SEATTLE FIREFIGHTERS

PENSION BOARD

2015

Policy and Procedures

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Introduction

LEOFF 1 FIREFIGHTERS

DATE: March 30, 2015

TO: Seattle Fire Fighters

FROM: Seattle Fire Fighters Pension Board

Policies and Procedures

Seattle Firefighters Pension Board

The primary purpose of adopting the attached Policies and Procedures is to provide updated, clear, written rules by which Seattle Fire Fighters can obtain the disability benefits and necessary medical services they are entitled to receive under Washington State Pension Laws.

If you have any comments or questions about the enclosed Policies and Procedures, please do not hesitate to contact the Secretary of the Board at (206) 625-4355 or 1-800-993-3473.

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Section One - Benefits

See "Section Two – Procedures" for instructions for reimbursement and pre-authorization

Acupuncture

- Acupuncturist must have a valid State License.
- Treatment requires a referral from member's primary care physician.
- Coverage is limited to one treatment per day, maximum of $135 per day.
- Limited to actual acupuncture treatment, does not cover additional procedures without prior Board approval.

Appliances and non-Durable Medical Goods, Prescription

- Wheelchairs, hospital beds and other devices may be covered by Medicare, check with provider to determine if the item is covered, Pension Fund will reimburse for portion not covered by Medicare.
- Devices must be approved by the Pension Office prior to purchase, even when prescribed by a physician.
- The Pension Office has an authorized medical equipment vendor that should be used for the purchase of medical appliances.
- The authorized vendor will be used for out-of-area needs as well.
- For all appliances or non-durable medical goods costing less than $250.00, present the authorized prescription to the authorized vendor for billing to Blue Cross.
- For all items purchased, submit the itemized receipt for the item and the authorized prescription to the Pension Office for reimbursement.
- Pre-Authorization from the Pension Office and a Claim Form is required for appliances and non-durable goods which exceed $250.00.
- Pension Office may authorize appliances up to $2500.00. A letter from the prescribing Physician stating the medical necessity must accompany the request for approval.
- Some items such as wheelchairs and hospital beds may be available through the Pension Office directly, contact the office for further information.
- Allowable limits with prior approval apply for the following items:

- A. Lift chairs $800.00
- B. Mobility scooters $1200.00
- C. Lifts/ramps for scooters or wheelchairs $2000.00

Chiropractic Treatment

- Provider must be a licensed Chiropractor.
- Coverage limited to fee schedule adopted by the Board (current $75.00 per adjustment)
- Maximum of 26 treatments per calendar year, one treatment per day (may be altered per Pension Board Review.)
- X-rays are a covered expense to a maximum of two sets of x-rays per year.
- Plan will reimburse for adjustments only, additional chiropractic costs are not reimbursable.
- A Claim Form is required.

Cosmetic Surgery

- Reconstructive surgery required to correct a disfiguring condition as a result of accidental injury or illness is covered.
- Any condition not covered by the above description requires prior approval by Board.
- A letter from the member's primary care physician explaining the medical necessity of the procedure must be submitted to the Pension Board.

Counseling

- Counseling is covered under the direction of a state-licensed psychologist, psychiatrist, or counselor upon referral by a primary care physician.
- A diagnosis and prognosis report must be submitted to the Pension Office after the original examination.
- The specialist will submit a monthly progress report to the Pension Office.
- Outpatient treatment for counseling will be subject to a maximum calendar year limit of 26 visits.
    - After 26 visits the member's progress will be reviewed by a primary care physician to determine if continuing care is warranted.
- Inpatient treatment in a state-licensed facility is a covered benefit.

- Marriage counseling is not considered a necessary medical expense and is not reimbursable.
- If disability leave is incurred, it will be considered non-duty until medical and/or other relevant evidence substantiates a duty-caused disability.

Dental

- Dental coverage is limited to $2500.00 per year. To determine amount of remaining annual coverage, contact Blue Cross using the number on the back of the Blue Cross card.
- For standard dental services, use the Blue Cross card, no other paperwork is required.
- If the dentist is a Blue Cross provider, the dentist will bill Blue Cross directly and no paperwork or payment would be required of member.
- If the dentist is not a Blue Cross provider, member or dentist will submit the invoice directly to Blue Cross, and Blue Cross will pay the dentist directly.
- If dentist requires upfront payment for services, member will submit bill to Blue Cross with a note stating the bill has been paid, and reimbursement will be paid directly to member.
- Treatment for accidental injury to teeth must commence within 90 days of the injury and must be administered by a licensed dentist. Contact Pension Office to ensure coverage.
- For an injury, the dentist must provide a letter to the Pension Office detailing services provided and stating services were the result of an injury.
- Treatment for an injury to teeth incurred in the line of duty, to include bridgework, is covered and not subject to the $2500.00 annual limit.
- Oral surgery, including implants, may be covered if determined to be medically necessary by a licensed physician.
    - Physician must provide letter detailing the medical necessity for the procedure.
    - Prior approval by the Pension Office is required.
    - Implant limit is $2000.00 per tooth.
- Premiums for other dental insurance coverage are not reimbursable.
- For dental work performed outside the country, contact the Pension Office prior to having the work done for information on the proper procedures to ensure reimbursement.

Eyeglasses and Eye Care

- Provided when medically necessary.
- A referral from member's primary care physician is required.
- Examinations and Treatment must be provided by a state-licensed physician and/or optometrist.
- Prescribed eyeglasses may be obtained from any source of the member's choice.
- Eyeglass lenses, frames and/or prescription sunglasses are covered every 24 consecutive months provided the total cost falls within the limits shown below.
- Additional enhancements (scratch-resistant coating, tinted lenses, sunglasses, additional pairs, etc.) are allowed provided the total cost is within the limits shown below.
- Amounts shown apply to a single order – member may not divide the amount between multiple orders.
- Amounts listed below are the maximum reimbursable amounts regardless of any added enhancements:
    - Single Vision $455.00
    - Bifocals $480.00
    - Trifocals $540.00
- If there is a change in the prescription, eyeglass lenses may be covered every 12 months in the following maximum amounts:
    - Single Vision $260.00
    - Bifocals $290.00
    - Trifocals $360.00
- Contact lenses are covered up to $225.00 annually
- Replacement of lost frames or lenses outside of listed time frames is only reimbursable if the loss occurs as a result of performance of duty.
- Corrective eye surgery – Lasik / Ocular implants.
    - Procedure must be performed by a licensed physician (Ophthalmologist).
    - Appliances and equipment must be FDA approved.
    - Procedure must be performed in the United States.
    - Corrective surgery is a one-time benefit.
    - Reimbursement is limited to $1400.00 per eye.

Hearing Aids

- Upon referral by a primary care physician, an audiology test must be conducted.
- If audiology test determines hearing aids are medically necessary, hearing aids are covered at $3800.00 per ear once every 36 months.
- Cost must include insurance covering repairs and batteries for three years from date of purchase.

Immunizations

- Immunizations for out-of-country travel are not reimbursable.
- Immunizations are covered at your primary care physician's office.
- Immunizations given outside of a medical clinic (i.e.; a pharmacy) may be covered using the Blue Cross card.
- If not covered directly, submit an itemized receipt to Blue Cross for reimbursement.

Laboratory Services

- Laboratory Service providers must meet the following requirements to be eligible for reimbursement:
    - Have a state business license
    - Be licensed by the Department of Health
    - Have an assigned Medicare number
- Laboratory services must be ordered by a treating physician.

Long-Term Medical Care

- Nursing/Adult Family Home/ In-Home/Hospice (generically referred to herein as Long-Term Care) is covered if deemed medically necessary by a primary care physician.
- A state-required assessment of the member must be performed by an independent agency or the attending physician. It cannot be performed by the Long-Term Care facility.
- The assessment requires prior approval from the Pension Office.
- The intent is to provide care for members when they are unable to care for themselves in an independent living situation and their only other option would be a Skilled Nursing facility.
- Facilities must provide medical care twenty-four hours a day, seven days a week (24/7).

- The published daily costs for the facility are intended to include most medical items the member may need and should be provided by the facility.
    - Lifts
    - Special commodes
    - Hospital beds
    - Other standard items
- Items covered in addition to the daily facility amounts include items such as;
    - Adult diapers
    - Specialized wheelchairs
    - Special items deemed necessary
- Assisted Living Facilities
    - Coverage is limited to medical menu items and does not include the basic room and board costs.
    - The medical menu items are limited to a maximum coverage of $150.00 per day, and require a letter from member's primary care physician specifying which items are medically necessary.
- Transportation for non-emergency events for members confined to a long-term care environment are reimbursable as follows:
    - Three, round-trip transports per month at a maximum cost of $175.00 per transport.
    - Coverage is for doctor's appointments, transportation to hospitals for tests, and other situations deemed medically necessary.
    - Prior approval must be obtained from the Pension Office.
- Payment is authorized to Long-Term Care Facilities to hold a bed for a member who has been temporarily transferred to another facility for a period of not more than 30 days.
- Special Procedures
    - The member or their legal representative must first obtain a letter from the member's primary care physician stating the need for long-term care.
    - The member or their legal representative must obtain a "REQUEST for COVERAGE" questionnaire from the Pension Office. This will provide guidance and request information from the physician and the prospective care providers.

  - The completed Request form must be submitted with required documentation to the Pension Office for review.
  - The Pension Office will review the request with the member or their representative to assist them with any questions they may have.
  - The goal of the Board is to help the member through the process during this difficult time.
  - The pension staff will review the request and under guidelines set forth by the Board, will notify the member or their legal representative of what coverage will be provided.
  - Care must be provided only by state-licensed providers under applicable state guidelines approved by the Board.
- Long-term medical care by family members
  - Services or supplies furnished to member by a provider who is an immediate relative are not reimbursable.
  - "Immediate relative" is defined as a spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent, or spouse of grandchild.

Massage Therapy

- Therapist must be state licensed.
- Member must be referred by a primary care physician.
- Massage Therapy is provided when a letter from a primary care physician is received by the Pension Office stating massage therapy is medically necessary for treatment of a specific injury.
- The maximum number of massage therapy treatments allowed per year is twenty-six (26).
- The maximum dollar amount is $60.00 per treatment.
- Coverage is limited to one (1) treatment per day.
- Five (5) treatments are allowed when prescribed by the member's primary care physician as part of an overall treatment plan.
- After the initial five treatments, the member must be examined by their primary care physician who shall determine if the treatments are beneficial. If the physician so determines, he/she may prescribe an additional five treatments between examinations.

- The second series of treatments also requires a letter from member's primary care physician.

Medications (Prescription and Over-the-Counter)

- PRESCRIPTION MEDICATIONS:
    - Blue Cross provides prescription medications through participating pharmacies or by mail order. Present authorized prescription and Blue Cross card to participating pharmacy or utilize the mail order program.
    - Mail Order forms are available through the Pension Office.
    - Prescriptions purchased under emergency conditions are reimbursable. Submit the prescription and itemized receipt for purchase to the Pension Office for reimbursement.
    - Reimbursement for prescription copays requires only the receipt from the pharmacist, provided it shows the physician's name and the item prescribed.
- PRESCRIBED OVER-THE-COUNTER MEDICATIONS:
    - Over-the-counter drugs, when prescribed prior to purchase and deemed medically necessary, are reimbursable.
    - The only reimbursable over-the-counter drugs are those prescribed for treatment of specific medical conditions; pain medication, acid reflux medication, etc.
    - General supplements are not covered unless identified by the member's primary care physician for a specific medical condition.
    - Submit the prescription and the itemized receipt to the Pension Office for reimbursement

Naturopathic Medicine

- Provider must be state licensed.
- Naturopathic Physician care is provided when a referral letter from a primary care physician is received by the Pension Office stating that medical care from a Naturopathic Physician is part of an overall medically-necessary treatment plan for a specific illness.
- The primary care physician will re-evaluate the progress of the patient to determine the effectiveness of the treatment.
- Medically-necessary lab work requested by the Naturopath will be reimbursed only if performed at labs meeting the following requirements;
    - Have a state business license

    - Are licensed by the Department of Health
    - Have been assigned a Medicare number
- The maximum allowable payment for a visit to a Naturopath is $150.00.
- Coverage is limited to one visit per day.

Organ Transplants

- A referral is required.
- Payment is provided for reasonable medical expenses associated with organ/tissue transplants.
- Transplant must be deemed medically necessary by a Pension Board Physician and approved by the Board.
- Reasonable donor medical expenses as a result of the procedure are considered necessary medical expenses for the procedure and are reimbursable.
- Procedures are limited to federally-licensed facilities.

Orthotics

- A $450.00 maximum reimbursable amount per year regardless of the number of pairs received.

Physical Examinations (Annual)

- Annual physical examinations are reimbursable and encouraged for all members.
- The purpose of these examinations is to detect latent medical problems before they become serious and treatment more difficult.
- Members will schedule physical examinations with their primary care physician.
- Recommended annual protocols:
    - Medical History and exam
    - Complete blood count
    - Urinalysis
    - Chemistry profile
    - PSA (males)
    - Hem occult
    - Complete cholesterol profile
    - Chest X-ray
- Recommended every five (5) years

    - Colonoscopy
    - Spirometry
    - Audiogram
- Recommended annually for female firefighters
    - Pap Smear
    - Mammography

Physical Fitness

- The Board encourages and supports physical fitness for Fire Fighters and is aware of its importance in the prevention of injuries and disease.
- Physical fitness is the individual member's responsibility.
- Reimbursement is not provided for weight reduction or fitness programs as a necessary medical expense. This includes, but is not limited to, club memberships, fitness equipment, home spas, and dietary aids.

Physical Therapy/Rehabilitation

- Physical therapy and rehabilitation following illness, injury, and/or surgery are approved medical treatments, including approved orthopedic appliances.
- Medically-necessary rehabilitative surgeries that are covered by Medicare will be considered for reimbursement on a case-by-case basis.

Referrals

- Visits to specialists and many of the listed benefits require a referral from the member's primary care physician.
- A Referral Form must be submitted by the member to the Pension Office.
- Incomplete forms may delay processing of the request.

Smoking Cessation

- Treatment is covered for smoking cessation through a structured, medically-supervised program.
- Reimbursement is subject to a $350.00 annual limit (12 months).
- A Referral must be obtained from a primary care physician prior to treatment and submitted for reimbursement.

Sterilization and Sexual Dysfunction

- Sterilization (which is not the result of injury or organic disorder) is not considered a necessary medical expense and is not reimbursable.
- Treatment for sexual dysfunction is covered when considered medically necessary by the member's primary care physician.

Substance Abuse

- Treatment for substance abuse must be provided by a state-licensed facility.
- The primary care physician will determine the suitability of the treatment program.
- Treatment may consist of inpatient or outpatient treatment with the approval of primary care physician.
- Reimbursement for substance abuse treatment is subject to a maximum lifetime limit of $18,000.00.
- Member's primary care physician must provide a referral letter identifying the selected facility or organization and stating the need for the prescribed treatment.

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Section Two – Procedures

Blue Cross

- When contacting the Blue Cross office, use the Pension Office address as your home address. This ensures all paperwork is received by the Pension Office.
    - 2200 6th Ave, Suite 820, Seattle, WA 98121
- If member maintains other insurance coverage, they must ensure all service providers are aware that their other insurance should be billed as primary and Blue Cross is billed as secondary coverage.

Procedures

- Always present Blue Cross ID card for all medical services, dental services, and prescriptions.
- Claim forms must be submitted by the member to the Pension Office for each separate service provided.
- Referral Forms *(see Page 26)* must be submitted by the member to the Pension Office when:
    - Seeking treatment from a specialist or caregiver different than the member's primary care physician
    - Requesting purchase of medical appliances or devices
    - Requesting long-term care arrangements
- When seeing a provider, submit a Claim or Referral form to the Pension Office providing the date of service, the provider's name, and the reason for the visit.
    - If this is a repeat visit, check the line on the Claim form that says, "Referral on File."
    - If the visit is part of treatment for an ongoing condition, send a Claim form at least once per year explaining the ongoing situation.
    - When in doubt, send a Claim form to the Pension Office.
- Members with other insurance must first submit all bills to the other insurance for payment. *See details in Other Insurance below*
- If bills are received at the member's home, contact the provider and ensure provider is using the correct Blue Cross ID number.
    - Members should NOT use their Social Security Number.
- Contact Blue Cross directly to inquire about the status of a bill (1-800-722-1471).

- If Blue Cross does not have a record of the bill, mail a copy to the Blue Cross office.
    - Premera Blue Cross, P.O. Box 91059, Seattle, WA 98111-9159
- Pending Claims – contact the Blue Cross office to determine claim status.
- Possible reasons for pending claim
    - A referral form was not received by the Pension Office
    - A claim form was not received by the Pension Office
- If a bill is received from Polyclinic, forward them to the Pension Office as soon as possible, marked “Attention: Sue”

Reimbursement

- Reimbursement for medical services, dental services, prescriptions, or premiums will require the following items being submitted with the receipt of payment for service(s):
    - An itemized bill for service(s).
    - An Explanation of Benefits (EOB), if the member has other coverage.
    - Prior approval from the Pension Office with a letter from the primary care or attending physician authorizing service.
- Reimbursement for prescriptions requires two items being submitted together:
    - An itemized receipt for the prescribed item
    - The prescription from the physician
- Reimbursement for co-payments or any other electronically prescribed prescriptions requires the receipt from the pharmacist showing the physician’s name and the item prescribed.
- Reimbursement for medical insurance premiums;
    - Medicare Part B – Obtain the Medicare Part B Refund form from the Pension Office.
        - If member is receiving Social Security payments, they will receive a copy of the SSA-1099 form showing the cost of the Plan’s premium, enclose that document with the Medicare Part B Refund form and send to Pension Office.
        - If member is not receiving Social Security payments, request a copy of form SSA-2458 from the Social Security office. Send that document with a Medical Part B Refund form to the Pension Office.
    - Other insurance premiums:

  - When a member is eligible for Medicare, the pension office will no longer reimburse for other medical coverage. Member may continue to carry other coverage but will not be reimbursed for the premiums.
  - If you have special circumstances contact the Pension Office.
  - For members under 65 years of age, reimbursement is limited to member's portion of the premium only (does not include family members' portion.)
  - Obtain a letter from the "other insurance" company stating the amount of the premiums for the previous year's coverage. It must state that it was for member's medical coverage only and not for any other family members. This is information is normally provided by the Human Resource department. Check stubs for payments do not provide sufficient information for auditing purposes.
  - There is no reimbursement for dental coverage.
- Reimbursements for medical expenses received by the Pension Office in excess of one year from the date of service may be denied.
- Elective medical treatments performed outside the United States are not reimbursable.
- Emergency medical treatment performed outside the United States will be reviewed by the Board on a case by case basis.

Other Insurance Procedures

- Prior to age 65, when other insurance is available (coverage from spouse or other employment) the member is required to sign up for that coverage and will be reimbursed by the Pension Fund.
- Please contact the Pension Office prior to signing up for other insurance.
- Members must submit a statement of other insurance premiums for the previous year to the Pension Office for reimbursement.

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Section Three – Policy

Reference

The following documents provide guidance to the Seattle Fire Fighters Pension Board for the management of the Seattle Fire Fighters Pension Fund.

- Washington Law Enforcement Officers' and Fire Fighters' Retirement System Act, Chapter 41.26, Revised Code of Washington (RCW), as amended hereinafter as the "LEOFF ACT."
- RCW 41.16, Fire Fighter's Pension Law of 1947, as amended, cited herein as the "1947 Act."
- RCW 41.18, Fire Fighter's Pension Law of 1955, as amended, cited herein as the "1955 Act."
- WAC Chapter 415-105 "Local Disability Board Procedures."
- S.S.B. 6212 Retired members under the Board's jurisdiction can elect Board members.
- RCW 41.26.150 provides payment for medical services not payable from other sources.
- RCW 41.26.159(2) provides that amounts payable will be reduced by any amount received or eligible to be received from other sources such as Medicare or coverage provided by another employer or spouse's employer. The Board will only pay the amount over and above what the member is eligible to receive from other sources.
- By-laws of the Seattle Fire Fighters Pension Board.
- Policies, Procedures and Operating Instructions issued by the Seattle Fire Department.

Board Authority/Responsibility

- The granting of disability leave, retirement and other benefits; and the cancellation of disability leave/retirement and subsequent return of members to duty, is the statutory duty of the Board.
- All actions by Pension Board Physicians are subject to review and approval of the Board.
- Previously granted disability benefits may be denied by the Board, with just cause, by a motion to rescind.
- *Disability is covered extensively in Appendix A – Active Fire Firefighters*

Policy

All members shall be subject to all by-laws, policies and procedures of the Board, as well as the provisions of the Pension Laws. The Board shall be responsible for the administration and enforcement of these Policies and Procedures.

- In case of illness or injury of a member, all payments for disability benefits (salaries) and necessary medical services shall be made in accordance with the provisions of the Pension Laws and the by-laws, policies, and procedures of the Board.
- To receive disability benefits and/or necessary medical services paid for from the Fund, all members shall follow the procedures set forth in these Policies and Procedures. A member's failure to follow these procedures, may subject the member to the loss of payment for benefits and/or services otherwise due under the Pension Laws.
- Illegal acts, directly attributable to the member, resulting in court ordered treatment as part of a sentence may subject the member to the loss of payment for benefits and/or services otherwise due under the Pension Laws.
- Members must provide all information related to the member's illness or injury required by a Pension Board Physician, the Board, and/or the Secretary. Members are not required to give confidential information about their illness or injury to parties other than the Board, Staff and Pension Board Physicians.
- A Pension Board Physician shall communicate confidential information about a member's illness or injury only to the Board and/or Secretary.
    - Confidential information may be released to other parties only with the member's written permission.
- Medical Evaluation – It shall be incumbent upon each member obtaining a medical evaluation at the Board's direction, to advise each and every examining physician that:
    - Such evaluation is being conducted at the direction of the Board
    - Any reports relating thereto are for the benefit of the Board
    - Doctor-patient privilege may not be invoked with respect thereto
    - The physician may be called upon by the Board to testify as to his findings [WAC 415-105-040 (6)]
- Hearing – In sections where the Board has determined statutes do not permit payment, the member has the right to request a Board hearing should they believe circumstances warrant individual consideration. In such cases, the burden of proof lies with the member. The Board will make a final decision based on relevant evidence submitted by the member.

- This policy excludes payment for medical treatment performed outside the United States. Emergency medical treatment performed outside the United States will be reviewed by the Board on a case by case basis.

Forms

The required forms listed below must include all information requested by the form. All required forms shall be submitted to the Pension Office as soon as practicable for claim payment.

- CLAIM FORM – Submittal of the Claim Form is the member's responsibility and shall be completed for each incidence of injury or illness. The form must be filled out before a member can be paid for disability time loss and/or any medical services or expenses paid. Depending on the circumstances, statements for medical expenses that are over a year old might not be paid. Claim forms do not require a physician's signature.
- REFERRAL FORM – There are separate referral forms for Active members and Retired members. Submittal of the Referral Form is the member's responsibility and shall be completed for each referral to a specialist or to a primary care physician other than the Pension Board Physicians. The form must be filled out before a member can be paid for disability time loss and/or any medical services or expenses paid.
    - Depending on the situation, the pension staff may authorize the use of a Claim Form in lieu of a Referral Form.
    - If a referral to a specialist is already on file at the Pension Office, a Claim Form is all that is needed for subsequent visits. Please state on the Claim Form that a Referral is on file. Contact the Pension Office if you have any questions.
- The Referral Form shall be completed by the member and signed by the member's primary care physician prior to submitting to the Pension Office:
    - For the member's initial visit for any illness or injury
    - When referred to a specialist
- OTHER HEALTH/BENEFITS FORM – Annually, members are required to submit an Other Health Benefits Form to the Pension Office. The Pension Office will mail the form to members.

Medicare

- At age 65, members are required to sign up for Medicare Part A and Part B. Members should begin the process several months prior to their birthdate to ensure proper coverage.

- Members with insufficient quarters of work credit to qualify for Social Security or Medicare are still required to sign up for Medicare Part A & B.
- If member does not qualify for Medicare at age 65, but member's spouse is at least 62 years old and has 40 quarters of work credit, the member must sign up for Medicare using the spouse's work credits.
- Failure to sign up for Medicare Part A & B at age 65 will result in member being responsible for any coverage that Medicare would have paid.
    - Medicare generally covers 80% of medical cost and Blue Cross covers the other 20%.
    - Failure to sign up for Medicare means member is responsible for the 80% that Medicare would have paid.
- Do not sign up for the Medicare Part D drug program or any drug coverage program. Members are already covered for prescription drugs.
- Current prescription drug coverage is considered "Credible Coverage".
    - Having Credible Coverage means your plan meets or exceeds a standard level of coverage as set by Medicare.
    - When filling prescriptions, continue to utilize your Blue Cross card.
- Members will be reimbursed for premium payments made to Medicare for member only – does not cover premiums for spouse or other family members.
- Members covered by Medicare are not required to maintain any other coverage.
- Members age 65 and older will only be reimbursed for Medicare Part A and B insurance premiums. Member may continue to carry other coverage, but will not be reimbursed. If you have an unusual circumstance please contact the Pension Office a few months prior to turning 65.
- If you are employed after turning 65 and your employer offers medical coverage, contact the Pension Office.
- Call the Pension Office with any questions.

Medical Coverage from Pension Fund

- FIRE FIGHTERS UNDER LEOFF ACT – PLAN I – RCW 41.26, AS AMENDED
    - Are covered for all "necessary medical expenses" (as determined by a licensed physician or surgeon) and approved by the Board.
    - Must use the designated medical services or referral system.
- FIRE FIGHTERS UNDER PRIOR ACT, RCW 41.18, AS AMENDED.

  - Members are covered for medical expenses attributable to service connected medical conditions, or service connected medical conditions that surface after retirement. The proof of service connection needs to be conclusive and requires the written concurrence of a Pension Board Physician.

- The Board's Policy and Procedures, as well as applicable State laws, must be followed by all fire fighters entitled to medical coverage in order to obtain proper medical treatment and/or payment of medical bills.
- A member entitled to receive pension, disability and/or medical benefits from the fund, must maintain a current address on file in the Seattle Fire Fighter's Pension Office.
- A Firefighter who becomes sick or injured may contact a Pension Board Physician of his choice, during business hours by calling (206) 329-1760 or 1-800-648-8837. It is very important when calling the Polyclinic Centralized Appointment Number to identify yourself as a retired fire fighter.
- The Polyclinic – 904 7th Ave – 8:30 AM to 5:00 PM, Monday thru Friday.
  - Dr. Jeffrey Meehan & Dr. John Stimson are located at 904 7th Ave. Phone # 206-329-1760
  - Dr. Thomas King is located at the Polyclinic at 11011 Meridian Ave. North. Phone # 206-860-2348
- This system is not intended to limit, in any way, telephone access to your physician's nurse. If you want to describe your condition to the nurse to determine whether you should come in or how quickly you should come in, you should do so.
- Specialist
  - For the services of a specialist, the member shall be referred by their primary care physician.
  - Reimbursement for referred services will not be paid until approved by the Board. The necessary medical expenses of a medical specialist will be paid only if a referral is obtained from a Pension Board Physician or authorization is obtained from the Pension Office.
- Primary care physician
  - Retired members may choose a physician of their choice as their primary care physician. The following procedures must be followed in order to obtain proper medical treatment and/or payment of medical bills.
  - Retired members must request a Referral form to be completed by a Pension Board Physician. After the Pension Board Physician completes

their portion of the form, the member must complete the member's portion of the form. Upon completion of the form by the Pension Board Physician and the member, the form shall be sent to the Pension Office for placement in the member's medical file.

- The physician of the retired member's choice becomes the member's primary care physician. This physician now has the authority to refer a member for testing or to see a specialist.

Medical Coverage from Other Source

- State Law RCW 41.26.150 (2) requires members who have other insurance, or are eligible for other insurance through another employer, their spouse or any other source; submit all medical bills to the appropriate insurance as primary. This includes Medicare. Notify the medical provider that Blue Cross should be billed as secondary coverage.

LEOFF – PLAN I

- RCW 41.26.150 provides payment for medical services not payable from some other source.
- RCW 41.26.150(2) provides that amounts payable will be reduced by any amount received or eligible to be received from other sources such as Medicare or coverage provided by another employer. This means the Board will only pay the amount over and above what the member is eligible to receive from these other sources.
- It is the policy of the Board to reimburse (on an annual basis) for Medicare premiums, paid by the member.

PRIOR ACT RETIREES – RCW 41.18

- Medical coverage under the prior act is limited to treatment of service connected disabilities only.

Medical Care from family members, exclusion policy

- Services or supplies that are furnished to member by a provider who is an immediate relative are excluded from coverage.
    - Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.

Transportation

- Transportation from a private residence to a medical facility for non-emergency services is not covered.

- The cost for transportation from a medical facility to a residence is not covered unless determined to be medically necessary.
- *See Long-Term Care in the Policy Section for information on transportation for members in an assisted-living facility*

Retirement for Disability

- Applications for disability retirement are subject to review and approval of the Board as provided by applicable pension laws.

Death of a Retired Fire Fighter, Procedures

- Notify the Pension Office as soon as possible.
- Send a copy of the Death Certificate.
- If married, send a copy of the Marriage Certificate.

Address: 2200 6th Avenue, Suite 820 Seattle, Washington 98121

Phone: (206) 625-4355 or 1-800-993-3473

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Section Four –Abbreviations, Definitions

Abbreviations

EOB	Explanation of Benefits
RCW	Revised Code of Washington
WAC	Washington Administrative Code
LEOFF	Law Enforcement Officers and Fire Fighters

Definitions

Board	The Seattle Fire Fighters Pension Board, was established by the 1947 Act to administer the Seattle Fire Fighter's Pension Fund. The Board consists of the Mayor of Seattle or his designee (who must be an elected City of Seattle official), the Director of Finance, the Chairman of the Seattle City Council's Finance Committee, and two elected Fire Fighters regularly employed by the Seattle Fire Department, or retired members subject to the jurisdiction of the Board. The Mayor or his designee is Chairman of the Board. An alternate Fire Fighter/Retired member is appointed by the two elected Fire Fighters to serve in either's absence. [RCW 41.26.110] [RCW 41.16.020].
Disability	An illness or injury which causes a member to become incapable of performing his/her regularly assigned Seattle Fire Department duties. Whether or not a member is disabled shall be determined by a primary care physician, subject to review and approval by the Board.
Duty Physician	A Pension Board Physician assigned the duty, on a 24-hour basis, to be available to members for consultation and treatment of medical emergencies.
Fund	The Seattle Fire Fighters Pension Fund established by the 1947 Act.
Immediate Relative	Spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent, or spouse of grandchild
Medical Emergency	An illness or injury requiring medical treatment beyond basic first aid and normally requiring the services of the Medic I system.
Member	A retired or active uniformed employee of the Seattle Fire Department.
Medically Necessary	Health-care services and/or supplies that your physician decides are required to diagnose, prevent, or treat an illness, injury, or disease

Pension Fund Office	Office of the Secretary of the Board is located at 2200 6th Avenue, Suite 820, Seattle, Washington 98121-1822, (206) 625-4355 or 1-800-993-3473, FAX (206) 625-4521, Email Address davess@seattle.gov. All forms can be emailed if you choose.
Pension Board Physician	Physician employed by the Board to advise the Board on medical matters and to provide necessary medical services.
Pension Laws	The Washington State laws RCW 41.16, 41.18 & 41.26. WAC 415-105
Primary Care Physician	Member's chosen physician approved by the Board to provide medically necessary services and referrals.
Secretary	The Secretary and/or the Benefits Administrators appointed by the Board to provide staff support to the Board.
Subrogation	Subrogation is the substitution of one person in the place of another with reference to a lawful claim. When the Pension Fund pays medical bills for a member injured by a third-party, the Fund is by statute entitled to recover the amount paid. See Section 3.13.
Third-Party Claims	**A.** When a member is injured by the act of another person who is legally responsible for the damage incurred, the member has a right of action which is usually pursued by the member who retains a private attorney to either negotiate a settlement or litigate a recovery. In either case, to the extent that the Pension Fund pays medical expenses on behalf of its member for such an injury accident, it is the Pension Fund which is entitled to recovery of that amount. **B.** RCW 41.26.150(3) creates the subrogation interest referred to above which is for recovery of the costs for medical services in connection with the member's sickness or disability, to the extent those funds have been paid by the fund. The claim for damage to your person is your responsibility to pursue. The fund will obtain the information from you as a result of your "Claim/Referral" form and will contact your attorney to keep him/her informed of the amount of the lien claimed against your recovery. **C.** To the extent that the member enters into a "contingency" agreement with an attorney, the Fund will honor that agreement and pay a percentage of the subrogated interest recovery (the lien) up to a maximum of 33-1/2%.

Appendix A - Active Firefighter Procedures

Procedures

The following procedures must be followed by all active members to obtain proper medical treatment and to receive payments for disability benefits and/or necessary medical services.

No member shall be laid off from duty due to illness or injury, or returned to duty from layoff for an illness or injury, except when authorized by these Policies and Procedures.

- The primary responsibility of a member on disability leave is to get well for return to duty as soon as possible, pursuant to the instructions of a primary care physician.
- Members shall be returned to duty from disability leave as soon as they are able to perform their regularly assigned Fire Department duties with average efficiency. This determination shall be made by a primary care physician, subject to review and approval by the Board.

Disability at Work

- A member who becomes ill or injured while on shift with the Seattle Fire Department shall immediately notify his/her supervisor of the illness or injury. When the illness or injury is not a medical emergency, but requires the services of a physician, the supervisor or the member (after notifying his/her immediate supervisor), shall contact a primary care physician directly during regular business hours, otherwise through the Dispatcher.

Disability at Work – Medical Emergency

- In the event a member needs medical emergency assistance from the Medic I system, it shall be requested through the Dispatcher. After dispatching a Medic I unit, the Dispatcher will immediately contact a primary care physician.
    - If the illness or injury occurs during regular business hours, the member may request a primary care physician of his/her choice.
    - If the illness or injury occurs after regular business hours, on weekends, or during holidays, the Dispatcher shall notify the Duty Physician immediately).
- The Medic I Unit shall contact the Medic I Physician or the most readily available medical assistance. In treating the member, the normal Medic I guidelines shall be followed. When the member's condition has been stabilized and the member is no longer in immediate danger, the member shall be released by the Medic I

Physician to the primary care physician who will take charge of the member's medical treatment.

- If the primary care physician concludes the member's medical treatment should be handled by the attending physician, the primary care physician may make such arrangements.

Disability Not at Work

- As soon as practicable, a member who becomes ill or injured off shift shall contact a primary care physician directly during regular business hours, otherwise through the Seattle Fire Department Dispatcher at (206) 386-1494.
- In the event a member needs treatment for a life-threatening medical emergency, the Medic I system or the most readily available medical assistance shall be required. As soon as practicable, the member or his/her representative shall contact a primary care physician to be laid off duty.
- When the member's condition has been stabilized and the member is no longer in immediate danger, the member shall be released to the primary care physician who will take charge of the member's medical treatment.
- If the member is being treated outside of the Puget Sound area, or for some other reason the primary care physician concludes the member's medical treatment should be handled by the attending physician, the primary care physician may make such arrangements.

Disability Retirement – Limited Duty

- No member shall be entitled to a disability retirement allowance if the appropriate authority advised that there is an available position for which the member is qualified and to which one of such grade or rank is normally assigned and the Board determines that the member is capable of discharging, with average efficiency, the duties of the position [WAC 415-105-060)].

Emergency Medical Treatment

- Members in need of treatment for a life-threatening medical emergency shall comply with the following procedures:
- If the need for life-threatening emergency medical treatment occurs within the Seattle metropolitan fire response area, as designated by the Fire Chief, the member may utilize Medic I or the most appropriate medical assistance.
- If the need for life-threatening emergency medical treatment occurs outside of the Seattle metropolitan fire response area, as designated by the Fire Chief, members shall utilize the most appropriate medical assistance.

Failure-to-Comply Presumption of Recovery

- A member's failure to comply with Board authorized reporting requirements will constitute a discontinuance of required physician care. The member may have disability leave canceled.

Layoff

- Only primary care physicians and Pension Staff are authorized to layoff members for an illness or injury and only primary care physicians can return members to duty when in the physician's judgment they are mentally and physically fit for duty - by immediately notifying the Dispatcher and the member of the time of such layoff or return to duty.
- The primary care physician shall not layoff a member without personally examining him/her, unless in the physician's judgment, extenuating circumstances exist.
- If a member is laid off without being examined by a primary care physician, the physician must set a definite time to examine the member, as soon as practicable, not to exceed eight (8) business hours from time of layoff.
    - Business hours are defined as: 8:30 AM to 5:00 PM seven (7) days per week, including holidays. Weekend and holiday examinations may be conducted by the on-call Pension Board Physician.
- The member shall comply with all reporting requirements of the Board.
- A primary care physician shall confine a member on disability to a medical facility or to a residence approved by the physician unless, in the physician's judgment, such confinement is not necessary treatment for the member's recovery from his/her illness or injury.
- If a member's recovery will be at a location other than his/her primary residence or an approved medical facility, the member shall inform the primary care physician and the Pension Office of the location and a means to contact the member.
- A member on disability leave shall not engage in any activity, which in the Pension Board Physician's judgment, would hinder and/or delay the member's recovery.
- If a member cannot be contacted at his/her place of recovery, after reasonable attempts by a Pension Board representative, the member may be subject to a personal visit by a representative of the Board.
- If the primary care physician exempts a member from such confinement during his/her period of recovery, he will so inform the member and the Pension Office, as soon as practicable. In turn, the member shall verify such exemption from

confinement, in person or by telephone with the Pension Office, as soon as practicable.

- A member on disability leave must obtain permission from a primary care physician to travel for personal reasons or to engage in any activity which would hinder or delay his/her recovery.
    - Personal travel shall not be permitted during the first two (2) weeks of any disability, to ensure adequate physician monitoring of the members medical condition.
    - As soon as practicable, the primary care physician shall notify the Pension Office of permission to travel for personal reasons (this is after the initial two week restriction) or engage in any permitted activity.
    - Member shall verify such permission, in person or by telephone, with the Pension Office, as soon as practical.
- The member shall verify his/her layoff by the primary care physician with his/her assigned company. When practicable, verification shall be made at least one and one-half (1½) hours prior to the time the member is required to report for duty.

Limited Duty

- A member on disability leave or retirement, who is unable to perform the duties of his/her rank may, at his/her request, be returned to duty in such other like or lesser rank as may become open and available, the duties of which he/she is then able to perform.
- A member of LEOFF I on Disability Leave may be assigned to a Limited Duty position only by mutual agreement of the member, the primary care physician, the Pension Board and the Chief of the Department [RCW 41.26.140(2) SFD I 120].

Physician Consultation

- Members who are not ill or injured, but who want to consult a primary care physician, may contact the physician directly during regular business hours, for an appointment.
- Medical Services outside of regular business hours for active members.
- At least one Pension Board Physician (the Duty Doctor) or the pension staff is available 24 hours a day. The Duty Doctor shall carry a pager or similar alerting device.
- As soon as practicable, a member who becomes ill or injured outside of regular business hours shall contact the Duty Physician through the Seattle Fire Department Dispatcher at (206) 386-1494.

- If the Duty Physician is not the member's regular primary care physician, the member may be transferred to his/her regular physician during regular business hours. It is the responsibility both of the Duty Physician and the member to notify the member's regular physician of the transfer.

Physician Review of Disabilities

- At least once every calendar week, it shall be the responsibility of any member on disability to be examined by the primary care physician who laid off the member, unless the physician has exempted the member from this procedure. The physician shall notify the Pension Office of all such exemptions. In turn, the member shall verify such exemption, in person or by telephone, with the Pension Office, as soon as practicable.
- In the case where a member has been referred to a specialist, it shall be the responsibility of the member on disability to be examined by the specialist at least once every calendar week. Exemption from this procedure shall be authorized only by the primary care physician who laid off the member, after consultation with the specialist. The primary care physician shall notify the Pension Office of any such exemption. In turn, the member shall verify such exemption, in person or by telephone, with the Pension Office, as soon as practicable.
- Any member on disability leave, shall contact the Pension Office in person or by telephone, weekly, to advise the Board of his/her status. Exemption from this procedure shall be authorized only by the primary care physician, the Board, or Pension Office staff.

Return to Duty

- A member laid off by a primary care physician shall normally be returned to duty by the same physician (unless the member is transferred to another primary care physician pursuant to Section 11.10).
    - If the same physician is unavailable, another primary care physician may return the member to duty.
- A member shall verify his/her return to duty by the Pension Board Physician with his/her assigned company as soon as possible and at least one and one-half (1½) hours prior to his/her next scheduled duty shift.
- A member returned to duty that is regularly scheduled to work that day shall immediately verify his/her return to duty and report to his/her assigned company, or to a company designated by the supervising Chief.

Trial Service Period

- A member on disability leave, in the event medical and/or other relevant evidence is inconclusive concerning the members fitness for regularly assigned duty may be returned to regular assigned duty in the same position held at the time of discontinuance of service for a Trial Service Period to determine the members fitness for duty. Such a Trial Service Period does not entitle the member to a second six-month period of disability leave for the same disability if, based on the Trial Service Period, the member is found to be disabled. [WAC 415-105-050 RCW 1.26.150(1)]

Appendix B – Contact Numbers

Pension Website	www.cityofseattle.net/firepension
Pension Office	(206) 625-4355 or 1-800-993-3473
	2200 – 6th Ave., Suite 820, Seattle WA 98121
Pension FAX	(206) 625-4521
Pension e-mail	davess@seattle.gov
Pension Info Line	1-855-558-7565
Blue Cross, Premera	1-800-722-1471
	PO Box 91059, Seattle, WA 98111
B.S.I. Trust	1-800-203-0544
City Credit Union	(206) 398-5500
IAFF Local 27	(206) 285-1271
Medicare	1-800-633-4227
Pension Board Physicians	
Dr. Jeffery Meehan	(206) 329-1760
Dr. John Stimson	(206) 329-1760
Dr. Thomas King	(206) 860-2348
Poison Control	1-800-222-1222
SFD Alarm Center	(206) 386-1494
SFD Business Office	(206) 386-1400
SFD Relief Association	(206) 285-7651
Social Security	1-800-772-1213

Appendix C – Sample Forms

Attached are copies of the Referral Form and the Claim Form.

Member may photocopy these pages for submittal to the Pension Office.

Additional copies of the forms may be obtained by contacting the Pension Office at: (206) 625-4355 or 1-800-993-3473, or online at www.cityofseattle.net/firepension

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