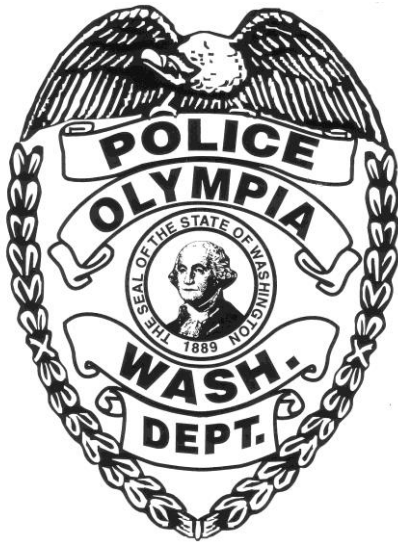


LEOFF 1 DISABILITY BOARD



Policies & Procedures 2018 Revision



LEOFF 1 DISABILITY BOARD POLICIES & PROCEDURES

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LEOFF 1 DISABILITY BOARD

LEOFF 1 Claim Forms & Resources Quick Links

Submit claims (within 1 yr. from date of service)

Fax-360-709-2735

Email-humanresources@ci.olympia.wa.us

Mail-Attn: HR, City Hall, PO Box 1967, Olympia, WA 98507

[Change of address](#)

[Direct Deposit](#)

Hearing Aid Provider List

LEOFF Board Doctor: Dr. William Penn, Yelm Family Medicine, 360.458.7761

[Medicare Enrollment Form](#) (apply 60 days prior to turning age 65)

[Out of country claims](#)

Regence Non-Formulary Process Contact: Phone: 800-750-1467 Fax: 888-437-1510

[Application for Payment of Services](#) (**requiring LEOFF 1 Disability Board approval-e.g. hearing aids, long term care, dental exceeding \$600**)

[Reimbursement Instructions](#) (**NOT requiring LEOFF 1 Disability Board approval-e.g. routine prescriptions, optical, dental under \$600, co-pays after insurance pays their portion**)

- Reimbursement Claim Form ([Fire member](#))
- Reimbursement Claim Form ([Police member](#))

FIRE

Contact Labor First: Toll free 844-818-1088 or Local-360-205-1415 (M-F 8am-7pm EST)

- [Northwest Fire Fighter Trust \(NWFFT\) Medical benefits](#)
- [Davis Vision Plan](#)- Contact: 800-999-5431
- [Epic Hearing Healthcare](#)-866-956-5400

POLICE

[MedAdvantage/Kaiser](#)

- [Vision Services Plan \(VSP\)](#) 800-877-7195
- [VSP FAQ'S](#)
- [Vision Services Plan \(VSP\) Claim Form](#) (submit for \$200 hardware allowance)
- [Medical and Prescription Reimbursement Form](#) (Kaiser/a.k.a. Group Health Members)

LEOFF 1 DISABILITY BOARD (Board)

POLICIES AND PROCEDURES

I. GENERAL

A. Purpose

These policies and procedures are established for the purpose of:

1. Apprising retired employees of the City of Olympia who are members of Law Enforcement Officers and Firefighters 1 (members) of the benefits provided under RCW 41.26 and the means by which such benefits may be obtained.
2. Serving the public interest by regulating the payments of benefits.
3. Informing both members and the general public of the procedures under which the (Board) operates so as to provide consistency and uniformity in dealing with individual member's claims.

B. Scope

These policies and procedures shall be applicable to all ex-employees covered by RCW 41.26, unless otherwise specifically provided herein.

C. Effect of Policies and Procedures

All ex-employees of the City of Olympia covered by LEOFF 1 shall be subject to these policies and procedures to the extent consistent with applicable state law and shall at all times follow the procedures outlined 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 policies and/or procedures. A member's failure to follow these policies and/or procedures may, at the discretion of the Board, subject them to the loss of benefits otherwise due under the RCW 41.26.

D. Promulgation of Policies and Procedures

It is the responsibility of the Board Secretary (or designee) to notify all members about changes to Board Policies and Procedures upon completion of any changes and/or ensuing updates formally adopted by the Board. Upon adoption of new policies and/or procedures by the Board, each member shall be notified that a copy of the updated policies and procedures and privacy manual are available online. It shall be the responsibility of the Board Secretary (or designee) to document each member's receipt of notification confirmation of the updated rules so as to remove any future possibility of a member alleging that they were unfamiliar with the requirements contained herein and lost benefits as a result.

E. Appeal Procedure

Any member feeling aggrieved by an order of the Board, which is within the jurisdiction of the State Retirement Board, shall comply with the provisions of [RCW 41.26.200](#) in filing such an appeal to the State Board.

II. MEETING PROCEDURES

A. Membership - Board

The Board members shall be appointed as specified in [RCW 41.26.110, 1 \(a\)](#), 2, and 3.

B. Regular Meetings

The Board shall hold a regular monthly meeting on the second Monday of each month at 5:30 p.m., in a conference room at City Hall. If the Monday is a City holiday, the meeting shall be held on the third Monday of the month. The Board shall elect one Board member to serve as Chairperson and one Board member to serve as Vice-chairperson at the January Board meeting of each year. The Vice-chairperson shall serve as Chair in the absence of the elected Chairperson. In the absence of the Chairperson and Vice-chairperson, the Board member present who is the most senior in tenure to the Board shall serve as Chair.

The Board Secretary or designee shall keep the official minutes record of the deliberation of the Board meetings, and prepare the minutes for entry or submission (if required) to the State Retirement Board. In the event an interested party requests a stenographer to be present at a meeting to record the proceeding, such request must be made in writing no less than five (5) working days prior to the meeting in question. If a party wants a verbatim transcription of the tape recording made of a previous meeting, they must give similar written notice within ten (10) working days of the desired date for delivery of the transcript. In either case, the requesting party shall pay for all costs associated with the request.

III. PROCEDURES TO RECEIVE BENEFITS

Sections A-I track changes has been removed, because the City no longer has any active LEOFF 1 members

A. Medical Services

Whenever a member requires medical services, such services may be paid for by the City, if approved by the Board. Only those medical services which are deemed reasonable and medically necessary and not payable from some other source [[RCW 41.26.150\(2\)](#)] may be paid for, provided the condition which has caused the need for such medical services was not caused or brought on by dissipation or abuse, and the necessity of such medical services shall be determined by the Board based upon the medical evaluation of the medical provider and other relevant information. [[RCW 41.26.150 \(1\), \(2\)](#)]

All members shall be covered by a City-purchased insurance plan for group hospitalization and medical aid. It is a member's responsibility to choose a City-purchased insurance plan and apply for coverage. The City designates the insurance plan that a member joins to be the designated provider of medical services for that member. In addition, those medical services available under the chosen plan shall be the medical services authorized by the Board. [[RCW 41.26.150\(4\)](#)]

The Board shall be responsible for reasonable and medically necessary co-payments and deductibles under city-purchased insurance plans. [[RCW 41.26.110](#)]

(3)]In the event a member fails to be covered by a City-purchased plan or incurs expenses for medical services not covered by a City-purchased insurance plan, the Board may refuse to pay for those medical services unless the Board has approved payment **in advance** of treatment. [\[RCW 41.26.110 \(3\)\]](#) The Board can make exceptions to this policy in special circumstances if payment for such medical services is medically necessary and approved by the Board in advance of treatment. [\[RCW 41.26.110 \(3\)\]](#) If warranted by the facts, the Board may pay for services that have not come to the Board for prior approval. The Board retains the sole right to determine whether or not to pay for services if the service has not been brought to the Board for prior approval.

Medical services payable as a LEOFF benefit shall be reduced by any amount received or eligible to be received under worker's compensation, social security, including public welfare, insurance or pension plan, or other similar source. In the event any such alternative source of payment is available, it shall be incumbent upon the requesting member to apprise the Board of such source and failure to do so may result in a revocation of medical benefits and be deemed a violation of [RCW 41.26.150](#). It shall be the policy of the Board to pay only the difference in benefits rather than pay the full amount and seek repayment from the other source, unless the affected member shows to the satisfaction of the Board that they have demanded payment of such benefits expeditiously, and that the Board's failure to make such advance repayment would cause unreasonable hardship to the member. [\[RCW 41.26.150 \(2\) and \(3\)\]](#)

When a member becomes eligible for Medicare Part B (at age 65 or earlier due to a disability), the member **is required** to enroll in Medicare Part B under the guidelines established by Medicare (currently within 90 days prior, on , or 90 days after the member becomes 65.) Premiums for Medicare Part B which are paid by the member will be reimbursed by the Board. [\[RCW 41.26.150 \(5\)\]](#)

All requests by members for reimbursement of medical services must be submitted to the City for payment within one year of the date of service. Requests not submitted to the City within the required one-year time period will become the responsibility of the member. The Board may, in its discretion, waive this requirement, if the member can demonstrate a delay in timely submission due to circumstances beyond their control. [\[RCW 41.26.110 \(3\)\]](#)

Requests can be submitted in one of the following manners:

Fax: 360.709-2735

Email: humanresources@ci.olympia.wa.us

Mail: Attn: Human Resources, City Hall, P.O. Box 1967, Olympia, WA 98501

In person: Attn: LEOFF 1 Secretary, City Hall, 601 4th Ave. E., Olympia.

All routine requests for prescriptions, vision, and dental requests (dental equal to or less than \$600) reimbursements must be accompanied by the following documents:

- Police Claims Reimbursement Form or Fire Claims Reimbursement Form
- Explanation of Benefits (EOB)
- Receipt of payment
- Prescriptions (taped to separate paper)

VSP Hardware Reimbursement Form (For Kaiser members)

Claims for ongoing vision care, durable equipment or dental services exceeding \$600/yr. shall require Board approval and must be submitted prior to treatment accompanied by a completed [Application for Payment of Services](#) requiring Board approval with a health care provider's statement of member's current condition. These forms are available on the City's [LEOFF Board website](#) or can be obtained from the Board Secretary or designee. [\[RCW 41.26.110 \(3\)\]](#)

Durable medical equipment (DME) is a covered benefit through insurance. However, the medical necessity criteria does apply. It is **very important** for the member to ask the provider if they are a contracted DME provider prior to purchase.

Blood Glucose Meter and Test Strips: Member should contact insurance company regarding coverage prior to submittal to Board.

Non-covered formulary process: When a prescription written by a provider is not covered by the member's insurance, the member must still submit the request to the insurance company and obtain a denial of benefits. The insurance company will provide documentation of approval or denial. The member must forward the documentation in order for staff to process a reimbursement payment.

A. Counseling Services

Members are authorized to receive counseling services from a State of Washington licensed psychologist, psychiatrist or counselor for up to six visits per year **without** prior board approval.

For continued counseling services, all visits **after** the initial six visits shall be submitted to the Board for consideration **prior** to the 7th (seventh) visit.

B. Chiropractic Services

Chiropractic services, shall be paid for by the City up to a maximum number of 20 visits per calendar year.

If a member needs more than 20 visits in a calendar year, they should submit an [Application for Payment of Services](#) to the Board and allow the Board to take action approving or denying prior to receiving any treatment beyond the 20th treatment. When treatment exceeds 20 visits per year, the Board may require an evaluation of the affected member's chiropractic condition and prognosis, or a plan for continued chiropractic care, or a second chiropractic opinion of continued care by a Board appointed chiropractor, or a combination of any of the above.

C. Vision Care Services

Each member is entitled to the services of a participating physician or a participating optometrist for an examination of the eyes once each calendar year. The member should check with their insurance to determine participating physician or optometrist.

In addition to the services of the participating physician or participating optometrist, members are entitled to a reimbursement toward the cost of necessary lenses and

frames or contact lenses, as shown in the Schedule of Vision Care Benefits below. If the member uses Costco for vision, then the member will be reimbursed up to the allotment in the table below. If the member does not want to use Costco, the member should contact their insurance as to their benefits, but without Board approval, the member will only be reimbursed per the table below.

Reimbursements will be made toward the cost of lenses only once in each two (2) calendar years for each member.

SCHEDULE OF VISION CARE BENEFITS

1. All expenses in excess of those listed below will become the responsibility of the LEOFF I member.
2. This coverage is limited to the member only. An itemized statement of expenses will be submitted to the City of Olympia for payment.
3. Members are authorized to one (1) benefit every two (2) years.
4. Tints, photo chromatics, lens care equipment, polarization, etc., are not covered options.
5. Allowed expenses:
6. Members who are covered under MedAdvantage must first apply the \$200 benefit for hardware and then submit receipts and proof of benefits paid for remaining reimbursement for any additional amount allowed.

Type of Lenses and Frame		
Single Vision	\$40.50 (each lens)	\$81
Bifocal	\$59.00 (each lens)	\$118
Trifocal	\$75.00 (each lens)	\$150
Progressive	\$90.00 (each lens)	\$180
Contacts	\$100.00 (each lens)	
Frame	\$132.00	

D. Long Term Care

A physician's report of medical necessity must substantiate that the member requires long-term nursing assistance (either at home or in a nursing home).

The Board has the right to ask that its own doctor to examine the member to verify the medical reasons for long-term assistance. [\[RCW 41.26.150, 1\(a\)\]](#) The Board can ask its doctor to recertify the medical reasons every six months. Currently, the board doctor is Dr. William Penn, Yelm Family Medicine, 360.458.7761.

If medically possible, the Board prefers to pay for in-home care rather than nursing home care.

The Board reviews in-home care costs periodically to make sure those costs are less than nursing-home care.

If the Board approves in-home or nursing home care, it will pay up to the amount the Panorama Rehabilitation and Convalescent Care Center in Lacey, Washington charges for 24 hour-a-day nursing home care in a semi-private room

The Board may also look at where the member lives and the type of care needed in deciding what it will pay for in-home or nursing home costs. [RCW 41.26.030 (22) (b) ii and iii I]

The Board will only pay for services from licensed and bonded care givers.

If the member needs help at home, the Board won't pay for services of a custodial or housekeeping nature such as house cleaning, laundry services, cooking, recreational companionship, and other homemaker tasks.

The Board will follow State law when paying for long term care.

E. Hearing Aids

The Board may approve hearing aids if prescribed by a physician or a licensed hearing aid examiner/audiologist. Charges will be limited to treatment necessary to achieve functional correction. Members should seek pre-approval by the Board prior to purchase hearing aids. However, if warranted by the facts, the Board may pay for services that have not come to the Board for prior approval. The Board retains the sole right to determine whether or not to pay for services if the service has not been brought to the Board for prior approval.

When seeking pre-approval:

1. Members must submit written quotes to the Board from at least two companies that provide hearing aids, unless the member wants to purchase hearing aids from Costco, which can be done without a 2nd quote.

If there is a Costco within 25 miles of the LEOFF member's residence, one of the two quotes must be from Costco. Costco membership is not required for a hearing aid quote. The quotes must be for the least expensive hearing aids that 1) will meet the requirements recommended by the physician, audiologist or licensed hearing aid provider, 2) fit the member properly and 3) must have a three year warranty. If the member does not have a Costco membership, the Board will reimburse the LEOFF member for the cost of the membership fee for the warranty period. Staff can authorize the Costco hearing aid purchase without taking the request to the LEOFF board. The Board will review hearing aid prices annually to ensure that members are receiving quality hearing aids at the best market rate.

2. When more than one quote is submitted, member preference will not be one of the deciding factors in the Board's decision on which of the two quotes to approve. The final decision will be at the discretion of the Board.
3. Hearing aids must have a three-year warranty. Reimbursement will be made for hearing aids batteries and for ordinary and necessary repair not due to carelessness on the part of the member.

F. Preventative Care

1. Routine Annual Physical Examination:

Routine annual physical examinations are authorized for members. Expenses for such examination and associated tests shall be limited to \$350 per year. In no event shall routine physical examinations be scheduled less than twelve months apart.

2. Vaccinations and immunizations:

Members are authorized one annual flu vaccination. All other vaccinations shall be authorized when prescribed by a physician. Vaccinations will not be covered for members who have chosen to live or visit another country.

3. Colonoscopy Examination:

Board will consider payment for Colonoscopy Exams when the following conditions are met and appropriate documents are submitted by the member:

- a) Member must be age 50 and is medically recommended by their personal physician to undergo such examination.
- b) Member must submit copy of a written prescription of the recommended examination from their personal physician.
- c) Member must submit a copy of the Explanation of Benefits received from the medical insurance carrier indicating denial of benefits/coverage of medical services.
- d) Member must submit a completed LEOFF Board Request for Payment of Medical Services for review and consideration for approval of payment.

4. Bone Density: - DEXAscan Examination

Bone density (DEXAscan) exam is authorized only when medically recommended by personal medical provider of members who are 70 years and older. Expenses for such medically recommended examination shall be limited to \$350 every two years.

In the event a member is covered by a health care plan paid for by the City of Olympia/MEDICARE which may provide benefits coverage for any of the examinations above, the member shall use that plan benefit before applying for compensation under this rule. Payment or reimbursement will be made upon pre-approval of the Board.

G. Dental Benefits

LEOFF I retirees who **are actively employed** and have dental coverage through their current employer or can acquire group dental coverage through their spouses' dental plans, have the option to remain with their current group dental plan. The City will pay or reimburse the premium for the member's coverage up to \$50.00 per month. Members who select this

option will not be allowed to seek reimbursement from the City for any dental care.

LEOFF I members retirees who **are not actively employed** can purchase their own dental plan. The City will reimburse the premium for the member's coverage up to \$600.00 per year (\$50.00 per month). If the cost of the dental plan selected by the member is less than \$600.00 per year, the member will be reimbursed for additional dental bills up to a maximum total reimbursement of the difference between the cost of the dental insurance and \$600.00. If the member seeks additional dental reimbursement above \$600.00 per year, the member must submit the additional costs and medical necessity information to the Board before undergoing the procedure. If warranted by the facts, the Board may pay for services that have not come to the Board for prior approval. The Board retains the sole right to determine whether or not to pay for services if the service has not been brought to the Board for prior approval.

1. Dental Provision

\$600 annually to be applied directly towards preventative care that will include **one** annual cleaning and x-ray; restorative, that will include fillings, crown; tooth extraction, periodontal (treatment of tissues supporting the teeth), pulpal and root canal treatment.

If a member needs more than one cleaning per year, they must seek board approval **prior** to any additional cleaning(s) within that year for additional cleanings by submitting the following:

a) Application for Payment of Services

b) Substantiation from a medical doctor (**not a dentist**) outlining the medical condition/reason which warrants additional cleaning(s)

c) **Recertification is required every two (2) years**

2. Denture Provision

Member is required to submit two quotes from dentist/licensed denturists. Dentures (full/partial) will be reimbursed at 50% of lowest quote. LEOFF Board approval **must be obtained prior** to receiving services.

If warranted by the facts, the Board may pay for services that have not come to the Board for prior approval. The Board retains the sole right to determine whether or not to pay for services if the service has not been brought to the Board for prior approval.

Lenses and Frames Vision table *moved up to Vision Section*

LEOFF Application for Payment of Services

Case No: _____

Please Print Clearly & Legibly – Incomplete Form Will Be Returned

A) This Section to Be Completed by LEOFF 1 Member

Member Name: _____ Active: _____ Retired: _____

Member Telephone: _____ Police: _____ Fire: _____

Member Address: _____

Alternate Contact/Phone: _____ Email: _____

Describe Your Condition and Why It Is Duty Related: _____

Describe the Service/Treatment Requested: _____

Total Cost of Treatment/Service: \$ _____.

Amount Paid by Insurance/Medicare: \$ _____.

Amount Requested from the Board \$ _____.

LEOFF member-Please attach the Explanation of Benefits statement(s) from your insurance provider(s) and/or Medicare which indicates the

Member Signature: _____ Date: _____

Please attach a copy of the Power of Attorney if signed by the alternate contact.

B) This Section To Be Completed by Member's Attending Health Care

Provider's Name: _____ Provider's Telephone: _____

Clinic/Office Name: _____

Provider's Address: _____

Describe the Patient's Current Condition and State Whether It Is Duty Related: _____

Describe Your Recommended Treatment Plan and Why It Is Medically Necessary: _____

Please Describe Any Reasonable Alternative Treatment Plans. Include Expected Outcome & Costs: _____

Provider's Signature: _____ Date: _____

Fax completed form to: (360) 709-2735 or
Mail to: Attn: HR, City Hall, PO Box 1967, Olympia WA 98507-1967

LEOFF 1
Claims Reimbursement Form (Fire)

Name (Last, first)		*Vendor #		Date claim submitted	
		*Bars #	014-1714-530-22.02		
Address		Primary phone #		Check if new (address, phone or email)	<input type="checkbox"/>
City, State Zip		Cell #			
Email			*HR internal use		

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

[illegible]

Submit claims for reimbursement via:

Mail: Attn: HR, City of Olympia, PO Box 1967, Olympia, WA 98507
Email: humanresources@ci.olympia.wa.us
Fax: 360-709-2735

LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website:
[LEOFF Board Information](#)

LEOFF 1
Claims Reimbursement Form (Police)

Name (Last, first)		*Vendor #		Date claim submitted	
		*Bars #	014-1715-530-22.02		
Address		Primary phone #		Check if new (address, phone or email)	<input type="checkbox"/>
City, State Zip		Cell #			
Email			*HR internal use		

PLEASE COMPLETE AND SUBMIT THIS FORM WITH ALL CLAIM REIMBURSEMENTS

[illegible]

Submit claims for reimbursement via:

- Mail: Attn: HR, City of Olympia, PO Box 1967, Olympia, WA 98507
- Email: humanresources@ci.olympia.wa.us
- Fax: 360-709-2735

LEOFF 1 Disability policies and procedures, forms and detailed information about how to submit claims are posted on the city's website: [LEOFF Board Information](#)

LEOFF 1 MEMBER INFORMATION UPDATE FORM

In order to maintain up-to-date information for LEOFF 1 members, please notify us whenever you have a change to your personal information below. This will ensure that you receive benefit information and reimbursements in a timely manner. If you have any questions, contact your LEOFF 1 Secretary or designee, Carl Watts, at 360-753-8305.

PLEASE COMPLETE AND RETURN ANY CHANGES IN ONE OF THE FOLLOWING WAYS:

- **Confidential Fax:** 360-709-2735
- **Email:** humanresources@ci.olympia.wa.us
- **Mail to:** Attn: HR, City Hall, PO Box 1967, Olympia, WA 98507-1967

Please Print Legibly

Name	Marital Status	DOB	Main Phone	Cell Phone	Other phone
Primary Address	City	State	Zip	Effective Date	
Snowbird Address	City	State	Zip	Beginning Date	End Date
Email 1		Police or Fire			
Email 2		Medicare Y or N			
Authorized Caregiver Name	Address			Email	Phone

LEOFF 1 Member Signature
(Authorized guardian, POA)

Date