City of Aberdeen Police & Fire Pension Boards

Operating Procedures and Administrative Policies

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PREAMBLE

The purpose of these rules and regulations is to establish uniform general operating procedures and to reduce to writing the administrative policies of the City of Aberdeen's Police and Fire Pension Boards. The rules of procedure for Board meetings and for processing claims and applications shall be uniform for each Board unless otherwise stated or clearly inapplicable. The Boards recognize that conditions may arise which are not expressly addressed by these rules and regulations. In such cases, each Board reserves the right to take whatever action is necessary consistent with applicable statutes and state regulations.

SCOPE

These rules and regulations shall be applicable to all firefighters or law enforcement officers, active and/or retired, covered by chapters 41.16, 41.18, 41.20, and 41.26 RCW, unless specifically provided herein.

EFFECT OF RULES AND REGULATIONS

All fire and police personnel of the City of Aberdeen within the scope of these rules and regulations shall be subject to the policies and procedures contained herein to the extent consistent with applicable state statutory provisions and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the particular member shall be held to be contrary to state law, such member shall not be relieved of any other requirement contained herein and any such finding shall not relieve the member from the responsibility to comply with all other procedures and policies contained herein.

A member's failure to follow these procedures may subject him/her to the loss of benefits otherwise due under state law.

PART 1. DEFINITIONS

1.1 **"Application"** means a filed request by a member for Board approval of disability leave or retirement.

1.2 **"Board"** means either the board of trustees of the relief and pension fund of the Aberdeen police department as established pursuant to RCW 41.20.010 (the Aberdeen Police Pension Board) or the Aberdeen Fire Pension Board as established pursuant to RCW 41.16.020, as retained by RCW 41.26.110.

1.3 "**Business day"** means a day that Aberdeen City Hall is open for the public to conduct City business.

1.4 **"City"** means the employer, the City of Aberdeen, WA.

1.5 **"Claim"** means a filed request by a member to the Board for approval of reimbursement of expenses incurred for medical services or treatment; or the pre-approval of a medical appliance; or pre-approval of a surgical procedure, or pre-approval of successive treatment.

1.6 **"Conditional return"** is a return to duty by a member for the purpose of determining whether the member's disability persists.

1.7 **"Disability"** means the existence of a physical or mental (psychological) condition which renders the member unable to discharge with average efficiency the duty of the grade or rank to which the member belongs, or the position in which the member regularly serves. If a member is able to perform the regular duties of any available position to which a member of his grade or rank is normally assigned, with average efficiency, the member is not considered disabled.

1.8 **"Disability Leave Allowance"** is the payment equal to the member's regular salary on the first day of disability leave [Per AGO No. 78.8] or the applicable portion thereof, received by the member from the City. Disability leave allowance is not granted in advance for any specific amount of time. Such leave may encompass a period of one hour to a maximum of six months.

1.9 **"In line of duty"** means that the member's disability occurred as a direct result of the performance of the member's duties.

1.10 **"Member"** means a current or retired law enforcement officer or firefighter eligible for benefits provided under RCW 41.26. "Member" also includes, where applicable, pre-LEOFF 1 retirees under Chapters 41.16, 41.18, and 41.20 RCW.

PART 2. THE BOARD

2.1 Powers of the Board. The Aberdeen Fire Pension Board shall have the powers granted by the State legislature or necessarily implied from such grant of powers in chapters 41.16, 41.18, and 41.26 RCW, and chapters 415-104 and 415-105 WAC. The Aberdeen Police Pension Board shall have the powers granted by the State legislature or necessarily implied from such grant of powers in chapters 41.20 and 41.26 RCW, and chapters 415-104 and 415-105 WAC.

2.2 Board members.

A. Aberdeen Fire Pension Board members and officers. The Fire Pension Board shall consist of five members in accordance with RCW 41.16.020:

1. The mayor or a city councilmember serving as the mayor's designated representative, who shall serve as the chair of the board;
2. The Finance Director;
3. The chair of the Finance Committee; and
4. Two regularly employed or retired firefighters elected by secret ballot of those employed and retired firefighters who are subject to the jurisdiction of the board. The members elected by the firefighters shall each serve a two year term, with one member being elected each year to provide staggered terms. The two firefighters elected as members shall, in turn, select a third eligible member who shall serve as an alternate in the event of an absence of one of the regularly elected members. In case a vacancy occurs in the membership of the firefighters or retired members, the members shall in the same manner elect a successor to serve the unexpired term. A member elected by the firefighters shall continue to serve until a successor has been elected.
5. The Human Resources Director shall serve as Board Secretary. In case of absence or inability of the mayor or the mayor's designated representative, the board may select a member to serve as chair pro tempore who shall during such absence or inability perform the duties and exercise the powers of the chair.

B. Aberdeen Police Pension Board members and officers. The police pension board shall consist of six members in accordance with RCW 41.20.010:

1. The mayor or a city councilmember serving as the mayor's designated representative, who shall serve as chair;
2. The president of the city council or mayor pro tem;
3. The Finance Director; and
4. Three active or retired members of the police department. The members elected by the police department and the retired law enforcement officers of the city shall be elected for staggered three year terms commencing on July 1 of each year. Nominations for the term expiring on June 30 of that year shall be filed with the Board Secretary in May and elections held in June of each year in the manner set forth in RCW 41.20.010(3). In case a

vacancy occurs in the membership of the police department or retired members, the Board shall fix a date for the election of a successor to serve the unexpired term. The election shall be conducted in the same manner as elections for a full term.

5. The Human Resources Director shall serve as Board Secretary. In case of absence or inability of the mayor or the mayor's designated representative, the board may select a member to serve as chair pro tempore who shall during such absence or inability perform the duties and exercise the powers of the chair.

C. Voting and quorum. Each Board member shall have one vote which must be cast by that member in person. A majority of the Board shall constitute a quorum and have power to transact business.

D. Presiding officer. The Chair shall preside at all meetings and hearings of the Board and may call special meetings. The Chair shall have the privilege of discussing matters before the Board and voting thereon. The Chair shall have all the duties normally conferred by parliamentary procedures on such officers and shall perform such other duties as may be requested by the Board.

E. Legal Advisor. The Corporation Counsel serves as the legal advisor to the Pension Boards. In the event the Corporation Counsel is disqualified due to a conflict of interest, or is unavailable for any reason, the Board may retain an attorney to provide independent legal advice and representation.

PART 3. GENERAL PROVISIONS OF BOARD MEETINGS

Meeting procedures:

3.1 Meetings. The Board shall meet regularly on the second Monday of each month in the third floor committee room at City Hall. The Police Pension Board meeting shall commence at 4:00 pm and the Fire Pension Board meeting shall commence at 4:15 pm or as soon thereafter as the Police Pension Board meeting concludes. If necessary, special meetings may be called by the Chair or a majority of the Board.

3.2 Public attendance. Board meetings are open to the general public. However, the Board may close under RCW 42.30.140(2) those portions of meetings where consideration of an individual application or claim includes discussion of sensitive personal or medical information relating to the member.

3.3 Recording not allowed. No one attending any Board meeting may video tape or tape record any portion of the meeting without the prior approval of the Board.

3.4 Public examination of records. A copy of a record of proceedings, minutes, agendas, or Board action will be furnished to a requesting party upon request and payment of copy fees set by resolution of the city council. Personal information relating to a member's claim or application shall be released as required by chapter 42.56 RCW, by court order, or with written permission of the member.

3.5 Full hearings – transcripts. The Board may hold a full hearing on any matter when deemed necessary or on a motion for reconsideration under Board Rule 4.2. At such a hearing:

A. Any person testifying before the Board may have his or her attorney present.

B. Opportunity shall be afforded all parties to respond and present relevant evidence and argument on all issues involved.

C. Unless precluded by law, informal disposition may also be made of any contested case by stipulation, agreed settlement, consent order, or default.

D. The record of a hearing shall include:
   1. All pleadings, motions, intermediate rulings;
   2. Evidence received or considered;
   3. A statement of matters officially noticed, if any;
   4. Questions and offers of proof, objections, and ruling thereon, if any;
   5. Proposed findings and exceptions, if any; and
   6. Any decision, opinion, or report by the Board.

E. An audio recording shall be made of all hearings. All full hearings before the Board may be recorded by a court reporter. A copy of the record, or any part thereof, shall be transcribed by the court reporter. Transcriptions may be furnished to a requesting party upon request to the court reporter and payment of the costs thereof for transcriptions will be assumed by the requesting party. Transcriptions of oral testimony from a full hearing will not be ordered by the Board unless it is requested by the Board or the state retirement systems for review.

F. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

G. The Board may:
1. Administer oaths and affirmations, examine witnesses, and receive evidence;
2. Issue subpoenas as provided in Board Rule 3.6;
3. Rule upon offers of proof and receive relevant evidence;
4. Take or cause depositions to be taken pursuant to rules promulgated by the Board;
5. Regulate the course of the hearing.

3.6 Subpoenas. The Board may compel the attendance of a witness at any hearing as follows:

A. The Board may issue a subpoena on its own motion or on the request of any party;

B. If an individual fails to obey a subpoena, or obeys a subpoena but refuses to testify when requested concerning any matter under examination or investigation at the hearing, the Board may petition the superior court of the county where the hearing is being conducted for enforcement of the subpoena. The petition shall be accompanied by a copy of the subpoena and proof of service, and shall set forth in what specific manner the subpoena has not been complied with, and shall ask an order of the court to compel the witness to appear and testify before the Board.

C. Witnesses subpoenaed to attend such a hearing shall be paid the same fees and allowances, in the same manner and under the same conditions, as provided for witnesses in the courts of this State by RCW 2.40 and by RCW 5.56.010, as now or hereafter amended: Provided, that the Board shall have the power to fix the allowance for meals and lodging in like manner as is provided in RCW 5.56.010, as now or hereafter amended, as to courts. Such fees and allowances, and the cost of producing records required to be produced by its subpoena, shall be paid by the Board, or by the party requesting the issuance of the subpoena.

PART 4. PROCESSING APPLICATIONS AND CLAIMS GENERALLY

4.1 Submission of claims. All applications and claims shall be submitted to the Board Secretary as follows:

A. The appropriate Board approved form must be used.

B. Disability leave applications must first be submitted to the member's department to be forwarded to the Board Secretary. All other claims should be submitted directly to the Board Secretary.

C. All applications or claims must be complete, legible, and submitted to the Board Secretary at least five (5) calendar days prior to a scheduled Board meeting to be placed on the current meeting agenda. Untimely submitted material may be considered at the discretion of the Board or placed on the next available agenda.

D. Material which is not submitted on the appropriate form will be considered at the discretion of the Board and may not necessarily be accepted as admissible evidence for a claim. Illegible material will not be considered.

4.2 Reconsideration of Board decisions – full hearings. The Board's decision to approve or deny applications or claims may be made without a full hearing solely on the basis of the written information submitted to the Board. Any member aggrieved by a decision made without a full hearing may file with the Board a request for reconsideration and receive an opportunity for a full hearing on the matter.

A. A request for a full hearing must be filed in writing within 14 calendar days of notification of the Board's decision. Upon receipt of such a written request, the Board will set a hearing date and time at the next available Board meeting. Notice will be sent to the member at least 10 business days before the hearing date.

B. At a scheduled hearing, a member and/or a representative will be afforded time to present information or testimony before the Board. In addition to, or in lieu of, oral testimony, any written material must be submitted to the Board Secretary ten (10) business days before the hearing date to be included with the regular agenda. Written material submitted at the time of a hearing will be considered at the discretion of the Board.

4.3 Appeal procedure.

A. Any member aggrieved by an order of the Board, which is within the jurisdiction of the State Retirement Systems, shall comply with the provisions of RCW 41.26.200 in perfecting such an appeal to the State Retirement Systems director.

B. In the event a final determination of the local Board is not within the jurisdiction of the State Retirement Systems director, the interested member is hereby required to file his/her motion for review with the Grays Harbor County Superior Court within the appropriate time frame.

C. In accordance with RCW 41.26.125(3), the director of the State Retirement Systems does not review a Board finding that a disability retirement was not incurred in the line of duty. Direct review, however, may be sought from the United States Department of the Treasury, Internal Revenue Service, concerning any federal tax consequences of a Board finding that a disability was not incurred in the line of duty.

PART 5. DISABILITY LEAVE AND RETIREMENT

General Procedures:

5.1 **Applications.** Applications for disability leave shall be submitted on forms provided by the Board together with all supporting information required on that form as required by Part 5 of these rules.

5.2 **Statements required.** All applications for disability retirement shall be submitted on forms provided by the Board, together with statements from two (2) doctors and the City's statement and report on the application for disability retirement, and:

A. If the disability claimed is the result of an accident, a detailed statement, including date, time and place, shall be submitted with the application;

B. If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating this claim, per WAC 415-105-040(1): "The applicant must prove the existence of (a) a disabling condition, and (b) whether or not the condition was incurred in line of duty."

5.3 **Application for disability retirement.** Each application for disability retirement shall be deemed to be an application for disability leave not to exceed six months and disability retirement benefits, unless otherwise provided.

5.4 **Six month examination.** When the Board receives an application for a disability retirement, arrangements shall be made to have the applicant examined before the sixth month of leave by a physician designated by the Board. The report of the designated physician, as well as all information submitted by the applicant, shall then be reviewed by the Board's consulting physician and the Board's physician shall submit an analysis, either orally or in writing, of the applicant's condition to the Board.

5.5 **Waiver of six month examination.** Applicants for disability retirement will be reexamined by a physician during the fifth or the sixth month of disability leave in order to determine their eligibility for disability retirement, except in conditions where:

A. The Board physician assures the Board that the applicant's condition is continuous and unrecoverable, such that it has not and will not be corrected before the end of the sixth month, whereby, Rule 5.4 will not necessarily apply, or

B. If the applicant establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and voluntarily waives all or any portion of disability leave.

No applicant will be granted a disability retirement without an examination during the fifth or sixth month unless these conditions are met.

5.6 Requests for additional information. The Board may, in its discretion, postpone any decision and request additional information or a hearing under Board Rule 3.5.

5.7 Decision and order. If the evidence shows to the satisfaction of the Board that the member is disabled and that the disability will be continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision and order which shall contain the following presented in clear and concise terms:

A. Findings of fact supported by substantial evidence in the record that support the grant of a disability retirement allowance. Findings of fact shall also include:
   1. Whether the disability was incurred in other employment, if applicable;
   2. Dates encompassing disability leave and/or dates relating to approved conditional return to duty;
   3. Whether applicant waived disability leave under Board Rule 5.8.

B. Conclusions of law on the basis of the facts in the case.

C. A finding of whether or not the disability was incurred in the line of duty.

D. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review.

5.8 Member may waive disability leave period. If a member establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and longer, the member may voluntarily sign a written waiver of his rights to all or part of the six month disability leave in order to have his disability retirement application acted on at an earlier date than would otherwise be permitted.

5.9 Examination when waiver received. When the Board receives an application for a disability retirement where the applicant voluntarily waives his/her right to disability leave, arrangements shall be made to have the applicant examined as soon as practicable by a physician designated by the Board.

5.10 Denial of disability retirement. If an application for disability retirement is denied, the Board shall enter a written decision and order which shall contain findings of fact and conclusions of law. The applicant and the City will be promptly notified of the decision and of the applicant's rights to request for reconsideration to the Board under Rule 4.2, if applicable, or to appeal to the State Retirement Board.

PART 6. OBLIGATIONS OF MEMBERS WHILE ON LEAVE

6.1 Authorization to return to active service from disability.

A. It shall be incumbent upon all members granted disability leave to seek authorization from their physician and the City to return to active service at the earliest possible time.

B. In the event the medical and other relevant evidence is inconclusive, the Board may specify, in a written order, a reasonable period for a trial return to service to determine the member's fitness for active duty. The reasonable length of such a trial period shall be supported by medical evidence. A trial return to service does not entitle a member to a second six-month period of disability leave for the same disability if, based upon this period of service, he/she is then found to be still disabled.

6.2 Member cooperation in Board evaluation. While on disability leave, the member shall be obligated to comply with the directives of the Board. Such directives may include, but are not limited to, requests for medical or psychological evaluation or testing; requests for submittal of other relevant reports; and orders to appear before the Board. If the Board finds compliance with such a request was within the control of the member and he failed to comply, it will presume compliance with the request would have shown the member to have recovered. This presumption can be overcome by competent medical evidence provided by the member to the Board. Each member shall, as a condition precedent to returning to active service or being placed on disability retirement, sign a sworn statement that all information provided to the Board is truthful. Any person knowingly making a false statement to the Board shall be guilty of a felony, pursuant to RCW 41.26.062.

6.3 Missed IME's. A member who is unable to attend an Independent Medical Examination (IME) must contact the Board Secretary prior to 48 hours before the scheduled appointment to cancel and/or reschedule the examination. A member who fails to provide 48 hours notice that they cannot attend a scheduled IME appointment will be responsible for rescheduling the appointment with the specified physician and paying the charge for the previously missed appointment. Members must resolve missed appointment charges prior to disability benefits being awarded. Award of disability benefits may also be held in abeyance until the missed charge is resolved with the physician and the make-up appointment is completed.

6.4 Member's address. If a member in receipt of disability leave allowance moves to a location more than one hundred (100) miles from the location of the Board, any travel expenses incurred to appear before the Board or its designated physician shall be borne by the member. A member shall keep the Board advised of his or her current address.

6.5 Determination of fitness. Any medical standards designed to set minimum health qualifications before a firefighter or law enforcement officer is hired, issued by the State Department of Retirement Systems or used by an employer, are not the applicable standards for determining eligibility for disability leave or retirement benefits.

6.6 Treatments. During the period of leave, the Board shall have the authority to inquire of any examining physician as to what physical, medical or therapeutic treatments might be employed to rehabilitate the applicant and, based upon such evaluation, to direct the applicant to participate in rehabilitation. If the applicant fails or refuses to submit to such treatments, the Board may terminate the applicant's disability benefits.

6.7 Member to seek authorization to return to duty. It shall be the responsibility of each member granted disability leave pursuant to RCW 41.26, to seek authorization from his/her physician and the City to return to active service at the earliest possible time the member believes he/she is fit for duty. In the event the Board finds that a member has not actively sought authorization from his/her physician and the City to return to active service immediately upon cessation of disability, the Board shall require the member to report to a Board-approved physician to determine the member's ability to return to duty. Thereafter, the Board shall determine whether or not the member's disability leave allowance shall be continued.

6.8 Return to duty. The original claim form signed by a member will serve as his agreement that, if the member returns to duty for a trial period, any further leave due to the same disability is to be counted as a continuation of the prior leave claim and does not begin a new six-month leave period.

6.9 Trial return to duty. If, at the end of the trial return period, the employee is performing his duties with average efficiency, the trial return period will cease. The member or the City will contact the Board at the end of the trial return period. If the member has not been able to perform his duties with average efficiency during the trial return period, the member or the City will notify the Board. The Board will then make its decision on the member's retirement, pursuant to Section 5.

PART 7. MEMBERS ON DISABILITY RETIREMENT LEAVE

7.1 Re-entry from retirement. In the event a member is placed on retirement, in addition to the findings described in Board Rule 5.7, the Board may determine that the member's disability is continuous and unrecoverable, such that no possibility exists for return to duty or there is no possibility rehabilitation could restore the member to fitness for duty. In the event the Board finds that periodic examination is needed, it shall be incumbent upon the Board to order such reexamination. In the event the retired member is residing at a location more than 100 miles from his former place of employment, the member may be authorized to be examined by a physician in his immediate area. Such physician shall first be approved by the Board and prior to such evaluation the examining physician shall be apprised by the Board of the basis upon which the examination is to be conducted and the issues to be addressed within his evaluation report. The retirement allowance of any member who fails to submit to medical examination as provided above shall be discontinued or suspended until the required medical information to justify continuation of a retirement allowance is provided by the member. In the event such refusal continues for one (1) year, his retirement allowance shall be canceled. Failure of the member to affirmatively respond to the request for reexamination shall be deemed a continuing refusal.

7.2 Periodic re-examination of retiree. Each member placed on disability retirement who is under 49.5 years of age is subject to periodic review, to include a medical examination and completion of the Board's re-evaluation questionnaire, approximately every six months, to determine whether disability retirement should be continued.

7.3 Discontinuation of a retirement allowance – notice. Where a periodic reexamination determines that retired member may no longer be disabled or the member requests to return to duty, the member shall be notified of the Board's action to discontinue or cancel his retirement allowance by mail. The notification shall contain notice of the time, place, and nature of a hearing to be held under Board rules Part 3. The purpose of the hearing will be to determine whether the member continues to be disabled.

7.4 Decision, findings and conclusion. Every decision and order revoking a disability retirement shall be in writing or stated in the record and shall be accompanied by findings of fact and conclusions of law. The appellant shall be notified of the decision and order by first class and/or certified mail. When practicable, the appellant shall also be notified either in person or by telephone.

PART 8. MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS

General: All claims for medical expense reimbursement must comply with Parts 3, 8 and 9 of these rules.

8.1 Medical services - definition. Medical services for LEOFF I members hired after March 1, 1970, are defined in RCW 41.26.030(19) to be the minimum services legally required to be furnished or authorized by the Board. Medical services not listed in that section may, in the discretion of the Board, be considered for authorization on a case-to-case basis. Medical services for pre-LEOFF 1 members vested under the provisions of chapters 41.16, 41.18, or 41.20 RCW shall be considered for authorization on a case-by-case basis under the statutes applicable to the particular plan. The minimum services legally required to be furnished or authorized for LEOFF 1 members who are also vested under a prior plan shall be the services under the plan which provides the greater benefit to the member.

8.2 Submission of medical expense claims. All medical expenses incurred and claimed for reimbursement by the member will be submitted through the member's health insurance provider before the claim is sent to the Board for approval. The medical expenses claim submitted for reimbursement is to be that portion not covered by the existing health insurance provider.

8.3 Inquiry prior to incurring treatment services. Some medical procedures require Board approval prior to incurring medical treatment. It is the member's responsibility to submit all pre-approval documents and/or treatment plans to the Board. In addition, members are advised to consult first with their health insurance providers or the City's Human Resources Department to learn what is or is not covered in existing health insurance BEFORE incurring treatment services. Elective medical procedures, surgery and/or appliances/supplies may not be covered by the health insurance provided by the City or authorized by the Board.

8.4 Board authorization of reimbursement for medical expenses. The Board considers only the medical necessity of the treatment/service/equipment prescribed and the reasonableness of the charges. After the Board reviews and authorizes reimbursement of a medical expense, payment of the claim is to be made by the City. The City will arrange payment to the provider or reimbursement to the member if proof of payment by the member is provided with the claim.

a) These rules authorize the Board Secretary to process and pay the following routine claims upon receipt that are in compliance with these rules. Examples of such claims are:
   i.) prescription co-pay amounts,
   ii.) dental exams in compliance with Rule 9.9,
   iii.) routine vision expenses in compliance with Rule 9.7,

iv.) Once initially approved by the Board and in compliance with 9.10 for periodic updating, if requested, costs related to home health care, hospice care, and long-term care,

v.) Expenses related to sexual dysfunction and infertility in compliance with 9.10 (I)(1), and

vi.) Medicare Part B premiums in compliance with Rule 8.8(B).

b) All claims will be shared with the Board at the next regular or special meeting for review and inspection.

c) The Board may, at its discretion, direct the Board Secretary to cease immediate claim processing and payment for a particular type of claim (i.e. dental claims) or for a particular member, pending additional research or investigation into board policy limits or authorization, member eligibility, or any other reasonable question(s) surrounding the Board's authority and responsibility to authorize such payment.

8.5 Member's responsibility to prepare claims. Each member is responsible for maintaining contact with the City's Human Resources Department about the medical/health insurance coverage provided by the City. Members must support claims for reimbursement for medical/diagnostic services with information from the health care provider. The following documents are examples of documentation which support the request for reimbursement and should be provided with the request for reimbursement:

a) A prescription for the medical service or supply item from the member's physician or other provider, including a written explanation describing how and why this particular medical service or supply treats the medical condition of the member, and

b) An Explanation of Benefits from the insurance plan(s) describing why the service or supply item was denied even after documentation was submitted by the member's physician or other provider, and

c) A written explanation from the member's physician or other provider describing why no other insurance covered medical service or supply item would meet the medical necessity for the member.

8.6 Forms required. Claims for payment of medical services shall be submitted on forms provided by the Board together with any supporting information. These forms, along with instructions for making claims for medical expense reimbursement, are provided to the City by the Board and are available to the member from the City's Human Resources Department.

8.7 Time for filing. All claims except those under 8.8(B) must be submitted to the City within six (6) months of the member's receipt of the original billing. Claims submitted after this time will only be approved by the Board if it is submitted late due to circumstances not within the control of the member. No claim will be allowed before the expenses are actually incurred, except as specifically authorized in these rules.

8.8 Medicare benefits.

A. It is the member's responsibility to contact the Social Security Administration regarding eligibility for Medicare health insurance coverage Parts A and B. If eligible for Medicare coverage, each member is required to obtain this insurance for medical expenses. Claims will first be reduced by any portion eligible to be covered by Medicare or other health insurance available to members. (See Rule 8.9.) Neither the City nor the Board is obligated to authorize payment for medical expenses which would otherwise have been covered under Medicare [See RCW 41.26.150(2)].

B. The Board will authorize the City to reimburse the member for Medicare Part B premiums, as well as premiums for medical insurance that supplements Medicare, if required by the Board or City, when the member submits proof of a paid premium. (See rules 8.4, 8.5, 8.6, and 8.7; RCW 41.18.060 and 41.20.120). The following documents will be accepted as proof of a paid Medicare Part B premium: [1] Notice of Medical Insurance Enrollment and Premium Deductions; or [2] any form from the Social Security Administration reflecting the effective date of the deduction and the amount deducted. The Board, or the City, will not be responsible for any penalties imposed by the Social Security Administration for late enrollment by a member who is eligible for Medicare.

C. Claims submitted under 8.8(B) must be submitted within 36 months of the expense being incurred.

8.9 Offset for third party payments and subrogation.

A. Payment of claims shall be reduced by any amount received or eligible to be received under Worker's Compensation, Social Security, Medicare, insurance provided by another employer or spouse's employer, pension plan, or other similar source in accordance with RCW 41.26.150(2).

Members possessing insurance benefits covering the expenses of necessary medical services, which would otherwise be the obligation of the City, shall first present the claim to the appropriate insurance carrier and, only thereafter, make claim to the Board for those costs which are not paid by the insurer.

B. The City shall have the subrogation rights described in RCW 41.26.150(3). The City may provide for the payment of approved medical claims by insurance, self-funded medical benefit plan, enrollment of the member in an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization), or any other method offered by the City.

8.10 Criteria for authorizing reimbursement. For each claim, the Board shall determine if the criteria listed in Rule 8.11, and in any applicable provision of these rules, are met. If there is a doubt as to the reasonableness of a medical service charge, the burden is on the claimant to establish reasonableness.

8.11 General provisions. The following rules apply to all claims for medical services and supplies as defined in RCW 41.26.030(19) for LEOFF 1 members and as authorized under these rules.

A. The Board will allow claims under the conditions set forth in RCW 41.26.030(19) and RCW 41.26.150. Thus, claims for medical services and supplies will be approved only if they meet the following conditions:

1. The sickness or disability for which services are rendered was not brought on by dissipation or abuse.
2. The services and/or supplies are medically necessary. Services are medically necessary if the services are:
    a. Essential to, consistent with, and provided for by the diagnosis or the direct care and treatment of an illness, accidental injury or condition harmful to or threatening the member's life or health;
    b. Consistent with standards of good medical practice within the organized medical community;
    c. Offered in the most appropriate setting, supply or service which can be safely provided;
    d. Not primarily for the convenience of the member, his/her physician, or other provider.
3. The charges are reasonable and considered to be usual and customary unless a provision in these rules provides for reimbursement of a lesser amount.
4. If the member belongs to a pre-paid health plan, he/she could not have obtained reasonably equivalent services or supplies at no additional charge through such plan. The Board will decide which services are reasonably equivalent.
5. If the member is being treated by more than one physician or specialist, the member must advise the Board of the primary physician/specialist and such collateral/supplemental treatment must be described in the treatment plan.

B. The fact that the medical service or supplies were furnished, prescribed or approved by the member's physician or other provider does not, in itself, assure that the Board will determine such services are medically necessary.

C. The City shall provide the Board any supporting information to assist the Board in determining whether the criteria set forth in these rules are met. Such information may include reasons why the claim should be denied or limitations of a member's coverage by a third party payer.

D. The Board will not approve claims for interest on delinquent accounts or charges for missed appointments.

E. Reimbursement of costs of reports furnished to the Board. The Board will receive and review for approval members' claims for costs of furnishing reports to the Board under the following conditions:

1. Progress reports. As part of Board-approved payment for medical services, the Board requires a treatment plan and at least one (1) progress report from the service provider if treatment is continuous for six (6) months or more. The Board will not approve payment of separate charges for these reports as they are considered to be part of the approved treatment plan and are to be included in charges for individual treatment appointments or office visits.
2. Evaluations and treatment plans. Reports to the Board which provide information needed to consider continuation of member's disability retirement leave or to approve plan for treatment of member's claimed disability/illness while on disability leave, should not be billed as a separate charge. The Board considers these reports to be the responsibility of the member as part of the evidence submitted to the Board in support of the member's disability retirement leave application (See Rule 6.2). Further, the Board requires a treatment plan to be prepared and submitted for prior approval if the treatment is continuous for six (6) months or more (See Rule 9.3).
3. Reports of examinations by Board-designated physicians. The report of an independent evaluation by a Board-designated physician who examines the member to establish medical grounds for disability retirement eligibility during the fifth or sixth month of disability leave shall be paid by the Board (See Rule 5.4).
4. Fees charged for medical evaluation report letters for required periodic medical examination reviews for disability retirees under age 49½. The Board will consider authorizing payment for fees charged for medical reports toward fulfillment of the periodic medical examination review which have been shown to have first been submitted to the member's health insurance provider. The Board will cover the amount of the billing not reimbursed by or rejected by the health insurance provider.

8.12 Additional medical services for LEOFF 1 members. Pursuant to the authority granted to the Board under RCW 41.18.060 and 41.20.120, and the authority under RCW 41.26.150(1) to designate medical services payable by the City in addition to those listed in RCW 41.26.030(19), the Board designates Part 9 herein to be additional medical services for which members may submit claims, subject to the conditions and limitations set forth in these rules and given statutes.

8.13 Quorum of the Board. A quorum of the Board may approve payment of members' claims at other than regular Board meetings. [Refer to Part 2, Rule 2.2 (C)]

PART 9. REIMBURSEMENT OF CLAIMS FOR MEDICAL SERVICES

9.1 General rule. The Board will approve payment of claims for all medical services defined in RCW 41.26.030(19) under the conditions set forth in RCW 41.26.150 and Part 8 of these rules. The limitations and conditions for reimbursement of claims for medical treatment/procedures in Parts 3, 8 and 9 of these rules shall also apply to claims submitted under RCW 41.18.060 and 41.20.120.

9.2 Emergency treatment. Charges for emergency services and treatment not covered by the member's insurance provider will be approved in cases of sudden, acute medical emergencies or accidental injuries, provided claims are processed as required in Part 8 of these rules.

9.3 Continuous treatment or services. Treatment or services requiring continuous, consecutive and frequent treatment for mental health/psychological counseling, substance abuse treatment, chiropractic treatment, acupuncture, acupressure, and massage therapy are subject to provisions set forth herein. Evaluations and treatment plans, including estimate of duration and frequency of treatment, must be submitted for review and prior approval by the Board before the member undertakes treatment. Claims for reimbursement of the cost of continuous treatment undertaken at member's own volition without prior Board approval will be considered at the Board's discretion and may not be approved.

A. Members covered by health insurance. When the member is covered by a health insurance provider, the member is required to submit claims to their health insurance provider for payment. Certain health insurance providers, such as Regence, Blue Shield or Blue Cross, pay for medical services up to a specified amount, subject to the contract entitlement. Once medical service costs exceed the member's contract year entitlement, the portion of the claim not covered or rejected by health insurance shall be submitted to the Board [See Rule 9.3 (C)].

B. When the member is covered by a comprehensive insurance provider, the member is required to first seek medical services from those health insurance providers since they are known to have medical staff/specialists available.
   1. If the group plan health insurance provider's physicians certify that specific medical services are unable to be provided through their facilities, the member should seek a referral through the health insurance provider's physician to a physician/specialist outside of that group plan health facility.
   2. When there is a referral, such group plan health insurance provider is required to pay up to an aggregate maximum dollar amount per contract year for specific services.

3. If a physician of a group plan health insurance provider refuses to make such a referral, the reasons for the refusal should be reported in writing to the Board by the member or the physician since the reasons could bear upon the issue of the medical necessity of such services.
4. If such a referral is not provided with the claim, the Board will consider such services provided outside the member's group plan health facility as elective on the part of the member and may deny such claim.

C. Medical expenses exceeding entitlement of a given health insurance plan. In the event the cost of specific medical services will exceed the aggregate contract year entitlement provided by a health insurance provider, the member may be asked to submit a treatment plan for the Board's review prior to approval of payment for services over and above the designated contract maximum.

D. Medical treatment or services found unreasonable. If continuous treatment or charges thereof are found to be unreasonable or excessive, the Board may require the member to undergo specific medical examination and provide a medical evaluation from a physician or specialist. If a member fails to undergo such an examination, the Board will construe such services as elective on the part of the member and will deny such claim.

E. More than one physician for same condition. If the member is being treated simultaneously for the same injury, illness, or condition by a physician or specialist in addition to his primary care physician, the member must advise the Board of his/her primary physician/specialist and provide the Board with the treatment plan which describes the supplemental and/or additional medical service. In addition, the Board may require a statement from the primary physician describing reasons for referral to other physicians/specialists.

9.4 Chiropractic services. Claims for chiropractic services are subject to the provisions set forth in Rule 9.3 and the following conditions:

A. Treatment plan required for continuous treatment. The Board requires an evaluation and treatment plan for chiropractic services which exceed insurance coverage.

B. Submission of treatment plan. The service provider is required to submit an initial individualized treatment plan which was prepared within one (1) month of commencement of treatment for which reimbursement will be requested or upon request of the Board. Reports of the progress of the member in the treatment program are to be submitted by the therapist at least once every six (6) months if treatment continues for six (6) months or more. If the member will be in treatment for more than six (6) months, a new (second) treatment plan must be submitted within seven (7) months of the initial commencement of treatment. The Board will review the progress reports and treatment plans

to determine whether charges for such treatment should continue to be approved for payment.

C. Components of the treatment plan. A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to, the following:
1. Current medical diagnosis;
2. Significant history;
3. Description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment);
4. Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job and/or tasks of daily living with average or better efficiency.

9.5 Mental health services. Claims for mental health service, including psychological counseling services, are subject to provisions set forth in Rule 9.3, and the following conditions:

A. Treatment plan required for continuous treatment. The Board requires an evaluation and treatment plan for more mental health visits not covered by insurance.

B. Conditions for approval of mental health service. Payments for mental health services provided to a member during a continuous 12-month period which exceed or are not covered by insurance will be approved only under the following conditions:
1. The mental health services are provided by a psychiatrist, a licensed psychologist, a Master's level clinical social worker who is certified by the National Registry of Health Care Providers in Clinical Social Work or the N.A.S.W. (National Association of Social Workers), or a licensed mental health counselor who is licensed by the Department of Health in the State of Washington, or by any other state whose certification requirements are, at a minimum, equivalent to the certification requirements set forth by Washington State. It shall be the sole responsibility of the member seeking treatment to provide the necessary documentation to the Board establishing the treating provider’s licensing and/or certification credentials. The Board may choose to make an exception to any of the qualification provisions in this paragraph in the case of a mental health provider who is able to provide evidence of education, credentials and work experience satisfying the spirit of this paragraph.
2. The member's physician or department administrative officer has recommended such services. (Exception: The member may seek consultation with a mental health specialist, as defined in item (1) above, without administrative recommendation or a physician's referral for two

(2) sessions. If treatment is to be continuous, submission of a treatment plan, prepared by the service provider, is required within the first month of treatment. See rules 9.2 and 9.3.)

3. The service provider submits an initial individualized treatment plan which was prepared within one (1) month of commencement of treatment or upon request of the Board. Updated treatment plans are to be submitted by the person providing treatment once every six (6) to ten (10) sessions in order for the Board to determine whether charges for such treatment should continue to be approved for payment.
4. The maximum amount allowed for reimbursement will be set by the Board on a case by case basis for services provided by psychiatrists, psychologists, clinical social workers, certified mental health counselors, and advanced registered nurse practitioners and will represent an average charge considered usual and customary.

C. Components of the treatment plan. A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to, the following:

1. Current medical diagnosis (DSM-IV 5-digit diagnostic code plus other axes involved and any relationship to the condition);
2. Significant history;
3. Prescribed medication (dosage, frequency, side effects, estimated length of treatment);
4. Description of treatment or therapy (treatment modality, frequency, length of treatment sessions, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professionals who participate in the treatment);
5. Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job or tasks of daily living with average or better efficiency.

D. Member compliance to submit claims. Nothing in this rule relieves the member from complying with the requirements of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider and of Rule 9.3.

9.6 Substance abuse services. Claims for outpatient or inpatient treatment for substance abuse are subject to the provisions set forth in Rule 9.3. The Board will consider reimbursement requests for treatment (alcohol or drug abuse) which exceeds insurance coverage on a case by case basis. For members applying for payment for repeated treatment which exceeds insurance coverage, a full written case review by a Board-selected specialist or a certified alcohol/substance abuse evaluation service, will be obtained and reviewed by the Board before approving additional treatment or payment of member's claim. Repeat patients are expected to pay for the new treatment and evaluation themselves unless the City or insurance provides payment for additional substance abuse treatment programs. After a period of one (1) year

following completion of repeated treatment, the Board may approve reimbursement if the member provides the Board with satisfactory evidence that he/she has continued his/her recovery process

9.7 Vision benefits. Payments for eyeglasses and contact lenses, plus the reasonable costs of necessary eye examination services of a licensed ophthalmologist or optometrist, will be approved pursuant to the authority granted to the Board under RCW 41.26.150, if eyeglasses are prescribed by an ophthalmologist or optometrist.

The Board will approve payment for one pair of eyeglasses or contact lenses, at the member's option or as prescribed, to correct vision when required for a new prescription in accordance with the following schedule:

A. Eyeglass lenses and frames. $325.00 (less any amount paid for by insurance pursuant to 9.7 (E) below) maximum per single set of frames and pair of lenses not more than once every twenty four (24) consecutive months. Lenses covered include single vision, bifocal, or trifocal lenses. Frames must be of average quality and serviceability unless other frames are prescribed. The Board may waive the 24 month period for lenses only on a case by case basis where unusual circumstances arise causing a change in vision recognized by a licensed ophthalmologist or optometrist.

B. Contact lenses. $100.00/per eye not to exceed $200 maximum during any 24-month period including disposable contact lenses.

C. Members may receive reimbursement for either contact lenses or eye glasses within a 24 month period.

D. Replacement. Claims for a replacement pair of eyeglass frames and/or lenses or contacts will be allowed if proof of accidental damage is provided.

E. Maximum allowable amount. The maximum amount allowed for reimbursement by the Board will represent an average charge for vision services considered usual and customary within the applicable geographical area. Refer to Rule 8.11(A)(3).

F. Applied offset. Any payment by the City will be limited to the net balance after any insurance reimbursement or other settlement is deducted (See Rule 8.9).

9.8 Medical equipment and supplies. In addition to the rental of durable equipment provided for in RCW 41.26.030(19)(b)(iii)(E), the Board will consider for approval claims for purchase of durable medical equipment and supplies under the following conditions:

A. **Hearing aids** – For first time users, prior approval must be obtained from the Board before the member purchases a hearing aid device. Included with the request for the initial hearing aid must be 3 cost estimates for the device. All requests will be considered on an individual basis.

1. Conditions for pre-approval of hearing aid purchase. Applications for pre-approval for purchase of hearing aid(s) must meet all of the following conditions and include all documentation required herein:
   a. Medical evaluation by an otolaryngologist to rule out any treatable ear conditions;
   b. Hearing evaluation by a state-certified audiologist to include an audiogram and recommendations regarding the type of hearing aid(s) that will perform the necessary medical function and, in the case of an active member, the hearing aids necessary to perform the duties of the assigned position;
   c. A statement by the evaluating audiologist, as well as a copy of the audiological evaluation (e.g., audiogram), must be included in the application as proof the member's hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g., medication, surgery, etc.);
   d. Verification from the State Department of Labor and Industries that the hearing loss is not the financial responsibility of any other past or current employer of the member under Worker's Compensation;
   e. The hearing aid requested shall be of average quality and serviceability;
   f. The Board may ask for additional medical information to determine medical necessity of equipment charges which exceed amounts that the Board determines to be reasonable and customary. Also, the Board may request the member obtain additional cost estimates of equipment charges that the Board determines to be unusual or excessive;
   g. The fitting of hearing aid(s) shall be done only by a state-certified audiologist. Once the member is satisfied with the hearing aids, (most providers have a 30-day or more trial period), it is the member's responsibility to complete a Claim Form and attach the invoice from the provider for submission to the Board;
   h. The Board will not pay for batteries, maintenance or damage to the hearing aids unless the device was damaged while the officer was on duty or the hearing aid was initially issued for a hearing-related duty disability.
2. **Replacement of hearing aids.** The Board will consider approval of payment of member's replacement hearing aid expenses not more frequently than **once every five years** upon submitting a minimum of one cost estimate of a hearing aid device and audiologist report. However, replacement of hearing aid(s) will be approved on a case-by-case basis if the need for replacement is duty-related and the member provides the Board with documentation of the medical necessity for replacement.

3. Repair of Hearing Aids. Members requesting payment for repair of hearing aid(s) must document why the devices are no longer serviceable.
4. Schedule of Limits of Approval of Payment.
    a. Reasonable charges/fees for services of a licensed otolaryngologist or state-certified audiologist for examination will be allowed.
    b. Invoices or billing for payment for hearing aid(s) must first be submitted to any third party or health insurance which might provide coverage for the member. The Board will then consider approval of the balance not covered by insurance or third party payer.
    c. Any payment by the City will be limited to the net balance after any insurance reimbursement, third party payer or other settlement is deducted.
    d. The maximum amounts allowable will be the cost of a hearing aid of average quality and serviceability. Any difference between the amount allowed by the Board and the cost of the hearing aid purchased by the member shall be the responsibility of the member.
5. Member compliance to submit claims. Nothing in this rule relieves the member from complying with the requirement of Rule 8.7 that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider and of Rule 8.9(A).

B. Purchase of Durable Medical Equipment and Supplies. The Board must receive and review a request for pre-approval to purchase durable medical equipment and/or supplies. This will include purchase of wheelchairs, special equipment, medical or surgical equipment, orthotics, etc., which are prescribed by a physician as medically necessary for treatment of member's illness or disability. These items are in addition to those considered necessary medical services and supplies under RCW 41.26.030(19) (iii). Members and the City are advised that fees and charges for purchase/rental of such durable medical equipment and supplies (or percentage thereof) may be covered by health insurance providers. Therefore, members must first submit claims for payment to health insurance before sending them to the Board.

C. Other. The Board will not approve any claims for equipment or supplies which have a non-medical use or function.

9.9 Dental benefits.

A. Dental charges incurred by a member who sustains an accidental injury to his or her teeth and who commences treatment by a legally licensed dentist within ninety (90) days after the accident, will be paid by the Board.

B. The reasonable expense of a semi-annual general check-up including cleaning and annual x-rays, not covered by insurance, will be covered for each member.

C. Reimbursement for dental or orthodontic procedures that are determined to be medically necessary by a dentist, orthodontist, or oral surgeon will be decided on a case-by-case basis by the Board. The determination of medical necessity shall be made by the Board, in its sole discretion, under all the facts and circumstances of a given case, including the member's history of regular check-ups.

D. All claims for dental services, except for (B), must be approved in advance by the Board.

E. Nothing in this rule relieves the member from complying with the requirement of Rule 8.7 in that claims must be submitted within six (6) months of the member's receipt of the original billing from the provider, and of Rule 8.9(A) (claims must be submitted to insurance carrier).

9.10 Additional medical services and supplies. The following services may be considered by the Board as additional medical services and approved for payment subject to the requirements set forth in Part 8 of these rules and the following listed conditions. Claims will be considered on an individual basis.

A. **Acupuncture, acupressure, and massage therapy**. Claims for acupuncture or acupressure services and/or massage therapy are subject to the provisions set forth in Rule 9.3. Payments for acupuncture/acupressure and/or massage therapy provided to a member by an acupuncturist and/or massage therapist during a continuous six (6) month period will be approved under the following conditions:

1. Services have been prescribed by a licensed physician;
2. Services are provided by a certified acupuncturist (C.A.), including an M.D. or a D.O., as well as other providers awarded a diploma of acupuncture by the National Commission for the Certification of Acupuncturists (N.C.C.A.), or a licensed massage therapist.
3. Member/provider first submits a claim for payment to the member's insurer or third party payer, as directed in member's health insurance contract;
4. If treatment will exceed insurance coverage an evaluation and proposed treatment plan must be submitted by the prescribing physician to the Board for pre-approval as required by Rule 9.3;
5. Claims for acupuncture/acupressure and/or massage therapy expenses must be filed with the Board within six (6) months of the member's receipt of the original billing as required by Rule 8.7.

B. **Birth control procedures, devices and supplies.**

1. Vasectomies, tubal ligations, and other surgical procedures for purposes of birth control are not considered medically necessary.
2. If procedure is medically necessary for the health of the member, application for pre-approval must be submitted to the Board, along with

the physician's statement attesting to the medical necessity. The Board will consider such applications on a case-by-case basis.

a. The member or the member's provider must first submit a claim for payment of such medically necessary, pre-approved procedures to member's insurer or third party payer, as directed in member's health insurance contract;
b. Claims for payment of the difference between the cost of pre-approved services and the amount covered by insurance must be filed with the Board within six (6) months of the member's receipt of the original billing as required by Rule 8.7.

3. Claims for payment of devices and/or supplies used for birth control are not considered to be necessary medical expenses and will not be approved by the Board.

C. **Cosmetic and reconstructive surgery.**

1. Cosmetic surgery. Surgery to improve appearance or to correct physical defects, such as a pre-existing or congenital condition, is defined as "cosmetic surgery". Applications for cosmetic surgery will not be approved. Claims for reimbursement or payment of claims for cosmetic surgery will not be approved.
2. Reconstructive surgery. Surgery required as the result of accidental injury or incidental to/following disease of an involved body part and which is necessary to improve or correct the function of the involved body part, will be considered on a case-by-case basis.

D. **Exercise and physical fitness programs**. The Board, and the City, encourages and supports physical fitness for members and is aware of its importance in prevention of injuries and disease; however, physical fitness is considered the responsibility of the individual member. Members enrolled on the Regence MedAdvantage PPO plan may participate in the Healthways SilverSneakers Fitness Program which is covered by the medical plan. Members should refer to the program booklet for participating fitness memberships. Members not enrolled on the Regence MedAdvantage PPO plan may enroll in exercise programs, physical fitness clubs and/or health spas on their own, at their own expense which is not eligible for reimbursement by the Board.

E. **Home health care services**. If confined to his/her home following an accident or illness, a member is eligible for home health visits for intermittent skilled nursing care under the following conditions:

1. Services are prescribed by a physician;
2. Services are part of a written treatment plan prepared by the physician and periodically reviewed by a physician;
3. If care exceeds six months, the Board may require submission of a new treatment plan, or may require member to be examined by a Board-appointed physician;

4. Services are provided by a professional or paraprofessional licensed and/or certified by the state or professional credentialing agency, or services of a Medicare-participating home health agency.
5. Services of an informal caregiver, who ordinarily resides in the member's home or is a member of the family of either the member or the member's spouse, and who provides unpaid assistance to a spouse, relative or other claimant, are not eligible for approval of reimbursement;
6. If eligible for Medicare, member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid for by the City or the member.
7. The maximum cost allowed shall not exceed the average daily cost of nursing home care as set by the Board.
8. Request for reimbursement shall be made by completion of all forms required for consideration of a medical claim and includes the City of Aberdeen's Assessment of Need for Nursing Home, Assisted Living, or Home Health Care Services form. All medical documentation required from the prescribing physician and the home health care provider or providing agency, necessary to support the claim, must be attached.

F. **Hospice care**. Benefits will be provided for hospice care for a terminally ill member under the following conditions:
1. Member is admitted to a DSHS-certified or Medicare-approved program;
2. Care provided is part of a written plan of continuous care, prescribed and periodically reviewed by a physician;
3. If eligible for Medicare, member has applied for or is receiving both Part A and Part B of Medicare coverage, whether paid for by the City or the member.

G. **Long-term care facilities**. Confinement in an adult family home, assisted living facility, boarding home, or nursing home is to be provided as a minimum required service. The Board will review and consider for approval of placement and payment of charges for care in any of these facilities under the following conditions:
1. Placement is prescribed by a physician or advanced registered nurse practitioner.
2. The facility must be licensed by the State of Washington.
3. If the facility is located outside the State of Washington, it shall be the responsibility of the member to provide documentary evidence that the facility is licensed in the state or country where the facility is located and that the licensing requirements are similar, equal to, or greater than those required by the State of Washington.
4. If placement exceeds six (6) months, the Board may require submission of an updated progress report or a new treatment plan, or may require member to be examined by a Board-appointed physician.

5. If eligible for Medicare, member has applied for, or is receiving, both Part A and Part B of Medicare coverage, whether paid for by the City or member.
6. The provider's/member's claims for payment will be submitted directly to member's insurance/third party payer or the Board. The member must exhaust all available long-term care benefits under his insurance plan(s) if requested by the Board.
7. Application for prior approval of long-term care services/placement will be considered on a case-by-case basis.
8. The maximum daily reimbursement allowance in this section will be based on the most recent Genworth Cost of Care Survey. The survey provides median costs by geographic region. For services listed in the survey, the Board will reimburse up to the median cost for Washington state. (Contact the City's Human Resources Department for the current approved rates.). Additional costs for room upgrades are the member's responsibility. Medically necessary level of care costs of Alzheimer fees above the average rate will be reviewed on a case-by-case basis, but total reimbursement may not exceed the amount allowed for skilled nursing facility care. Any amount over the current amount allowed by the Board will be the responsibility of the member. Charges will be prorated when the member is in a hospital, skilled nursing, or upon the death of the member.
9. The Board will consider reimbursing above the established maximum where the member can show that he or she cannot obtain the necessary medical service at the established maximum rate.
10. Payment or reimbursement of charges for long-term care facilities do not include expenses not related to medical care if billed separately. Such expenses would include toiletries, laundry, parking, or food. When billed as part of the costs of placement in the facility and not identified separately on the billing statement, then the total cost of placement will be considered up to the policy limits.

H. **Organ transplants**. The Board will not accept requests for pre-approval of organ transplantation surgery. Members are advised to process all such applications through their physicians to their health insurance providers and Medicare-certified transplant centers. If organ transplantation surgery is performed on patient demand, and/or outside the member's medical/hospital coverage or Medicare-certified transplantation center, the Board will not accept or consider for approval any claim for reimbursement or payment (See Rule 8.3).

I. **Sexual dysfunction and infertility**. Some services and prescriptions for sexual dysfunction are determined to be reimbursable. However, the Board reserves the right to judge each case on its own merits, considering medical necessity. The Board will provide coverage for a maximum 4 doses per

month. Anything over that amount will be considered by the Board on a case by case basis.

J. **Smoking cessation**. The services of an approved physician, approved psychologist or approved smoking cessation provider will be provided for a smoking cessation program as provided by the Regence Blue Shield plan. No benefits for smoking cessation will be provided other than those covered by the Regence Blue Shield plan.

PART 10. REVIEW OF BOARD RULES: AMENDMENTS, REVISIONS PER STATE RETIREMENT SYSTEMS.

10.1 Periodic review. These local Board rules and regulations may be reviewed annually, or as often as necessary, and revised to assure that:

A. Provisions herein remain in conformance with state law and regulations;

B. Dollar amounts specified in schedule of benefits reflect current and reasonable average charges in the local area;

C. Provisions herein reflect current philosophy and intent of the Boards.

Member claims are subject to the last revised rulings adopted and exceptions will not be made. Any newly revised rulings and statutes supersedes previous policies and makes obsolete any prior existing rule or statute, therefore, claims may not be made to apply to obsolete policies.

10.2 Chronology of Amendments/Revisions of Board rules.

Adopted/Effective Date	Policy Revisions/Amendments
March 13, 2006	**September 9, 2013** **March 10, 2014** **December 8, 2014**