality healthcare providers specific to their injury type in their desired location. The Sedgwick medical card and provider panel cards listing these providers can be sent via email or text from the online portal.

e. Process for collaborating with providers on return to work strategies;

Collaboration with the medical provider, injured worker and DPI begins with the first report of lost work time. In discussions with the claimant, employer and treating physician, RTW evaluation potential begins and continues throughout the life of the claim until RTW is achieved or ruled out. Both case managers and claims professionals set diaries for the tracking of RTW as well as to develop action plans centered around RTW. We address RTW issues with the treating physician using several tools. These include functional capacity evaluation (FCE) forms and written functional job descriptions.

When case managers contact DPI and the medical provider, they help evaluate and discuss the injured employee's physical restrictions and collaborate with employers to assess modified or full-duty opportunities. Our case managers also cooperate with providers in obtaining specific employee job capabilities to ensure that release-to-work information is usable. Case managers positively affect injured worker's medical treatment by applying proprietary diagnostic-based optimal treatment plan and disability guidelines, which facilitate maximum medical improvement (MMI). By managing treatment to achieve MMI faster, and through ongoing negotiations with the treating provider(s), our case managers are more successful in returning employees to work in a light, modified or full capacity.

Our mutual goal with our clients is to return the injured employee back to work in the most expedient way possible. An organized RTW program is essential to maximizing integrated disability plan performance.

When modified duty is available within the employer site, assessment of functional capabilities begins with the initial three-point contact by the claims administration/staff. Physician contact is made to determine RTW potential within the available modified duty program or job. If RTW at modified duty within current functional capabilities is identified, contact with the employer ensues to coordinate the early RTW for the employee.

f. Process for taking action against a provider proving non-compliance of treatment or contractual obligations;

Sedgwick's medical director, Dr. Teresa Bartlett, oversees the clinical intervention team managing UR and case management. Sedgwick nurses intervene with physicians providing treatment outside of guidelines. Sedgwick provides written notification to physicians providing healthcare outside of treatment guidelines or prescribing drugs that are subject to adverse trends notifications. Sedgwick addresses health safety concerns regarding the injured employee's care directly with the physician. Sedgwick selects physicians for our networks who are associated with the highest quality healthcare.

g. Accessibility of network to LEAs and injured employees;

Sedgwick recommends the use of our Occunet network with customization to provide exceptional coverage and ease of access to care. Occunet is a long standing Sedgwick owned PPO network that has solid penetration with both first treating and specialty providers as well as medical facilities. The reach of this network is consistent with the needs and geographic reach of the North Carolina LEAs.

Additionally, Sedgwick has a dedicated network management team who can assist in customizing the network through the use of our nomination and credentialing process. This ensures that DPI has the flexibility to add providers that are well-known in their LEA location, have experience working with the workers' compensation patient, ensure timely RTW and have quality outcomes. The network is exclusively used for workers' compensation and has an aggressive pricing structure.

h. List all managed care providers;

Sedgwick has developed in-house and private labeled solutions to meet the needs of our clients nationwide. Our in-house services include:

- Nurse triage/clinical consultation
- Telephonic case management
- UR
- Pharmacy UR
- RTW case management
- Complex pharmacy management
- Network administration
- Medical bill review
- Subrogation
- Encounter data management
- Loss control

We complement our core managed care services with private labeled programs integrating management oversight, our practice patterns, and ownership for state reporting and cost savings.

Through this private label approach, we are able to offer our clients deep discounts, superior outcomes and well managed utilization. Sedgwick has created an electronically integrated and streamlined referral, notes and billing process. All charges for services are applied to the claim file. Our vendor partners are below:

- Field case management, catastrophic case management and vocational rehabilitation – supported by GENEX
- Pharmacy benefits management – supported by Helios
- Physical medicine and rehabilitation network – supported by MedRisk
- Diagnostic services and Specialty services – supported by One Call Care Management
- Physician advisor network – supported by MES Solutions, Network Medical Review and Dane Street

i. Direct care implementation;

Sedgwick can direct care through the use of many tools that will be made available to DPI. The use of the Sedgwick provider benchmarking and search tool allows supervisors and their injured workers to access in network medical providers at the time of injury. Medical cards can be developed in the provider search tool to include provider contact information, turn by turn directions, and pharmacy first fill information. Medical cards can be downloaded for print, email or text to the injured worker's mobile device.

Provider panel cards that are customized by DPI locations are produced by a Sedgwick resource team on behalf of DPI. Panel postings are created with quality, validated providers, include emergency instructions and can include client preferred providers, as desired. The managed care implementation project manager works with the customer to determine any panel posting customization, such as the addition of a client logo or store number, as desired.

Network provider directories are also available online or in hard copy for DPI locations.

Sedgwick colleagues use the provider benchmarking and search tool when directing care. The benchmarking and search tool is threaded throughout our programs and used by early intervention triage nurses, examiners, nurse case managers, UR nurses, etc.

Additionally our specialty network providers are consistently used for services such as pharmacy benefits management, durable medical equipment, diagnostic testing, physical medicine and rehabilitation, and transportation and translation services. Our preferred partners are electronically integrated into our claims management process for seamless referrals, and return of medical documentation and medical bills that are attached to the claim file. Sedgwick performs due diligence when selecting preferred providers and ensures interfaces between preferred partners maintain a high level of IT security with encryption at rest ensuring the protection of our clients' files.

j. Clinical modeling approaches.

Quality healthcare is paramount to ensuring that employees injured on the job are quickly brought back to full productivity. At Sedgwick, we recognize that the best opportunity to mitigate claims costs, are by engaging appropriate resources promptly. Our early intervention process is multipronged:

- Predictive modeling – the largest historical claims database in the industry has enabled the creation of customizable referral triggers, which provides for prospective identification of claims for clinical intervention.

- Nurse triage/clinical consultation – providing a clinical resource at the time of injury, offers the injured employee assurance that their employer is concerned about the well-being, and assurance that the claim starts on the right track.
- Telephonic and RTW case management – engages early in the life of the claim, with option variable clinical intervention to meet the requirements for the claim. Our focus is on providing a proactive, acuity-based program, engaging our nurses on cases where they can have the most impact. Sedgwick promotes a collaborative approach between nurse case manager, customer, injured worker and treating physician, which can lead to reasonable recovery goals. There is also a focus on expeditious RTW and planning for modified or transitional duty options. Sedgwick provides an employee "advocacy" approach, which reduces litigation rates, thru engagement of the injured employee to address psychosocial concerns or barriers. And, refers to employer and community resources where available.
- UR – the Sedgwick national UR unit promptly evaluates any medical treatment requests submitted, against evidence-based guidelines. The prompt evaluation and decision of medical treatment ensures care is timely and appropriate for the medical diagnosis. Sedgwick will incorporate the DPI requirement for authorization of UR referral by DPI or the NC attorney general.
- Pharmacy benefits management – beginning from the very first prescription, the Sedgwick first fill program offers injured employees no out of pocket expense and prompt fills at a network pharmacy.
- Pharmacy UR – the Sedgwick pharmacy UR nurses, evaluate medication, identified through pre-determined triggers. This early engagement provides a security against over-prescribing or medication safety hazards.
- Real-time "nurse chat" – provides injured employees, an "at your convenience" way to connect with a medical expert. Also available post-injury, to provide general information and employee satisfaction.

At Sedgwick, our goal is to allow injured workers the opportunity to recover to pre-injury health, while remaining at work. Statistics has shown that injuries resolve more quickly, when the employee remains performing their daily routine, and remains at work. When necessary, claims examiners and case managers aggressively manage RTW options beginning with the first notice of lost time, and continue to seek options for RTW throughout the life of the claim. They work with DPI, the injured worker and the treating physician to discuss all light-, partial- and full-duty RTW options, and aggressively manage a formal release to RTW or maximum medical improvement.

Sedgwick has the ability to create a clinical model solution that perfectly matches the needs of DPI, and through the implementation process will establish the best clinical program.

Clinical consultation

The Sedgwick nurse triage/clinical consultation program provides crucial medical assistance at the time of injury, 24/7/365. An extensive implementation process provides our clinicians with necessary information to support the injured employee. The unique 800-number immediately advises our clinicians of the key employer information and instructions, preferred provider matches for each location, and access to all ancillary service selections. The registered nurses perform a clinical assessment and offers care recommendations, while collecting can the necessary demographic information. As an option, customers may request that the nurse complete the formal workers' compensation claim intake within this single call. When the injury warrants, our nurses provide self-care recommendations. In those instances, they will make a follow-up phone call to the injured worker the next day to ensure that the injury is improving.

If medical care is required, the nurse will offer to schedule the appointment during the call using the pre-selected quality preferred providers from the Sedgwick 5-star provider tool. This ensures that the injured employee is treating with in-network providers, who supports the workers' compensation treatment philosophy of proactive medical care and stay at work/prompt RTW, and have proven, quality outcomes.

In 2014, 31% of the callers were discharged with self-care, and clients experienced a 10% increase in network penetration. The end result is timely access to quality medical care for the injured worker and a reduction in medical costs for DPI.

5.0 Bill Review Services

5.1 Overview and Expectations

The DPI bill review process requires the TPA to perform bill review services on medical bills. See Attachment K for Medical Bill Review data

5.2 Bill Review Requirements

Vendor shall describe the following:

a. Features and benefits of your bill review process.

Sedgwick medical bill review is electronically integrated into the claim process allowing for prompt and accurate disposition of all bills. Claims, UR and telephonic case management notes integration allows treatment plans and utilization limits to be embedded into the medical bill review system ensuring regulatory compliance.

Our bill review system re-prices for all state fee schedules, all applicable state rules and regulations, usual and customary (UCR) reductions, PPO reductions, UR treatment plans and clinical edits. Proprietary NCCI and clinical edits are embedded into the system allowing for proper adjudication of unbundled, up-coded and inappropriate services.

Sedgwick UR nurses, claims examiners, bill reviewers and bill review nurses augment the system ensuring that the treatment and charged amount are related to, and appropriate for, the work related injury.

Our approach to savings calculations differentiates us in the marketplace. All UR bills are fully re-priced before the application of the PPO contracted rates. Sedgwick does not charge for duplicate bills or bills submitted for reconsideration.

Additionally our out of network bill review product provides caps where PPO discounts are not available. Out-of-network bills are also negotiated telephonically or reduced using a fair and reasonable database.

b. How your service will integrate with your network of providers.

The Sedgwick bill review service is integrated with all network partnerships managing contractual agreements, state fee structures and NCCI edits. Medical bills are transmitted to network partners systematically for proper application of contractual discounts.

The Sedgwick bill review software and our JURIS claims management software are also interfaced with specialty networks and pharmacy benefit networks allowing for electronic confirmation of eligibility of benefits, transfer of medical notes and medical care billing; all of which is directly attached to the injured worker's claim file.

c. Bill review service for out-of-network providers.

Out-of-network bills are reviewed per the applicable state fee schedule/UCR database and reduced accordingly. In addition, high level office visits and consultations are reviewed to determine if the appropriate level of service was billed per the accompanying medical records, and are paid in accordance with the appropriate reimbursement rate. Bills reaching a specific threshold are eligible for the quick pay solution, for negotiation for reduced charges.

Out-of-network pharmacy bills are routed to our PBM for outreach and transfer to a network pharmacy. Our approach also allows Sedgwick to provide clinical oversight and intervention services for all of our client's prescription drug transactions, regardless of whether the transaction occur in-network or out-of-network.

d. How your service integrates the latest NCIC fee schedules, usual and customary rules, proprietary code-specific client edits, provider network discounts and other vendor services.

Sedgwick has a team of Sedgwick colleagues that is responsible for ensuring that the bill review application is current and updated regarding fee schedules, ground rules and database updates. Databases are purchased from Ingenix, and reviewed and updated on an as needed basis. If Ingenix is not timely in providing the data, we will pull data from the state websites as necessary to ensure timely implementation of updated fee schedules and ground rules. The product management team is constantly communicating with the various state bureaus and boards to stay abreast of pending legislation and fee schedule updates that impact bill processing. Sedgwick uses the FairHealth Usual and Customary database. It is completely updated bi-annually.

e. Bill review process to reduce bill turnaround time.

Our bill review system integrates with our claims system. Our claims system JURIS serves as the central hub for the integration. Claim and treatment plan data are fed from JURIS into the bill review application. In turn, medical bill payment recommendations are fed into JURIS from the bill review platform. All of this information is ultimately stored in a data warehouse.

Sedgwick best practice allows 21 days from receipt of the medical bill to payment of the provider; we typically average 11.6 days. The standard turnaround time for bill review once the medical bill is approved by the examiner is:

- Routine bills — five days
- Specialty/nurse review — 10 days
- Non-network negotiations — 12 days

f. Bill review process when a bill is submitted for review (in and out of network).

Sedgwick provides both the best possible process and the best savings dollars available in the marketplace. Our bill review is a seamless component of the claim process and our platform allows us to provide a customized solution to getting bills paid timely and at a low cost.

Our colleagues use sophisticated software to re-price for all state fee schedules, all applicable rules and regulations contained in the various state codes, UCR reductions, PPO reductions, UR treatment plans and clinical edits. Proprietary, NCCI, and clinical edits are imbedded into the system allowing for proper adjudication of unbundled, up-coded and inappropriate services. Further clinical review completed by nurses that are our colleagues, provided based on predefined criteria such as charged amount, treatment type and treatment complexity. Our approach to out-of-network negotiation and specialty review is unique. We provide caps for all fees associated for review of bills that do not achieve a PPO discount but are negotiated telephonically or reduced via a specialized fair and reasonable database, resulting in significant savings for employers on a costly element of bill review.

A staff of UR nurses, claims examiners, bill reviewers and bill review nurses augment the system for situations where a thorough review of notes and records will yield the best possible result. Our process results in higher fee schedule and UCR savings resulting in the lowest cost for bill review services. The end result and greatest benefit of our bill review process is we consistently deliver higher net savings and ROI than our competitors.

g. Submission of medical bills for electronic processing, as mandated by the NCIC.

The Sedgwick bill review software transmits medical EDI reporting. Sedgwick has a regulatory compliance team in our medical bill review department responsible for ensuring that data transactions are continuously accurate and timely in accordance with state reporting requirements.

h. Bills review process for accuracy, duplication and adjudication.

Sedgwick has a rigorous quality assurance program. Daily random audits are conducted and 100% of bills with total charges of $10,000 or are audited. Duplicate edits are in place in the system based on date of service, CPT coding and federal tax ID markers. Exact duplicates, when all of the matching criteria are met, are systematically denied. Possible duplicates, when some of the matching criteria are met, are flagged for human review. The original bill control numbers containing the matching data elements is displayed alongside the new bill for review. The accuracy of duplicate detection from converted history is contingent upon the quality of the historical data elements.

i. Process for approved payments.

All bills entered into the system are released with an explanation of review (EOR) document. This EOR documents the reasons for the recommended payment, partial payment or denial and advises the provider of next steps (address to send information or phone number to call) should the provider question or disagree with the recommendation. The system allows the creation of user defined reason codes. Sedgwick currently uses two different check printing vendors. Depending on which one the client is assigned to, all of their payments including medical payments would be issued from that vendor's production facility. Our check printing vendors are located in Portland, Oregon and Jacksonville, Florida.

Sedgwick best practice allows 21 days from receipt of the medical bill to payment of the provider; we typically average 11.6 days and bill review process accounts for 4.3 days. The standard turnaround time for bill review once the medical bill is approved by the examiner is:

- Routine bills — five days
- Specialty/nurse review — 10 days
- Non-network negotiations – 12 days

DPI has the ability to review all payments and claim documents using our online viaOne portal.

j. Any specialized or alternative bill review services.

Pharmacy bills are reviewed by Sedgwick bill review against current claims data, and then transmitted to the pharmacy benefits manager for application of agreed upon pharmacy rates for generic and brand medications; and in pharmacy or home delivery.

6.0 Bill Review Fees

Complete Attachment G, TPA Cost Proposal of RFP

Bill Review Fees and associated percentage of savings fees shall be billed to the claim file and in accordance with the split funding provisions of the RFP.

7.0 Reports

Provide samples of reports generated from your system and those mentioned in your proposal response.

We have included our bill review reports in the appendix. During the implementation process, Sedgwick's managed care implementation project manager will discuss the frequency of receipt reports that are desired by DPI. Also, the managed care client services director will be coordinating ongoing review of outcomes data and proactively managing the managed care program.

B. Technical Requirements of Carve-Out Services

DPI may, at its sole discretion, select Carve-Out Vendors to perform the following services:

- **Pharmacy, Durable Medical Equipment and Home Health Care (Section B1)**
- **Nurse Case and Vocational Rehabilitation Management (Section B2)**
- **Physical Therapy and Chiropractic Services (Section B2)**
- **Diagnostic Services (Section B2)**
- **Surveillance (Section B3)**
- **Transportation and Translation Services (Section B3)**

Chosen carve-out vendors will be evaluated based on their responses to Section B and the appropriate carve-out service sections of this RFP. ALL CARVE OUT VENDORS MUST RESPOND TO SECTION B (SEE CHART BELOW). CARVE OUT VENDORS MUST THEN ALSO RESPOND TO THE APPROPRIATE CARVE-OUT SERVICES SECTIONS BELOW (For example, a Carve-Out Vendor submitting a proposal for Surveillance must respond to Section B AND Section B3).

Carve-Out Vendors must fully explain how their experience and services offered are relevant to the requirements of this RFP. Carve-Out Vendors shall work directly with the selected TPA in accordance with the requirements of this RFP.

Any Vendor choosing to respond to the Carve-Out Services component of this RFP must meet the following minimum requirements. Vendors shall include a description of how the Vendor will comply with and meet each requirement stated below:

All Carve-Out Services – Minimum Requirements	
1	**Vendor must have at least five (5) years of experience providing the services required.** Sedgwick does comply with this requirement. Sedgwick has been providing workers' compensation claims management services for over 44 years, since 1971, and North Carolina public entities have been Sedgwick clients since 1971.

2	**Vendors must confirm willingness to support and work with TPA in accordance with the requirements of this RFP.** **Carve-Out Vendors shall accept referrals from the TPA selected by NCDPI and shall enter into all contractual agreements necessary for it to provide the TPA with all employee claims information and other information in a form and via an electronic transmittal method required by the TPA. Costs, if any, relating to electronic transmittal agreements and/or arrangements shall be dictated by agreements between the Carve-Out Vendor and the TPA.** Sedgwick managed care vendors (Helios, MedRisk) will support the requirements within this document.
3	**Vendor must provide 5 references. Other state agencies are preferred.** **See Attachment C.** Sedgwick has provided references in Attachment C.
4	**Vendor must provide description of corporate background.** The name of our firm is Sedgwick Claims Management Services, Inc. or Sedgwick. We became a corporation December 22, 1969 in the state of Illinois. 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. Our corporate office is located at 1100 Ridgeway Loop Road, Memphis, Tennessee 38120. Sedgwick is the industry preferred TPA for sophisticated, large employers seeking a customized claims management solution. We have over four decades of experience serving the nation's most prominent organizations for national workers' compensation, multiline liability, first- and third-party property, short-term disability, long-term disability and FMLA/leave of absence administration. We handle over 2.8 million claims annually and have fiduciary responsibility for claim payments almost $12 billion annually. We are ranked as the largest TPA in the country handling self-insured and alternatively funded claims administration programs. Sedgwick is an independent, investor owned TPA, without any insurance company and/or brokerage affiliation. Sedgwick's more than 12,000 colleagues in 250 offices in United States, Canada and the United Kingdom are focused on our corporate mission to be the premier TPA in the industry. We operate in a fully transparent environment, maintain SOC1, Type II certification (formerly referred to as SAS70, Type II certification), and provide state-of-the-art, fully-secured systems technology. Sedgwick owns and operates all core claims operations and leverages fully integrated ancillary partnerships to provide a single source, comprehensive array of claims, risk and technology services. Business Insurance has recognized Sedgwick for being the largest and one of the best TPAs based on customer service, quality, innovation and value. At Sedgwick, we understand the unique environment and technical intricacies of exposures facing public entities. We partner with over 150 public entity programs across the United States representing more than 11% of our total annual revenue. Our large public entity practice has experience handling public schools, cities, counties, states, university systems, transportation divisions and energy departments nationwide.

5	**Vendor must provide an overview of organization and how serves required under this RFP will be rendered.** Managed care team: Don Sloan, EVP managed care operations; Dr. Teresa Bartlett, director of medical quality/FCM/RTW and clinical consultation; Mike McFadin, SVP medical bill review; Jim Harvey, SVP products/product development/networks; Terri Riley, SVP client services - Southeast region and implementation; Robin Moleski, VP clinical operations; Andrea Buhl, VP clinical strategy; Tom Weise, VP clinical outcomes; Tracey Radford, VP managed care client Services Director.
6	**Vendor must provide location(s) of where services will be rendered.** **See Attachment B.** We propose to handle the DPI program out of the Raleigh, North Carolina claim office.
7	**Vendor must provide information on proposed staff and staffing model.**

Position	Estimated staffing required
Claims examiner (LT)	10.00
Claims associate (MO)	7.00
Claims team lead	3.00
Claims assistant	2.00
OSS coordinator	0.50
DQA - split funding	1.00
Director claims	0.50
Director client services	1.00
Total estimated staffing	**25.00**

8	**Vendor must provide proof of Professional Liability, Workers' Compensation and General Liability Coverage.** We have provided our certificates of insurance in the appendix.

9	**Vendor must maintain disaster recovery procedures for claims, eligibility, billing and accounts receivable records, which include:** • **Documentation to support regulatory compliance and** • **Daily data back-ups.** We have a complete information technology disaster recovery plan (IT-DRP) that is tested twice annually. In addition, a full business continuity plan is in place for operational recovery in the event of a disaster or loss. As part of a larger business continuity plan that coordinates business office and information technology protocols, Sedgwick has developed an IT-DRP to document-specific actions and procedures that are to be executed in response to a disruption to the primary application systems at the Little Rock data center. The IT-DRP is maintained within an offsite-housed database to allow for easy updates and modifications and is maintained, updated and tested by Sedgwick's outsourced technology infrastructure vendor, Fidelity Information Services (FIS). FIS' disaster recovery testing and reporting is measured by contractual service level agreements. A coordinated but separate plan for operational recovery is also stored in this database and is updated by national operations within Sedgwick. The plan is put into action by official declaration from one of the plan-identified Sedgwick leadership team. All business critical systems are backed up at least daily; back-ups are stored offsite in secured data storage facilities. Sedgwick contracts with FIS for site recovery. Additionally, back-up offices are designated for each of our field offices. In the event of a business interruption to a field office requiring implementation of our business continuity plan, telephone calls and critical claims activity can be re-routed to the designated back-up office or to an alternative site. Sedgwick can also use secure Web-based applications, VPN connections and Citrix servers to provide our colleagues access to business critical applications from alternate sites with Internet connectivity following a business interruption. This allows for a great degree of flexibility in recovering from business interruptions to our field offices. In the event of a disaster declaration, base and core systems are the first to be restored and are done so within 48 hours of the disaster declaration. This is the recovery time objective (RTO). Base and core systems will be restored to the data state that existed no greater than 24 hours before the event occurrence, which constitutes our recovery point objective (RPO).
10.	**Vendors must perform their own bill review services, if any.** Sedgwick agrees to comply with this requirement.

B1 Pharmacy Benefits Management, Including Durable Medical Equipment and Home Health Care (Carve-Out)

1.0 Overview and Expectations

The DPI pharmacy management program requires a Vendor that can collaborate seamlessly with the TPA, and understands the complexity of pharmacy benefits management and other services rendered under this carve-out. See Attachment D and K for information on Pharmacy Program.

Pharmacy benefits solution

The Sedgwick pharmacy benefit solution is the most comprehensive in the industry offering a PBM in partnership with Helios, a pharmacy UR program (with an return on investment of 4:1) and a complex pharmacy management program (with an return on investment of 7:1). Our in-house programs are staffed by Sedgwick registered nurses, pharmacists and physicians.

Pharmacy benefits management program

Our pharmacy solution is the most comprehensive in the industry and includes:

- More than 60,000 participating local and big box pharmacies, physician clinics and medical providers in the network
- Acute and chronic injury-specific formularies
- Generic versus name brand conversions at point-of-sale
- A timely first fill program with no financial risk to the injured worker or our client
- Home delivery
- PBM is electronically interfaced with our claims management system for expedited billing
- In network and out of network prescriptions are routed through the PBM system for adjudication to fee schedule/UCR
- Outreach to ensure all-out of network prescriptions are moved to an in network provider for future fills
- A medical team comprised of nurses skilled in prescription drug management, Pharm-D, physical medicine and rehabilitation physicians

Our PBM provides a service that is unique to the industry. In routing both in network and out of network bills through our PBM, we capture all client data and provide our clients with full visibility into their total pharmacy program spend.

Pharmacy UR

Our pharmacy UR nurses receive point-of-sale alerts when requests for medications are out of formulary or not typically prescribed for the work-related injury. These nurses contact the prescribing physician to establish an alternate treatment strategy. The average resolution time is less than four hours ensuring the injured employee has the needed medication and the prescription is safe and appropriate for the injury type. This program has an average return on investment of 4:1 and is only used when a flag at a participating pharmacy is triggered.

Complex pharmacy management

Our industry-leading complex pharmacy management program to help control the use of narcotics, opioids and other prescriptions not in line with the treatment of work-related injuries. This program has a return on investment of 7:1 and has been successful in addressing long-term open claims with pharmaceuticals that are considered high cost or high risk, such as opioids.

Interventions include:

- Contacting the treating provider to discuss medication goals, treatment alternatives and weaning plans
- Coordinating drug testing to ensure the injured worker is taking the medications as prescribed when drug diversion is suspected
- Ensuring that the injured worker has optimal symptom relief and function
- Incorporating this service before the determination of a Medicare set-aside calculation

Pharmacy cards and first fill

Customized Sedgwick medical cards offer first fill forms at the time of injury. The first fill program ensures DPI employees can obtain certain first fill medications at time of injury. Helios takes the risk for denied claims. Pharmacy cards can be customized, and generic medication conversions are automated.

Medical oversight

Dr. Teresa Bartlett, senior vice president of medical quality and medical director, is our senior adviser in matters affecting the design and delivery of medical management services for the company's claims clients. Dr. Bartlett provides strategic counsel and operational support in all areas of medical management including managed care, RTW, medical bill review, medical outcomes protocols, and health and safety matters. Dr. Bartlett has operational responsibility for UR, pharmacy UR, complex pharmacy management and clinical consultation products and is involved in the day to day delivery from a management perspective.

Dr. Melissa Broadman, senior vice president pharmacy and UR provides oversight to the physician advisory program and clinically complex claims. Dr. Broadman provides education and training to our colleagues and our network medical providers.

Dr. Paul Peak, a doctor of pharmacy, participates on our complex pharmacy management team. Dr. Peak provides consultation to the medical provider community for alternative pain control strategies, targeting long-term claims with high cost and high risk.

Our Sedgwick physician advisor network is comprised of three independent preferred provider organizations that have access to peer review for every specialty in every location nationally.

Value

The Sedgwick PBM provides a service that is unique to the industry. In routing both in network and out of network bills through our PBM we capture all client data and provide them with full visibility into their total pharmacy program spend. Our approach also allows Sedgwick to provide clinical oversight and intervention services for all of our clients' prescription drug transactions, regardless of whether the transaction occurs in-network or out-of-network.

The PBM, once alerted to an out-of-network prescription bill, contacts that pharmacy and will try to recruit them to the network. This successful approach has resulted in a network of more than 60,000 pharmacy providers nationally.

Sedgwick has developed an automated red flag/trigger system to alert the pharmacist, at point-of-sale, of a medication that is not in the formulary for a particular injury type. The Sedgwick pharmacy UR team will then become engaged and contact the prescribing medical provider when needed to revise the prescription order.

Additionally automated triggers built into the PBM program alert the Sedgwick complex pharmacy management nurses and physicians of high risk and high cost medications such as opioids or narcotics. In doing so, our medical team responds with a call to the prescribing physician to discuss a weaning plan, alternate treatment strategies, drug testing and a host of other options. This program has resulted in a 25% reduction in cost and 38% reduction in narcotic usage with an overall return on investment of 7:1 for our clients.

A comprehensive, holistic approach coupled with consistent processes and procedures routed in evidence based medicine is important in addressing and resolving escalating and complex claims.

2.0 Operation and Services

Vendor shall respond to the following in its proposal:

a. Do you manage your own retail pharmacy network?

Sedgwick has co-created a differentiated pharmacy benefits management program with a contracted vendor partner, Helios. Helios manages the retail pharmacy network on behalf of Sedgwick and our customers.

b. Describe features/integration of your prescription card and first fill program.

Sedgwick will develop and provide customized prescription cards to each DPI injured employee. Additionally, the employee will receive a medical card, which includes a first fill (short fill) form at the time of injury to ensure they can obtain their first prescription without paying out of pocket. These medical cards are available through our Sedgwick provider benchmarking and search tool which is available online to DPI supervisors and injured employees in our bundled service offering. The medical card provides information about in-network medical providers, turn by turn directions to office locations, first fill pharmacy information and information regarding UR requirements and contacts.

The injured worker can use any in-network pharmacy provider. Sedgwick's pharmacy network comprises over 60,000 retail pharmacies, over 96% of all retail pharmacies including Walgreens, CVS, Rite-Aid, Target and Walmart. Employee communication is driven by the employee welcome packet and pharmacy card. The pharmacy card is mailed within 48 hours of an accepted claim directly to the employee's address. The pharmacy card includes the names and addresses of the closest in-network pharmacies to the employee's address.

In addition to the employee welcome packet and pharmacy card, we provide a first fill card to be used with any reported accident. In this situation the employee can present the card to any in-network pharmacy to receive medications while the claim is pending approved status.

Sedgwick's PBM partner goes at risk financially for the first fill if the claim is latter deemed non-compensable. The examiner will communicate all pharmacy-related instruction to the injured employee per our client services instruction. The pharmacy will use the BIN number on the claimant's pharmacy card or first fill card to identify the appropriate pharmacy benefit manager to bill.

Point-of-sale pharmacy UR and complex pharmacy management service referrals may be triggered electronically with notification to our pharmacy nurses or by a referral from the claims examiner or nurse case manager. All documents for referral and resulting documentation from the file assessment and intervention are integrated into the electronic claim file.

b. Describe how your customer service is handled.

Sedgwick provides access to a pharmacist for all medication related questions for DPI claims. A designated 800-number is provided during the implementation process to access all customer service needs including the pharmacist. Additionally, Sedgwick has available the pharmacy medical director and pharmacy UR team for any claims related questions and support. Sedgwick will provide DPI a designated 800-number for all pharmacy related questions with extended hours. Also, pharmacies have an automated authorization process; any questions are referred to the Sedgwick designated pharmacy 800-number.

c. Describe how you enroll new customers into your PBM program.

During implementation Sedgwick will meet with DPI to define the business rules and triggers needed based on a historical claims review. These triggers and business rules are developed for all specialty services. Pharmacy triggers are communicated to Helios who will then develop an electronic transmission system specific to DPI's needs. Most Sedgwick clients find that this comprehensive formulary meets their needs. However, should DPI customize a formulary, the Sedgwick pharmacy product manager and Sedgwick client services director will facilitate a discussion to address specific concerns and identify formulary requirements. Once the request is outlined including specific medications, drug classes, and related claims examiner training requirements, the Sedgwick team will create a timeline for completion. Most client specific formularies are completed within 30-90 days depending on the required level of customization.

The same level of customization and incorporation of triggers and business rules is explored during the implementation process for all specialty services.

d. What is your generic efficiency and penetration rate? How do you maximize the utilization of generic medications?

Sedgwick offers three levels of prescription formularies: first fill, acute and chronic. Most Sedgwick clients find that this comprehensive formulary approach meets their needs. However, should DPI customize a formulary, the Sedgwick pharmacy product manager and Sedgwick client services director will facilitate a discussion to address specific concerns and identify formulary requirements. Once the request is outlined including specific medications, drug classes, and related claims examiner training requirements, the Sedgwick team will create a timeline for completion. Most client specific formularies are completed within 30-90 days depending on the required level of customization.

e. What is your mail order efficiency and penetration rate? How do you maximize the utilization of mail order medication?

Our clients with new implementation experience 12.6% efficiency and penetration rate however we typically see penetration rates improve as a program matures. Qualifying claims are identified through claims data eligibility provided through our electronic interfaces with the pharmacy benefit management partners. Our PBM reaches out to the provider to address the use of mail order prescriptions for future refills.

f. How do you manage the use of compounds? Do you offer a mail order program?

Sedgwick leverages our national specialty network comprised of direct contracts with physician dispensers and compounding partnerships Sedgwick can monitor the utilization of compound medications and provide oversight and utilization management of compound medications. The 5-star provider tool also includes a pharmacy indicator, alerting users of providers with dispensing history.

Sedgwick offers a strong mail-order service. Through coordination at the claims examiner and clinical desk, the mail-order threshold is identified, and can then be discussed with the injured employee during ongoing contacts.

Once the prescription is received by the PBM, it is validated and approved before being filled. Once approved, the medication order is released and shipped directly to the employee.

New prescriptions: When orders for new prescriptions are received, they are validated and approved. Once processed, the medication order will be filled and shipped. Generally medication is received 14 business days; however, shipping times may vary.

Refills: Requests to refill prescriptions are generally processed within 24 hours and are usually returned within five business days.

g. How do you reduce and manage the use of out-of-network, third party and physician dispensed transactions?

The Sedgwick PBM provides a service that is unique to the industry. In routing both in network and out of network bills through our PBM we capture all client data and provide them with full visibility into their total pharmacy program spend. Our approach also allows Sedgwick to provide clinical oversight and intervention services for all of our clients' prescription drug transactions, regardless of whether the transaction occurs in-network or out-of-network.

The PBM, once alerted to an out-of-network prescription bill, reaches out to that pharmacy and will try to recruit them to the network, or transfer the prescription to an in network pharmacy.

Sedgwick pharmacy nurses and physicians provide outreach and education regarding ODG guidelines to prescribing physicians in an effort to establish goals of care and alternative medication strategies.

h. Do you offer real-time online connectivity to customers, including adjusters?

Yes. Our PBM is electronically integrated with our claims management team and pharmacy UR nurses for point-of-sale alerts specific to formulary and utilization. All medical documentation provided by our partners, our nurse case managers and examiners are available for view by our customers using the online viaOne portal.

i. Describe your method for adjuster authorization requests.

The Sedgwick pharmacy UR nurses receive point-of-sale alerts when requests for specific high risk medications are out of formulary or not typically prescribed for the work related injury. These nurses review the appropriateness of the medication based on evidence based medicine, ACOEM and/or ODG guidelines, and physician notes while following all state regulated UR requirements. Sedgwick has developed alternative electronic routing processes with our pharmacy benefit management network that allows the network to send authorization requests to claims examiners (adjusters) instead of UR nurses when the requested medication is unrelated to the accepted workers' compensation injury. Online connectivity to the pharmacy benefits utilization tool provides for immediate entry of authorization decision, and reporting capabilities of the outcome of these transactions.

j. Describe your formulary maintenance and administration; re-indexing service.

The Sedgwick PBM solution integrates key players in the workers' compensation pharmacy distribution system such as Concentra, U.S. Healthworks, third-party billers, dispensing physician groups, compounding pharmacies and multiple mail-order pharmacies. Our solutions include specialty network arrangements, automated re-indexing and out-of-network conversion. Our formularies are defined by our preferred provider who has established formularies specific to the needs of the injured workers. All new medications are evaluated for efficacy, consistency with ODG guidelines and cost control before the inclusion in a formulary

k. What is your approach to early intervention, including potential misuse/abuse situations?

Sedgwick, along with our PBM partner Helios have developed a sophisticated electronic interface alerting our claims management team and pharmacy UR nurses of medications that are out of formulary for particular injury type as well as medication utilization. Our system is integrated with key providers in the workers' compensation pharmacy distribution arena including Concentra, US Healthworks, third-party billers, dispensing physician groups, compounding pharmacies and multiple mail order pharmacies.

Early intervention occurs at many points in the referral process. The nurse triage/clinical consultation program offers DPI a one call model at the time of injury.

Our registered nurses, available 24 hours a day, 365 days a year, provide a clinical assessment during the call. Self-care recommendations are made when appropriate. A follow-up survey call is made the next day with an option to speak with a nurse for medical follow up. Should medical care be required, the nurse will schedule the appointment during the call with an in-network provider using our proprietary provider benchmarking and search tool. This connects the injured worker immediately with an in-network provider with proven quality outcomes for that particular injury type. Pharmacy first fill information can be provided to the injured worker if needed directing the injured worker to an in-network pharmacy that is easily accessible.

In 2014, 31% of the callers were provided with self-care recommendations and did not require medical attention. Additionally, clients experienced a 10% increase in network penetration.

The end result is timely access to quality medical care for the injured worker and reductions in DPI's medical spend.

l. Describe your program for managing Opioid usage.

Sedgwick's pharmacy solution includes an injury-specific and acute to chronic formulary, which ensures that drugs inappropriate for both the injury type and the age of the claim are identified at the point-of-sale. As a part of our adverse trend alert program, our claims examiners and nurses will then receive a notification and intervene with a drug management plan.

We do not stop there. Sedgwick has a centralized team of pharmacy specialty nurses, physicians and pharmacist dedicated to helping employers prevent opioid abuse, avoid medically unnecessary prescriptions, and keep their employees safe. The team collaborates with the examiner until the pharmacy components of the claim are under control.

Our enhanced service helps clients gain control by:

- Providing consistent coverage and quality
- Promoting early intervention
- Detecting changes in prescribing patterns
- Helping to wean patients from long-term use
- Preventing dependence
- Detecting diversion and abuse patterns
- Reducing pharmacy spend
- Reducing Medicare set asides for pharmacy costs
- Facilitating drug safety education for injured employees

Point-of-sale alerts and notifications are automatically sent to our dedicated team of pharmacy nurse professionals through the pharmacy benefit management system when an adverse medication trend is identified based on client-specific criteria.

Our expanded point-of-sale alert triggers include new prescription short-acting fentanyl products, new start long-acting opioids (out of formulary), and prescriptions over a designated dollar amount. Adverse trend notifications include opioid use for more than 90 days, opioid use over 120 mg (morphine equivalent), new start long-acting opioids (in formulary), and acetaminophen use over 4000 mg.

When an alert or notification is received, Sedgwick's specialized team of pharmacy nurses will review the medical information and type of drug prescribed, compare the request with the ODG or state-specific guidelines, document the information in the pharmacy benefit management system, and complete the UR.

They will also:

- Review the entire claim
- Complete a chronology of accepted conditions along with a diagnosis and diagnostic work-up
- Obtain an addiction risk assessment from the treating physician
- Obtain an opioid contract signed by the provider and injured employee
- Seek urine drug testing
- Analyze all medications, and assess and document current issues (morphine equivalents, acetaminophen dosages, long- and short-acting opioid use, and duration of all medications)
- Send a notification to the claims examiner to enable changes to be made

In addition to our formularies and point-of-sale alerts, our tailored solutions also include drug spend evaluations, out-of-network bill review services, drug trend notifications, home delivery and step therapy.

With our enhanced services, clients also have reporting options that provide additional details, including:

- Number of opioid agreements sent and return rate
- Risk assessments requested and return rate
- Follow-up documents requested and return rate
- Drug screenings conducted and the results
- Morphine equivalents exceeding 120 mg and the actions taken

We provide added benefits for our clients by going beyond basic claims and pharmacy management services.

There are several advantages built into our programs including:

- Experienced nurse case managers and medical directors – our team ensures there is a valid diagnosis for every prescription filled. If the injured employee's treating physician does not respond to proposed changes or is not open to best practices, the case will be evaluated by a physician advisor.
- Special cares for injured employees complaining of pain – narcotics are not always the right treatment for pain. We work to ensure the appropriate use of medication within guidelines that provide compassionate care and healing.

- Thorough drug education for employees – this is designed to ensure they understand how to use narcotics appropriately and the dangers of misuse.
- Analysis of the medication's effectiveness – this helps to determine if the pain has diminished and if the injured employees can RTW.
- Alternate therapeutic plans – in the event that the initial therapy fails or does not provide effective relief, we can suggest alternative pain control modalities including non-opioids and options for employees who cannot tolerate opioids.
- Leading edge technology – our nurses and claims examiners have access to the information they need to do their jobs quickly, appropriately, and in a manner that controls costs while ensuring the health and safety of injured employees. Instead of going to multiple websites for eligibility, history, utilization and formulary details, examiners can access all of these in a central location. If there are identical prescriptions from multiple prescribers, potential errors or other problems, we can immediately alert our pharmacy benefit partners and they can contact the physicians to request the necessary changes.

m. Describe your bill review services, if any.

We route both in network and out of network pharmacy bills through our PBM and in doing so capture all client data providing full visibility into the total pharmacy program spend. Our approach also allows Sedgwick to provide clinical oversight and intervention services for all of our clients' prescription drug transactions, regardless of whether the transaction occurs in-network or out-of-network.

Medical bills are electronically integrated into our claims management system and attach to the claim file. Claims, UR and telephonic case management notes integration allows treatment plans and utilization limits to be embedded into the medical bill review system ensuring regulatory compliance.

Our bill review system re-prices for all state fee schedules, all applicable state rules and regulations, usual and customary (UCR) reductions, PPO reductions, UR treatment plans and clinical edits. Proprietary NCCI and clinical edits are embedded into the system allowing for proper adjudication of unbundled, up-coded and inappropriate services.

Sedgwick UR nurses, claims examiners, bill reviewers and bill review nurses augment the system ensuring that the treatment and charged amount are related to, and appropriate for, the work related injury.

Differentiating Sedgwick from the marketplace is our approach to savings calculations. All bills are fully re-priced before the application of the PPO contracted rates.

n. How do you handle "Red Flag" issues?

Sedgwick has developed a state-of-the-art process to identify abuse/fraud, and over utilization of medication and other medical services. Our cutting edge tracking of medication and diagnosis updates from the claims system will provide for UR opportunities. The Sedgwick dedicated pharmacy UR team receives these notifications directly from the system, and are then evaluated, engaging the prescribing physician as necessary.

Complex claims are also identified based on adverse trend analysis, and the Sedgwick pharmacy medical director will engage in a round table with the provider, examiner and employer. The abhorrent pharmacy prescribing patterns flag is viewable to the examiners and nurses to identify providers in the provider benchmarking and search tool. Sedgwick considers prescribing patterns in the quality benchmarking scores.

o. Describe how you manage prescriptions when a claimant has multiple open workers' compensation claims?

Sedgwick shares daily claims eligibility data with the pharmacy benefits management system to ensure all prescriptions are applied to the proper claim.

p. How do you prevent prescriptions from being released to injured workers whose claims have been denied?

The Sedgwick daily claims eligibility file ensures all prescriptions are properly filled for open, accepted claims only. Denied claims result in the pharmacist suspending at point-of-sale. In the event of the first fill program, the PBM will go at risk for any denied claims. Additionally, a dedicated Sedgwick pharmacy benefits management team is available to the examiners, employers and nurses, for any questions about claims, claims eligibility or prescriptions as needed.

q. What steps will be made to avoid interruption of pharmacy benefits?

Sedgwick has established a strong managed care implementation process that is seamless to the injured workers medical management. The implementation project manager, will coordinate all required tasks, notification to open claimants and development of new pharmacy cards during the implementation process. The entire conversion process will be conducted in conjunction with DPI.

r. Describe your Durable Medical Equipment and Home Health Care Programs.

Sedgwick partners with One Call Care Management and Helios as preferred vendors for the distribution of approved durable medical equipment and we partner with One Call Care Management for Home Health Care services. Sedgwick provides oversight using our best practice guidelines controlling utilization and ensuring quality outcomes for our customers.

During implementation Sedgwick will establish business rules and triggers for the engagement of UR for medical equipment and supply requests as well as home health care service requests. Those established triggers or business rules are electronically integrated into our claims management system for use by our examiners and nurses. Business rules typically include dollar or utilization thresholds.

Our preferred partners offer our clients deep discounts, superior outcomes and well managed utilization. Sedgwick has created an electronically integrated and streamlined referral, medical notes and billing process. All fees are applied to the claim file and available for review by our customers using our online viaOne portal.

3.0 Communications

Vendor shall respond to the following in its proposal:

a. Do you have licensed pharmacist available for questions/consultations from claim professionals, case managers, claimants, physicians, etc.?

Yes, Sedgwick provides access to a pharmacist for all medication related questions for DPI claims. A designated 800-number is provided during the implementation process to access the pharmacist.

Sedgwick has a medical team available for client consultation and round table discussions of complex cases.

Dr. Teresa Bartlett, senior vice president of medical quality and medical director, is our senior advisor overseeing the design and delivery of medical management services for our clients. Dr. Bartlett provides strategic counsel and operational support in all areas of medical management, including managed care, RTW, medical bill review, medical outcomes protocols, and health and safety matters. Dr. Bartlett has operational responsibility for UR, pharmacy UR, complex pharmacy management, nurse triage/clinical consultation and field case management programs.

Dr. Melissa Broadman, senior vice president of pharmacy and UR provides oversight to the physician advisor program and clinically complex claims. Dr. Broadman provides education and training to our colleagues and our network medical providers.

Dr. Paul Peak, a doctor of pharmacy participates on our complex pharmacy management team. Dr. Peak provides consultation to the medical provider community for alternative pain control strategies, targeting long-term claims with high cost and high risk.

Our Sedgwick physician advisor network is comprised of three independent preferred provider organizations that have access to peer review for every specialty in every location nationally.

b. Do you provide a toll free number?

A designated 800-number is provided during the implementation process to DPI for customer service.

c. Provide details of how you will communicate with the chosen TPA, providers, adjusters, DPI and claimants.

Sedgwick's integrated claims program provides connectivity with our preferred specialty providers for ease and timeliness of referral and return of medical documentation and billing information. Our examiners and medical case managers use electronic diaries to monitor the progression of the claim and make frequent outreaches to medical providers on the claim for status updates to ensure the claim is trending toward resolution and RTW goals are established and on track. Communication preferences are documented based on the needs of DPI. Claimants are provided with updates telephonically, by email or text message depending upon their preference. Sedgwick employs the use of our mobile app for notifications to claimants regarding claim status, check payment dates and upcoming medical appointment reminders.

d. Provide a proposed schedule with timelines and a detailed plan for how you would implement your program.

A sample implementation project plan is included in the appendix.

During the implementation process Sedgwick will work with DPI to define criteria for referrals, reporting, triggers and business rules which will be incorporated into the project plan as well as our electronic client service instructions and electronic claims management system.

e. Describe the communication your staff will provide in both Durable Medical Equipment and Home Health Care Services.

Specific DPI instructions will be captured during implementation and incorporated into our electronic claims management process. Communication criteria can be customized by DPI.

Sedgwick has established electronic connectivity with our preferred partners ensuring timely communication and referrals for durable medical equipment and home health care services. Medical documentation and billing information is transmitted back and attached to the claim file for review and management by our examiners, UR nurses and nurse case managers.

During the implementation process, the managed care implementation project manager will perform full training with all parties, providing full information on the process and access to customer service for support. There will be internal training with the DPI examiners and nurses, as well as external training with the DPI locations on the access points and workflows.

4.0 Fees

a. Complete Attachment H, PBM Cost Proposal of RFP

Sedgwick has completed Attachment H.

b. Fees for services provided shall be submitted to the TPA for processing and payment to Vendor.

Sedgwick agrees to comply with this requirement.

5.0 Reports

a. Provide samples of reports generated from your system and those mentioned in your proposal.

We have included a sample reporting package in the appendix. Reports can be generated upon request.

B2 Other Medical Services (Carve-Out)

Other Medical Services includes: Nurse Case Management and Vocational Rehabilitation; Physical Therapy and Chiropractic Care; Diagnostic Services.

1.0 Overview and Expectations

DPI seeks proposals from other medical services providers, as noted that can collaborate seamlessly with the TPA and will support aggressive management of the services rendered. Medical services will be directed by the TPA or WCA.

2.0 Operation and Services

Vendor shall respond to the following in its proposal:

a. Describe Medical Services you will provide and features of your program.

Sedgwick will provide a fully integrated telephonic case management (TCM), field case management (FCM), vocational rehabilitation, physical medicine and rehabilitation, chiropractic care and diagnostic services.

In the Sedgwick strategic clinical management design, the telephonic case management TCM focuses on proactive medical management and RTW, while collaborating with the examiner and DPI toward claim resolution. Nurse case managers have a real-time electronic claims link with examiners. This expedites the process for referring and communicating critical information DPI can access all clinical notes through viaOne view, our online portal.

The TCM program is a criteria-based telephonic medical case management program beginning with the first notice of loss and combines rules-based real-time assignment to both nurses and claims examiners simultaneously, injury evaluation, UR/management, and medical case management. Our focus is applying the right resource at the right time, focusing on cases that a nurse can impact either medically or through RTW efforts. This coordinated effort results in a timely employee recovery and lowered medical and indemnity costs.

Sedgwick's TCM program provides:

- Early and aggressive telephonic medical and RTW management by specially trained clinical professionals.
- UR of all medical treatment requests submitted by the treatment providers; ensuring medical treatment is clearly related to the compensable claim. Our UR process reviews the medical documentation with nationally recognized evidence based medical guidelines to ensure treatment requests are appropriate. The nurse will negotiate appropriate treatment or use a physician advisor to assist should a denial of treatment be necessary.

- Application of ODG for each claim supports early RTW and ongoing trending analysis by location for our clients.
- Treatment plan information integrated in the fee management system to assure billing is consistent with the approved plan, and appropriate.
- Strategy sessions — working sessions between the nurse, claims examiner and DPI to ensure that the case is on track.
- Integrated audit — an integrated tool to measure the outcome of the file, regardless of the resources assigned.
- Access to physician advisors as necessary for consultations.
- Client access to case manager and examiner electronic file notes in our proprietary claims system.

Field case managers are available to accompany injured employees to medical appointments, if necessary. We recommend the use of full field case management for serious or highly-complex claims, but do recognize that some employers choose field case management for specific reasons. A specific budget for any full field assignment is required at assignment and is a continuous management process.

A majority of field case management assignments are done on a task basis. Using pre-negotiated rates we can use directed external resources to meet a specific need. We recognize each client has their own philosophy regarding on-site case management and will train our team to follow the referral triggers agreed upon during implementation.

Should a claim escalate and require vocational rehabilitation, Sedgwick, through its' field case management team, can deploy a Masters prepared vocational counselor.

The vocational rehabilitation counselor can use a multitude of assessment tools and techniques to develop a plan that is in line with limitations defined by the medical provider while developing an opportunity for RTW for the injured employee.

These assessment tools include but are not limited to job analysis, job placement, job modification, vocational evaluations, labor market surveys, transferable skills analysis, vocational evaluation and testing.

Goals of the vocational rehabilitation counselor are managed in by the Examiner in collaboration with DPI. Timely recognition of RTW barriers and engagement of a vocational rehabilitation specialist can impact a claim significantly and move the claim toward closure expeditiously.

RTW evaluation and guidelines begin with the verification of lost time and are applied to every claim. Claims examiners and case managers consult with the medical provider, physical therapist, claimant and employer to determine functional limitations and RTW options.

Non-core services such as physical therapy, chiropractic care and diagnostic services are offered by Sedgwick and receive oversight by the Sedgwick managed care practice and the Sedgwick managed care products and services team. Sedgwick provides specialty networks partners with electronic connectivity for ease of making a referral and transmission of medical notes and bills. Our specialty service providers use Sedgwick best practices and are held accountable for utilization and quality outcomes. Additionally Sedgwick takes on the responsibility of state reporting and UR for our specialty service providers.

Outcome reporting offers an ongoing objective view into the success of our programs.

b. Provide your NC Provider list, if any

Our medical and specialty providers participate in multiple networks that reach all LEAs and ensure access to care for all needed specialty services by DPI injured workers.

c. Describe how your customer service is handled.

A designated 800-number is provided during the implementation process to access all customer service needs. Additionally, Sedgwick has managed care professionals and our medical director Dr. Teresa Bartlett who are available for consultation. Sedgwick will provide DPI a designated 800-number for questions with extended hours.

d. Will you offer real-time online connectivity to customers, including adjusters?

Yes. Our specialty service preferred providers are electronically integrated with our claims management team. All medical documentation provided by our partners is transmitted electronically into our claims management system providing examiners and nurses with up to date medical progression of the injured worker. Our customers can view claims using the online viaOne portal.

e. Describe your method for adjuster authorization requests.

Sedgwick has developed electronic connectivity with our specialty network partners that allow the network to send authorization requests to claims examiners. Examiners in turn can expedite referrals to our specialty network partners and transmit supporting documentation. Sedgwick examiners and nurse case managers use ODG guidelines to support the authorization or denial of service requests.

f. Describe your bill review services, if any

Sedgwick medical bill review is electronically integrated into the claim process allowing for prompt and accurate disposition of all bills. Claims, UR and telephonic case management notes integration allows treatment plans and utilization limits to be embedded into the medical bill review system ensuring regulatory compliance. Our bill review system re-prices for all state fee schedules, all applicable state rules and regulations, usual and customary (UCR) reductions, PPO reductions, UR treatment plans and clinical edits. Proprietary NCCI and clinical edits are embedded into the system allowing for proper adjudication of unbundled, up-coded and inappropriate services.

Sedgwick UR nurses, claims examiners, bill reviewers and bill review nurses augment the system ensuring that the treatment and charged amount are related to, and appropriate for, the work related injury. Differentiating Sedgwick from the marketplace is our approach to savings calculations. All bills are fully re-priced before the application of the PPO contracted rates.

Out-of-network bills are also negotiated telephonically or reduced using a fair and reasonable database.

g. How do you handle "red flag" issues?

Red flag issues relating to nurse case management, diagnostic services, vocational rehabilitation and physical therapy are escalated for nursing review using ODG guidelines. Sedgwick medical director, Dr. Teresa Bartlett is available to our clinical team for consultation and rounding of complex claims. Sedgwick physicians and pharmacists often engage with the prescribing physician to refine the goals of care, RTW, and other clinical issues preventing the claim from progression toward closure.

3.0 Communications

Vendor shall respond to the following in its proposal:

a. How do you measure the effectiveness of the services you provide?

At Sedgwick, we evaluate all data elements – networks, clinical results, medical spend and overall loss costs to evaluate the cost of claims at the onset of the program, and the ultimate cost at closure. Sedgwick assigns a designated client services director for managed care to support the model evaluation process. This evaluation ensures that there is continual evaluation of the program and outcomes to push for ongoing improvement.

b. Describe how your services will be transitioned into the DPI program. Provide a proposed schedule with timelines and a detailed plan for how you would implement your program.

Due to the comprehensive Sedgwick integration process, the implementation process for case management and specialty networks is virtually seamless. Once client authorization is received, our systems are updated to transmit ongoing claims data updates and case management information to the claim file. There will be a coordinated effort for the program go live process, and appropriate internal and client level training.

c. Provide details of how you will communicate with the chosen TPA, providers, adjusters, DPI, and claimants about the benefits and restrictions of your program.

Sedgwick's integrated claims program provides connectivity with our preferred specialty providers for ease and timeliness of referral and return of medical documentation and billing information. Our examiners and medical case managers use electronic diaries to monitor the progression of the claim and make frequent outreaches to medical providers on the claim for status updates to ensure the claim is trending toward resolution and RTW goals are established and on track. Additionally, our electronic claims files are integrated with our bill review system offering a seamless process that is critical to the timely management of a claim.

Communication preferences are documented based on the needs of DPI. Claimants are provided with updates telephonically, by email or text message depending upon their preference. Sedgwick employs the use of our mobile app for notifications to claimants regarding claim status, check payment dates and upcoming medical appointment reminders.

d. Do you provide a toll-free number?

Yes, during implementation Sedgwick will provide DPI with a dedicated 800-number.

e. Describe the communication your staff will provide in the services you are proposing.

At Sedgwick the telephonic case management and specialty network providers are fully integrated, providing for near real-time sharing of information. The nurse supports the mechanism of injury, medical reserving process and gathering restricted duty/RTW information to support the progression of the claim toward closure. There is ongoing collaboration with the examiner to provide clinical expertise for the file handling, aggressive medical management with the provider and lowest possible loss costs.

4.0 Fees

a. Complete Attachment I, OTHER MEDICAL SERVICES Cost Proposal of RFP

Sedgwick has completed Attachment I.

b. Fees for services provided shall be submitted to the TPA for processing and payment to Vendor

Sedgwick agrees to comply with this requirement.

5.0 Reports

a. Provide samples of reports generated from your system and those mentioned in your proposal response.

A managed care report card is available in the appendix for your review.

B3 Other Services (Carve-Out)

Other Services include: Surveillance; Transportation and Translation

Section B3 is not applicable to the services Sedgwick is providing.

Section VII NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS

NOTE: For "Agency", substitute "Department", "University", etc., as applicable.

1. **GOVERNING LAW: This contract is made under and shall be governed and construed in accordance with the laws of the State of North Carolina.**
2. **SITUS: The place of this contract, its situs and forum, shall be North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation and enforcement shall be determined.**
3. **INDEPENDENT CONTRACTOR: The Contractor shall be considered to be an independent contractor and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with the Agency.**
4. **KEY PERSONNEL: The Contractor shall not substitute key personnel assigned to the performance of this contract without prior written approval by the Agency's Contract Administrator. The individuals designated as key personnel for purposes of this contract are those specified in the Contractor's proposal.**
5. **SUBCONTRACTING: Work proposed to be performed under this contract by the Contractor or its employees shall not be subcontracted without prior written approval of the Agency's Contract Administrator. Acceptance of a vendor's proposal shall include any subcontractor(s) specified therein.**
6. **PERFORMANCE AND DEFAULT: If, through any cause, the Contractor shall fail to fulfill in timely and proper manner the obligations under this agreement, the Agency shall thereupon have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. In that event, all finished or unfinished deliverable items under this contract prepared by the Contractor shall, at the option of the Agency, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials. Notwithstanding, the Contractor shall not be relieved of liability to the Agency for damages sustained by the Agency by virtue of any breach of this agreement, and the Agency may withhold any payment due the Contractor for the purpose of setoff until such time as the exact amount of damages due the Agency from such breach can be determined.**

   In case of default by the Contractor, the State may procure the services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The State reserves the right to require a performance bond or other acceptable alternative performance guarantees from successful vendor without expense to the State.

   In addition, in the event of default by the Contractor under this contract, the State may immediately cease doing business with the Contractor, immediately terminate for cause all existing contracts the State has with the Contractor, and de-bar the Contractor from doing future business with the State

   Upon the Contractor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against the Contractor, the State may immediately terminate, for

cause, this contract and all other existing contracts the Contractor has with the State, and de-bar the Contractor from doing future business.

Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

7. **TERMINATION: The Agency may terminate this agreement at any time by 30 days' notice in writing from the Agency to the Contractor. In that event, all finished or unfinished deliverable items prepared by the Contractor under this contract shall, at the option of the Agency, become its property. If the contract is terminated by the Agency as provided herein, the Contractor shall be paid for services satisfactorily completed, less payment or compensation previously made.**
8. **PAYMENT TERMS: Payment terms are Net not later than 30 days after receipt of correct invoice(s) or acceptance of services, whichever is later, or in accordance with any special payment schedule identified in this RFP. The using agency is responsible for all payments to the contractor under the contract. Payment by some agencies may be made by procurement card and it shall be accepted by the contractor for payment if the contractor accepts that card (Visa, Mastercard, etc.) from other customers. If payment is made by procurement card, then payment may be processed immediately by the contractor.**
9. **AVAILABILITY OF FUNDS: Any and all payments to the Contractor are dependent upon and subject to the availability of funds to the Agency for the purpose set forth in this agreement.**
10. **CONFIDENTIALITY: Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of the Agency.**
11. **CARE OF PROPERTY: The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished it for use in connection with the performance of this contract or purchased by it for this contract and will reimburse the State for loss of damage of such property.**
12. **COPYRIGHT: No deliverable items produced in whole or in part under this agreement shall be the subject of an application for copyright by or on behalf of the Contractor.**

    Clarification and disclosure: As part of the portfolio of services proposed under this renewal, Sedgwick leverages a number of proprietary and third-party software products which are copyrighted. Sedgwick does modification of its proprietary software to benefit all clients it services, and such development is made available to all such clients but still falls under Sedgwick's copyright. We believe the intent of this RFP's copyright requirement is to prevent development of entirely new software specifically for the North Carolina Department of Public Instruction which would then be copyrighted by Sedgwick or other parties to this contract. If that is the intent, we agree to comply.
13. **ACCESS TO PERSONS AND RECORDS: The State Auditor and the using agency's internal auditors shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7 and Session Law 2010-194, Section 21 (i.e., the State Auditors and internal auditors may audit the records of the contractor during the term of the contract to verify accounts and data affecting fees or performance).**

14. **ASSIGNMENT: No assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may: a. Forward the contractor's payment check(s) directly to any person or entity designated by the Contractor, or b. Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s). In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.**

15. **COMPLIANCE WITH LAWS: The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.**

16. **AFFIRMATIVE ACTION: The Contractor shall take affirmative action in complying with all Federal and State requirements concerning fair employment and employment of people with disabilities, and concerning the treatment of all employees without regard to discrimination by reason of race, color, religion, sex, national origin or disability.**

17. **INSURANCE: During the term of the contract, the contractor at its sole cost and expense shall provide commercial insurance of such type and with such terms and limits as may be reasonably associated with the contract. As a minimum, the contractor shall provide and maintain the following coverage and limits:**

    a. **workers' compensation - The contractor shall provide and maintain workers' compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of $150,000.00, covering all of Contractor's employees who are engaged in any work under the contract. If any work is subcontracted, the contractor shall require the subcontractor to provide the same coverage for any of its employees engaged in any work under the contract.**

    b. **Commercial General Liability - General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of $500,000.00 Combined Single Limit.**

    c. **Automobile - Automobile Liability Insurance, to include liability coverage, covering all owned, hired and non-owned vehicles, used in connection with the contract. The minimum combined single limit shall be $150,000.00 bodily injury and property damage; $150,000.00 uninsured/under insured motorist; and $1,000.00 medical payment.**

    d. **Professional liability in the minimum amount of $1,000,000 per occurrence.**

    Providing and maintaining adequate insurance coverage is a material obligation of the contractor and is of the essence of this contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The contractor shall at all times comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this contract. The limits of coverage under each insurance policy maintained by the contractor shall not be interpreted as limiting the contractor's liability and obligations under the contract.

18. **ADVERTISING: The vendor shall not use the award of a contract as part of any news release or commercial advertising.**

19. **ENTIRE AGREEMENT: This contract and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements. This Request for Proposals, any addenda thereto, and the vendor's proposal are incorporated herein by reference as though set forth verbatim. All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.**

20. **AMENDMENTS: This contract may be amended only by written amendments duly executed by the Agency and the Contractor. The NC Division of Purchase and Contract shall give prior approval to any amendment to a contract awarded through that office.**

21. **TAXES: G.S. 143-59.1 bars the Secretary of Administration from entering into contracts with vendors if the vendor or its affiliates meet one of the conditions of G. S. 105-164.8(b) and refuse to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under G. S. 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the vendor and (3) Systematic exploitation of the market by media-assisted, media-facilitated or media-solicited means. By execution of the proposal document the vendor certifies that it and all of its affiliates, (if it has affiliates), collect(s) the appropriate taxes.**

22. **YEAR 2000 COMPLIANCE/WARRANTY: Vendor shall ensure the product(s) and service(s) furnished pursuant to this agreement ("product" shall include, without limitation, any piece of equipment, hardware, firmware, middleware, custom or commercial software, or internal components, subroutines and interfaces therein) which perform any date and/or time data recognition function, calculation or sequencing, will support a four digit year format, and will provide accurate date/time data and leap year calculations on and after December 31, 1999, at the same level of functionality for which originally acquired without additional cost to the user. This warranty shall survive termination or expiration of the agreement.**

23. **GENERAL INDEMNITY: The contractor shall hold and save the State, its officers, agents and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the contractor in the performance of this contract and that are attributable to the negligence or intentionally tortious acts of the contractor provided that the contractor is notified in writing within 30 days that the State has knowledge of such claims. The contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of contractor goods to the State. The representation and warranty in the preceding sentence shall survive the termination or expiration of this contract.**

24. **OUTSOURCING: Any vendor or subcontractor providing call or contact center services to the State of North Carolina shall disclose to inbound callers the location from which the call or contact center services are being provided.**

    If, after award of a contract, the contractor wishes to outsource any portion of the work to a location outside the United States, prior written approval must be obtained from the State agency responsible for the contract.

Vendor must give notice to the using agency of any relocation of the vendor, employees of the vendor, subcontractors of the vendor, or other persons performing services under a state contract outside of the United States.

25. By EXECUTIVE ORDER 24, issued by Governor Perdue, and N.C. G.S.§ 133-32, it is unlawful for any vendor or contractor (i.e. architect, bidder, contractor, construction manager, design professional, engineer, landlord, vendor, seller, subcontractor, supplier or vendor), to make gifts or to give favors to any State employee of the Governor's Cabinet Agencies (i.e., Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, Transportation, and the Office of the Governor). This prohibition covers those vendors and contractors who:

(1) Have a contract with a governmental agency; or

(2) Have performed under such a contract within the past year; or

(3) Anticipate bidding on such a contract in the future.

For additional information regarding the specific requirements and exemptions, vendors and contractors are encouraged to review Executive Order 24 and G.S. Sec. 133-32.

Executive Order 24 also encouraged and invited other State Agencies to implement the requirements and prohibitions of the Executive Order to their agencies. Vendors and contractors should contact other State Agencies to determine if those agencies have adopted Executive Order 24."

Revised 10/25/2010

Attachment A CONTRACTOR CERTIFICATIONS

INSTRUCTIONS

The person who signs this document should read the text of the statutes listed below and consult with counsel and other knowledgeable persons before signing.

The text of Article 2 of Chapter 64 of the North Carolina General Statutes can be found online at:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/ByArticle/Chapter_64/Article_2.pdf

The text of G.S. 105-164.8(b) can be found online at:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_105/GS_105-164.8.pdf

The text of G.S. 143-48.5 (S.L. 2013-418, s. 2.(d)) can be found online at:

http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf

The text of G.S. 143-59.1 can be found online at:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.1.pdf

The text of G.S. 143-59.2 can be found online at:

http://www.ncga.state.nc.us/EnactedLegislation/Statutes/PDF/BySection/Chapter_143/GS_143-59.2.pdf

The text of G.S. 147-33.95(g) (S.L. 2013-418, s. 2.(e)) can be found online at:

http://www.ncga.state.nc.us/Sessions/2013/Bills/House/PDF/H786v6.pdf

CERTIFICATIONS

Pursuant to G.S. 143-48.5 and G.S. 147-33.95(g), the undersigned hereby certifies that the Contractor named below, and the Contractor's subcontractors, complies with the requirements of Article 2 of Chapter 64 of the NC General Statutes, including the requirement for each employer with more than 25 employees in North Carolina to verify the work authorization of its employees through the federal E-Verify system." E-Verify System Link: www.uscis.gov

Pursuant to G.S. 143-59.1(b), the undersigned hereby certifies that the Contractor named below is not an "ineligible Contractor" as set forth in G.S. 143-59.1(a) because:

Neither the Contractor nor any of its affiliates has refused to collect the use tax levied under Article 5 of Chapter 105 of the General Statutes on its sales delivered to North Carolina when the sales met one or more of the conditions of G.S. 105-164.8(b); and

[Check one of the following boxes]

- ☒ **Neither the Contractor nor any of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001; or**
- ☐ **The Contractor or one of its affiliates has incorporated or reincorporated in a "tax haven country" as set forth in G.S. 143-59.1(c)(2) after December 31, 2001 but the**

United States is not the principal market for the public trading of the stock of the corporation incorporated in the tax haven country.

Pursuant to G.S. 143-59.2(b), the undersigned hereby certifies that none of the Contractor's officers, directors or owners (if the Contractor is an unincorporated business entity) has been convicted of any violation of Chapter 78A of the General Statutes or the Securities Act of 1933 or the Securities Exchange Act of 1934 within 10 years immediately before the date of the bid solicitation.

The undersigned hereby certifies further that:

He or she is a duly authorized representative of the Contractor named below;

He or she is authorized to make, and does hereby make, the foregoing certifications on behalf of the Contractor; and

He or she understands that any person who knowingly submits a false certification in response to the requirements of G.S. 143-59.1and -59.2 shall be guilty of a Class I felony.

NAME OF VENDOR: Sedgwick Claims Management Services, Inc.

SIGNATURE OF AUTHORIZED AGENT: _____

TITLE OF AUTHORIZED AGENT: Chief Marketing Officer

STATE OF Tennessee

COUNTY OF Shelby

SIGNED AND SWORN TO (OR AFFIRMED) BEFORE

ME, THIS THE 23rd **DAY OF** January **20** 15

(AFFIX OFFICIAL/NOTARY SEAL)

_____

NOTARY PUBLIC

MY COMMISSION EXPIRES: _____

Attachment B: Where Service Contracts Will Be Performed

In accordance with NC General Statute 143-59.4 (Session Law 2005-169),

This form is to be completed and submitted with the vendor's (technical) proposal/bid.

Issuing Agency: Department of Public Instruction **Solicitation # DPI 40-PC00117-15**

Agency Contact Person & phone #: Joni Robbins, 919-807-3664

Solicitation Title / Type of Services: RFP / workers' compensation Insurance

VENDOR: Sedgwick Claims Management Services, Inc.

City & State: Raleigh, North Carolina

Location(s) from which services will be performed by the contractor:

Service	City/Providence/State	Country
Workers' compensation	Raleigh, North Carolina	United States

Location(s) from which services are anticipated to be performed outside the U.S. by the contractor:

None

Location(s) from which services will be performed by subcontractor(s):

Service	Subcontractor	City/Providence/State	Country
None			

Location(s) from which services are anticipated to be performed outside the U.S. by the subcontractor(s):

None

(Attach additional pages if necessary.)

Attachment C: References

Prospective contractor must supply at least five (5) references for which they have provided similar services for within the last three (3) years.

Reference #1:

- **Name:** Los Angeles Unified School District
- **Address:** 333 S. Beaudry Ave, Los Angeles, California 90017
- **Telephone Number:** 213-241-3974
- **Contact Person:** Dawn Watkins
- **Service Provided:** Workers' Compensation; uses all Sedgwick products (no unbundling)
- **Service Date(s):** 8/1/2003 - 1/31/2016

Reference #2:

- **Name:** North Carolina Association of County Commissioners
- **Address:** 215 N. Dawson Street, Raleigh, North Carolina 27601
- **Telephone Number:** 919-715-1124
- **Contact Person:** Michael Kelly
- **Service Provided:** Workers' Compensation
- **Service Date(s):** 7/1/1981 - 12/31/2012

Reference #3:

- **Name:** State of West Virginia
- **Address:** 1124 Smith St, Charleston West Virginia 25301
- **Telephone Number:** 304-558-1966 ext 1265
- **Contact Person:** Tonya Gillespie
- **Service Provided:** Workers' Compensation
- **Service Date(s):** 12/1/2007 - 11/30/2013

Reference #4:

- **Name:** State of Iowa
- **Address:** Hoover State Office Building, 1305 E Walnut St, Des Moines, IA 50319
- **Telephone Number:** 515-242-6143
- **Contact Person:** Ed Holland
- **Service Provided:** Workers' Compensation
- **Service Date(s):** 6/25/2001 - 6/30/2019

Reference #6:

- **Name:** City of Virginia Beach Public Schools
- **Address:** 1568 Corporate Landing Parkway #200, Virginia Beach, Virginia 23454
- **Telephone Number:** 757-263-2464
- **Contact Person:** Karen D. Curll
- **Service Provided:** Workers' Compensation
- **Service Date(s):** 7/1/2007 - 7/1/2013

ATTACHMENT G - TPA Cost Proposal – Price Option I

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Administration New Claim Fees *Initial term assumes three years and will expire upon the anniversary date of the program inception date. Optional period pricing (years 4-7) are available in subsequent cost proposal attachments.		
Indemnity	Year 1: $775 Year 2: $791 (+2%) Year 3: $806 (+2%)	Per claim
Medical Only	Year 1: $150 Year 2: $153 (+2%) Year 3: $156 (+2%)	Per claim
Reportable Only	Year 1: $10 Year 2: $10 Year 3: $10	Per claim
Recordable Only	Year 1: $10 Year 2: $10 Year 3: $10	Per claim
Account Administration Fee	Year 1: $12,000 Year 2: $12,240 (+2%) Year 3: $12,485 (+2%)	Annual
Administration Existing Open Claim Fees		
Transfer - Approx. 1500 Indemnity and 2500 Medical Claims	$0 - Included Sedgwick assumes up to 1,500 open indemnity claims and 2,500 open medical only claims for continued administration. In the even that more than 1,500 indemnity or 2,500 medical only claims require administration, we would like to have an additional discovery conversation to determine if additional staff and fee's need to apply.	Fee will be divided into three annual FY payments.

Account Start Up	$0 - Included	
Reporting Fees		
VIA 1-800	$0 - Included	**Per Claim**
VIA Internet	$0 - Included	**Per Claim**
VIA Fax	$0 - Included	**Per Claim**
Telephonic Case Management	Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per Assignment**
Utilization Review	$109	**Per Review**
Physician Consultant	$250	**Per Review**
Subrogation Fee	15%	**Of Recovery**
PPO Network		
Use of Network Fees	$0 – No separate fee is applicable for use of network. See bill review pricing below.	
Bill Review Fee		
Bill Review - Fee Schedule	$46.00 per bill	**Flat Rate Per Bill - for reduction to state fee schedule**
PPO, Nurse Review and/or Out of Network	0% – Included in the bill review fee. *Any bills over $100,000 will be pass-through the network at cost	**% of Savings** **NOTE: DPI will only accept pricing options with flat rates per bill** **Bill review percentage savings will exclude fee schedule reductions**

Duplicate Bill Review	$0 – Not applicable to duplicate bills	**No Bill Review Fees will be charged to DPI for Carve-Out Services** **Complete Medical Bill Payment Example Below**
Other Fees/Charges		
Special Report Fees	$0 - Included with *viaOne query* access	In the event that custom programming is required, the fee is $155 per hour.
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Per Check Issuance	All banking transaction fee's are included. Escheatment services are charged separately.	

Medical Bill Payment Example

Description	Charges	Fees/Percentages
Original Provider Charges	$5,000.00	
Fee Schedule Reduction	($750.00)	$46 per bill - bill review fee
Bill Review Savings (excluding fee schedule reductions) **If various percentages apply for PPO, Nurse Review or Out of Network, show separately**	2014 Sedgwick PPO Savings in NC is 7% $350 PPO savings	0% of savings.

Optional Services

Description		
viaOne OSHA		
Sedgwick has a variety of OSHA reporting capabilities, depending on the involvement of DPI's staff; these are detailed below. **Option 1 - *viaOne OSHA* basic**		

Incident information is loaded into viaOne OSHA from JURIS when a new claim is set up but is not updated when changes occur in JURIS. DPI reviews and updates all data, tracks time away from work and makes all recordability determinations. This option is well suited for companies that have larger fixed locations with staff responsible for OSHA recordkeeping. Please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $7 per incident set up in viaOne OSHA.

Option 2 - *viaOne OSHA* update

Incident information is loaded into viaOne OSHA from JURIS and is updated with time away from work from JURIS time tracking screens. DPI, however, makes all recordability decisions. This option allows a balance between the conveniences of leveraging the information in JURIS with the ability for DPI to retain control over recordability decisions. Please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $12 per incident set up in viaOne OSHA.

Option 3 - *viaOne OSHA* auto determination

Incident information is loaded into viaOne OSHA and updated with time away from work from JURIS' time tracking screens. The OSHA determination is made by JURIS based on OSHA recordkeeping rules, an evaluation of data provided by an OSHA analyst. This option is well suited to companies with many smaller locations where OSHA recordkeeping is assigned as a collateral duty. However, please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $21 per incident set up in viaOne OSHA. The Sedgwick call center must be utilized for viaOne OSHA Option 3.

Allocated expenses

Description		

The claim fees agreed to shall include all costs incurred by Sedgwick in handling claims submitted, except those costs normally referred to as "allocated expenses." These expenses will be billed to the individual claim file when incurred.

In some cases, including medical management, investigative, structured settlements, Medicare set-aside, claim indexing services, and extra-territorial claims administration services, Sedgwick utilizes subcontractors to perform specialized services in the timely resolution of a claim. Invoices for these services are paid as allocated expenses on individual claim files unless otherwise agreed upon by DPI. When subcontracted services are provided under DPI's contract with Sedgwick, Sedgwick may receive a portion of these charges as reimbursement for the costs associated with billing/administration, system interfaces, service enhancements, and program management. In no event do client charges exceed the amount outlined in their contract with Sedgwick.

Allocated expenses include but are not limited to:

- Attorney fees and costs
- Court costs and appeal bonds
- Cost of providing rehabilitation services
- Cost of surveillance activities and other outside investigations
- Cost of expert witnesses, accident reconstruction specialists, or any other specialist necessary

for the investigation and/or defense of a claim

- Cost incurred to obtain statements, photographs, records, transcripts, depositions, digital call recording, etc.
- Cost of independent medical examiner
- Cost of medical bill review, PPO, managed care, and other similar programs
- Cost of medical experts, peer review, utilization review, case management, pre-certifications, and medical necessity evaluations
- Medicare compliance services fees and costs
- Index filings
- Cost of vocational evaluations, vocational services, training, or other vocational activities
- Cost of outside assistance necessary to prepare or protect a client's subrogation right or Special Disability Trust Fund claim
- Expenses for travel to depositions, mediations, arbitrations, hearings, or other legal proceedings at the client's request or as required by law or rule of a federal, state, or local agency

Definitions

Description		

Life of contract: Sedgwick 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 for an additional annual fee.

Lost time claim: A lost time claim is defined as follows:

- A claim for which a payment is made or reserve is posted under the indemnity portion (i.e., not medical and not expense) of the qualified claim
- Time lost from work exceeds the state prescribed waiting period
- For which an application for adjudication of a claim or hearing notice is received or otherwise involves litigation or communication from or to a petitioner's attorney
- Where paid medical costs exceed $3,000
- Denied claims that otherwise would be classified as indemnity claims
- Claims that DPI requests to be investigated or classified as an indemnity claim
- Any claim for which subrogation is investigated or pursued
- Any claim open longer than twelve months

Medical only claim: A medical only claim is defined as any claim that is not a lost time claim or an incident-only claim.

Incident only: Incident only claims are claims reported by DPI that require no payment or activity other than generating a record in the claims administration system. These claims carry no reserves and no contacts are made by Sedgwick. If contacts are required on incident only cases, additional fees will apply.

EXHIBIT A - TPA Cost Proposal – Price Option I (Optional Years 1 & 2)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Administration New Claim Fees *Pricing below assumes optional years in addition to the initial three year term, for years four and five of the contract period.		
Indemnity	Year 4: $822 (+2%) Year 5: $839 (+2%)	**Per Claim**
Medical Only	Year 4: $159 (+2%) Year 5: $162 (+2%)	**Per Claim**
Reportable Only	Year 4: $11 Year 5: $11	**Per Claim**
Recordable Only	Year 4: $11 Year 5: $11	**Per Claim**
Account Administration Fee	Year 4: $12,734 (+2%) Year 5: $12,989 (+2%)	**Annual**
Administration Existing Open Claim Fees		
Transfer - Approx. 1500 Indemnity and 2500 Medical Claims	Will not be applicable to current TPA during mid-contract periods. Additional fee's may apply if it is determined additional transfer files from another TPA is required.	**Fee will be divided into 3 annual FY payments**
Account Start Up	Not applicable	
Reporting Fees		
VIA 1-800	$0 - Included	**Per Claim**
VIA Internet	$0 - Included	**Per Claim**
VIA Fax	$0 - Included	**Per Claim**

Telephonic Case Management	Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per Assignment**
Utilization Review	$109	**Per Review**
Physician Consultant	$250	**Per Review**
Subrogation Fee	15%	**Of Recovery**
PPO Network		
Use of Network Fees	$0 – No separate fee is applicable for use of network. See bill review pricing below.	
Bill Review Fee		
Bill Review - Fee Schedule	$46.00 per bill	**Flat Rate Per Bill - for reduction to state fee schedule**
PPO, Nurse Review and/or Out of Network	0% – Included in the bill review fee. *Any bills over $100,000 will be pass-through the network at cost	**of Savings** **NOTE: DPI will only accept pricing options with flat rates per bill** **Bill review percentage savings will exclude fee schedule reductions**
Duplicate Bill Review	$0 – Not applicable to duplicate bills	**No Bill Review Fees will be charged to DPI for Carve-Out Services** **Complete Medical Bill Payment Example Below**
Other Fees/Charges		
Special Report Fees	$0 - Included with	In the event that custom programming is required, the

	viaOne query access	fee is $155 per hour.
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Per Check Issuance	All banking transaction fee's are included. Escheatment services are charged separately.	

Medical Bill Payment Example

Description	Charges	Fees/Percentages
Original Provider Charges	$5,000.00	
Fee Schedule Reduction	($750.00)	$46 per bill - bill review fee
Bill Review Savings (excluding fee schedule reductions) **If various percentages apply for PPO, Nurse Review or Out of Network, show separately**	2014 Sedgwick PPO Savings in NC is 7% $350 PPO savings	0% of savings.

EXHIBIT B - TPA Cost Proposal - Price Option I (Optional Years 3 & 4)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Administration New Claim Fees *Pricing below assumes optional years six and seven, in addition to the initial three year term, plus year four and five.		
Indemnity	Year 6: $856 (+2%) Year 7: $873 (+2%)	**Per Claim**
Medical Only	Year 6: $166 (+2%) Year 7: $169 (+2%)	**Per Claim**
Reportable Only	Year 6: $11 Year 7: $11	**Per Claim**
Recordable Only	Year 6: $11 Year 7: $11	**Per Claim**
Account Administration Fee	Year 6: $13,249 (+2%) Year 7: $13,514 (+2%)	**Annual**
Administration Existing Open Claim Fees		
Transfer - Approx. 1500 Indemnity and 2500 Medical Claims	Will not be applicable to current TPA during mid-contract periods. Additional fee's may apply if it is determined additional transfer files from another TPA is required.	**Fee will be divided into 3 annual FY payments**
Account Start Up	Not applicable	
Reporting Fees		
VIA 1-800	$0 - Included	**Per Claim**
VIA Internet	$0 - Included	**Per Claim**
VIA Fax	$0 - Included	**Per Claim**

Telephonic Case Management	Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per Assignment**
Utilization Review	$109	**Per Review**
Physician Consultant	$250	**Per Review**
Subrogation Fee	15%	**Per Recovery**
PPO Network		
Use of Network Fees	$0 – No separate fee is applicable for use of network. See bill review pricing below.	
Bill Review Fee		
Bill Review - Fee Schedule	$46.00 per bill	**Flat Rate Per Bill - for reduction to state fee schedule**
PPO, Nurse Review and/or Out of Network	0% – Included in the bill review fee. *Any bills over $100,000 will be pass-through the network at cost	**of Savings** **NOTE: DPI will only accept pricing options with flat rates per bill** **Bill review percentage savings will exclude fee schedule reductions**
Duplicate Bill Review	$0 – Not applicable to duplicate bills	**No Bill Review Fees will be charged to DPI for Carve-Out Services** **Complete Medical Bill Payment Example Below**
Other Fees/Charges		
Special Report Fees	$0 - Included with viaOne	In the event that custom programming is required,

	query access	the fee is $155 per hour.
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Per Check Issuance	All banking transaction fee's are included. Escheatment services are charged separately.	

Medical Bill Payment Example

Description	Charges	Fees/Percentages
Original Provider Charges	$5,000.00	
Fee Schedule Reduction	($750.00)	$46 per bill - bill review fee
Bill Review Savings (excluding fee schedule reductions) **If various percentages apply for PPO, Nurse Review or Out of Network, show separately**	2014 Sedgwick PPO Savings in NC is 7% $350 PPO savings	0% of savings.

ATTACHMENT G - TPA Cost Proposal - Price Option II

The salary multiplier quoted will remain constant for the term of our agreement (up to 7 years). NCDPI will pay the actual salaries of the program staff multiplied by the cost multiplier below.

Administration New Claim & Takeover claims

Sedgwick offers a pricing option II, as an annual budget-based option. In budget-based pricing, it is the actual staffing necessary to service the claims that drives our fee. Rather than being charged a fee for every claim, DPI is charged only for the staffing necessary to provide claims services.

The fee is calculated by taking the actual program salaries, bonuses, and temporary expenses multiplied by the salary multiplier. Sedgwick will invoice DPI ¼ of the estimated amount on a quarterly basis. Sedgwick will then provide an accounting of the salary, bonus, and temporary expense along with a running variance in budget total. Sedgwick will periodically invoice or return to DPI any additional amounts due based on this true-up process.

If acquisitions, divestitures, changes in program requirements, or a fluctuation in claim volume materially impacts the staffing requirements of the unit, Sedgwick and DPI will agree upon the appropriate staffing modifications. After new staffing levels have been mutually agreed upon, Sedgwick and DPI will agree on a revised budget and fee that reflects such modifications.

Sedgwick will present DPI with an annual updated staffing budget based upon known and/or anticipated claim volume. The salary multiplier will then be applied to this agreed upon staffing to calculate future unit fees. The salary multiplier quoted will remain constant for the term of the agreement and DPI will pay the actual salaries of the program staff multiplied by this multiplier.

Indemnity
Medical Only
Reportable Only
Recordable Only
Account Administration Fee
Transfer - Approx. 1500 Indemnity and 2500 Medical Claims. (Sedgwick assumes up to 1,500 open indemnity claims and 2,500 open medical only claims for continued administration. In the even that more than 1,500 indemnity or 2,500 medical only claim's require

Position	Estimated staffing required	Estimated colleague annual salary	Estimated program salaries
Claims examiner (LT)	10.00	$63,000	$630,000
Claims associate (MO)	7.00	$37,500	$262,500
Claims team lead	3.00	$75,000	$225,000
Claims assistant	2.00	$30,000	$60,000
OSS coordinator	0.50	$36,000	$18,000
Data quality analyst	1.00	$45,000	$45,000
Director claims	0.50	$96,900	$48,450
Director client services	1.00	$96,900	$96,900
Total estimated staffing	**25.00**		**$1,385,850**
Salary multiplier			**2.22**
Estimated annual fee			**$3,076,587**

administration, we would like to have an additional discovery conversation to determine if additional staff and fee's need to apply).		
Account Start Up	$0 - Included	
Reporting Fees		
VIA 1-800	$0 - Included	**Per Claim**
VIA Internet	$0 - Included	**Per Claim**
VIA Fax	$0 - Included	**Per Claim**
Telephonic Case Management	Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per Assignment**
Utilization Review	$109	**Per Review**
Physician Consultant	$250	**Per Review**
Subrogation Fee	15%	**Of Recovery**
PPO Network		
Use of Network Fees	$0 – No separate fee is applicable for use of network. See bill review pricing below.	
Bill Review Fee		
Bill Review - Fee Schedule	$7.50 per bill	**Flat Rate Per Bill - for reduction to state fee schedule**
PPO, Nurse Review and/or Out of Network	Preferred provider organization (PPO) networks: 27% of savings Out-of-network: 20% savings Maximum fee $5,000 for bill amount <$100,000	**% of Savings** **NOTE: DPI will only accept pricing options with flat rates per bill** **Bill review percentage savings will exclude fee**

	Maximum fee $12,000 for bill amount $100,000 – $300,000 Maximum fee $17,000 for bill amount >$300,000	**schedule reductions**
Duplicate Bill Review	$0 – Not applicable to duplicate bills	**No Bill Review Fees will be charged to DPI for Carve-Out Services** **Complete Medical Bill Payment Example Below**
Other Fees/Charges		
Special Report Fees	$0 - Included with viaOne query access	In the event that custom programming is required, the fee is $155 per hour.
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Per Check Issuance	All banking transaction fee's are included. Escheatment services are charged separately.	

Medical Bill Payment Example

Description	Charges	Fees/Percentages
Original Provider Charges	$5,000.00	
Fee Schedule Reduction	($750.00)	$7.50 Per Bill - Bill Review Fee
Bill Review Savings (excluding fee schedule reductions) **If various percentages apply for PPO, Nurse Review or Out of Network, show separately**	2014 Sedgwick PPO Savings in NC is 7% $350 PPO savings	27% of savings. Preferred provider organization (PPO) networks only

Optional Services

Description		
viaOne OSHA		

Sedgwick has a variety of OSHA reporting capabilities, depending on the involvement of DPI's staff; these are detailed below.

Option 1 - *viaOne OSHA* basic

Incident information is loaded into viaOne OSHA from JURIS when a new claim is set up but is not updated when changes occur in JURIS. DPI reviews and updates all data, tracks time away from work and makes all recordability determinations. This option is well suited for companies that have larger fixed locations with staff responsible for OSHA recordkeeping. Please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $7 per incident set up in viaOne OSHA.

Option 2 - *viaOne OSHA* update

Incident information is loaded into viaOne OSHA from JURIS and is updated with time away from work from JURIS time tracking screens. DPI, however, makes all recordability decisions. This option allows a balance between the conveniences of leveraging the information in JURIS with the ability for DPI to retain control over recordability decisions. Please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $12 per incident set up in viaOne OSHA.

Option 3 - *viaOne OSHA* auto determination

Incident information is loaded into viaOne OSHA and updated with time away from work from JURIS' time tracking screens. The OSHA determination is made by JURIS based on OSHA recordkeeping rules, an evaluation of data provided by an OSHA analyst. This option is well suited to companies with many smaller locations where OSHA recordkeeping is assigned as a collateral duty. However, please note that our ability to recreate OSHA records on older incidents is limited. Fees are $5,400 for implementation, $330 per user per year and $21 per incident set up in viaOne OSHA. The Sedgwick call center must be utilized for viaOne OSHA Option 3.

Allocated expenses

Description		

The claim fees agreed to shall include all costs incurred by Sedgwick in handling claims submitted, except those costs normally referred to as "allocated expenses." These expenses will be billed to the individual claim file when incurred.

In some cases, including medical management, investigative, structured settlements, Medicare set-aside, claim indexing services, and extra-territorial claims administration services, Sedgwick utilizes subcontractors to perform specialized services in the timely resolution of a claim. Invoices for these services are paid as allocated expenses on individual claim files unless otherwise agreed upon by DPI. When subcontracted services are provided under DPI's contract with Sedgwick, Sedgwick may receive a portion of these charges as reimbursement for the costs associated with billing/administration, system interfaces, service enhancements, and program management. In no event do client charges exceed the amount outlined in their contract with Sedgwick.

Allocated expenses include but are not limited to:

- Attorney fees and costs
- Court costs and appeal bonds

- Cost of providing rehabilitation services
- Cost of surveillance activities and other outside investigations
- Cost of expert witnesses, accident reconstruction specialists, or any other specialist necessary for the investigation and/or defense of a claim
- Cost incurred to obtain statements, photographs, records, transcripts, depositions, digital call recording, etc.
- Cost of independent medical examiner
- Cost of medical bill review, PPO, managed care, and other similar programs
- Cost of medical experts, peer review, utilization review, case management, pre-certifications, and medical necessity evaluations
- Medicare compliance services fees and costs
- Index filings
- Cost of vocational evaluations, vocational services, training, or other vocational activities
- Cost of outside assistance necessary to prepare or protect a client's subrogation right or Special Disability Trust Fund claim
- Expenses for travel to depositions, mediations, arbitrations, hearings, or other legal proceedings at the client's request or as required by law or rule of a federal, state, or local agency

Definitions

Description		

Life of contract: Sedgwick 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 for an additional annual fee.

Lost time claim: A lost time claim is defined as follows:

- A claim for which a payment is made or reserve is posted under the indemnity portion (i.e., not medical and not expense) of the qualified claim
- Time lost from work exceeds the state prescribed waiting period
- For which an application for adjudication of a claim or hearing notice is received or otherwise involves litigation or communication from or to a petitioner's attorney
- Where paid medical costs exceed $3,000
- Denied claims that otherwise would be classified as indemnity claims
- Claims that DPI requests to be investigated or classified as an indemnity claim
- Any claim for which subrogation is investigated or pursued
- Any claim open longer than twelve months

Medical only claim: A medical only claim is defined as any claim that is not a lost time claim or an incident-only claim.

Incident only: Incident only claims are claims reported by DPI that require no payment or activity other than generating a record in the claims administration system. These claims carry no reserves and no contacts are made by Sedgwick. If contacts are required on incident only cases, additional fees will apply.

ATTACHMENT H - PBM Cost Proposal

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Rx		
Retail Brand Medication	-14%	**AWP**
Retail Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Brand Medication	-20%	**AWP**
Home Delivery Generic Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Retail Compound Brand Medication	-14%	**AWP**
Retail Compound Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Retail Compound Brand Medication	-20%	**AWP**
Home Delivery Generic Compound Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
State if lesser of pricing in above or state fee schedule will apply		
Other Services		
Durable Medical Equipment	0%	Pass-through charges at Sedgwick

		negotiated rates
Home Health Care	N/A	Pass-through charges at Sedgwick negotiated rates
State if lesser of pricing in above state fee schedule will apply		
Account Start Up	$0 - Included	
Consultant (Complex Pharmacy Management)	$115 per hour: registered nurse management and physician management • 1st medication $375 • 2-4 meds $650 • 5-7 meds $975 • 8-12 meds $1,400	Per hour/nurse Medication schedule/physician
Bill Review Fee		
Bill Review - Fee Schedule	TPA claims administration per bill rates will apply, from either option I or option II selected.	**Flat rate per bill**
Review and/or Out of Network	TPA claims administration PPO/OOO network fees will apply, from either option I or option II selected.	**Percentage of savings** **Note: DPI will only accept pricing options with flat rates per bill review percentage savings will exclude fee schedule reductions.**
Duplicate Bill Review	$0 – Not applicable	**If bill review fees apply, define and provide an example of process.**
Other Fees/Charges		
Special Report Fees	$0 – Included in RMIS user access. Through the use of	

	viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour.	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Travel Expenses	Pass-through at cost	
Medication Review (Utilization Review)	Pharmacy utilization review: $109 per review and physician advisor as required $250 per review.	Per review

EXHIBIT C - PBM Cost Proposal (Optional Year 1 & 2)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Rx		
Retail Brand Medication	-14%	**AWP**
Retail Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Brand Medication	-20%	**AWP**
Home Delivery Generic Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Retail Compound Brand Medication	-14%	**AWP**
Retail Compound Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Retail Compound Brand Medication	-20%	**AWP**
Home Delivery Generic Compound Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
State if lesser of pricing in above or state fee schedule will apply		
Other Services		
Durable Medical Equipment	0%	Pass-through charges at Sedgwick

		negotiated rates
Home Health Care	N/A	Pass-through charges at Sedgwick negotiated rates
State if lesser of pricing in above state fee schedule will apply		
Account Start Up	$0 - Included	
Consultant (Complex Pharmacy Management)	$115 per hour: registered nurse management and physician management • 1st medication $375 • 2-4 meds $650 • 5-7 meds $975 • 8-12 meds $1,400	Per hour/nurse Medication schedule/physician
Bill Review Fee		
Bill Review - Fee Schedule	TPA claims administration per bill rates will apply, from either option I or option II selected.	**Flat rate per bill**
Review and/or Out of Network	TPA claims administration PPO/OOO network fees will apply, from either option I or option II selected.	**Percentage of savings** **Note: DPI will only accept pricing options with flat rates per bill review percentage savings will exclude fee schedule reductions.**
Duplicate Bill Review	$0 – Not applicable	**If bill review fees apply, define and provide an example of process.**
Other Fees/Charges		
Special Report Fees	$0 – Included in RMIS user access. Through the use of	

	viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour.	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Travel Expenses	Pass-through at cost	
Medication Review (Utilization Review)	Pharmacy utilization review: $109 per review and physician advisor as required $250 per review.	Per review

EXHIBIT D - PBM Cost Proposal – (Optional Year 3 & 4)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Rx		
Retail Brand Medication	-14%	**AWP**
Retail Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Brand Medication	-20%	**AWP**
Home Delivery Generic Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Retail Compound Brand Medication	-14%	**AWP**
Retail Compound Generic Medication	-35%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
Home Delivery Retail Compound Brand Medication	-20%	**AWP**
Home Delivery Generic Compound Medication	-55%	**AWP**
Dispensing Fee	$3.15	**Per Prescription**
State if lesser of pricing in above or state fee schedule will apply		
Other Services		
Durable Medical Equipment	0%	Pass-through charges at Sedgwick

		negotiated rates
Home Health Care	N/A	Pass-through charges at Sedgwick negotiated rates
State if lesser of pricing in above state fee schedule will apply		
Account Start Up	$0 - Included	
Consultant (Complex Pharmacy Management)	$115 per hour: registered nurse management and physician management • 1st medication $375 • 2-4 meds $650 • 5-7 meds $975 • 8-12 meds $1,400	Per hour/nurse Medication schedule/physician
Bill Review Fee		
Bill Review - Fee Schedule	TPA claims administration per bill rates will apply, from either option I or option II selected.	**Flat rate per bill**
Review and/or Out of Network	TPA claims administration PPO/OOO network fees will apply, from either option I or option II selected.	**Percentage of savings** **Note: DPI will only accept pricing options with flat rates per bill review percentage savings will exclude fee schedule reductions.**
Duplicate Bill Review	$0 – Not applicable	**If bill review fees apply, define and provide an example of process.**
Other Fees/Charges		
Special Report Fees	$0 – Included in RMIS user access. Through the use of	

	viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour.	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Travel Expenses	Pass-through at cost	
Medication Review (Utilization Review)	Pharmacy utilization review: $109 per review and physician advisor as required $250 per review.	Per review

ATTACHMENT I - OTHER MEDICAL SERVICES Cost Proposal

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick managed care provides all telephonic case management services, including return to work specialists. Sedgwick has also developed a field case management network, fully managed by Sedgwick with service expectations, performance guarantees and quality audits of field nurse case managers. Sedgwick has also established co-branded networks with the following vendor partners for medical specialty network services. DME, home health, transportation and translation: Sedgwick Specialty Network - One Call Care Management. Physical Therapy: Sedgwick Physical Therapy Network – Medrisk. Diagnostic Studies: Sedgwick Diagnostic Network - One Call Care Management. Standard contract bill review fees would be applied for bills adjudicated with specialty network partners.		
Nurse Case Management & Vocational Rehabilitation		
Nurse Case Management	Field nurse case management hourly: $90 per hour plus direct expenses. Telephonic case management $ Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per hour**
Vocational Rehabilitation	$90	**Per hour**
Travel Expenses	Pass-through at cost.	**Per**
Wait Time Expenses	Pass-through at cost.	**Per**
Physical Therapy and Chiropractic Care		
Physical Therapy Services	TPA claims administration per bill rates will apply, from either option I or option II selected.	Pass-through charges at Sedgwick negotiated rates.
Chiropractic Care Services	TPA claims administration per bill rates will apply, from either option I or option II	Pass-through charges at Sedgwick negotiated rates.

	selected.	
Diagnostic Services	TPA claims administration per bill rates will apply, from either option I or option II selected.	Pass-through charges at Sedgwick negotiated rates.
State if lesser of pricing in above state fee schedule will apply		
Bill Review Fee		
Bill Review	TPA claims administration per bill rates will apply, from either option I or option II selected.	
Duplicate Bill Review	$0 – Not applicable	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$0 - Included	
Special Report Fees	$0 – Included in RMIS user access. Through the use of viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour.	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Consultant – (Physician Advisor)	Physician advisory/peer review: $225 per review	
Other Fees/Charges	$	
Mileage	Travel is pass-through at cost	

EXHIBIT E - OTHER MEDICAL SERVICES Cost Proposal (Optional Year 1 & 2)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: - Sedgwick managed care provides all telephonic case management services, including return to work specialists. Sedgwick has also developed a field case management network, fully managed by Sedgwick with service expectations, performance guarantees and quality audits of field nurse case managers. Sedgwick has also established co-branded networks with the following vendor partners for medical specialty network services. DME, home health, transportation and translation: Sedgwick Specialty Network - One Call Care Management. Physical Therapy: Sedgwick Physical Therapy Network – Medrisk. Diagnostic Studies: Sedgwick Diagnostic Network - One Call Care Management. Standard contract bill review fees would be applied for bills adjudicated with specialty network partners.		
Nurse Case Management & Vocational Rehabilitation		
Nurse Case Management	Field nurse case management hourly: $90 per hour plus direct expenses. Telephonic case management $ Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per hour or flat rate**
Vocational Rehabilitation	$90	**Per hour**
Travel Expenses	Pass-through at cost.	**Per**
Wait Time Expenses	Pass-through at cost	**Per**
Physical Therapy and Chiropractic Care		
Physical Therapy Services	TPA claims administration per bill rates will apply, from either option I or option II selected. Administrative Fees $0	Pass-through charges at Sedgwick negotiated rates.
Chiropractic Care Services	TPA claims administration per bill rates will apply, from	Pass-through charges at

	either option I or option II selected. Administrative Fees $0	Sedgwick negotiated rates.
Diagnostic Services	TPA claims administration per bill rates will apply, from either option I or option II selected. Administrative Fees $0	Pass-through charges at Sedgwick negotiated rates.
State if lesser of pricing in above state fee schedule will apply		
Bill Review Fee		
Bill Review	TPA claims administration per bill rates will apply, from either option I or option II selected.	
Duplicate Bill Review	$0 – Not applicable	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$0 - Included	
Special Report Fees	$0 – Included in RMIS user access. Through the use of viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Consultant – (Physician Advisor)	Physician advisory/peer review: $225 per review	

Other Fees/Charges		
Mileage	Travel is pass-through at cost	

EXHIBIT F - OTHER MEDICAL SERVICES Cost Proposal (Optional Year 3 & 4)

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: - Sedgwick managed care provides all telephonic case management services, including return to work specialists. Sedgwick has also developed a field case management network, fully managed by Sedgwick with service expectations, performance guarantees and quality audits of field nurse case managers. Sedgwick has also established co-branded networks with the following vendor partners for medical specialty network services. DME, home health, transportation and translation: Sedgwick Specialty Network - One Call Care Management. Physical Therapy: Sedgwick Physical Therapy Network – Medrisk. Diagnostic Studies: Sedgwick Diagnostic Network - One Call Care Management. Standard contract bill review fees would be applied for bills adjudicated with specialty network partners.		
Nurse Case Management & Vocational Rehabilitation		
Nurse Case Management	Field nurse case management hourly: $90 per hour plus direct expenses. Telephonic case management $ Case management monthly (per case) • 1–30 days: $370 • 31–60 days: $280 • >61 days: $185* * $185 fee applies every 30 days thereafter.	**Per hour or flat rate**
Vocational Rehabilitation	$90	**Per hour**
Travel Expenses	Pass-through at cost.	**Per**
Wait Time Expenses	Pass-through at cost.	**Per**
Physical Therapy and Chiropractic Care		
Physical Therapy Services	TPA claims administration per bill rates will apply, from either option I or option II selected. Administrative Fees $0.	Pass-through charges at Sedgwick negotiated rates.
Chiropractic Care Services	TPA claims administration per bill rates will apply, from	Pass-through charges at Sedgwick negotiated rates.

	either option I or option II selected. Administrative Fees $0.	
Diagnostic Services	TPA claims administration per bill rates will apply, from either option I or option II selected. Administrative Fees $0.	Pass-through charges at Sedgwick negotiated rates.
State if lesser of pricing in above state fee schedule will apply		
Bill Review Fee		
Bill Review	TPA claims administration per bill rates will apply, from either option I or option II selected.	
Duplicate Bill Review	$0 – Not applicable	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$0 - Included	
Special Report Fees	$0 – Included in RMIS user access. Through the use of viaOne query, DPI will have the ability to create many ad hoc reports and in addition Sedgwick can often leverage existing established reports for current clients to provide the desired information and reduce the report cost. In the event that custom programming is required, the fee is $155 per hour.	
Data Storage/Management Service Fees	$0 - Included	
Ongoing Services	$0 - Included	
Consultant – (Physician Advisor)	Physician advisory/peer review: $250 per review	

Other Fees/Charges		
Mileage	Travel is pass-through at cost	

ATTACHMENT J - OTHER SERVICES Cost Proposal

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Surveillance		
Full Day	$ N/A	**Per**
Half Day	$ N/A	**Per**
Travel Time	$ N/A	**Per**
Wait Time Expenses	$ N/A	**Per**
Mileage	$ N/A	**Per**
Transportation and Translation		
Transportation Services	$ N/A	**Show Schedule of Fees**
Translation Services	$ N/A	**Show Schedule of Fees**
Bill Review Fee		
Bill Review	$ N/A	
Duplicate Bill Review	$ N/A	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$ N/A	
Special Report Fees	$ N/A	
Data Storage/Management Service Fees	$ N/A	
Ongoing Services	$ N/A	
Consultant	$ N/A	
Other Fees/Charges	$ N/A	

EXHIBIT G - OTHER SERVICES Cost Proposal

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Surveillance		
Full Day	$ N/A	**Per**
Half Day	$ N/A	**Per**
Travel Time	$ N/A	**Per**
Wait Time Expenses	$ N/A	**Per**
Mileage	$ N/A	**Per**
Transportation and Translation		
Transportation Services	$ N/A	**Show Schedule of Fees**
Translation Services	$ N/A	**Show Schedule of Fees**
Bill Review Fee		
Bill Review	$ N/A	
Duplicate Bill Review	$ N/A	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$ N/A	
Special Report Fees	$ N/A	
Data Storage/Management Service Fees	$ N/A	
Ongoing Services	$ N/A	
Consultant	$ N/A	
Other Fees/Charges	$ N/A	

EXHIBIT H - OTHER SERVICES Cost Proposal

Project Name: RFP# DPI 40-PC00117-15	Fee Charged	Comments
VENDOR: Sedgwick Claims Management Services, Inc.	**Show "None" ---**	**If no charge or fee will apply**
Surveillance		
Full Day	$ N/A	**Per**
Half Day	$ N/A	**Per**
Travel Time	$ N/A	**Per**
Wait Time Expenses	$ N/A	**Per**
Mileage	$ N/A	**Per**
Transportation and Translation		
Transportation Services	$ N/A	**Show Schedule of Fees**
Translation Services	$ N/A	**Show Schedule of Fees**
Bill Review Fee		
Bill Review	$ N/A	
Duplicate Bill Review	$ N/A	
If Bill Review Fees Apply, define and provide an example of process		
Other Fees/Charges		
Account Start Up	$ N/A	
Special Report Fees	$ N/A	
Data Storage/Management Service Fees	$ N/A	
Ongoing Services	$ N/A	
Consultant	$ N/A	
Other Fees/Charges	$ N/A	

Appendix

- Workers' compensation flowchart
- Standard reporting samples
- Data interface documentation
- Sedgwick organizational charts
- Sedgwick bios
- SOC1
- Bill review reports
- Certificates of insurance
- Implementation project plan
- Managed care report card

BID ADDENDUM

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS May SUBJECT YOUR BID TO REJECTION

Bid Number: 40-PC00117-15 **Bid Opening Date/Time: January 26, 2015 2:00PM E.S.T.**
Description: Worker's Compensation Insurance
Addendum Number: 1
Addendum Date: December 18, 2014

INSTRUCTIONS:

1. Please return one properly executed copy of this addendum with bid response or **prior** to the Bid Opening Date/Time listed above.

2. **Bid # 40-PC00117-15 replaces Bid # 40-PC00107-15. Bid # 40-PC00107-15 HAS BEEN CANCELLED.**

3. **Send PROPOSALS ONLY FOR BID # 40-PC00117-15.**

****

4. Check **ONE** of the following options:

- [X] Bid has **not** been mailed. **Any changes** resulting from this addendum are included in our bid.
- [ ] Bid has already been mailed. **No changes** resulted from this addendum.
- [ ] Bid has already been mailed. Changes resulting from this addendum are as follows:

_____

_____

****

Execute Addendum:

Bidder: Sedgwick Claims Management Services, Inc.

Authorized Signature: Robert Peterson

Name and Title (Typed): Robert J. Peterson, Chief Marketing Officer

Date: January 23, 2015

BID ADDENDUM

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS May SUBJECT YOUR BID TO REJECTION

Bid Number: 40-PC00117-15 **Bid Opening Date/Time: January 26, 2015 2:00PM E.S.T.**
Description: Worker's Compensation Insurance
Addendum Number: 2
Addendum Date: December 18, 2014

INSTRUCTIONS:

1. Please return one properly executed copy of this addendum with bid response or **prior** to the Bid Opening Date/Time listed above.

2. **CORRECTION: WORKERS' COMPENSATION RFP SCHEDULE OF DATES (PAGE 6)**
TIME SHOWN FOR NON-MANDATORY CONFERENCE IS INCORRECT

THE CORRECTED TIME FOR THE NON-MANDATORY CONFERENCE IS 11AM. THE CORRECTED SCHEDULE OF DATES IS SHOWN BELOW:

Responsibility	DATE	ACTION
DPI Purchasing	12/16/2014	Issue of RFP
Vendors	**01/12/2015 11AM EST**	**Non-Mandatory Conference**
Vendors	01/15/2015 2PM EST	Deadline to Submit Written Questions
Vendors	01//26/2015 2PM EST	Submission of Proposal
Vendors	TBD	Oral presentations by Finalists
Vendors	TBD	Best and Final Offers from Finalists
DPI Purchasing	TBD	Contract Award

****

3. Check **ONE** of the following options:

☒ Bid has **not** been mailed. **Any changes** resulting from this addendum are included in our bid.

☐ Bid has already been mailed. **No changes** resulted from this addendum.

☐ Bid has already been mailed. Changes resulting from this addendum are as follows:

_____

_____

****

Execute Addendum:

Bidder: Sedgwick Claims Management Services, Inc.

Authorized Signature: [signature]

Name and Title (Typed): Robert J. Peterson, Chief Marketing Officer

Date: January 23, 2015

BID ADDENDUM

FAILURE TO RETURN THIS BID ADDENDUM IN ACCORDANCE WITH INSTRUCTIONS MAY SUBJECT YOUR BID TO REJECTION

Bid Number: 40-PC00117-15 **Bid Opening Date/Time:** January 26, 2015 2:00PM EST
Description: Worker's Compensation Insurance
Addendum Number: 3
Addendum Date: January 16, 2015

INSTRUCTIONS:

1. Return one properly executed copy of this addendum with bid response or **prior** to the Bid Opening Date/Time listed above.

2. Written Questions and Responses are in the table below:

Citation	Vendor Question	State Response
	Is there information about the number of workers' compensation cases that were assigned to medical case management in 2014	Excess of $4 million was spent on Nurse Case Management. Number of cases assigned FY14@428, FY13@438, FY12@ 433.
	Is there information about the number of workers' compensation cases that were assigned to vocational case management in 2014	Number of cases assigned FY14@54, FY13@96, FY12@98
	Vendor understands that any Addenda must be executed and submitted with the proposal. Does DPI require that Addenda be signed by an individual authorized by the organization to contractually obligate the organization? Or could the Addenda be signed by another authorized individual, such as the individual identified within the	Any person identified within the Letter of Transmittal as having authorization to either clarify and/or commit the organization is permitted to sign any addenda.

	Letter of Transmittal as the person to be contacted for clarification?	
Page 28, 2.0.d Operation and Services	Question: Describe how you enroll new **customers** into your PBM program. Below is the revised question the way it should read. (Change customers to claimants) Describe how you enroll new **claimants** into your PBM program. Is it correct that "claimants" should replace the word "customers" in the original question?	Correct. Claimant should replace the word customer.
Attachment J – OTHER SERVICES Cost Proposal, Page 67, Surveillance	How many hours does DPI consider a "Full Day" and "Half Day?" Is this on-site time? Will it be acceptable to propose to bill DPI on an hourly basis in lieu of Full Day or Half Day? Can you also please define "Wait time expenses?"	Full or Half Day fees should be shown under $. Vender shall define number of hours (full or half) in Comments. DPI will also accept an hourly rate. Wait time, if charged shall be defined by vendor.
	What is the approximate number of tail claims that will move to TPA if new TPA selected?	Approx 1500 open indemnity (tail claims) and 2500 open medical claims (non-tail claims)
	Is it possible to have an idea of an approximate % of Hispanic employees DPI may have please?	Unknown
Restrictions and Other Notices to Vendors, 9, Page 5 and Section V, 10. Other Materials, Page 40	Will you please accept additional documents be submitted with our proposal response?	Yes. Under a separate appendix.

Section I, Page 11	Will you please share the name of your current TPA?	CorVel
Section II, 3.3a.iii, Page 23	Can you please clarify if all services are to be billed on a monthly basis or just the TPA services?	TPA administration services will be billed monthly. Other charges will be billed to claimant's file and paid accordingly.
Section B1, 2.0, Question o, Page 28	Will you please provide examples of what you would consider "Red Flags?"	Excess use of particular Rx, multiple open claims, etc.
Section V, 7, Page 39	Please provide a copy of the Scope of Work referenced in this section.	Section II of the RFP is considered the Scope of Work.
Attachment D, Page 54	Please provide the breakdown between retail and mail prescriptions.	Not Available
Attachment D, Page 54	Please provide your Generic Fill Rate.	FY14@ 76%, FY13 and FY12 @74%
Attachment D, Page 54	Please provide your Network Penetration rate and how it is calculated.	FY14 Rx Savings 28.1% Program Utilization 98.6%
Attachment D, Page 54	Please define "other" pharmacy.	Not otherwise defined.
Attachment D, Page 54	Please provide the percentage of prescriptions being filled through mail order out of your total prescription count.	Not Available
Page 6 WORKERS' COMPENSATION RFP SCHEDULE OF DATES	In the RFP schedule of dates, the NCDPI did not list the date vendors will receive responses to written questions. Does the NCDPI intend to respond to all vendor questions by a specific date?	Responses to written questions will be posted as quickly after the written question submission deadline as possible.
Section IV The Procurement Process, Letter E. Page 34	The RFP specifies that, "...proposals from each responding firm will be opened publicly and the	Bid openings are only done in person and are not limited to bidding entities.

	name of the Vendor and cost(s) offered will be announced..." Will proposals be opened and costs announced via conference call, in person or both? Will public announcement be limited to bidding entities?	Alternately, you may send an email to joni.robbins@dpi.nc.gov after the bid opening date requesting the information and it will be emailed to you.
	We are preparing for the bid and noticed this time you are asking for disc instead of a flash drive. I was wondering if we need to burn a CD/DVD onto a disc instead of a flash drive can a flash drive be used instead of the disc? The disc has a risk of getting broken even though we would put it in something as secure as possible to avoid that. Please advise asap because we are going to order one or the other today if possible.	A USB is fine.
Section V: Proposal Content and Organization, #5(a) Project Proposal, Proposed Plan (page 37) and #7 Technical Approach (page 39)	Please clarify/differentiate what DPI is looking for the Vendor to provide with regard to each section. Vendor wishes to avoid unnecessary repetition in our response, as #5(a) and #7 seem very similar. #7 references the "the Scope of Work section of this RFP." Please clarify which section this is as there is no	Questions are similar. RFP is clarifying how Vendor is to provide details to the project proposal and technical approach. Section II

	such named section.	
	Can you please clarify the format in which to submit our response to the RFP. Should our responses be added to the existing pamphlet, or should the questions be extracted and submitted in a different word document referencing the sections being answered?	Either way.
Instructions for Delivery, Page 1: "IMPORTANT NOTE: Indicate firm name ("Technical Proposal" or "Cost Proposal") (if applicable), and RFP number on the front of each sealed proposal envelope or package, along with the date for receipt of proposals specified above."	Does DPI require the Cost Proposal be provided in a sealed envelope separate from the Technical Proposal?	No
Section V: Proposal Content and Organization, pp. 36-40, and Form on first page of RFP (no page number): "Solicitation RFP No. DPI 40-PC00117-15 Worker's Compensation Insurance Vendor: _____ THIS PAGE IS TO BE FILLED OUT AND RETURNED WITH YOUR PROPOSAL. FAILURE TO DO SO MAY SUBJECT YOUR PROPOSAL TO REJECTION. ATTENTION Federal Employer Identification Number or alternate identification number (e.g., Social Security Number) is used for internal processing, including bid tabulation. Enter ID number here: _____ Pursuant to N.C.G.S. 132-1.10(b) this	In Section V, DPI provides the required organization/sequence for all proposals. Where within the required sequence should the form on the first page of the RFP be included?	It should be at the front of your proposal.

identification number shall not be released to the public. This page will be removed and shredded, or otherwise kept confidential, before the procurement file is made available for public inspection."		
Section B-1—Pharmacy Benefits Management including DME & Home Health Services (Carve Out), Page 28	Are we allowed to separate theses services or do we have to bid on all 3 Services. For example, can we carve out the DME and Home Health Services and bid on just those 2 Services?	All three services must be offered and bid on.
Section V: Proposal Content and Organization, pp. 36-40, and Attachment A, CONTRACTOR CERTIFICATIONS, pp. 49-50	In Section V, DPI provides the required organization/sequence for all proposals. Where within the required sequence should Attachment A be included?	Section V, #8
	The RFP has been divided into four primary components with the first component being labeled as Third Party Services – Administration, PPO Network, Bill Review Services. Our company is a provider of bill review services including PPO Network access. Are we able to respond to that facet of the component if we are able to work with any TPA who would be chosen?	All TPA services must be offered and bid on. If TPA subcontracts with a bill review and PPO service; this must be noted in the bid response.

	Can Case Management be carved out separately?	Case Management and Voc services are to be bid together.
B. Technical Requirements of Carve-Out Services Pages 28-30 Page 28 Page 30	Are vendors permitted to unbundle the carve-out services within Sections B1, B2 and B3. Please see the following two examples: Is it acceptable for a vendor to respond to letter "s." within Section B1, for DME and Home Health, without responding to the Pharmacy Section, letters "a.-r."	No. Rx, DME and Home Health Care are to be bid together.
	Is it acceptable for a vendor to respond to section B3. Transportation and Translation without offering Surveillance Services.	Surveillance is a stand -alone bid. Transportation and Translation are to be bid together.
	Is there any intent or opportunity for the deliverable date to be extended until the second week of February?	No
Proposal Section V, page 38	We are a privately held case management company. Is a CPA audited financial report required of all vendors since our only financial involvement is forwarding invoices for services rendered by our staff? May we submit CPA prepared tax returns and a balance sheet, income statement and cash flow statement prepared by an	Yes.

	independent bookkeeping professional? This type of information has been accepted on previous RFPs and we do not routinely complete CPA audits due to the time demands and burdensome cost.	
	In order to be eligible for RFP DPI 40-PC00117-15 is it necessary to provide all three services of Pharmacy, DME and Home Health. Our current offering include: Pharmacy and DME.	All three services must be bundled and offered as one bid.
Technical Requirements of TPA 1.0 - 5, Page 17	What was the total paid in fines and penalties per fiscal year, for the last 3 years?	Not Available
Technical Requirements of TPA 1.0 - 5, Page 17	How many LFPs does DPI's current TPA work with in regards to requesting payments for the split funding portions of claims payments?	Approx. 17. See pages 12 and 13 of RFP. Section F. Locally Funded Providers
Technical Requirements of TPA 2.0, Page 18	How many split-funded claims were reported for fiscal years 2013 and 2014, broken out by medical and indemnity claims?	Many of the claims shown on page 57 are split. The actual number of split claims is not available. The last 3 fiscal years, local expenses for indemnity and medical have been approximately $7 million of the total WC benefits paid (shown on page 57).
Technical Requirements of TPA 2.0, Page 18	What was the average new claims reported per month for the last year, broken out by medical and indemnity claims?	See page 57.
Technical Requirements of TPA 3.2 d) Adjuster Requirements, page 22	What will be the required reporting and communication protocols with the LFPs?	See Performance Requirements.

B2 Other Medical Services 2.0 Operation and Services, page 29	How will DPI be evaluating the ongoing effectiveness of nurse case management partners?	DPI is looking for a responsive, team approach between NCM and the TPA. Cost, service, and availability will be reviewed on a quarterly basis.
Section V – 6.a), Page 37	How many claim supervisors are servicing DPI in Raleigh? How many dedicated lost time and medical only adjusters are in Raleigh?	Between 2 offices. 1 Manager 5 Supervisors 21 Adjusters 6 Med Only Adjust 5 Claim Assistants
Section V – 6.a), Page 37	How many claim supervisors are servicing DPI in Charlotte? How many dedicated lost time and medical adjusters are located in Charlotte?	See above.
Attachment G- TPA Cost Proposal, page 58	TPA Cost proposal states that "No bill review fees will be charged to DPI for Carve Out Services". Is it DPI's intention that the TPA will be required to issue checks/payments to carve out vendors and receive no specific fee for administering the established carve out fee schedule and issuing the respective checks? For example, when DPI contracts with a provider of physical therapy services and that provider begins billing for the services, is the TPA permitted to charge for processing that particular bill to DPI's agreed upon fee schedule with that carve out vendor or identifying duplicate billing? Or, is it the intent of DPI just to eliminate charges for networks and fee schedule reductions?	If TPA chooses to charge DPI for processing bills from carve out services, or any other bill review fees, TPA must show all of the intended charges on the TPA Cost Proposals. If carve out vendor is charging a fee for processing or other bill review fee(s), the vendor must show all of the charges on the appropriate Cost Proposals submitted.

Attachment K- Medical Bill Review, page 70	The number of total bills and charges has been provided. For each fiscal year, please provide a more detailed breakdown of "All Other Medical Bills". How many bills and what are the charges for each of the following categories of medical bills: - Physical Therapy Services - Chiropractic Services - Durable Medical Equipment - Home Health Care - Diagnostic Services - Outpatient Physician - Inpatient Hospital - Outpatient Hospital	FY14 Medicals $33.5 million Breakdown as follows --- Rx $6.5 million NCM $4 million DME $753k Other Medical (hospital/physician)$16.1 million PT $3.1 million Radiology $1 million Transport $510k Diagnostics $1million
	Can the company financials (confidential) be in a separate attachment of the RFP on the same USB ?	Not sure what is meant by "separate attachment of the RFP on the same USB". All required information must be presented and organized per instructions stated in RFP.
B3-Other Services; Section 2.0b; Page 30	How does the NC DPI prefer to have the vendor describe their NC Provider list? Is the NC DPI interested in the ability for coverage in the State of NC, by displaying a matrix of counties and type of transportation coverages, or in the form of a map with "pin points", as a visual presentation of the coverages? Does a list of vendors and their	A clear understanding is needed.

	coverage areas have to be provided?	
B3-Other Services; Section 3.0b; Page 30	Clarification requested. Does the DPI want the vendor to reveal step-by-step (including timeframes) of how the vendor would implement their program into the DPI specifically? Is the vendor to include how the program will be implemented for all parties involved (TPA, adjusters, etc.)?	Vendor is to reveal how they will implement the carve- out services they are bidding; and how they will provide detail to TPA.
B3-Other Services; Section 3.0c; Page 30	Clarification requested. In this item, does the vendor need to explain how they will educate the parties that will be utilizing their services? Is DPI requesting an explanation of how communication of the benefits and restrictions will be handled and explained to each party, TPA, providers, adjusters, DPI and claimants?	How carve-out services provided by vendor will be communicated to the TPA, DPI and claimants.
B1	The carve-out section for B1 states PBM and DME & Home Health care. Will you choose different vendors for the home health and DME carve out, along with PBM? For example, do you have to provide PBM services in order to be considered for DME and home health?	All three services must be provided and bid together.
Section II, B1, 2.0, (o), page 28	Please define and/or give examples of what DPI means by "red flag" issue for DME and Home Health.	Over use of supplies/services, non-compliance issues, etc.

Section II, B2, 2.0, (g), page 29	Please define and/or give examples of what DPI means by "red flag" issue for Diagnostic Services.	See above.
Section II, B3, Other Services, 2.0, (g), page 30	Please define and/or give examples of what DPI means by "red flag" issue for Transportation and Translation.	See above.

****

3. Check **ONE** of the following options:

- [X] Bid has **not** been mailed. **Any changes** resulting from this addendum are included in our bid.
- [ ] Bid has already been mailed. **No changes** resulted from this addendum.
- [ ] Bid has already been mailed. Changes resulting from this addendum are as follows:

_____

_____

****

Execute Addendum:

Bidder: Sedgwick Claims Management Services, Inc.

Authorized Signature: _____

Name and Title (Typed): Robert J. Peterson, Chief Marketing Officer

Date: January 22, 2015

All Agencies | Awarded Bid List | Bid Vendor List | Contracts List | Contracts Vendor List | NCAS Payment List

Contract Awards By: Agency
Fiscal Year: 2014-15

Agency: Public Instruction
Bid Description: Worker's Compensation Insurance

List of Bid Vendors

(Click an icon to view report or choose link to view list of contracts)

- **Advantage Surveillance, Inc. (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **Align Networks (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **Carolina Case Management & Rehabilitatio (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **One Call Care (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **Sedgwick Claims Management Services (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **Southern Rehabilitation Network (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance
- **myMatrixx (Bid Number: 40-PC00117-15)** Worker's Compensation Insurance

CONTRACT FOR WORKERS' COMPENSATION THIRD PARTY ADMINISTRATOR AND PPO SERVICES
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.

This Contract is entered into by and between the North Carolina Department of Public Instruction, located at 301 North Wilmington Street, Raleigh, NC 27601 (hereinafter referred to as "NCDPI") and Sedgwick Claims Management Services, Inc., located at 1100 Ridgeway Loop, Memphis, TN 36120 (hereinafter referred to as the "Contractor" or "Third Party Administrator") (collectively referred to as the "Parties").

1. The term of this Contract for Third Party Administrator and PPO Services (hereafter collectively referred to as the "Contract Services"), unless terminated as provided herein, shall become effective on July 1, 2015, and expire on June 30, 2018. NCDPI reserves the right, in its sole discretion, to extend this Contract for four (4) additional one (1) year terms.

2. Contractor understands and agrees that Contractor will use and enter into all necessary contractual agreements for it to obtain the carve-out services from the Carve-Out Vendors selected by NCDPI and at the prices agreed upon by the Carve Out Vendors and NCDPI. Further, Contractor agrees to enter into all agreements and arrangements with the Carve-Out Vendors that are necessary for it to obtain employee claims information and other information relating to services it requests from Carve-Out Vendors selected by NCDPI in a form and via an electronic transmittal format required by the Contractor. Costs, if any, relating to electronic transmittal agreements and/or arrangements shall be dictated by agreement(s) between Contractor and individual Carve-Out Vendors. NCDPI shall not be a party to these agreements between Contractor and individual Carve-Out Vendors and shall not be responsible for payments under those separate agreements. The Carve Out Vendors selected by NCDPI for workers' compensation Claimants are:

   A. Matrix Healthcare Services, Inc, d/b/a myMatrixx, 5706 Benjamin Center Drive, Suite 103, Tampa, Florida 33634 (Pharmacy and Durable Medical Equipment Services);
   B. Carolina Case Management and Rehabilitation Services, Inc., 118 Wind Chime Court, Raleigh, NC 27615-5712 (Medical/Nurse Case Management and Vocational Rehabilitation Services);
   C. Southern Rehabilitation Network, Inc., 9370 Falls of the Neuse Road, Suite 101, Raleigh, NC 27615 (Medical/Nurse Case Management and Vocational Rehabilitation Services);
   D. Align Networks, Inc., 7785 Baymeadows Way, Suite 305, Jacksonville, FL 32256 (Physical Therapy and Chiropractic Services);
   E. One Call Medical, Inc., d/b/a One Call Care Diagnostics, 20 Waterview Boulevard, Parsippany, NJ 07054 (Diagnostic and Radiology Services);

F. Advantage Surveillance, Inc., 360 Commercial Park Drive, Thomasville, North Carolina, 27360 (Surveillance); and
G. One Call Care Transport + Translate, 841 Prudential Drive, Suite 900, Jacksonville, Florida 32207 (Transportation and Translation Services).

3. In the event of any inconsistency or conflict between or among the documents comprising this Contract, such inconsistency or conflict shall be resolved by giving precedent to the documents in the order set forth below:

A. This Contract document;
B. Contractor's Response to the Request for an Extension of Time for the Effectiveness of Bid;
C. Contractor's Response to Best and Final Offer 40-PC00117-15, dated April 8, 2015;
D. Contractor's Response to Best and Final Offer 40-PC00117-15; dated March 31, 2015;
E. Contractor's Response to Request for Clarification, dated March 13, 2015;
F. Contractor's Response to Bid Addendum Number 3;
G. Contractor's Response to Bid Addendum Number 2;
H. Contractor's Response to Bid Addendum Number 1;
I. NCDPI's Request for Proposal Number 40-PC00117-15; and
J. Contractor's Response to Request for Proposal Number 40-PC00117-15.

4. Contractor understands and agrees that payment for referred Contract Services performed will be made after review and approval by the Contract TPA and authorization for payment by the NCDPI Account Administrator.

5. The NCDPI Contract/Account Administrator for this Contract is E.B. Townsend, CPCU, AU, Chief of Insurance, 301 North Wilmington Street, Raleigh, NC 27601, 919.807.3522, eileen.townsend@dpi.nc.gov.

6. The Contractor Contract Administrator is Tom Pfingstag, 901-415-7921. Thomas.Pfingstag@sedgwick.com

7. Each individual signing below warrants that he or she is duly authorized by their respective Party to sign this Contract and to bind their respective Party hereto.

8. This Contract is signed in duplicate originals, one of which shall be retained by each Party.

APPROVED BY:

Sedgwick Claims Management Services, Inc.

President, National Accounts Date: 6-4-15

ROBERT PETERSON
Name/Title

North Carolina Department of Public Instruction

Date: 6/12/15

Philip Price
Chief Financial Officer

Date: 6/12/15

June St. Clair Atkinson, State Superintendent

Workers' Compensation Administration

Contents:

Statutory Authority

The Workers' Compensation law provides medical benefits and disability compensation including a weekly compensation benefit for time lost. The weekly benefit is equal to 66 2/3 of the employee's average weekly earnings up to a maximum established by the Industrial Commission each year. When an employee is injured, the employee must go on workers' compensation leave and receive workers' compensation weekly benefits after the waiting period required by G.S. 97-28.

Purpose

The purpose of this policy is to insure that employees injured on the job are provided compensation in accordance with the Workers' Compensation Act and to provide consistent application of these rules and regulations. Further, the purpose is not only to provide swift and certain remedy to an injured employee, but also to insure a limited and determinate liability for the employer.

Covered Employees

All North Carolina State government employees are covered under the North Carolina Workers' Compensation Act. This includes:

- all employees and officers of the State,
- elected officials,
- members of the General Assembly, and
- persons appointed to serve on a per diem, part-time or fee basis.

Workers' Compensation Administration (continued)

Benefits

Any employee who suffers an accidental injury or contracts an occupational disease within the meaning of the Workers' Compensation Act is entitled to benefits provided by the Act.

The employee is entitled to medical benefits and compensation for time lost from work and any disability which results from the injury.

The State has a "self-insured" program and expenditures are paid from current operating budgets.

Election of Third Party Recovery

Under certain circumstances, involving third party liability, an employee may elect to pursue recovery for a work-related injury through the third party rather than file a claim for workers' compensation. If an employee chooses to do this, a statement acknowledging that the employee was advised of his rights under the Workers' Compensation Act must be prepared by the agency and signed by the employee.

Employee Responsibility

Responsibility for claiming compensation is on the injured employee. The employee or the employee's representative shall:

- give notice of an accident to the employer as soon as possible, and not later than 30 days after occurrence of the accident or death, and
- file a claim through the appropriate person in the agency with the North Carolina Industrial Commission within two years from the date of injury or knowledge thereof.

Advisory Note: No compensation shall be payable unless written notice is given within 30 days, unless reasonable excuse is made to the satisfaction of the Industrial Commission for not giving such notice and the Commission is satisfied that the employer has not been prejudiced thereby.

Workers' Compensation Administration (continued)

Agency Responsibilities

Each State agency is responsible for administering an effective and efficient workers' compensation program, which may include third party administration of claims. The agency shall ensure the employee receives the benefits provided by the Workers' Compensation Act. To meet these objectives and to effectively control costs associated with work-related injuries and illnesses, each agency shall:

- designate a Workers' Compensation Administrator to be responsible for ensuring effective processing and monitoring of all claims,
- fund medical treatment and compensation for loss of wages,
- effectively communicate WC policy and procedures to all employees,
- participate in compromise settlement agreements and NC Industrial Commission Hearings or Mediations, where appropriate, and
- the agency, or its designated representative, shall report an injury to the North Carolina Industrial Commission, using the NCIC Form 19, within five days from knowledge of any claim that results in more than one day's absence from work or if medical expenses exceed the reportable amount which is established by the Industrial Commission.

Office of State Human Resources Responsibilities

In the administration of the State Government Workers' Compensation Program, the Office of State Human Resources shall:

- act as technical resource, and liaison for Workers' Compensation Program,
- provide consultation to agency personnel in managing their workers' compensation programs and insuring that all agencies provide consistent application of coverage and compensation to injured employees,
- contract oversight, monitoring and evaluation of the effectiveness of third party administration of claims, and intermediary between third party administrator and the State,
- measure and evaluate the effectiveness of the workers' compensation program at each agency and recommend changes to achieve optimum results,

Workers' Compensation Administration (continued)

- maintain a statistical data base summarizing statewide analysis of total expenditures and injuries, and
- develop training and educational materials for use in training programs for the agencies.

Return to Work

When an employee, who has experienced a work-related injury or illness and has been released to return to work by the treating physician, there are three possible return to work situations. The agency shall develop a structured Return to Work Program to address these situations.

1. **Has Reached Maximum Medical Improvement and Is Released to Return to Work** - When an employee has reached maximum medical improvement and has been released to return to work by the treating physician, the agency shall return the employee to the same position or one of like seniority, status and pay held prior to workers' compensation leave.
2. **Has Not Reached Maximum Medical Improvement but Is Ready to Return to Limited Duty** - When an employee has not reached maximum medical improvement and is ready to return to limited work duty with approval of the treating physician, but retains some disability which prevents successful performance in the original position, the agency shall provide work reassignment suitable to the employee's capacity which is both meaningful and productive, and advantageous to the employee and the agency. This work assignment shall:
   - be a temporary assignment and
   - not exceed 90 days without approval from the agency personnel officer.
3. **Has Reached Maximum Medical Improvement But Has a Disability** - When an employee has reached maximum medical improvement and has been released to return to work by the treating physician, but has received a disability which prohibits employment in the previous position, the agency shall:
   a) Attempt to place the employee in another position (with an appointment like that held prior to the injury) that is suitable to the employee's capacity and is meaningful, productive, and advantageous to the employee and the agency.

Workers' Compensation Administration (continued)

The agency shall treat reemployment of the employee with priority as described in the Selection Policy, Special Employment and Reemployment Considerations, Recruitment and Selection Section.

b) During the work placement efforts, the employee shall be appointed to the first suitable vacancy that occurs.

c) If the employee accepts a position in a lower pay grade than the pre-injury position, the employee's pay must be adjusted, as appropriate, within the range of the lower pay grade.

(d) If a position is not available that is suitable to the employee's capacity, the employee shall continue on workers' compensation leave until work placement or separation.

(e) Work placement efforts may be in the form of referral to agency internal vacancies, Office of State Human Resources vacancy listings, third party reemployment services, vocational rehabilitation, etc.

Advisory Note: The Workers' Compensation Act does not prohibit the separation of an employee in receipt of workers' compensation benefits if it is determine critical to fill the position. Separation may occur anytime in accordance with the Separation Due to Unavailability Policy, but may not occur as retaliation.

Refusal of Suitable Employment

The Workers' Compensation Act prevents employers from firing or demoting employees in retaliation for pursuing remedies under the Act, but does not speak to reemployment after an employee has been released by the treating physician to return to work. If an employee, who has been on workers' compensation leave, has reached maximum medical improvement and released to return to work by the treating physician refuses suitable employment in keeping with the employee's capacity, the employer shall request stop payment of compensation and implement dismissal procedures.

Workers' Compensation Leave

Contents:

Policy

In addition to the benefits provided by the Workers' Compensation law, employees injured on the job as a result of a compensable accident and who lose time from work shall be provided leave in accordance with the provisions outlined below.

Covered Employees

Full-time and par-time (half-time or more) permanent, probationary, trainee and time-limited employees are eligible for Workers' Compensation Leave.

Temporary, intermittent or part-time (less than half-time) are not eligible for this leave.

Leave on the Day of the Injury

No leave is charged on the day of the injury if the treating physician instructs the employee not to return to work in either permanent duty or restricted duty.

The employee shall:

- obtain a written statement from the physician indicating that the employee must not return to work in either permanent duty or restricted duty and
- present the statement to the supervisor at the appropriate time.

Workers' Compensation Leave (continued)

Additional Leave

If the injury results in additional time away from work, the employee must go on workers' compensation leave and receive the workers' compensation weekly benefit after the required waiting period required by G.S. 97-28.

One of the waiting period options listed below must be chosen. Once an election is made, it may not be rescinded for the duration of the claim.

Option 1: Elect to take sick or vacation/bonus leave during the required waiting period and then go on workers' compensation leave and begin drawing workers' compensation weekly benefits.

Option 2: Elect to go on workers' compensation leave with no pay for the required waiting period and then begin drawing workers' compensation weekly benefits.

If the injury results in disability of more than a specified number of days, as indicated in G.S. 97-28, the workers' compensation weekly benefit shall be allowed from the date of disability. If this occurs in the case of an employee who elected to use leave during the waiting period, no adjustment shall be made in the leave used for these workdays.

Use of Partial Leave

In Option 1 or 2 above, after the employee has gone on workers' compensation leave, the weekly benefit may be supplemented by the use of partial sick or vacation/bonus leave, earned prior to the injury, in accordance with a schedule published by the Office of State Human Resources each year. This will provide an income approximately equal to their take-home or net pay.

Workers' Compensation Leave (continued)

Compensatory Leave

Compensatory leave may be substituted for sick or vacation/bonus leave used during the waiting period if applied within the timeframes provided under the Hours of Work and Overtime Compensation Policy.

How to Pay Partial Leave

If the employee has earned leave or compensatory time and chooses to use it while drawing the weekly benefit, it shall be paid on a temporary payroll at the employee's hourly rate of pay. It is subject to State and Federal withholding taxes and Social Security, but not subject to retirement, just the same as other temporary pay.

No Leave Required for Follow-up Medical Visits

Employees injured on the job in a compensable accident, in order to reach maximum medical improvement, requiring medical or therapy visits during regularly scheduled working hours shall not be charged leave for time lost from work for required treatment.

Paid time should be limited to reasonable time for treatment and travel; any excess time will be charged as vacation/bonus or sick leave or leave without pay.

Vacation and Sick Leave Credits Continue

While on workers' compensation leave, the employee shall continue to accumulate vacation and sick leave to be credited to the employee's account for use upon return to permanent duty.

Leave Paid if Employee Does Not Return

If the employee does not return to permanent duty from workers' compensation leave, vacation and sick leave accumulated **only during the first twelve months of workers' compensation leave** will be exhausted by a lump sum payment, along with other unused vacation/bonus leave which was on hand at the time of the injury, as well as any bonus leave granted subsequently.

Workers' Compensation Leave (continued)

Leave in Excess of 240 Hours

Since the employee is on workers' compensation leave and is not able to schedule vacation time off, the accumulation may in some cases exceed the 240 hours maximum that can be carried forward. It shall be handled as follows:

The 240-hour maximum to be carried forward to the next calendar year may be exceeded by the amount of vacation accumulated during workers' compensation leave. The excess may be used after returning to permanent duty or carried on the leave account until the end of the calendar year at which time any excess vacation shall be converted to sick leave.

If the employee separates during the period that excess vacation is allowed, the excess leave to be paid in a lump sum may not exceed the amount accumulated during the first twelve months of workers' compensation leave.

Advisory Note: This policy also applies to employees covered under salary continuation provisions of G.S. 143-166 and 115C-337.

Health Insurance

While on workers' compensation leave, an employee is in pay status and shall continue to be covered under the State's health insurance program, in compliance with State Health Plan guidelines. Monthly premiums for the employee will be paid by the State. Premiums for any dependent coverage must be paid directly by the employee.

Retirement Service Credit

While on workers' compensation leave an employee does not receive retirement credit. As a member of the Retirement System, the employee may purchase credits for the period of time on an approve leave of absence. Upon request by the employee, the Retirement System provides a statement of the cost and a date by which purchase must be made. If purchase is not made by that date, the cost will have to be recomputed.

Workers' Compensation Leave (continued)

Total State Service Credit

While on workers' compensation leave, an employee is in pay status and shall continue to receive total state service credit.

Longevity Pay

While on workers' compensation leave, an employee is in pay status and will continue to receive longevity credit. Employees who are eligible for longevity pay shall receive their annual payments.

Reinstatement Salary

Upon reinstatement, an employee's salary shall be computed based on the last salary plus any legislative increase to which entitled. Any performance increase which would have been given had the employee been at work may also be included in the reinstatement salary, or it may be given on any payment date following reinstatement.

North Carolina State Government

WORKERS' COMPENSATION EMPLOYEE HANDBOOK

November 2015

State Human Resources

PURPOSE

The contents in this handbook are designed to provide employees of the State of North Carolina with an understanding of the workers' compensation coverage provided to them by the State under the State Government Workers' Compensation Program and the general provisions of the North Carolina Workers' Compensation Act. It provides employees who have suffered an accidental injury on the job or contracted an occupational disease with the general guidelines to follow in filing their claim and the benefits they obtain.

The handbook is designed to give a general explanation of the employee's entitled benefits concerning workers' compensation coverage and the rights and duties of the employee and the employer. This is not a legal explanation of the North Carolina Workers' Compensation Act. If any questions are not specifically covered further information may be found in North Carolina General Statute 97, which is the North Carolina Workers' Compensation Act.

Notice To State Government Employees: If you have an accident or if you are injured on the job you should immediately notify your supervisor. If your injury requires medical treatment you should follow the agency or university procedures regarding medical treatment. A third party administrator may handle your agency or university's workers' compensation claims. If you have questions about coverage or benefits under workers' compensation you should follow your agency or university's procedures and either contact the agency or university Workers' Compensation Administrator or the third party adjuster assigned to your agency or university.

Agency / University Name: _____

Division: _____

Agency /University Workers' Compensation Administrator

Name: _____

Telephone Number: _____

Claims Adjuster

Name: _____

Telephone Number: _____

Agency / University Safety Officer

Name: _____

Telephone Number: _____

TABLE OF CONTENTS

EMPLOYEE COVERAGE

All North Carolina State Government employees are covered under the State Government Workers' Compensation Program. This includes all agency or university and university employees and officers. It also includes all State elected officials, members of the General Assembly or those appointed by the Governor to serve on a per diem, part time or fee basis. It covers full-time employees, part time employees and temporary employees.

COVERAGE DETERMINATION GUIDELINES

As defined under the North Carolina Workers' Compensation Act an injury is covered under workers' compensation if it was caused by an accident or incident that arose out of and in the course of your employment. The Workers' Compensation Act does not provide compensation for all injuries, but for injuries by accident. An accident is defined in the law as a separate event preceding and causing the injury. Unless there is an accident, an injury received while performing the regular duties in the usual and customary manner is not compensable.

There are two exceptions to the "by accident" requirements of the law. These are back injuries and hernias. If either of these injuries is caused by a specific traumatic incident of the work assigned they are compensable in the absence of an accident preceding the injury.

Certain diseases termed "occupational diseases" are compensable under the North Carolina Workers' Compensation Act. An occupational disease is any disease, which is proven to be due to causes, and conditions, which are characteristic of a particular occupation or employment, and the exposure is greater than that of the general public outside of the employment. Diseases of this nature are generally caused by a series of events of similar nature, occurring regularly or at frequent intervals over a period of time in the employment. Only those occupational diseases specifically designated in the North Carolina Workers' Compensation Act are compensable. All ordinary diseases of life to which the general public is equally exposed are excluded.

RESPONSIBILITY OF EMPLOYEE

Responsibility for claiming compensation is on the injured employee. You must immediately give notice of the accident to the employer or as soon as possible after the accident occurs; in any event within 30 days or the employer may refuse compensation. With reference to occupational disease, an employee must give notice to the employer when a competent medical authority first informs the employee of the nature and work related cause of the illness. Either the employee or the employer must file a claim with the North Carolina Industrial Commission (NCIC) within two years from the date or knowledge thereof; otherwise the statute prohibits the claim.

Generally in State agencies and universities, employees notify their immediate supervisor of an accident. You can provide written notice to your employer that an accident with an injury or diagnosis of a work-related illness has occurred in the manner required by your agency or university. Typically, this will be in one of the following forms:

1. The Office of State Human Resources (OSHR) "NC Employee Incident Report" form: This form is part of the OSHR Incident Investigation and Reporting Program. This form allows you to describe the accident and injury(ies). If you lose time from work due to your injury, you will need to complete the "Employee Use of Leave Options Election" form as well. These forms are located at workerscomp.nc.gov or may be obtained from your supervisor or agency or university WC Administrator.

2. Complete a NCIC Form 18. This form is used to notify the NCIC of a claim and will be provided by the employer or may be obtained from the NCIC. The form must be filed directly with the NCIC by the employee.

Upon receipt of notice of the injury or illness, the employer then completes an NCIC Form 19, which is the employer's report of injury. You will receive a copy of the completed form with a blank Form 18.

You are responsible to accept the medical treatment provided by the employer. The employer should provide medical treatment for the injury or refer you to a specific physician. If the employer fails to provide the necessary medical treatment or physician referral for the injury, you may obtain the necessary initial treatment from a physician or hospital of your own choice. State agencies and universities have specific procedures for their employees to follow for the treatment of injuries, such as in-house treatment or a predetermined list of physicians for you to visit. If your agency or university has specific treatment procedures you should follow their guidelines. Once the treating physician is established you cannot change treating physicians for the injury unless the employer or the NCIC approves a referral.

Any absences from work related to the injury must be authorized with a statement from the treating physician. Also, any medical restrictions resulting from the injury placed on you by the treating physician must be documented. Any documentation given to you by the physician must be provided to your supervisor or the agency or university Workers' Compensation Administrator as soon as possible.

An adjuster from the third party administrator will contact you in the claim investigation and administration process. You should provide all requested information, in order to move forward with processing of the claim.

Your supervisor is responsible for notifying the WC Administrator when you return to work after a period of disability relating to the injury. However, if you receive a payment for temporary total disability after you have returned to work, notify your supervisor or WC Administrator immediately. If you do not report the erroneous payment, you will be responsible for reimbursing the State for any overpayment made as a result of erroneous duplicate payments.

RESPONSIBILITY OF YOUR EMPLOYER

When an employee is injured the primary responsibility of the employer is to arrange for and provide the necessary treatment for any work related injury. The Third Party Administrator (TPA) is responsible for accepting or denying liability for the State and is also responsible for monitoring and processing the claims. Additionally, the TPA is responsible to pay medical benefits and compensation in accordance with the North Carolina Workers' Compensation Act. The agency or university and TPA try to provide the best possible medical care for injured employees to help them reach maximum medical improvement and return to work as soon as possible.

Each State agency and university has a Workers' Compensation Administrator who is responsible for the administration of the workers' compensation program for that agency or university. Each agency and university also has a Third Party Administrator Adjuster assigned to handle its claims. Employees may call either person for questions concerning their claim, depending on the process established by their agency or university.

LEAVE POLICY

Employees subject to the State Human Resources Act have certain leave options to elect if a compensable injury causes you to lose time from work. On the day of the injury, if you lose time from work due to the injury you shall not be charged leave for time lost from work. You are

expected to return to work unless the treating physician indicates that you must go home for the day.

If the injury results in more than one lost workday you must go on workers' compensation leave and receive workers' compensation weekly benefits for time lost from work. Currently under North Carolina Workers' Compensation Act there is a seven-day waiting period where no compensation for time lost from work shall be allowed except when the injury results in disability for more than 21 days. If the disability exceeds 21 days then the compensation shall be allowed from the date of the disability.

The following leave options covering the waiting period are provided for all state government employees, except certain law enforcement officers and public school employees injured in an episode of violence:

> *Option 1*: Elect to take sick or vacation leave during the required waiting period and then go on Workers' Compensation leave and begin drawing workers' compensation weekly benefits. Note that if the injury results in disability exceeding 21 days no adjustment will be made in the leave used for these workdays.
>
> *Option 2*: Elect to go on Workers' Compensation leave with no pay for the required waiting period and then begin drawing workers' compensation weekly benefits.

You will be required to complete the "Employee Use of Leave Options Election" form when placed on workers' compensation leave of absence to document your option selection.

Supplemental Leave Option: After you begin drawing the workers' compensation weekly benefit you also have the option to supplement this benefit by the use of partial sick or vacation leave, earned prior to the injury or illness, in accordance with a schedule published each year by the Office of State Human Resources. Since you must go on Workers' Compensation leave and draw weekly benefits, this supplemental leave use can provide an income approximately equal to your take home pay prior to the injury.

Once selection or waiver of any of the three options described above has been made, it may not be changed for the duration of the claim.

Employees injured on the job in a compensable accident who require medical or therapy visits during regularly scheduled working hours in order to reach maximum medical improvement, shall not be charged leave for time lost from work for required treatment. Paid time will be limited to reasonable time for the treatment and travel; any excess time will be charged as sick or vacation/bonus leave or leave without pay.

Salary Continuation Plans:

> *For Certain Law Enforcement Officers:* There is a salary continuation plan for certain law enforcement officers who are subject to the Criminal Justice Training and Standards Act. As described in G.S. 143.166-13 (a)(b) & G.S. 143.166-14, employees who are eligible to receive this special benefit will receive full salary compensation for up to two years if incapacity is the result of an injury by accident or occupational disease "resulting from or arising out of an episode of violence, resistance, or due to other special hazards that occur while the eligible person is performing official duties".
>
> *For Public School Employees Injured in An Episode of Violence:* There is also a salary continuation plan for employees who are full time employees of an educational institution supported by and under the control of the State when injured in an episode of violence as described in G.S. 115-C-338. Under those conditions the employee is entitled to salary continuation for the shortest of the

following three periods: 1) one year; 2) the continuation of the disability; or 3) the lost work time due to the injury.

In addition to salary continuation the employees in these two groups receive all other workers' compensation benefits other than temporary total weekly benefits during the period of salary continuation. If the disability results in incapacity for more than the allowed period of salary continuation, the employee would be subject to all provisions of the North Carolina Workers' Compensation Act.

AVERAGE WEEKLY WAGES

When you begin drawing weekly compensation benefits the amount of compensation is based on sixty six and two thirds percent (66 2/3%) of your average weekly earnings in the employment in which the injury occurred during the past 52 weeks prior to the injury. Adding all wages earned by you in that period, then dividing that number by 52 determines your average weekly wage. The average weekly wage is subject to a statutory compensation rate minimum and maximum amount, which is established annually by the North Carolina Industrial Commission. If you have lost more than seven consecutive calendar days at one or more times during the 52-week period these weeks are deducted when calculating the average weekly wage. If you have worked for less than one year in the job when injured the average weekly wages are based on the number of weeks worked prior to the injury.

MEDICAL BENEFITS

If you have a compensable injury you are entitled to medical benefits to treat the injury. Your employer pays for these medical benefits. The employer should provide a medical treatment authorization form for the employee to give to the treating physician. If not, make the physician aware that the injury occurred on the job and the bills should be forwarded to your employer. These include the payment of medical, surgical, hospital, nursing services, sick travel, prescription drugs, and rehabilitation services which are prescribed by the treating physician to give relief or affect a cure on the injury covered. The State Government Workers' Compensation Program allows for vocational rehabilitation assistance if the severity of the disability requires that vocational rehabilitation is necessary to assist you to obtain suitable employment consistent with your performance capabilities.

Payment of all medical benefits is subject to approval based on a fee schedule established by the NCIC. It is unlawful for any physician, nurse or hospital to accept any fee from a person for treatment of a workers' compensation compensable injury other than the fee approved by the NCIC and paid by the employer.

DISABILITY COMPENSATION

If an injury requires more than medical benefits you are entitled to certain compensation benefits. These benefits include temporary total or temporary partial benefits for time lost from work and permanent partial or permanent total disability compensation for any physical disability associated with the injury.

During any temporary total disability period, if you are unable to work due to an injury, you are entitled to sixty six and two thirds percent (66 2/3%) of your average weekly earnings subject to provisions of the North Carolina Workers' Compensation Act, which includes a maximum and minimum weekly amount you are allowed to receive. The maximum weekly benefit is adjusted annually, effective January 1st of each year. The weekly benefit effective when your claim is submitted remains in effect for the life of the claim.

If you are released by your treating physician to return to restricted duty and suffer wage loss before reaching maximum medical improvement you are entitled to temporary partial compensation equal to sixty six and two thirds percent (66 2/3%) of the difference between weekly earnings during light work and weekly earnings prior to the injury, subject to the maximum allowed by law.

If an injury results in any permanent or partial disability to a specific part of your body, you are entitled to compensation for loss of use of that specific part of the body based on a schedule provided by the NCIC. (The schedule for payment for loss of use is given later in this handbook.) The payment for loss of use of a specific member of the body is payable at the end of the healing period and is based on the number of weeks set forth in the schedule. If your injury does result in a permanent partial or permanent total rating, your treating physician will determine the rating.

If an injury results in facial or head scars which seriously disfigure you or cause the loss or permanent injury to an important organ of the body, you may be entitled to receive additional compensation up to $20,000. No compensation is allowed for scars where an employee is paid for permanent loss or partial loss of use of the same member. An employee is also entitled to payment for disfigurement due to the loss of permanent teeth resulting from a compensable injury.

DEATH BENEFITS

In the event of death resulting from an injury or occupational disease, death benefits are payable if the claim is filed with the NCIC in writing within two years. Effective June 24, 2011, compensation for death is paid for 500 weeks at sixty six and two thirds percent (66 2/3%) of the employee's average weekly wage. Death benefits are paid to the total dependents of the employee or next of kin which ever applies. If a surviving spouse is unable to support herself or himself due to physical or mental disability as of the date of death of the employee, compensation shall continue during the life of the widow or widower or until remarriage. Compensation payments due a dependent child shall be paid for 500 weeks or until the child reaches age 18. Funeral expenses are allowed up to $10,000.

RETURN TO WORK

When a State employee who has experienced a work-related injury or illness and has been released to return to work by their treating physician, there are three possible return to work situations in State Government:

1. An employee has reached maximum medical improvement and has been released to return to work by their treating physician; the employee returns to the original or similar position held prior to the injury.

2. An employee has not reached maximum medical improvement but is ready to return to restricted duty work with the approval of the treating physician. The agency or university will provide suitable modified duty for the employee. This is considered to be a trial return to work by the NCIC. If, within the first nine months, the treating physician determines that the employee is not able to perform the work, the employee must file an NCIC Form 28U to request reinstatement of disability compensation. When the employee reaches maximum medical improvement the employee should be returned to their original or similar position. The modified duty assignment should be temporary and not exceed 90 days without approval from the agency or university Personnel Officer. All modified duty assignments are subject to the agency or university's ability to provide such work.

3. An employee has reached maximum medical improvement and has been released by their treating physician but has received a disability, which prohibits employment in his/her previous position. The agency or university shall attempt to place the employee in another position (similar to the position held prior to the injury) that is suitable to the employee's capacity to work, and is meaningful, productive, and advantageous to the employee and the agency or university. During the work placement efforts the employee shall be appointed to the first suitable vacancy. If the employee accepts a permanent position in a lower pay grade than the pre-injury position, the employee's pay must be adjusted, as appropriate, within the lower pay grade. However, the employee may be eligible to continue receiving temporary partial workers' compensation benefits to supplement the lower pay. This disability benefit may continue for up to 300 weeks for claims filed prior to 6/24/2011 and 500 weeks for claims filed after that (previous periods of temporary total disability benefits will also be counted toward maximum number of weeks).

If a position is not available that is suitable to the employee's capacity, the employee shall continue on workers' compensation leave until work placement or separation, for the maximum period of time allowed by law.

Work placement efforts may be in the form of referral to agency or university internal vacancies, Office of State Human Resources vacancy listings, third party reemployment services, vocational rehabilitation, etc.

Your agency or university should have a structured return to work plan to address the return to work situations described above.

CONTINUATION OF BENEFITS

When you, as a State employee, are injured on the job or if you contract an occupational disease and are placed on workers' compensation leave you are taken off the State's regular payroll and placed in leave without pay - workers' compensation leave status. While in this pay status there will be no deductions made from your workers' compensation weekly benefits. If you have payroll deductions made from your regular pay such as credit union loans, etc., it is your responsibility to take care of these deductions while on workers' compensation leave. While on workers' compensation leave you are eligible for continuation of the following benefits:

Vacation/Sick Leave: While on workers' compensation leave you continue to accumulate vacation and sick leave to be credited to your account for use upon return to work. If you do not return to work, vacation and sick leave accumulated during the first twelve months of workers' compensation leave will be paid in a lump sum along with other unused vacation/bonus credit which was earned prior to the injury.

Hospitalization Insurance: While on workers' compensation leave, you are in pay status and will continue coverage under the State's health insurance program. The State will pay the portion of the monthly premium covered under the State Health Plan. Premiums for any dependent coverage must be paid directly by you.

Performance Increases: Upon reinstatement, your salary will be computed based on the last salary plus any legislative increases to which you are entitled. Any performance increases which would have been given had you been at work may also be included in the reinstatement salary, or it may be given on any payment date following reinstatement.

Longevity: While in workers' compensation leave status you continue to receive longevity credit and, if eligible, shall receive annual payments.

Retirement Service Credit: While on workers' compensation leave you **do not** receive retirement service credits. As a member of the Retirement System, you may purchase credits for the period of time out on approved leave of absence. Upon request, the Retirement System will provide a statement of the cost and the date by which purchase must be made.

Disability Income Plan of North Carolina: Eligible employees who become temporarily or permanently disabled and are unable to perform their regular work duties may receive partial replacement income on a short-term or long-term basis through the Disability Income Plan of North Carolina (the Plan). For detailed information, visit the Department of the State Treasurer, Retirement Systems Division webpage, http://www.treasurer.state.nc.us/RET/frbenhand.htm, or by calling (919) 733-4191.

CLOSING OF CLAIMS & CHANGE OF CONDITION

Claims are generally closed when the employee reaches maximum medical improvement and returns to work without restrictions. Claims that involve only medical benefits are closed when the last medical bill is paid.

Claims are considered closed when the last medical or disability compensation payment is made. The claim is closed with the completion of NCIC Form 28B. You will receive a copy of this form, notifying you that your claim is being closed.

If a significant change of condition occurs within 2 years from date of last payment, a request for further compensation must be made in writing directly to the NCIC. This request must be made within 2 years of last payment of compensation or statute prohibits payment of further compensation. Consideration for future medical needs can be claimed with the completion of a NCIC Form 18M, which can be obtained from the NCIC.

In cases that involve only medical benefits no such change of condition will be considered after 12 months from date of last payment of bills by your agency or university.

PAYMENT SCHEDULE OF INJURIES AND PERIOD OF COMPENSATION

If a claim results in permanent total loss of a specific member of the body, compensation is payable at the end of the healing period based on the schedule provided by the NCIC. If the injury results in partial loss of use of a specific member of the body compensation is paid on a percentage basis. The rate of payment is equal to sixty six and two thirds percent (66 2/3%) of the average weekly wages at the time of the claim times the number of weeks. This average weekly wage is subject to the statutory compensation minimum and maximum established by the NCIC. Below is the schedule for payment of injuries:

Thumb	75 weeks
First or index finger	45 weeks
Second or middle finger	40 weeks
Third or ring finger	25 weeks
Fourth or little finger	20 weeks
Great toe	35 weeks
Any other toe	10 weeks
Hand	200 weeks
Arm	240 weeks
Foot	144 weeks
Leg	200 weeks

Eye	120 weeks
Hearing (one ear)	70 weeks
Hearing (both ears)	150 weeks
Back	300 weeks

ASSISTANCE PROVIDED

If you have questions concerning your claim, you should contact your supervisor or the agency or university Workers' Compensation Administrator or your Claims Adjuster. The Office of State Human Resources also provides assistance to the agencies and universities and employees if they have questions. You can contact the State Government Workers' Compensation Program Administrator at (919) 807-4800 with questions.

If you disagree with the Third Party Administrator's handling of your claim you can contact the agency or university Workers' Compensation Administrator or the NC Industrial Commission (NCIC). An Information Specialist of the NCIC can be reached by calling (919) 807-2501, toll free at (800) 688-8349 or by referring to the NCIC website at www.ic.nc.gov.

If compensation has been denied and you wish to appeal the denial, you must file written notice to the North Carolina Industrial Commission, 430 N, Salisbury St., Dobbs Building, Raleigh, N. C. 27611, giving employee's name, employer's name, and date and nature of injury.

You must file notice with the NCIC within 2 years from the date of injury or last compensation payment, otherwise the statute prohibits filing any claim for further compensation.

If you would like a hearing before the NCIC you must file a request for hearing. This hearing request must be filed in writing. The NCIC will provide you with the appropriate form to request that a claim be assigned for hearing or mediation.

APPENDIX D

STATE OF NORTH CAROLINA
DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

HARLAN E. BOYLES
TREASURER

JACK W. PRUITT
DEPUTY TREASURER

Dear Member

As previously advised, you have been approved for disability benefits by the Medical Review Board of the Retirement System. The North Carolina Supreme Court has rendered a decision concerning the calculation of disability benefits for some Retirement System members. Under the provisions of the lawsuit, a member who was vested in the Retirement System on January 1, 1988, must choose to receive long-term benefits under the Disability Income Plan or a disability retirement benefit calculated on the basis of a statutory formula with service projected to age 65 or the earliest unreduced retirement date with no offset for social security benefits. The dollar amount of the disability retirement benefit in some instances may be higher than the long-term disability benefit to which you may be entitled. A comparison of the benefits payable under long-term disability and Disability Retirement under the Faulkenbury Class Action Lawsuit is attached. In making your decision, the following factors should be considered:

Long-term disability benefits under the Disability Income Plan are payable until the member reaches the age and/or service requirements to qualify for an unreduced service retirement allowance. Long-term benefits are payable at the rate of 65% of 1/12th of your annual base rate of compensation that was last payable to you prior to the beginning of the short-term benefit period including local supplements or coaches supplement plus 65% of 1/12th of your annual longevity payment to a maximum total benefit of $3,900 per month. The long-term benefit is reduced by any primary Social Security benefits you are entitled to receive including age 62 retirement Social Security benefits, temporary total Workers' Compensation payments, and payments from the federal Veterans Administration based on the same disability. **(In the event that you are not approved for Social Security payments, after the first 36 months of the long-term disability period, the long-term benefit will be reduced by an amount equal to a primary Social Security disability benefit to which you might be entitled had you been awarded Social Security disability benefits).** A member's receipt of long-term disability benefits maintains their death benefit coverage and should death occur while in receipt of the long-term payment, their designated beneficiary would be entitled to a lump sum payment equal to a year's salary of not less than $25,000 or more than $50,000.

Disability Retirement benefits under the Faulkenbury Lawsuit are calculated with service projected to age 65 if the member was vested on July 1, 1982; or to the earliest unreduced retirement date if the member became vested after July 1, 1982. In order to comply with the provisions of the lawsuit, the effective date of the disability retirement benefits must be established as the first of the month following the last day of actual work or the first of the month following the exhaustion of leave. In order for the effective date of retirement to be established retroactively requires that an amount equal to the benefits paid to you under short-term disability be recovered. This amount will be recovered from the retroactive benefits due under disability retirement, however, if this amount is not sufficient to cover the amount due, it will be necessary for you to pay any difference due. The total amount of the short-term benefits paid to you has not been determined at this time and we will advise you if any payment will be required as soon as the total amount is confirmed. The death benefit coverage equal to the year's salary is only applicable if death occurs within 180 days of the effective date of retirement as previously established.

After reviewing the enclosed estimate, you must make an irrevocable election to either accept long-term disability benefits under the Disability Income Plan or to receive disability retirement benefits under the provisions of the lawsuit by checking the appropriate space on the enclosed *Election Form*. The form must be signed and notarized. If you elect to receive disability retirement benefits under the provisions of the lawsuit, it will also be necessary for you to complete the enclosed *Election of Benefits* (Form 6E) by which you elect whether to receive the maximum benefit or an optional reduced benefit that would leave a benefit to your designated beneficiary after your death, and return the notarized Form 6E to the Retirement System along with the *Election Form*. **The Form 6E should not be completed if you elect to receive long-term disability payments under the Disability Income Plan.**

325 NORTH SALISBURY STREET, RALEIGH, NORTH CAROLINA 27603-1385
Courier #56-20-46 Telephone (919) 733-4191 Fax (919) 508-5350

Retirement Systems Division
325 North Salisbury Street
Raleigh, North Carolina 27603-1385

Date:

SA
SSN

Factors Used to Determine Benefits

Creditable Service:	Average Final Comp.
Date of Birth:	Accumulated Cont.
Bene. Date of Birth:	
Beneficiary Name:	

Comparison of Benefits

	Disability Income Plan	Disability Retirement
Gross Monthly Long-Term		Not Applicable
*Social Security Offset		Not Applicable
Workers Comp Offset		Not Applicable
Other Offset		Not Applicable
Net Monthly Long-Term Benefit		Not Applicable
Effective Date of Retirement	Not Applicable	
Monthly Maximum Allowance	Not Applicable	
100% Survivorship	Not Applicable	
50% Survivorship	Not Applicable	
100% Survivorship with Pop-Up	Not Applicable	
50% Survivorship with Pop-Up	Not Applicable	

*Note: As explained in the memorandum, if you have not already been approved for Social Security Disability benefits, after 36 months of long-term benefits, your long-term benefit will be reduced by an amount equal to a primary Social Security disability benefit to which you might be entitled had you been awarded Social Security benefits. If no Social Security offset is indicated above, you may wish to contact the Social Security Administration for an estimate to assist you in determining the amount of the future offset to assist you in making your decision.

**Note: As advised in the memorandum, an amount equal to the total of the short-term benefits must be recovered in order to establish the disability retirement benefits retroactively. In order to estimate if any additional payment will be required, you may estimate the retroactive payment due by multiplying the number of months from the effective date of retirement times the monthly amount of the benefit under the optional payment plan you select and compare this amount to the total of the short-term disability benefits received. If the total amount of the short-term disability benefit is more than the estimated retroactive payment, you will be required to pay any additional amount due. If the estimated retroactive payment is more than the amount of the short-term disability benefits you received, you will be due the difference.

STATE OF NORTH CAROLINA
DEPARTMENT OF STATE TREASURER
RETIREMENT SYSTEMS DIVISION

HARLAN E. BOYLES
TREASURER

JACK W. FRUITT
DEPUTY TREASURER

ELECTION FORM

The undersigned has reviewed the attached information and the undersigned hereby makes an irrevocable election to:

_____ Accept long-term benefits payable under the Disability Income Plan

_____ Accept disability retirement benefits as provided by the Faulkenbury Class Action Lawsuit

Sign your name in the space below and then have this form notarized.

_____(Signature)

_____(Social Security No.)

Subscribed and sworn to before me

This the _____day of _____,19___

_____
(Notary Public)

My Commission Expires: _____

(Notary Seal)

§ 135-48.37. Liability of third person; right of subrogation; right of first recovery.

(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery against any third party who was overpaid. If the Plan recovers damages from a liable third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a liable third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. The Plan has a lien, for not more than the value of claims paid related to the liability of the third party, on any damages subsequently recovered against the liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney, and the attorney shall disburse proceeds pursuant to this section. (2004-124, s. 31.25; 2006-264, s. 66(a); 2008-168, ss. 1(a), 3(a), (t); 2011-85, ss. 2.6(j), 2.10.)

North Carolina State Health Plan
FOR TEACHERS AND STATE EMPLOYEES
A Division of the Department of State Treasurer

My Plan Benefits
Pharmacy Benefits
Important Forms
Find a Doctor

2016 Annual Enrollment is October 15 - November 18, 2015. The information on this page is for current (2015) plan members enrolled in the Consumer-Directed Health Plan (CDHP). To view information on 2016 Annual Enrollment, including rates and what's new for 2016 plans for Active members, please click the Get Started button.

Get Started

Consumer-Directed Health Plan (CDHP) for Active Employees

Important Forms

Below are several forms you may need in communicating with the State Health Plan about your benefits.

- Prior Health Coverage Information
  If you had coverage under a previous plan, perhaps from a previous employer, use this form to receive credit against the waiting period for pre-existing conditions.
- Coverage Request for Incapacitated Dependent
  If you have a child over age 26 who is eligible as a mentally or physically incapacitated dependent, complete this form.
- Member/Dependent Authorization Request Form
  If you wish to authorize a person or entity to receive your PHI, please complete this form.
- Authorize a Representative – Appeals
  Use this form to allow a third party to appeal a denied claim or denied certification on your behalf.
- Flexible Benefit Plan (Section 125) Rejection Form
  Learn how to opt out of the Flexible Benefit Plan, IRS Section 125.

Request Reimbursement

In most cases, health care providers and pharmacies will file your insurance claims for you, and you will pay only your copay out of pocket. However, providers who are not part of the State Health Plan network will ask for full payment directly from you. In those cases, if the services are normally covered by the State Health Plan, you can request that your expenses be reimbursed.

Use the appropriate form below to request reimbursement from the State Health Plan.

- PPO Plan Medical Claim Form
  Use this form to request reimbursement for health care services, such as a visit to a doctor not in the Blue OptionsSM provider network. The Plan will only reimburse you up to the allowable, usual, customary, reasonable amount. Non-participating providers may bill you for the remainder of their charges.
- PPO Worldwide International Claim Form
  Use this form to request reimbursement for health care services when you receive care outside of the United States.
- Prescription Drug Claim Form
  Use this form to request reimbursement for prescription drugs, such as those not purchased from a pharmacy contracted with the State Health Plan. Your reimbursement will be the Plan's maximum allowable amount, not the charge for the prescription drug.

Reimburse the State

Pursue claims paid by the State Health Plan where a third party is liable.

If you are injured as the result of an auto accident or other mishap caused by another person, your medical expenses will usually be covered by that person (often his or her auto or property insurance company). However, your immediate medical expenses will be covered by the State Health Plan while you wait for the other person to

pay your expenses. Once you receive money from the other person, use the Overpayment form below to reimburse the State Health Plan for charges already paid.

Overpayment Form
Use this form to repay the State Health Plan if your medical expenses are paid for by both a third party and the State Health Plan. Such duplicate payments typically occur as a result of incidents such as auto accidents in which a third party is liable for your health expenses. This information allows the Plan to properly credit members' accounts and pursue other claims paid by the Plan where a third party is liable.

Continuation of Coverage Rights Under COBRA
This explains COBRA continuation rights when health benefit plan coverage would otherwise end because of a life event known as a "qualifying" event.

Subrogation – Third Party Recovery

The State Health Plan ("Plan") has the right of subrogation upon its injured members' right to recover from liable third parties. The Plan's objective is to recover medical expenditures incurred by the Plan where a third party is liable for the care.

Please note that in accordance with North Carolina General Statute (N.C.G.S.) § 135-48.37, the Plan is required to inquire about the terms of any third party recovery and disbursement to all lien holders if payment to the Plan is less than 100% of its lien. The Plan collects fifty (50%) percent of the total damages recovered by members after reasonable costs of collection have been subtracted from the total recovery.

Members should contact Health Management Systems, Inc. (HMS), which has been contracted by the Plan to perform subrogation services, at 800-294-2757 to determine whether the Plan is claiming a right to recovery. Alternatively, members may complete and fax the Lien Request form to 919-714-8575. Within five (5) business days HMS will provide a lien amount to members or their duly authorized representatives.

A Third Party Recovery Overpayment form is to be completed by providers for any overpayments due back to the Plan when a third party liability carrier has also paid the same claims. For a complete copy of N.C.G.S. § 135-48.37, which governs the Plan's right of subrogation and right of recovery, please click here.

Third Party Recovery Overpayment Form

Date_____

Name of Medical Facility _____

NC State Health Plan Member_____

NC State Health Plan ID # _____

Type of Injury _____

Dates(s) of Service _____

Amount of overpayment/refund sent to State Health Plan_____

Attorney's name, phone number & address (if applicable) _____
_____
_____

Insurance company name, phone number & address (if applicable) _____
_____
_____

Reason for overpayment/refund _____

This form should ONLY be completed when overpayments are due back to the State Health Plan because a third party liability carrier has already paid. Please complete the information on this Third Party Recovery Overpayment Form to the extent known, attach to the refund/overpayment check and forward to NC State Health Plan Overpayments, PO Box 20733 Raleigh, NC 27619.

If you should have any questions, please feel free to contact Health Management Systems at (800) 294-2757, extension 4.

APPENDIX F

Understanding Disability Benefit Offsets and Earnings Limitations

Disability benefit offsets and earnings limitations differ depending on whether you are receiving a benefit under the Disability Income Plan of North Carolina (DIPNC) for Teachers' and State Employees' Retirement System (TSERS) members or you are receiving a disability retirement benefit from the Local Governmental Employees' Retirement System (LGERS) or TSERS. The chart below can help you better understand how offsets or earnings limitations apply to you.

DIPNC (for TSERS) Offsets or Reductions

DIPNC long-term benefits are reduced:

- By an amount equal to your:
  - Workers' Compensation Temporary Total Disability benefits
  - Veterans Administration (VA) benefits
  - Other federal disability benefits or certain North Carolina military benefits

  if based on the same disability as your DIPNC benefit
- By excess monthly earnings from any type of public or private employment
- By severance pay as a result of reduction-in-force from the State
- By an amount equal to any Social Security (SS) benefits which you are receiving (excluding widow's/widower's benefit) or which you are entitled to receive, including age 62 SS retirement benefits
- If you had five or more years of membership service as of July 31, 2007, after the first 36 months of the long-term disability period, by an amount equal to a hypothetical amount of a SS disability benefit to which you might be entitled had you been awarded SS disability benefits

NOTE: If you had less than five years of TSERS or Optional Retirement Program (ORP) membership service as of July 31, 2007, after 36 months of long-term disability, DIPNC benefits will end unless you are receiving SS disability benefits.

Disability Offsets at a Glance

Type of benefit	Will this benefit be offset?
Excess Earnings	**Yes**
Military Retirement	No
Severance Pay	**Yes**
SS Disability Benefits	**Yes**
SS Hypothetical	**Yes**
SS Retirement Benefits	**Yes**
SS Widow's Benefits	No
Unemployment Benefits	No
VA Benefits Offset is for the same disability the member is applying for with us	**Yes**
Workers' Compensation – Permanent Partial	No
Workers' Compensation: Temporary Total Offset is for the same disability the member is applying for with us	**Yes**
Workers' Compensation Clincher Agreement	No

DIPNC (for TSERS) Earnings Limitations

While receiving DIPNC long-term benefits, on a monthly basis, you may earn, from any type of public or private employment, up to the difference between the monthly base rate of salary on which your monthly DIPNC benefit is calculated and the amount of your monthly DIPNC benefit after any required offsets, without affecting your DIPNC benefit. If you earn more than this amount, your DIPNC benefit will be reduced dollar-for-dollar by the amount of your excess earnings.

Example – Long-Term Monthly Earnable Allowance calculation:

1. Convert the Gross monthly long-term benefit before any offsets to 100% of salary = $31,775.58
2. Subtract the monthly long-term benefit after offsets from the amount in Step 1
3. The difference is the monthly earnable allowance

$2,065.43 ÷ .65 = $31,775.58
less Long-Term gross benefit after any offsets $2,065.43
Gross Monthly Long-Term Earnable Allowance $1,112.15

LGERS and TSERS Disability Retirement Offsets and Earnings Limitations

There are no offsets or reductions for other disability benefits, including Social Security benefits, for retirees receiving LGERS or TSERS disability retirement benefits.

While receiving LGERS or TSERS disability retirement benefits, on an annual basis, you may earn, from any type of public or private employment, up to the difference between your highest consecutive 12 months of salary in the 48 months preceding your disability retirement date and the amount of your annual disability retirement benefits, without affecting your disability retirement benefit. If you earn more than this amount, your disability retirement benefit will be reduced dollar-for-dollar by the amount of your excess earnings. The amount you are allowed to earn is increased each January by any increase in the annual national consumer price index (CPI).

Example: Local and State Disability Retirees earnable allowance:

12-month compensation: $ 25,432.65

Option 2 benefit: $722.18 x 12 = - $ 8,666.16

Amount retiree can earn = $ 16,766.49

For more information, please visit the Disability Benefits section for Government Benefit Recipients on our website at www.myncretirement.com. Notify the Retirement Systems Division immediately, if you have not already done so, to avoid a future overpayment.

Checklist for Disability Requirements

As a North Carolina disability benefit recipient, there are several requirements that you must follow to maintain your benefits. The following checklist identifies what forms are due and when they are due.

Requirements	Annual Earning – Statement of Income	Medical Records – Form 7AR *	Awards Letters
Disability Income Plan of North Carolina (DIPNC)	Submit Annually via Form 296	**Once a year** for members in the first five years of receiving Long- Term. **Once every three years** for members who have received Long-Term longer than five years. **	Social Security Workers' Compensation Veterans Affairs (VA) Benefits
LGERS – Disability Retirement	Submit Annually via Form 237	**Once a year** for members in the first five years of receiving LGERS Disability Retirement. **Once every three years** for members who have received LGERS Disability Retirement longer than five years. **	Not Applicable
TSERS – Disability Retirement	Submit Annually via Form 237	**Once a year** for members in the first five years of receiving TSERS Disability Retirement. **Once every three years** for members who have received TSERS Disability Retirement longer than five years.**	Not Applicable

* The frequency of medical reviews is at the discretion of the Medical Board, depending on circumstances, such as earned income or requests for verification of disability.

** Or, as requested by our Medical Board or Board of Trustees.

The Retirement Systems will notify you in advance when an updated Statement of Income or new medical records are due for review. Failure to complete the forms in their entirety, or to respond to the request, may result in an interruption of disability benefit. An interruption in disability benefits may cause any benefits through the State Health Plan to be interrupted.

Ask the Retirement Systems

Most Commonly Asked Questions
The North Carolina Retirement Systems receives hundreds of questions each month from members. The following are several of the most commonly asked questions and responses regarding disability benefits.

Q: Why do I have to complete a Statement of Income form every year?

For DIPNC (for TSERS) Recipients:
State law requires each DIPNC long-term disability benefit recipient to complete and submit a Statement of Income form to report earnings from employment and/or benefits from certain other sources each year to the Retirement Systems Division.

For LGERS or TSERS Disability Retirees:
State law requires each LGERS and TSERS disability retiree to complete and submit a Statement of Income form to report earnings from employment each year to the Retirement System until you reach the date on which you would have been eligible for unreduced retirement had you been able to continue working.

Q: What happens when I become eligible for a service retirement?

For DIPNC (for TSERS) Recipients:
While you are receiving DIPNC benefits, you earn TSERS creditable service for each month you are eligible for and paid a DIPNC benefit. Your TSERS membership service is added to your TSERS creditable service to determine your eligibility date for unreduced service retirement benefits. Approximately 90 days before you reach the eligibility requirements for an unreduced service retirement benefit, the Retirement System will send you a letter notifying you that you are being converted from long-term disability to service retirement, and explaining what forms you must complete in order to begin receiving your service retirement benefits. Upon submission of your completed service retirement paperwork to the Retirement System, your monthly service retirement benefit will be established,

Upon conversion to service retirement, you will no longer be subject to:

- Medical reexaminations
- DIPNC offsets
- DIPNC earnings limitations
- Completing an annual Statement of Income form

However, you will be subject to the return-to-work laws that apply to retirees who are receiving TSERS service retirement benefits (see Guidance on Return-to-Work Laws located on our website at www.myncretirement.com), except that you are not required to "sit out" during the 6 months (TSERS) following the effective date of your service retirement.

For LGERS or TSERS Disability Retirees:
When you reach the date on which you would have been eligible for unreduced retirement had you been able to continue working, the Retirement System will send you a letter notifying you that you are being converted from disability retirement to service retirement.
Upon conversion to service retirement, your monthly benefit amount will continue to be the same amount, but you will no longer be subject to:

- Medical reexaminations
- Disability retirement earnings limitations
- Completing an annual Statement of Income form

However, you will be subject to the return-to-work laws that apply to retirees who are receiving LGERS or TSERS service retirement benefits (see Guidance on Return-to-Work Laws located on our website at www.myncretirement.com), except that you are not required to "sit out" during the month (LGERS) or 6 months (TSERS) following the effective date of your service retirement.