Summary of benefits provided by the City of Aberdeen Fire and Police Pension Boards.

This document is only a summary and is not a guarantee of coverage or reimbursement.

Covered Item	Detail	Board Policy
Acupressure	*See Acupuncture, acupressure and massage therapy.*	
Acupuncture, acupressure, and massage therapy. (See also Continuous treatment or services)	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	9.10(A)
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.	9.10(B)

Covered Item	Detail	Board Policy
Chiropractic services. (See also Continuous treatment or services)	The Board requires an evaluation and treatment plan for chiropractic services which exceed insurance coverage. * 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. * 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.	9.4
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: 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.	9.3
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.	9.10(C)

Covered Item	Detail	Board Policy
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.	9.9
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. The Board will not approve any claims for equipment or supplies which have a non-medical use or function.	9.8
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.	9.2
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.	9.10(D)

Covered Item	Detail	Board Policy
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.	**9.8**

Covered Item	Detail	Board Policy
Hearing Aids (continued)	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).	

Covered Item	Detail	Board Policy
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.	9.10(E)
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.	9.10(F)
Interest charges	The Board will not approve claims for interest on delinquent accounts.	8.11(D)

Covered Item	Detail	Board Policy
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. 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.	9.10(G)

Covered Item	Detail	Board Policy
Long-term care facilities (continued)	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.	
Massage Therapy	*See Acupuncture, acupressure and massage therapy.*	
Mental health services (See also Continuous treatment or services)	Treatment plan required for continuous treatment. The Board requires an evaluation and treatment plan for more mental health visits not covered by insurance. 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.	9.5

Covered Item	Detail	Board Policy
Mental health services (continued) (See also Continuous treatment or services)	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. 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.	9.10(H)
Missed appointment charges	The Board will not approve claims for charges for missed appointments.	8.11(D)
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.	
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.	9.10(C)

Covered Item	Detail	Board Policy
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 such factors as 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.	9.10(I)
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.	9.10(J)
Substance abuse services. (See also Continuous treatment or 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	9.6

Covered Item	Detail	Board Policy
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. E. Applied offset. Any payment by the City will be limited to the net balance after any insurance reimbursement or other settlement is deducted.	9.7

The following pages provide additional information on the benefits provided by the City of Aberdeen's Pension Board Policies. Please note these benefits are subject to change. Questions should be directed to the City of Aberdeen's Human Resources Department at 360-537-3212.

When to Bill Your Insurance

All claims must first be submitted to your insurance provider(s) prior to submission to the Board. (Board Policy 8.9(A)). 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.
(Board Policy 8.2, 9.3(A) and (C))

Time for Filing

All claims (except Medicare Part B premiums) 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. *(Board Policy 8.7)*

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.

(Board Policy 8.5)

How to File Claims

The appropriate Board approved form must be used. All applications or claims must be complete, legible, and submitted to the City's Human Resources Department 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.
(Board Policy 4.1)

General provisions.

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.

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.
(Board Policy 8.11)

What doctors/service providers can I see?

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.

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.
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.

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.

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.
(Board Policy 9.3(B))

Medicare benefits.

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. Neither the City nor the Board is obligated to authorize payment for medical expenses which would otherwise have been covered under Medicare.

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. 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.

Requests for reimbursement of Medicare Part B premiums must be made within 36 months of the expense.
(Board Policy 8.8)

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.
(Board Policy 9.3(D)

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.
(Board Policy 9.3(E))

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.
(Board Policy 10.1)

Offset for third party payments.

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.
(Board Policy 8.9)

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 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.

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.
(Board Policy 4.2)

Appeal procedure

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.

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.

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
(Board Policy 4.3)