10/21/2025

DISABILITY BOARD AGENDA
210 W. 6TH AVE, KENNEWICK CITY HALL
COLUMBIA CONFERENCE ROOM

4:30 PM

1. **CALL TO ORDER**
2. **DISABILITY BOARD'S POLICIES, RULES, AND REGULATIONS**
   a. Disability Board Policies, Rules and Regulations for Review
3. **COMPARISON OF BENEFITS**
   a. Comparison of Benefits Available to LEOFF1 Members
4. **CONCLUSION**

TITLE 18

DISABILITY BOARD RULES AND REGULATIONS

18-04: SCOPE

SECTION:

18-04-010: Purpose: The purpose of these rules is to establish uniform methods of procedure for the conduct of the business of the City of Kennewick Disability Board ("Board"). This Board was established pursuant to the authority of RCW 41.16.020 and Chapter 294 which was passed in 1981, and its powers, duties, and responsibilities are as established by state law. In the event of any conflict of these rules with state law, the latter shall govern.

18-04-020: Scope: These rules and regulations shall be applicable to all LEOFF I employees and retirees covered by RCW 41.26, whether fire fighter or police officer, unless specifically provided herein.

18-04-030: Effect of Rules and Regulations: All fire fighters, law enforcement officers and retired members covered by RCW 41.26 shall be subject to the rules and regulations contained herein. A member's failure to follow these procedures may subject such member to the loss of benefits otherwise due under the acts. Upon adoption of these rules, a copy will be distributed to the appropriate agencies.

18-08 DEFINITION OF TERMS

SECTION:

18-08-010: Definitions

18-08-010: Definitions:

(1) Application. A request by a member for Board approval of disability leave or retirement.

(2) Claim. A request by a member for Board approval of payment for medical services or expenses.

(3) Disability. The existence of a physical and/or mental condition which renders the member unable to discharge, with average efficiency, the duty of the grade or rank to which the member belongs, or the position in which the member regularly serves. If a member is able to perform all of the duties of any available position to which a member of his grade or rank is normally assigned, the member is not considered disabled.

(4) In the line of duty. The member's disability occurred as a direct result of the performance of the member's duties.

(5) Member. A law enforcement officer or fire fighter eligible for benefits provided under RCW 41.26, LEOFF I plan.

18-12 BOARD MEMBERSHIP & DUTIES

18-12-010: Membership:

(1) The Board shall consist of five (5) members as follows:

(a) Two representatives from Kennewick City Council.

(b) One fire fighter representative.

(c) One police officer representative.

(d) One member from the public at large.

(2) The Council members shall serve a two-year term, and Non-Council members shall serve a two-year term expiring on March 31, or until such time as their successor is selected. A Member, Council or Non-Council, shall be removed if they have two or more unexcused absences in any calendar year.

(3) The members of the Board will appoint their own chairperson.

18-12-020: Election of Fire Fighter and Police Representatives:

(1) Nominations are submitted to the Secretary every two years, on the odd year. The nomination and election process is coordinated by the Board Secretary during January.

(2) Representatives will be elected by LEOFF I members from amongst all LEOFF I members (active and retired) as well as active LEOFF II members.

(3) For the sake of transition, both the incoming and outgoing members are encouraged to attend the February meeting, with the outgoing member voting and the incoming member observing. The incoming member will take over duties as of the close of that meeting.

18-12-030: Selection of Member-at-Large:

(1) Applications will be accepted every two years, on the even years. The interview and selection process is coordinated by the Board Secretary during January.

(2) The member-at-large will be selected by the Law Enforcement Representative, Fire Fighter Representative, and both City Council Representatives currently serving on the Disability Board.

(3) For the sake of transition, both the incoming and outgoing members are encouraged to attend the February meeting, with the outgoing member voting and the incoming member observing. The incoming member will take over duties as of the close of that meeting.

18-12-040: Duties of Board Members:

(1) Chairperson - The chairperson shall preside at all meetings, public hearings and disability hearings of the Disability Board and may call special meetings. The chairperson shall

have the privilege of discussing all matters before the Board and voting thereon except where to do so would constitute violations of an appearance of fairness of doctrine or a conflict of interest. The chairperson shall have all the duties normally conferred by parliamentary procedures on such officers and shall perform such other duties as may be requested by the Disability Board.

(2) Chairperson Pro Tem - The Chairperson Pro Tem shall assume the duties and powers of the chairperson in his or her absence.

(3) Secretary - The Secretary shall keep the minutes of all regular, adjourned and special meetings of the Disability Board. Such minutes shall be approved by the Board and copies shall be distributed to all members of the Board, all members of City Council, the City Manager and the Administrator for the Department of Retirement Systems. The Secretary shall prepare the agenda of regular and special meetings, shall give notice of all disability hearings, and shall draft and sign routine correspondence of the Board. The Secretary shall coordinate the elections of Fire and Police Representatives and the selection of member-at-large to the Board.

18-12-050: Meetings - General Information:

(1) The regular monthly meeting of the City of Kennewick Disability Board shall be held on the first Tuesday of each month. Meetings will be held in an available room at City Hall at ~~1:00 p.m~~. Rescheduled meetings shall be held within seven days prior to or seven days following the regularly scheduled meeting, provided that the day falls within the same month as the originally scheduled meeting. Special meetings of the Board shall be held upon the request of the Chairperson, of which notice shall be given in accordance with RCW 42.30.080.

(2) Three members shall constitute a quorum and the same shall have the power to transact all business. Each Board member is expected to notify the Secretary at least three working days prior to a scheduled meeting if that member will be unable to attend the meeting.

(3) "Robert's Rules of Order" shall guide the Board where the proceedings are not otherwise governed by rules or state law.

(4) The Board shall allow the public to attend regular meetings. However, pursuant to RCW 42.30.140(2), the Board reserves the right to close those portions of meetings in which the Board is deliberating upon quasi-judicial matters relating to specific benefits, where the Board finds that such deliberations might be expected to include discussion of sensitive personal information relating to a particular applicant.

(5) Information relating to any member's claim or application should be released only as required by RCW 42.17, or any court order, or upon written permission of the member, except certain medical information disclosed to medical experts as provided herein.

(6) The Board may hold a full hearing on any matter when deemed necessary.

(7) If any person(s) on the Board concludes that he has a conflict of interest or an appearance of fairness problem with respect to a matter pending before the Board so that he cannot discharge his duties, he shall disqualify himself from participating in the deliberations and the decision-making process with respect to the matter.

18-12-060: Hearings - General Information: At such a hearing as referred to in Section 18-12-050(6), the following statements shall apply:

(1) Any person testifying before the Board may have their attorney present.

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

(3) Unless precluded by law, information dispositions may also be made of any contested case by stipulation, agreed settlement, consent order or default.

(4) The record of a hearing shall include:

(a) All pleadings, motions, and intermediate rulings;

(b) Evidence received or considered;

(c) A statement of matters officially noticed, if any;

(d) Questions and offers of proof, objections and rulings thereon, if any;

(e) Prepared findings and exceptions, if any; and

(f) Any decisions, opinions or reports by the Board.

(5) All oral proceedings in a Board hearing shall be recorded. A copy of the record or any part thereof shall be transcribed and furnished to any party to the hearing upon request therefore, and payment of the reasonable costs thereof.

(6) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

(7) The Disability Board may:

(a) Administer oaths and affirmations, examine witnesses, and receive evidence;

(b) Issue subpoenas as provided in Section 18-12-070;

(c) Rule upon offers of proof and receive relevant evidence;

(d) Take or cause depositions to be taken pursuant to rules promulgated by the Board; and

(e) Regulate the course of the hearing.

18-12-070: Hearings – Witnesses: Subpoenas will be issued in accordance with KMC 2.16.950. The Board has the power to issue subpoenas and compel the attendance of witnesses without the intervention of Superior Court.

18-16 PROCESSING MEDICAL CLAIMS AND DISABILITY APPLICATIONS AND ANNUAL MEMBER UPDATES

18-16-010: Presenting to the Board:

(1) All claims and applications shall be submitted to the Secretary via the appropriate representative of the Board on forms approved by the Board. All material to be considered in connection with any application or claim must be submitted to the Board by the 15th of the month prior to the Board meeting at which such claim or application is to be considered. Material submitted after such time may be considered at the discretion of the Board.

(2) The Board's decision to approve or deny applications or claims will ordinarily be based on the forms and other written information submitted by the member and on information provided to the Board by its own doctors. The Board may, however, require a member to appear before the Board before deciding on the member's application or claim.

18-16-020: Medical Claim Appeals:

(1) Any decision of the Board regarding medical claims made in the manner provided in Section 18-16-010(2) may be appealed to the Board for a hearing and reconsideration of its decision. Notice of such an appeal must be filed with the Board no more than 30 days after notification of the Board's decision.

(2) When a notice of appeal is received by the Board, a hearing shall be scheduled before the Board. The party appealing the decision shall be given at least 10 calendar days notice of the time, place, and nature of the hearing.

18-16-030: Application for Disability Retirement: Every order of the Disability Board granting or denying a disability retirement allowance shall contain the following items presented in clear concise terms:

(1) Findings of fact supported by evidence in the record supporting the granting or denying of the disability retirement allowance. When a disability retirement is granted, findings of fact shall include:

(a) Whether or not the disability was incurred in the line of duty.
(b) Whether or not the disability was incurred while in other employment.
(c) Dates encompassing waiver of disability leave, if applicable; and that applicant established that such disability will be in existence for a period of six months.

(2) Conclusions of law in accordance with law on the basis of the facts in the case.

(3) Decision and Order.

18-16-040: Right to Appeal: If the Board denies disability leave or disability retirement or cancels a previously granted disability leave or retirement, the applicant shall be immediately notified and advised of the right to appeal such decision or order within 30 days, to the Director of the Department of Retirement Systems, pursuant to RCW 41.26.200. Such notification shall be in writing and served by personal service or mail. Provided, that written notice need not be given if the applicant or his duly authorized representative is in attendance at the meeting or hearing and is advised of the decision and of the right of appeal.

~~**18-16-050: Local Board Physician:**~~

~~(1) A duly licensed and practicing physician or physicians shall be appointed by the Board. No disability retirement shall be approved by the Board without prior examination of the claimant by the Board physician or a specialist of his selection who has been approved by the Board, on or near the expiration of the disability leave period. The Board physician shall render such other medical service as may be requested by the Board.~~

~~(2) In order to carry out the duties of this position, each physician appointed or approved by the Board is required to be knowledgeable concerning the duties, functions and general demands required of the employee being examined. The Disability Board shall furnish to the examining physician the position description of the applicant.~~

~~(3) Re-examination of any member on disability retirement shall be conducted by a Board-appointed or approved physician.~~

~~**18-16-060: Out-of-Area Physicians:**~~

~~(1) After applying for a disability leave, all out-of-area medical referrals must be approved by the local Board physician.~~

(2) ~~Authorization for such referrals must also be given by the Board.~~

(3) ~~All appointments will be scheduled through the Board Secretary~~.

18-16-070: Annual Member Updates and Privacy Policy Statements:

(1) Each member will be required on a yearly basis to update their personal information and sign a privacy policy statement at the request of the Board.

(2) The Board Secretary will mail an information worksheet and privacy policy statement to each member who will be required to respond in the time frame given. If the member fails to respond within that time frame, further claims submitted will not be processed until the information is received by the Board Secretary.

18-20 DISABILITY LEAVE

18-20-010: Application:

(1) All applications for disability benefits shall be submitted on forms provided by the Board. Applications shall include statements from at least one physician, the employer, the employee and the report on the application for disability retirement. Each application shall be accompanied by a list identifying by name, any physician who had been contacted within the last six months for the illness or injury for which disability is claimed; and

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

(3) If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating this claim.

18-20-020: Review of Application:

(1) Following receipt of an application for disability benefits, the Board shall review all relevant information pertaining to the question of the applicant's fitness for duty, and if in the opinion of the majority of the Board, the evidence supports the proposition that the member is unfit for duty, such member shall be granted disability leave, unless such leave is waived pursuant to RCW 41.26.120(4). In considering such application, the Board shall consider the duties of the position, and any other evidence that is relevant.

(2) The burden of proving the existence of a disabling condition, and whether or not the condition was incurred in the line of duty, shall be upon the applicant.

(3) In the event the Board finds that insufficient information is available to make a determination, the matter may be continued to the next regular Board meeting or be set for consideration at a special meeting. The Board shall also advise the member of the additional information needed, and of the member's obligation to provide additional information, and the deadline date by which such information must be provided.

(4) The Board shall be authorized to demand the appearance of the member and to request the appearance of such other persons, as it deems appropriate. Prior to the examination and evaluation, the Board Secretary shall advise each and every examining physician: that such evaluation is being conducted at the direction of the Board; that any reports relating thereto are for the benefit of the Board; and that the physician may be called upon by the Board to testify as to his findings. The member shall notify the physician that the doctor-patient privilege may not be invoked with respect to the above examinations and evaluations.

18-20-030: Physician's Report: The law enforcement or fire fighter agency which employs the member may request a physician's evaluation report at the time the member makes application for disability leave, if the disability is one which reasonably appears may lead to a disability retirement. The agency that requests the evaluation will compensate the evaluating physician.

18-20-040: Length of Disability Leave Allowance: Such leave shall encompass a period of not less than two regular work shifts and not more than six calendar months.

18-20-050: Member Cooperation: While on disability leave, the member shall be obligated to comply with directives of the Board. Such directives may include, but are not limited to: requests for medical or psychological evaluation or testing; requests for submittal of other relevant reports; and orders to appear before the Board.

18-20-060: Rehabilitation Directives: During the period of disability leave, the Board may ask any examining physician what treatments might be employed to rehabilitate the member. Based upon such evaluations, the Board may direct that the applicant participate in any reasonable rehabilitation program.

18-20-070: Activities of Members on Disability Leave:

(1) A member who engages in any activity while on disability leave and incurs any injury or illness as a result thereof, may needlessly confound the issue of whether or not his disabling condition was incurred in the line of duty. No member should engage in any activity while on disability leave which is contrary to the directives of the Disability Board or which would otherwise be detrimental to his return to active service.

(2) If a member in receipt of disability leave allowance, moves of his own volition, to a location more than 100 miles from the location of the Disability Board, any travel expenses incurred to appear before the Board or its designated physician shall be borne by the member. Such member shall keep the Board advised of his current address.

18-20-080: Determination of Fitness: The minimum medical and health standards previously promulgated by the state retirement board for entry or re-entry into the LEOFF System membership, were provided only to safeguard the fiscal integrity of the pension system and are not the applicable standards for any other purpose.

18-20-090: Return to Active Service:

(1) It shall be incumbent upon all members granted disability leave to seek authorization to return to active service at the earliest possible time.

(2) When a member has been disabled, a "Return to Work" slip from the Board-approved physician is required. Board authorization must be given prior to the member's return to duty.

18-24 DISABILITY RETIREMENT

18-24-010: Application:

(1) All applications for disability retirement shall be submitted on forms provided by the Board. Applications shall include statements from at least one physician, the employer, the employee and the report on the application for disability retirement. Each application shall be accompanied by a list identifying by name, any physician who had been contacted within the last six months for the illness or injury for which disability is claimed; and

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

(3) If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating this claim.

18-24-020: Disability Leave Inclusive: Each application for disability retirement shall be deemed to include an application for six months' disability leave, unless otherwise provided.

18-24-030: Disability Leave Waived:

(1) Any member may sign a written waiver of his rights to all or part of the six months disability leave in order to have his disability retirement application acted on at an earlier date than would otherwise be permitted.

(2) When the Board receives an application for a disability retirement where the applicant voluntarily waives his right to disability leave, arrangements shall be made to have the applicant examined as soon as practicable by a physician designated by the Board.

18-24-040: Examination and Evaluation by ~~Board Physician:~~

(1) Applicants for disability retirement shall be re-examined during the fifth or sixth month of disability leave in order to determine their eligibility for disability retirement, with the following exceptions:

(a) If the ~~Board doctor~~ assures the Board that the applicant's condition has not and will not be corrected before the end of the sixth month; or

(b) If the applicant establishes that the disabling condition will be in existence for a period of at least six months and he voluntarily waives disability leave. No applicant

will be granted a disability retirement allowance unless the conditions imposed by this subsection are met.

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

18-24-050: Review of Application: The Board will not act on any application for disability retirement before the fifth month of the applicant's disability leave, unless such leave is waived as provided in Section 18-24-030. The Board may, in its discretion, postpone any decision and request additional information or a hearing as provided in Section 18-12-050(7).

18-24-060: Board Approval of Disability Retirement:

(1) If the evidence shows, to the satisfaction of the Board, that the member is physically or mentally disabled from further performance of duty and that the disability has been continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision and order, accompanied by appropriate findings of fact and conclusions of law in compliance with RCW 41.26.120. Such written decision and order with supporting documentation shall thereafter be forwarded to the Director, Department of Retirement Systems, for review. In the event a regular meeting of the Board precedes, by no more than 40 days, the date at which the full six months will conclude and the evidence is clear that the disability can be expected to continue through the full six-month period, so as to eliminate unnecessary delay of receipt of retirement benefits.

(2) In order to qualify to receive a disability retirement allowance, the applicant will be required to prove that he is physically or mentally disabled to such extent that he is unable to discharge, with average efficiency, the duty of the position held at the time of discontinuance of service: Provided, that no member shall be entitled to a disability retirement allowance if the appropriate authority advises 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.

18-24-070: Board Denial of Disability Retirement - Right to Appeal: If an application for disability retirement is denied, the applicant and employer will be notified of the decision and the applicant's rights of appeal to the Director of the Retirement Systems. Notification must be given within 30 days in accordance with RCW 41.26.200.

18-24-080: Re-Examination and Return to Duty:

(1) In the event a member is placed on disability retirement, the Board shall determine whether or not the member is so disabled that no possibility exists for return to duty or that there is no possibility that rehabilitation could restore the member to fitness for duty. Further, the Board may at any point subsequent to retirement make such a determination. A copy of all such determinations shall be sent to the Department of Retirement Systems. Unless the Board has made such a finding, the Board's representative shall order a re-examination at six-month intervals and advise the Board of the results thereof with a copy to the Department of Retirement Systems:

Provided, that such re-examination need not be conducted on a member over 49.5 years of age. In the event the retired member is residing at a location more than 100 miles from his former place of employment, the member may be authorized to be examined by a physician in his immediate area, provided, however, such physician shall be first approved by the Board and prior to such evaluation the examining physician shall be apprised of the basis upon which the examination is to be conducted and the issues to be addressed in the physician's evaluation report.

(2) In the event such evaluation discloses fitness to perform duties of the rank or position held by the member at the time of disability retirement, the member shall be entitled to a hearing before the Board, and further consideration of the matter. Such notice and hearing shall comply with the Administrative Procedure Act, Chapter 34.05 RCW.

(3) The hearing provided by RCW 41.26.140(2) is to be held, unless the retiree waives such hearing, prior to actual cancellation of a disability retirement allowance.

(4) The retirement allowance of any member who fails to submit to medical examination as provided herein shall be discontinued and in the event such refusal continues for one year, his retirement allowance shall be cancelled. Failure of the member to affirmatively respond to the request for re-examination shall be deemed a continuing refusal.

(5) In order for the Board to cancel a previously granted retirement, it must find that a changed circumstance exists and that the member is not able to substantially perform job duties with average efficiency. A new diagnosis based on the unchanged medical condition, unchanged job duties and unchanged adaptation to the medical condition is not sufficient to cancel the previous Board order.

18-24-090: Member Disability Ceases - Notice of Hearing: Where a periodic re-examination determines that a retired member may no longer be disabled, the member shall be notified by certified mail. The notification shall contain notice of the time, place, and nature of a hearing to be held under Section 18-12-050(1). The purpose of the hearing will be to determine whether the member continues to be disabled.

18-24-100: Decision and Order Revoking Retirement Allowance: Every decision and order revoking a disability retirement shall be in writing or stated in the record and shall be accompanied by finding of fact and conclusions of law. The appellant shall be notified of the decision and order in person or by certified mail.

18-28 CLAIMS FOR MEDICAL SERVICES

18-28-010: Claim Forms: Claims for payment of medical services shall be submitted on forms provided by the Board. In order to maintain privacy, members are required to submit all claims in a sealed envelope addressed to the Disability Board. Explanation of benefits from member's medical insurance provider(s), if any, shall be submitted in addition to the statement of claims form provided by the Board for all claims.

18-28-020: Six-Month Limit: All claims must be submitted to the member's board representative or Secretary within six months of the date of service or the date of processing by the insurance carrier. Claims submitted after this period of time may not be approved by the Board.

18-28-030: Coordination of Benefits: Pursuant to RCW 41.26.150(2), payment of claims shall be reduced by any amount received or eligible to be received under Workman's Compensation, Social Security, Medicare, insurance provided by another employer, pension plan, or any other similar source.

18-28-040: Subrogation of Claims: Upon making payment for authorized medical services, the Board and employer shall be subrogated to all rights of the member against any third party who may be held liable for the member's injuries or for the payment of the cost of medical services in connection with a member's sickness or disability. Such subrogation shall be to the extent necessary to recover payments made to the member by the Disability Board and City of Kennewick. RCW 41.26.150(3).

18-32 MEDICAL SERVICES RESOLUTIONS

18-32-010: Health Plans
18-32-010: Additional Service

18-32-010: Health Plans: If a member currently has a prepaid health plan, they are required to obtain medical services through that prepaid health plan.

18-32-020: Additional Service: On a case-by-case basis, the Board may authorize additional services to a member. The member will be required to show a need for such additional services prior to authorization by the Board. In making its determination whether to authorize additional services, the Board shall not be bound by the rules of evidence, and the Board's decision shall be deemed final.

NOTE: Approval of additional services is at the discretion of the Board. For any member seeking additional medical services, prior approval must be obtained by the Board in order to be reimbursed for such claims.

18-36 SPECIFIC CLAIMS INFORMATION

18-36-010: General Statements:

(1) The Board will approve payment of claims for all medical services defined in RCW 41.26.030(22) under the conditions set forth in RCW 41.26.150. Services do not include late fees or charges.

(2) No case allowing payment of claims for services shall stand as binding precedent for future similar claims.

(3) Anyone needing special medical equipment or devices must first get approval from the Kennewick Disability Board ~~and if recommended, from the Board Physician.~~ If there is immediate need for the device, the Secretary can obtain phone authorization from members prior to the next regularly scheduled Board meeting.

(4) Medical equipment and devices include any item other than normal medical treatment and prescription.

18-36-020: Dental:

(1) Dental expenses will be considered necessary medical services in those circumstances when they are incurred by a member who sustains an accidental injury resulting in damage to his teeth or gums and commences treatment within 90 days following the accident, or when treatment is justified by way of curing or correcting an existing health problem.

(2) Routine dental care and normal wear or adjustment of dentures are not covered.

18-36-030: Psychiatric Care:

(1) Prior to seeking psychiatric therapy or treatment, members requesting psychological aid ~~are required to see a Board-approved physician (up to three visits) for evaluation. At the conclusion of the physician's evaluation, the physician will provide a report to the Board on the recommended length and type of treatment, if any.~~

~~(2) The attending physician must submit an initial treatment plan within 30 calendar days of commencement and treatment, and if the treatment continues, report member progress at least once every three months. If the member's treatment is expected to exceed 12 months, a second treatment plan must be submitted. The Board will review the progress reports and treatment plans to determine whether treatment should continue, or if the patient should be re-evaluated.~~

~~(3) Failure to seek evaluation from the Board physician prior to incurring expenses for that treatment may result in the Board's rejection of a member's claim for payment.~~

~~(4) Only services deemed necessary will be paid, provided those services are not a result of member dissipation and abuse. Such determination will be made by the Board after considering medical evaluation by the Board physician.~~

18-36-040: Optical Exams, Eyeglasses, and Contact Lenses: Each LEOFF I member is entitled to the services of a participating physician or a participating optometrist for an eye examination once each year. Note: A year is defined as that 12-month period following the purchase date of the eyeglasses or contact lenses.

(1) Claims for eyeglasses, frames and eye exams will be paid; however, there will be a limit of $100 per year on the cost of frames.

(2) Contact lenses claims will be paid up to a limit of $200 per year.

(3) Members will be reimbursed once a year for either one pair of glasses or contact lenses, but not both.

(4) Benefits are paid for necessary services only and shall exclude tinting, coloring, photo-gray, photo-sun, or other options. Tinting of glasses or contacts will not be paid for, unless such request is required for the line of duty, or is accompanied by a physician's prescription.

(5) Progressive lenses are not considered a covered expense.

(6) Glasses or contacts broken or damaged in the line of duty will be replaced regardless of other reimbursement in the same calendar year. An explanation from the employee and confirmation from one or more witnesses will be required. Replacement of eyeglasses or contacts due to breakage, loss, or theft while off duty (active members) or for retirees will not be paid for by the Board; provided the replacement would be reimbursement for a second set of glasses or lenses within a calendar year.

(7) Radial/laser keratotomy and blepharoplasty surgical procedures will be evaluated by the Board on a case-by-case basis.

18-36-050: Diet Programs/Fitness Clubs: The City of Kennewick's Disability Board encourages and supports physical fitness for its members and is aware of the importance physical fitness provides in the prevention of injury and disease. The Board will pay for all necessary medical costs but will not pay for any food supplement, membership in weight loss programs, physical fitness clubs, health spas or other such programs. The Board will pay for counseling services if prescribed by a physician and performed by a licensed psychologist, psychiatrist, or Dietician/Nutritionist.

18-36-060: Alcohol and Drug Treatment:

(1) All claims submitted for alcohol and drug treatment must have a letter from the ~~Board physician~~ recommending the individual seek treatment.

(2) Any member needing or being requested to go to an inpatient facility for drug or alcohol treatment is required to have Board approval prior to admission. ~~This approval is in~~

addition to a recommendation from the Board physician. The Board reserves the right to designate the treatment facility.

(3) Payment for inpatient treatment facilities will be made one time only. If problems should reoccur, the patient is responsible for the cost of treatment.

18-36-070: Hearing Aids:

(1) After receiving suitable evidence of medical necessity for hearing aids, the City of Kennewick Disability Board will authorize a payment for hearing aid(s) up to an amount determined by the Board and their designated hearing aid provider. The Board will consider authorization for a hearing aid device every five (5) years. Any claim submitted by a member who chooses not to use the Board designated hearing aid provider or lives outside the service area will be limited to ~~reimbursement up to the amount the designated hearing aid provider would charge.~~ Hearing aids prescribed due to injury, disease or other unusual circumstances will be considered on a case-by-case basis by the Board. The Board will also authorize the cost of necessary repairs, however, routine maintenance and batteries shall be the member's responsibility.

(2) The member may bring recommendations from their hearing specialists before the Board, which shall be reviewed on a case-by-case basis.

18-36-080: Chiropractic Care:

(1) No more than 12 visits per calendar year, including any provided through other sources such as workers' compensation, pre-paid medical, etc., will be approved. The Board may approve additional visits if prior to the added visits, the Board is presented with a report and recommendation for such added visits from a Board-approved physician.

(2) When treatment exceeds 12 visits per year, the Board may require an evaluation of the affected member's chiropractic conditions and prognosis, or a plan for continued chiropractic care from a physician.

(3) A member shall notify the Board, as soon as it is known, that chiropractic treatments may exceed the 12-visit limit in order to allow timely Board action and preclude any hardship on the member.

18-36-090: Physical Therapy:

(1) No more than 12 visits per calendar year, including those provided through other sources such as workers' compensation, pre-paid medical, etc., will be approved. The Board will only approve visits to a duly licensed R.P.T.

(2) When treatment exceeds 12 visits per year, the Board may require an evaluation of the affected member's physical conditions and prognosis, or a plan for continued physical therapy care from a physician.

(3) A member shall notify the Board as soon as it is known that the physical therapy treatments may exceed the 12-visit limit. This will allow timely Board action and preclude any hardship on the member.

18-36-100: Surgical Procedures: For any surgical procedure, the member shall:

(1) Advise the Board no less than one month in advance, unless emergency circumstances do not provide for such notification.

(2) The Board may elect to require a member to consult with a ~~Board-appointed physician~~ to obtain a second opinion regarding the necessity for the surgical procedure.

18-36-110: Acupuncture Treatments: No more than 12 visits per calendar year, including those provided through other sources such as workers' compensation, pre-paid medical, etc., will be approved. The Board may approve additional visits if a report and recommendation for the added visits are presented by a ~~Board-approved physician.~~

18-36-120: Restorative Care Programs: Due to the generality of restorative care programs, the Board will consider each restorative care program on a case-by-case basis.

18-36-130: Vaccinations and Immunizations:

(1) Flu/Pneumonia vaccinations are considered approved expenses.

(2) Allergy shots, Antigens and supplies for Antigens are considered approved expenses.

18-36-140: Impotency Medication:

(1) Prescription drugs for the treatment of impotency or any type of erectile dysfunction including Viagra, Levitra and Cialis will only be eligible for reimbursement if there is a medical diagnosis for an existing medical condition which causes the impotency or dysfunction being treated, i.e., prostate cancer, high blood pressure, diabetes, vascular disease, or other similar medical condition.

(2) Regardless of the circumstance for which the prescription drugs are deemed medically necessary and the number of doses prescribed by a physician, the Board will only provide reimbursement for a maximum of eight (8) doses per month of any combination of these drugs. Anything over this amount will be the responsibility of the member.

(3) Proper documentation to support the medical necessity of the drug shall be required prior to approval of reimbursement.

18-36-150: Premiums:

(1) Insurance premiums for Medicare Part B and supplemental Medicare Part B are eligible for reimbursement. At the beginning of each calendar year, members must provide a copy of their letter from the Social Security Administration to the Board that delineates their monthly insurance premium amount. Individual monthly requests for insurance premium reimbursement are not required. Reimbursements will be processed on a monthly basis.

(2) Eligible members must apply for Medicare Part B coverage to avoid the potential reduction of medical benefit payments. RCW 41.26.150(2) states that payments for medical services will be reduced by any amounts the member receives or is eligible to receive under workers' compensation, Medicare, insurance provided by your LEOFF employer or another employer, other pension plan or any other similar source.

(3) Members who become eligible after January 1, 2009, but elect not to enroll during their initial sign-up period will not be reimbursed for penalties or surcharges assessed by the Social Security Administration if coverage begins at a later date. The Board, or their designee, will notify members by certified mail prior to the date they become eligible for Medicare benefits to ensure timely enrollment. However, retirees are responsible for their own enrollment.

(4) Members who became eligible for Medicare Part B coverage prior to January 1, 2009, shall be eligible for full reimbursement of their premiums, including any penalty or surcharge associated with late enrollment, as long as the member enrolls for coverage by the completion of the next open enrollment period commencing on January 1, 2010, and running through March 31, 2010. If these members fail to enroll by March 31, 2010, they will no longer be eligible for reimbursement of penalties or surcharges assessed by the Social Security Administration should coverage begin at a later date.

18-36-160: Long-Term Care: The City of Kennewick LEOFF 1 Disability Board establishes the following long-term care policy pursuant to its authority to designate the medical services available to any sick or disabled member under RCW § 41.26.150(b).

(1) **Definitions**:

(a) Activities of Daily Living (ADLs): Daily self-care activities such as eating, dressing, bathing, toileting, transferring, grooming, and continence.

(b) Assisted Living: Generally, a state-licensed program offered at a residential community (not in the member's home) with services that include meals, laundry, housekeeping, medication reminders, and assistance with activities of daily living for individuals who can otherwise live independently. Assisted living facilities do not provide skilled nursing care or medical services.

(c) Custodial care: Custodial care provides in-home assistance in performing activities of daily living. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, and may also include a component of companionship.

(d) Home health care: Home health care encompasses skilled services such as nursing, and physical and occupational therapies prescribed by a physician and administered in the patient's home.

(e) Hospice care: Care designed to give supportive care to an individual in the final phase of a terminal illness. Hospice care focuses on comfort and quality of life rather than cure.

(f) Nursing home care: Also known as an extended care facility, a nursing home is a licensed facility which provides general long-term nursing care to those who are chronically ill or unable to handle their own necessary daily living needs due to medical limitations or advanced age.

(g) Skilled nursing care: Skilled nursing and skilled rehabilitation services are services prescribed by a physician that: 1) require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists and speech pathologists or audiologists; and 2) must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result; and 3) are not custodial in nature.

(2) **Reasonable long-term care expenses authorized**: Reasonable expenses related to long-term care that is determined to be medically necessary and is prescribed by a physician shall be reimbursed by the Board as required by RCW § 41.26.150(1) in an amount not to exceed the median daily or monthly rate for a semi-private room for the specific type of long-term care in the regional area within which the services will be provided, as reported in the most current

Genworth State-Specific Cost of Care Survey; provided, however, that reimbursement shall not be made for long-term care that becomes necessary as the result of dissipation or abuse. In this context, long-term care includes home health care, nursing home care as provided in RCW § 41.26.030(19)(I), skilled nursing care, and hospice care as provided in Section 4 below.

(3) **Custodial Care/Assisted Living:** Custodial care and assisted living, by definition, are not considered medically necessary, and the LEOFF 1 Disability Board need not approve requests for reimbursement for expenses related to long-term custodial care or assisted living. The Board retains the discretion to grant reimbursement under extenuating circumstances as determined on a case-by-case basis. Reimbursement may be appropriate in instances wherein the member's needs could be met by custodial care as opposed to confinement in a nursing care facility. In the event reimbursement for reasonable expenses related to custodial care or assisted living is authorized pursuant to this Section, the Board will pay up to the median daily or monthly rate based on a one bedroom occupancy for the specific type of long-term care in the regional area within which the services will be provided, as reported in the most current Genworth State-Specific Cost of Care Survey. Any decision to authorize reimbursement for custodial care or assisted living shall not set precedent or entitle any other member to reimbursement for similar expenses.

(4) **Hospice Care:** Reasonable expenses related to hospice care for a terminally ill member will be reimbursed under the following circumstances:

(a) The member is admitted to a DSHS-certified or Medicare-approved program; and

(b) The care provided is part of a written plan of continuous care that has been prescribed and is being periodically reviewed by a physician; and

(c) If eligible for Medicare, the member has applied for and is receiving both Part A and Part B of Medicare coverage, whether paid for by the employer or the member.

(5) **Independent Examination**: Pursuant to RCW § 41.26.150(1)(a), the LEOFF 1 Disability Board may, at any time, require the member seeking reimbursement for long-term care to submit to an examination by ~~the Board's appointed physician~~ for the purpose of ascertaining the nature and extent of the sickness or disability and the appropriateness of the recommended long-term care prescribed. The Board may also require periodic reports from the facility or treating physician to justify continued reimbursement of reasonable expenses related to long-term care.

(6) **Procedures for reimbursement:**

(a) All requests for reimbursement related to long-term care must be pre-approved by the City of Kennewick LEOFF 1 Disability Board.

(b) Expenses must be reasonable and related to medically necessary services in order to qualify for reimbursement. "Medically necessary services" are those prescribed by a physician. To determine whether expenses are reasonable, the Board may consider factors such as the cost of similar services, the availability or exclusiveness of a particular service, and the duration of time the service will be required, in addition to any other relevant information. In no circumstance shall the reimbursement exceed the median daily or monthly rates outlined in sections (2) and (3) above.

(c) To initiate the claim process, the member or his/her designee shall complete the Medical Report and Request for Long-Term Care Form. When reimbursement for expenses related to in-home care is requested, the member or his/her designee

shall also complete the Home Care Services Assessment Form. Failure to complete the required forms will result in denial of any request for reimbursement. Incomplete forms will be returned to the member for further information.

(d) Before reimbursement will be made, the member or his/her designee must provide documentation indicating that coordination of benefits has occurred and that all other entities legally obligated to pay a portion of the expenses related to long-term care have satisfied their financial obligation. Pursuant to RCW § 41.26.150(2), the legal financial obligation of the LEOFF 1 Disability Board is to make up the difference between the actual cost of reasonable necessary medical expenses and the amount paid by other forms of coverage (i.e., Medicare, private insurance, other pensions, workers' compensation, etc.).

(e) Itemized statements or billings must be submitted that adequately identify and/or describe the expenses incurred. Services that are not deemed to be medically necessary are not covered. Such services shall include, but are not limited to, house cleaning, laundry services, cooking, companionship, cable, telephone services, etc.

(f) All off-site facilities providing medically necessary services for which a member seeks reimbursement of reasonable expenses shall be licensed by the state in which they are located. In the event the Board approves reimbursement of expenses related to assisted living under Section 3 above, the assisted living facility must also be state-licensed. The member or his/her designee is responsible for providing documentation of the applicable state license.

(g) All individuals providing medically necessary services for which a member seeks reimbursement of reasonable expenses shall be state-licensed and bonded. The Board shall not provide coverage for a caretaker who ordinarily resides in the member's home, or is a member of the family of either the member or the member's spouse, unless such individual is also a licensed and bonded care provider. The member or his/her designee is responsible for providing documentation proving the care provider's license and bond requirements.

(h) The Board shall only reimburse for qualified expenses related to services rendered. The Board will not make advance payment of any charges.

18-40 TRAVEL REIMBURSEMENT

18-40-010: General Information:

(1) All out-of-town referrals must be pre-approved by the ~~Board physician.~~

(2) The Board will reimburse travel costs for out-of-area medical referrals when a medical problem cannot be diagnosed or corrected by the ~~local Board physician~~ or any other approved local physician. When a medical problem can be corrected locally, those members wishing to be treated by an out-of-area physician must pay their own expenses to and from the physician or treatment facility.

(3) Travel expense is for the member only.

(4) Travel reimbursement will be for the diagnostic trip only. Subsequent trip expense will be evaluated by the Board.

18-40-020: Allowance Rates:

(1) Travel reimbursement will be based upon the current City of Kennewick Travel Policy and Procedures.

(2) Travelers using private vehicles for City business must maintain adequate insurance coverage consistent with the laws of the State of Washington.

18-40-030: Procedures: Travel reimbursement forms for out-of-area referrals can be obtained from the Board Secretary. Upon return, this form should be completed and returned to the Secretary. As outlined by current City of Kennewick policy, receipts are required for all expenditures, including meals, and must be attached to the completed travel allowance form.

18-44: RECONSIDERATION

18-44-010: Procedure: The member may petition, in writing, the Board to reconsider any decision made, if done within 14 days of the Board's decision.

18-44-020: Grounds: The Board may reconsider its decision if one of the following grounds and supporting facts are alleged:

(1) Mistakes, inadvertence, surprise, excusable neglect or irregularity in making the decision;
(2) Newly discovered evidence;
(3) Fraud, misrepresentation, or the misconduct of an adverse party;
(4) The decision is void;
(5) Any other reason, which, in the Board's discretion, justifies relief.

18-44-030: Stay: Pending the reconsideration, the decision of the Board will be stayed. The stay shall apply to the next meeting of the Board, at which time the reconsideration will be heard.

18-48 AMENDMENT AND REVIEW OF POLICY

18-48-010: Amendments: These rules and regulations may be amended, repealed or altered in whole or in part by a majority vote of the total membership of the Board.

18-48-020: Review: These rules and regulations shall be reviewed annually to assure that:

(1) Provisions herein remain in conformance with Washington statutory and administrative codes and the City of Kennewick Code.

(2) Provisions herein reflect the current philosophy and intent of this Board.

WSLEA COMPARISON OF BENEFITS

Rev: March 25, 2025

Acupuncture

Jurisdiction	Policy Summary
[redacted]	Physician prescribed, certified acupuncturist.
	12 visits per calendar year
	12 visits per calendar year
	Physician prescribed, certified acupuncturist. Treatment plan over 2 visits.
	Submit claims w/in 6 months
	Physician prescribed.
	Physician prescribed as medically necessary.
	Tx beyond insurance requires tx plan in a month w/updates every 12 mos.
	Physician prescribed, certified provider. Treatment plan over 2 visits.
	Case by Case benefit. Submit directly to Board secretary's office.
Kennewick	Pre-approval required over 12 visits/year.
[redacted]	Physician prescribed, certified acupuncturist. Pre-approval over 2 visits.
	No policy
	Physician prescribed, licensed acupuncturist. 12 visits/year.
	12 visits/year.
	12 visits/year.
	Case by case – if medically necessary.
	Covered in plan 25/yr Massage/Acupuncture; to exceed needs pre-approval
	Administered by physician or licensed acupuncturist under guidance of physician.
	Administered by physician/licensed acupuncturist. 12 visits/year; pre-approval for additional. Dr letter required.
	One treatment day/$135; Rx from Doctor. State licensed.
	Licensed practitioner for Acupuncture and Massage Therapy. As prescribed by medical doctor.
	Physician prescribed, certified acupuncturist. Pre-approval over 3 visits. 12 visits/6-mos.
	12 visits in 6 months.
	Physician prescribed as medical necessity. Pre-approval over 4 visits.
	$750 per year/lifetime/one condition/$3000 for tx. Includes Naturopathy, acupuncture, massage, chiro and other holistic or alternative.
	12 visits per year through Regence BlueShield.
	Administered by or under direction of a physician. Pre-approval required.
	Physician prescribed, provided by certified acupuncturist. Treatment plan over 2 visits.
	Services provided by certified acupuncturist.
	Services provided by certified acupuncturist. Treatment plan 6 months or 10 visit.
	Services by certified acupuncturist. 12 visits/year.

Bariatric Surgery

Jurisdiction	Policy Summary
[redacted]	Have covered for medical necessity.
	Board will consider programs that are Dr prescribed.
	Diet Education 100% allowable charge. Non-surgical tx only.
	Have covered for medical necessity.
	Would consider if medically necessary.
	Not covered
	Have covered for medical necessity.
	Have covered for medical necessity.

Bariatric Surgery (Cont.)

Jurisdiction	Policy Summary
[redacted]	Covered by Medicare/Regence Blue Shield if medically necessary
	Have covered for medical necessity.
	Have covered for medical necessity.

Board Administration

Jurisdiction	Policy Summary
[redacted]	HR Director
	Sr HR Analyst
	Finance Director (meetings), Finance City Clerk (meeting minutes/elections), HR benefits (claims/policy changes), HR Payroll (pensions)
	Finance Director (meetings), Finance City Clerk (meeting minutes/elections), HR benefits (claims/policy changes), HR Payroll (pensions)
	Commissioner's Executive Secretary
	Sr HR Analyst
	Clerk (meetings/policies), HR (bills/pension)
	HR
	HR
	HR Director
	Deputy City Clerk – Finance
	HR
	Commissioner’s staff
	Commissioner’s staff
Kennewick	Police Department Administrative Assistant
[redacted]	Benefits Manager
	HR Analyst
	Commissioner's Office Clerk of the Board/Deputy Clerk Claims
	Commissioner's Office Administrative Assistant
	HR Director
	Commissioner's Office/Human Resources
	Human Resources
	Commissioner's staff
	Office Specialist III and Personnel Analyst1
	Accounts Payable - Chief Deputy Auditor
	HR Director
	Commissioner's staff
	Risk Management
	Accounting Specialist – Finance
	Executive Secretary
	Fire Department Administrative Assistant
	HR Director
	No LEOFF I pensioners
	Human Resources Generalist
	Assistant Retirement Director (pensions/Medicare); HR Benefits Specialist (medical)
	Commissioner's Office Administrative Assistant
	LEOFF 1 Pension Specialist Retirement Department
	Human Resources
	Human Resources
	Commissioner's Office Administrative Assistant
	Executive's Office
	Commissioner's Office Clerk of the Board

Cataract Upgrade

Jurisdiction	Policy Summary
[redacted]	Have covered - case by case.
	Board consideration if medically necessary
	Board consideration if medically necessary
	Have covered - case by case.
	Allowed up to $550 instead of payment for eyeglasses.
	Would consider case by case.
	Would consider case by case.
	Would consider medical necessity.
	Monofocal lens approved; no specialty multifocal approval
	Would consider medical necessity.
	Not covered
	Have denied as not medically necessary.
	Consider case by case.
	$1500 lifetime limit for Toric or Multifocal lenses during cataract surgery
	Have covered.
	Consider it medically necessary for the member's vision.
	Have covered for medical necessity, case by case.
	Would consider medical necessity.
	Denied any extra charges.
	Would consider medical necessity.
	Have denied as not medically necessary.
	Monofocal only.
	Have covered for medical necessity.

Chemical Dependence

Jurisdiction	Policy Summary
[redacted]	Repeat patients reimbursed 1 year after completion w/evidence of continued recovery.
	Provided through medical plan
	Provided through medical plan
	$2,000/year for 3 consecutive years. Written confirmation program completion.
	Per statute
	Medical plan covers, non-covered costs up to $5,000 over 2-year period, conditions apply.
	Pre-approval required. One-time $6,000 maximum
	If exceeding insurance coverages, Licensed psychiatrist, et all (see plan), Dr ordered with Tx plan. State licensed facility. Notify pension w/I 10 days of admission. Repeat tx: Pay for tx/reimbursed after one year of completion.
	100% allowable charges both inpatient and outpatient.
	Pre-approval required. Part of regular coverage.
	Prescribed by licensed physician.
	$2,000/year for 3-consecutive years.
Kennewick	Inpatient treatment facilities, one-time only. Pre-approval required.
[redacted]	Maximum $6,000. Pre-approval and written confirmation of program completion.
	Physician prescribed State-approved program. Pre-approval required.
	Licensed agency: Dr ordered, written plan w/in 5 days of admission. Complete tx, if tx discontinued member cost prorated.
	Not to exceed by 10% average cost for such care in Lewis Co area.
	Covered through city plan/expenses not covered can be submitted to board.
	Pre-approval required.

Chemical Dependence (Cont.)

Jurisdiction	Policy Summary
[redacted]	Not to exceed by 10% the average cost for such case in the Pacific Co area.
	State approved tx only
	Licensed facility approved by board Dr. Max $5,000 during consecutive years – Dr recommended. Written tx plan, within 5 days of admission. Remains in facility thru final or prorated.
	Only if administered by state-approved treatment program.
	$12,000 every 2 calendar years.
	Case by case.
	Board discretion, pre-approval needed.
	Complete use disorder program by City of Richland first before an out of network plan submission to Board for authorization.
	Complete use disorder program by City of Richland first before an out of network plan submission to Board for authorization.
	State licensed facility. Primary Dr letter/determine Tx. In/outpatient. Reimbursement lifetime max $18,000.
	100% billed charges in/outpatient. Up to lifetime max $30,000. State licensed facility $9,600 maximum. Pre-approval required. Repeat treatment considered after 1year
	Pre-approval required. Prescribed by physician, psychiatrist, or psychologist.
	Licensed treatment facility referred by doctor, one treatment per lifetime.
	Outpatient/residential including diagnostics, counseling. Not exceeding $7,000/2 years or total $14,000/lifetime.
	Covered by Regence BlueShield
	Pre-approved only in case of medical necessity.
	$6,000 maximum. Pre-approval required. Repeat treatment considered after 1year.
	Pre-approval by Board physician required. Maximum $5,000/2 consecutive years.
	$6,000 maximum. Pre-approval required. Repeat treatment considered after 1year.
	$6,000 maximum. Pre-approval required. Repeat treatment considered after 1year.
	Preferred & Participating Providers. 100% of Allowed amount.
	Drug/Alcohol inpatient and outpatient/100% to max $5,000 every two consecutive yrs/lifetime max $10,000.
	$5,000 maximum in a two-consecutive-calendar-years, $10,000 lifetime maximum.

Chiropractic

Jurisdiction	Policy Summary
[redacted]	Evaluation/treatment plan required every 6 months.
	Same as medical benefit if performed by licensed chiropractor.
	Spinal manipulations covered through Medicare. For diagnostic, exam and/or x-rays, submit itemized bill and EOB for reasonable charges to the Pension Board for reimbursement.
	Spinal manipulations covered through Medicare. For diagnostic, exam and/or x-rays, submit itemized bill and EOB for reasonable charges to the Pension Board for reimbursement.
	Covered by insurance plan. If visits exceed entitlement, can submit to Board for consideration.
	Covered by insurance; if +visits then board discretion.
	Insurance max applies. Any exceeding evaluation required to establish necessity
	Covered when provider licensed chiropractor.
	Tx beyond insurance requires tx plan in a month w/updates every 12 mos.
	20 visits per calendar year.
	100% of allowable charges; x-rays: once every 12/mos. 100% allowable charges.
	Pre-approval required over 20 visits per calendar year.

Chiropractic (Cont)

Jurisdiction	Policy Summary
[redacted]	Insurance policy criteria, 20 visits/year submit report from chiro to exceed/pr
	Evaluation/treatment plan required for services exceeding insurance coverage.
	Prior approval required after 2 treatments exceeding insurance coverage.
Kennewick	Pre-approval required for over 12 visits per calendar year. Board eval for addt'l.
[redacted]	Treatment plan required for more than 2 visits and every 6-continuous months.
	Prior approval after insurance limitations exhausted.
	Same as other necessary medical claims.
	15 visits year, exceed 15 visits requires board medical to determine necessity.
	12 visits/year Max $45 per visit. Pre-approval req'd after 12/year.
	20 visits annually. To exceed/board Dr to determine necessity.
	Pre-approval required after 35 visits/calendar year.
	Pre-approval required before exceeding defined insurance benefit
	Covered with city plan, 25 visits per year
	No policy
	Pre-approval required over 20 visits per calendar year.
	Pre-approval required over 20 visits per calendar year.
	Pre-approval required. No more than 35 visits per calendar year.
	As governed by statute.
	25 visits/calendar year.
	Covered same as active employes – 22 visits annually; Board covers remaining.
	Pre-approval required over 20 visits per year.
	Covered as any other medical.
	Licensed Chiro. $80 per session/26 sessions per year/1 tx day. X-rays covered up to two sets per year.
	Maximum $60/visit up to 24 visits/year without prior Board approval.
	Pre-approval required after 3 visits/six mos for same condition.
	12 visits/year unless prescribed by chiropractor or physician. Pre-approval before exceeding
	20 visits annually. Treatment plan required after 4 visits for same injury.
	$750 per year/lifetime/one condition/$3000 for tx. Includes Naturopathy, acupuncture, massage, chiro and other holistic or alternative choice.
	Covered by Regence BlueShield
	Reasonable expenses by licensed medical provider.
	First call $129; subsequent calls $40; x-rays $100. Kaiser members shall access services through Kaiser.
	Treatment plan required after 10 visits for same condition.
	Treatment plan required after 3 visits for same condition.
	Treatment plan required after 3 visits for same condition. 6-month progress reports.
	No specific policy
	12/year. Pre-approval required before exceeding defined benefit.

Claims Submission

Jurisdiction	Policy Summary
[redacted]	Rx should be monthly; Rx must be quarterly March, June, September, and December.
	Submit with required documentation within a rolling 12-month period from date of service with a 60-day grace period.
	Submit with required documentation within a rolling 12-month period from date of service with a 60-day grace period.
	Submit with required documentation.
	Submit within six months of billing date

Claims Submission

Jurisdiction	Policy Summary
[redacted]	Accept faxed, copied, or e-mailed claims
	Accept US Mail or email within 6 months
	Submission to a year of date of service
	Accept within 6 months of date of service
	Accept faxed, copies or e-mailed claims
	Accept faxed, copied, or e-mailed claims
	Submission to 6 months from date of service or processed by insurance.
Kennewick	Submission within six months of date of service/insurance processing.
[redacted]	Accept faxed, copied, or e-mailed claims
	Submission within 6 months of service
	Submission w/I 180 days of receipt of original bill.
	Submission up to one year from date of service.
	Submission within six months following original billing.
	Submission within one year: Fire: Medicare & Sup Police: Medicare & Sup HMA and Dental to board
	Submission within 6 months of dates of service.
	Accept faxed, copied, or e-mailed claims
	Active or covered thru spouse/premium reimbursement $50/month. Not active/no other plan: $600/year. Retired: 2 cleanings/year. Provision: $2000/annually premiums/fillings/crowns. Over 2k Tx plan preapproval required. Dentures: Preapproval/two quotes 100%.
	Two-year term; Nominations and ballots to all members
	Submission w/in 6 months
	Submission w/in 90 days of date of expense.
	Submission within 90 days of receipt of bill.
	Accept faxed, copied, or e-mailed claims
	Accept faxed, copied, or e-mailed claims
	Submission w/in 12 months after receipt of insurance EOB
	Submission by one year from date of service
	Submission by one year date of service
	Accept faxed, copied, or emailed claims
	One year from dates of service.
	Submission within a year of dates of service

Claim Filing Limits

Jurisdiction	Policy Summary
[redacted]	6 months of receipt of original bill
	Rx at least quarterly, March, June, Sept, December
	Rolling 12-month period from date of service with a 60-day grace period.
	Rolling 12-month period from date of service with a 60-day grace period.
	1 year from date of service
	6 months of billing date
	1 year from date of service
	1 year from date of service
	1 year of date of service
	The Clerk is authorized to approve regular out of pocket medical claims after insurance payment.
	Within 6 months from original billing.
	Within 6 months from the date incurred
	12 months from date of service
	1 year of date of service

Claim Filing Limits (Cont.)

Jurisdiction	Policy Summary
[redacted]	6 months of date of service or from date of denial by insurance carrier
	6 months of receipt of original billing
Kennewick	6 months of date of service or date processed by insurance carrier
[redacted]	6 months of receipt of original billing
	6 months of receipt of original billing
	180 days of receipt
	1 year of service date
	Submission w/in 12 mos of date of service.
	No later than one year.
	6 months of receipt of original billing
	120 days
	1 year of date of service
	1 year of date of service
	1 year of date member becomes aware, or should have become aware
	1 year of service date
	1 year of service date or knowledge of the claim
	6 months of service date
	1 year of service date
	Submission first to any medical/dental coverages then by 6 months date of expense.
	6 months of receipt of original billing
	6 months after receipt of insurance EOB; medication 1 year from date of service
	1 year of service date
	6 months of date of service
	1 year of service date
	1 year of service date
	1 year of service date
	6 months of receipt of original billing
	1 year of date of service
	Rx submission by 12months from purchase; Other claims 90 days of treatment date.
	1 year of service date

Claim Funding

Jurisdiction	Policy Summary
[redacted]	Separate fund for LEOFF I expenses.
	Separate fund for LEOFF1 expenses.
	Separate fund for LEOFF1 expenses.
	Claims paid from general fund and administered by Commissioner's office.
	Claims paid from general fund and administered by Board Secretary (City Clerk).
	Claims paid from general fund and administered by Commissioner's office/HR.
	Budgets for medical claims in Human Resources budget.
	Have separate fund for LEOFF I expenses.
	Employing agencies pay claims, Board has budget exams ordered by Board.
	Has separate fund for LEOFF I expenses.
	No separate budget, paid from general fund, administered by Auditor's Office.
	Submission within 120 days of dates of service
	Funded through general fund and processed by Human Resources.
	Budget through Sheriff's department/through Risk Management for long term care
	Set aside budget for claims.
	General fund transfers into pension fund based on actuary recommendation.
	Separate budget.
	No separate budget, paid from general fund, administered by Human Resources.

Claim Funding (Cont.)

Jurisdiction	Policy Summary
[redacted]	Submission in timely fashion, no 6+ month claims. Medication submission w/in a year from date.
	Claims paid from benefit fund out of the LEOFF sub-fund.
	Budgets fund in the Sheriff's office budget, individual districts administer fund.
	Has separate budgeted funds for LEOFF 1 expenses.
	Budget for claims as part of Sheriff's office budget, claims paid from Sheriff's Office.
	Budgets in a separate fund with general fund providing revenue.
	Have separate fund for LEOFF I expenses.
	Funded through general fund and processed by City Clerk's office.

Claim Processing

Jurisdiction	Policy Summary
[redacted]	Submitted to board within 6 months.
	Adams Co Auditor and Accounts Payable.
	Claims processed monthly following board approval.
	Claims processed monthly following board approval.
	Submit within rolling 12 mos. from date of service w/60-day grace period.
	Board secretary provides vouchers to Auditors Office for payment. Confidential information retained in Board files. Claims processed monthly following Board approval.
	Staff has $1,000 authorization limit for processing general medical claims, Claims paid weekly.
	HR
	All claims must be approved by the Board prior to payment.
	Claims processed monthly following Board approval.
	All claims must be approved by the Board prior to payment.
	Claims must be submitted with 6 months. Claims paid monthly.
	Claims paid as received, items requiring further Board review are paid quarterly.
	Secretary processed per Board policies.
	Process claims as received.
	Claims processed monthly following Board approval.
	Accountant in Sheriff's Department.
	All claims must be approved by the Board prior to payment, paid bi-monthly.
Kennewick	Auditor's Office Accountant.
[redacted]	Claims paid monthly.
	Board Clerk.
	HR Staff Assistant to Board, claims processed bi-monthly.
	Auditor's Office for County, Local Police & Fire Department's handle their own.
	Sheriff's Department after Board approval.
	Claims paid as received.
	Claims processed monthly following Board approval.
	Claims paid monthly after Board approval.

Claim Processing

Jurisdiction	**Policy Summary**
[redacted]	Human Resources.
	Secretary has $450 authorization limit for processing general medical claims, checks cut weekly.
	Claims paid monthly.
	Claims processed monthly.
	Office Specialist III in Human Resources
	Checks cut weekly. Board Secretary may process claims up to $450.
	Board Clerk, claims paid monthly following Board approval.
	Risk Mgmt sends authorization to pay to Accts Pay in Sheriff's Dept or another agency.
	HR Staff Assistant to Board.
	Secretary has $500 authorization limit for processing general medical claims, claims processed twice per month.
	Secretary processes per Board policies.
	Board secretary processed bills up to $500 without Board pre-approval.
	Secretary follows Board guidelines, claims processed as received.
	Civil Deputy, Sheriff's Office.
	All claims must be approved by the Board prior to payment, claims paid monthly.
	Staff process per Board guidelines; process warrants twice a month.
	All claims must be approved by the Board prior to payment, claims processed monthly
	All claims must be approved by the Board prior to payment; Claims processed monthly.
	Secretary processes per Board policies.
	HR Staff Assistant to Board/3rd Party Administrator processes and pays claims within 2-3 weeks of receipt.
	Warrants processed twice a month.
	Secretary processes per Board policies, claims paid weekly.
	Pension Records Clerk.

Cosmetic Surgery

Jurisdiction	**Policy Summary**
[redacted]	Only as result of accidental injury or disease necessary to correct function.
	Not medically necessary except post trauma reconstructive.
	No specific policy but would likely approve if medically necessary.
	Not considered a medical necessity.
	Not considered a medical necessity.
	Not considered a medical necessity.
	Only as result of accidental injury or disease necessary to correct function.
	Services for beautification purposes not considered.
	Do not provide.
	Only as result of accidental injury or disease necessary to correct function.
	Only if medically necessary.
	Reconstruction to correct as a result of injury.
	Reconstruction to correct/repair as result of injury.
	Not covered unless result of duty related injury.

Dental

Jurisdiction	**Policy Summary**
[redacted]	Check-up, cleaning, x-rays semi-annually. All other services require pre-approval. Orthodontic if determined medically necessary.
	$1,200/year.
	Reimbursed up to $6,000 every 2 years for dental care (preventative exams, cleanings, x-rays, tooth/gum repairs & maintenance, denture coverage, dental insurance). Must have at least 1 dental cleaning/year. Cosmetic dental services not covered. Accidental injury to teeth within 90 days of accident per RCW.
	Reimbursed up to $6,000 every 2 years for dental care (preventative exams, cleanings, x-rays, tooth/gum repairs & maintenance, denture coverage, dental insurance). Must have at least 1 dental cleaning/year. Cosmetic dental services not covered. Accidental injury to teeth within 90 days of accident per RCW.
	Accidental injury see policy/submit to board. Max $3,000 preventative/cleanings/maintenance/yearly. Shall have at least one cleaning/yr. Failure may impact other dental authorizations. No whitening. Case by case for implants/surgery.
	Allowance of $1,000 in conjunction w/vision per year
	2 exams, cleaning & x-ray up to $500/year; treatment of periodontitis allowed first occurrence only. Routine & periodontal $2,500/yr.
	Accidental injury
	Accidental injury to teeth only.
	Employer shall provide benefits similar to those for active employees. Two comprehensive dental insurance plans are provided.
	Employer shall provide benefits similar to those for active employees.
	Employer provides dental insurance.
	Per RCW except “Well care” as defined by member plan. Cosmetic dental/case by case, medically necessary. Pre-approval unless emergency.
	Accident w/in 90 days of accident
	$700 per year services or premium. Use it or lose it.
	$2,000 per calendar year (1-year roll-over of unused balance up to $4,000). Accidental injury to teeth. Dentures up to $350 per plate, once every seven years.
	$750/12-mo period; $1,200 one set dentures or bridge. No orthodontia unless for medical necessity.
	1 exam/year; 2 cleanings/year; $1,000/year routine dental; dentures, implants, bridgework 50% to $3,000/year; no teeth whitening; no cosmetic.
	No policy. No dental insurance.
Kennewick	Up to $500 per calendar year for check-ups, cleaning or denture reline.
	As governed by statute.
	$1,500/year. $1000 lifetime orthodontia. City covers insurance.
	Maximum $3,000/year. Cosmetic dental only as medically necessary.
	One annual routine/cleaning x-rays. All other dental preapproval required. Dental Injury start within 90 days of accident/completed within 2 years.
	Max $1,000/year. Wellness/x-rays/cleaning prescriptions by dentist.
	$500/year preventive and x-rays
	Accidental injury to teeth. Orthodontics for medical necessity, pre-approval rqd.
	Do not provide dental care.
	Only accidental injury to teeth.
	100% billed charges routine max $2,500. One mandatory cleaning/Yr. Can carry funds to max $5,000.

Dental

Jurisdiction	**Policy Summary**
[redacted]	$2000/year includes 2 cleanings/1 set of X-rays. Further expenses require prior approval.
	$1,500 maximum per year for premiums/deductibles for members on city plan. If not on city plan/case by case basis.
	Accidental injury to teeth received while on-duty. Olympia As governed by statute.
	$600/year preventive/restorative. Dentures 50% lowest of 2 quotes. Prior approval.
	Reimburse premium for retiree coverage through current employer up to $48/month.
	$300/year. Dentures if medical necessity and pre-approved.
	Procedures medically necessary to prevent physical problems, prior approval required. No orthodontia.
	$2,000 per year. Cosmetic not approved.
	No dental insurance.
	$2,000/year.
	Accidental injury to teeth and claims documented medically necessary.
	Covered under city plan w/ limits for Type of care. Two cleanings per yr.
	$1,200/year preventive/restorative. $1,500/dentures one set bridges/denture/implant, one lifetime payment. Orthodontics if medically necessary.
	$2,000/year exam, fillings, crowns, repair dentures; $1,500 one set/bridges/full or partial dental. Orthodontic not approved unless medical tx, no cosmetic dental.
	$2,000 annual applied towards premiums/dentures/cleanings/x-rays etc. by licensed dentist.
	$3,000 per year. Oral surgery/implants if medically necessary w/prior authorization and limits. No premium reimbursement.
	$750 annually for out-of-pocket dental expenses.
	Accidental injury to teeth only. Orthodontics for medical necessity pre-approved.
	100% routine dental care. No cosmetic procedures. Board will pay insurance excess up to $2,000.
	1 exam/year, 2 cleanings/year, routine dental, and peri if medically necessary. No cosmetic or whitening. $25 max fluoride tx/year.
	$1500/year through Washington Dental Service.
	Coverage through plan, claims to TPA w/I 24 months
	$2,000 year premiums allowed. No dental insurance/two cleanings/yr. with one of those cleanings and one checkup being mandatory. Fluoride $25/year. No ortho, whitening, cosmetic. Submission w/in one year.
	$2,000 per calendar year
	$2,000/calendar year for non-cosmetic dental care w/Regence; Willamette not to exceed max allowance.
	As governed by statute
	Reasonable expenses for medically necessary dental/ortho tx directly related to medical condition.
	Accidental injury to teeth. May approve one-time purchase of dentures. Reline of dentures not covered. Medically necessary claims considered.
	As governed by statute
	As governed by statute. Orthodontics for medical necessity only, pre-approved.
	$300/year for preventive.
	$3,000 per calendar year.
	As governed by statute.
	As governed by statute. Group dental plan provided - members pay premiums.
	$1500/year excludes cosmetic

Disclosure to Employer

Jurisdiction	Policy Summary
[redacted]	Insurance carriers have been willing to provide information.
	Insurance carriers have been willing to provide information.
	Authorizations requested as needed only.
	Insurance carrier considers Board additional insurance provider, no release required.
	Members sign authorization each year giving Board permission to discuss their PHI with family members or providers to resolve billing and/or coverage issues.
	Members work directly with insurance carriers.
	Routinely send out authorization forms.
	Claim form includes authorization for disclosure necessary to process claim.

Elections

Jurisdiction	Policy Summary
[redacted]	Nominations and ballots by July 1 annually.
	Nominations and ballots sent to all members.
	Nominations and ballots sent to all members.
	Nominations and ballots sent to all members.
	2-year term/expire Dec 31.
	Absentee ballots sent to all members – no election if only one member nominated.
	Secret ballot. Two-year term. Held in November.
	Nominations and ballots to members. Two-year term.
	Two-year term; Police: odd year Fire: even year; nominations & ballots to members
	Nominations and ballots to affected members. Police: odd years Fire: even years
	Nominations and ballots sent to all members.
	Nominations and ballots sent to all members. 2 yr term; by Jan 15th yearly
Kennewick	Two yr term, elections in even years/January. Nominations & Ballots to members.
[redacted]	Nominations and ballots sent to all members; December election.
	Nominations and ballots to all members via mail by January 2; Two-year term.
	Nominations and ballots to all members via mail by December; Two-year term.
	Two-year term, nominations, and ballots to all members
	Two-year term/even years in January Nominations and ballots to members.
	Two-year terms; Fire Rep: December/even years; Police Rep: December/odd years via mail nominations and ballots.
	Nominations and ballots/2-year term beginning January 1.
	Two-year term. Police: even year. Fire: odd years. Nominations/Ballots mailed.
	Secret ballots to all. 1st week/December every other year/two-year term.
	If only one person nominated there is no election.
	January yearly/1 yr. Nominations and ballots to members.
	Two-year terms/staggered. Nominations & ballots November annually.
	Nominations and ballots sent to all members.
	Two-year term. Nominations and Ballots to all members via US Mail.
	LEOFF1/December odd years; LEOFF2/even years
	Nomination and ballots to all members.
	Nominations and ballots to members via USPS. Two-year term/alternating.
	Two-year term, even years; Nomination and Ballots mailed to all members
	Nominations and ballots to members in December yearly
	Fire: Secret ballot/all fire members/January every other yr. Police: Secret ballot/all police members/January opposite year of Fire election. Two-year term.
	Nominations sent to all LEOFF I members. no balloting if only one nominee
	Nominations and ballots in US Mail to all members

Elections (continued)

Jurisdiction	**Policy Summary**
[redacted]	Nominations and ballots sent to all members. Police: 3 yr term/staggered. Fire: 2 yr term/staggered.
	Nomination and ballots to respective membership: 2 Yr Term/one LE one FF
	Two-year term; Police/odd years. Fire/even years; Nominations & ballots to affected groups members.
	Three-year term: Nominations and ballots sent to all members.
	Two-year term. Nominations and ballots sent to all members.
	Nominations and ballots sent to all members.
	Two-year term. Police Odd years. Fire: Even years; Nominations and ballots to members.

Equipment

Jurisdiction	**Policy Summary**
[redacted]	Pre-approval required. Must be medically necessary.
	Physician's prescription required for medical necessity. Utilize Medicare coverage. If not covered by Medicare, submit to board for possible reimbursement.
	Physician's prescription required for medical necessity. Utilize Medicare coverage. If not covered by Medicare, submit to board for possible reimbursement.
	No equipment or supplies which have a non-medical use or function.
	Must be prescribed by medical doctor. Prior authorization needed for reimbursement.
	Must be prescribed by medical doctor, anything over $250 needs prior approval, unless emergency. <$250 reimbursed.
	Durable medical equipment/orthotics prescribed by physician for patient's use only. Board may require quotes prior to purchase.
	Medical necessary rental of durable medical equipment, unless purchase more cost effective.
	Dr. Prescribed, must submit through any insurance coverage first then pension.
	Durable medical equipment prescribed by physician as medically necessary.
	Preapproval required to purchase
	>$500 Pre-Authorization from board required. Reasonable replacement costs.
	Physician prescribed as medically necessary
	100% of allowable charge.
Kennewick	Pre-approval required.
[redacted]	Pre-approval required; physician prescribed as medically necessary.
	Pre-approval required for non-emergency equipment costing over $100.
	Prothesis case by case basis likely covered/Dr documentation.
	Pre-approval required; Physician prescribed as medically necessary.
	Preauthorization prior for $500+ and 3 quotes. <$500 no quote necessary.
	Pre-approval. Medically necessary.
	Pre-approval required; physician prescribed as medically necessary.
	Pre-approval required; Physician prescribed as medically necessary.
	Pre-approval required for non-emergency equipment costing over $100.
	If cost +$500/prior approval unless emergency.
	Braces, splints, orthopedic appliances/orthotics, prosthesis for functional reasons.
	Medically necessary durable medical equipment defined by medical plan. All other considered case by case.
	Physician's verification of medical necessity.
	Provide the board with letter from Dr outlining services needed.
	Pension will reimburse after Medicare. Pre-auth on most. Primary doctor letter or Rx required depending on dollar amount. Under $250 with Dr RX.

Equipment

Jurisdiction	Policy Summary
[redacted]	Physician's letter/prescription required for medical necessity. Utilize preferred provider (they can also ship) is preferred.
	Pre-approval required; Physician prescribed as medically necessary.
	Prescribed by physician as medically necessary. Preauthorization required.
	Per RCW 41.26.
	Amount not covered by Medicare/Regence BlueShield must be pre-approved.
	Pre-approval required; physician prescribed as medically necessary.
	Pre-approval required; physician prescribed as medically necessary.
	Physician prescribed medically necessary. Pre-approval required over $250.
	Pre-approval required; physician prescribed as medically necessary.
	Prescribed by physician as medically necessary.

Federal Income Tax

Jurisdiction	Policy Summary
[redacted]	Prior act paid through ap, 1099 end of year, no tax withheld.
	Prior act paid through ap, 1099 end of year, no tax withheld.
	Prior act paid through ap, 1099 end of year, tax withheld upon request.
	Prior act paid through payroll, fit withheld.
	No FIT withheld.
	Prior act paid through payroll, 1099R at end of year, tax withheld upon request.

Handicapped / Disability Devices

Jurisdiction	Policy Summary
[redacted]	Reimbursed on case-by-case basis with documentation of medical necessity.
	Reimbursed on case-by-case basis with documentation of medical necessity.
	Paid for motorized scooter & lift for vehicle, as well as lift installation.
	Paid for "turnaround" apparatus for members vehicle.
	Have paid for stair lift; case-by-base no formal policy. Prosthetics 100% allowable charges.
	Paid wheelchair ramp, railing and other modifications to make home accessible.
	Have paid for wheelchair ramps and home modifications.
	Medical devices paid through DME with Rx, letter of medical necessity.
	Paid for lifts and ramp.
	Paid for wheelchair ramps walk-in shower, bathroom modifications, shower chair and toilet seat riser.
	Have paid for installation of grab bars, raised toilet seat, lift chair.
	Have paid shower remodeling; lift recliner.
	Partial Approval to reimburse a Lift Chair (2016 – minus heat/vibration features).
	Denied reimbursement of wheelchair ramp as not medically necessary.

Hearing Aids

Jurisdiction	Policy Summary
[redacted]	Covered.
	Pre-approval required. $3,000 max/every 3 yrs. Must provide 3 bids w/warranty. Costco ok, City card available.
	Amount determined by Board designated provider 1/five years. Necessary repairs are covered. Batteries not covered.

Hearing Aids

Jurisdiction	Policy Summary
[redacted]	Hearing tests (audiograms) covered by medical plan. Hearing aids reimbursed up to $2,500 per aid or $5,000 per pair during a 36-month period accompanied by supporting documentation for a licensed physician or hearing specialist. In addition, Board will reimburse for cost of batteries, including rechargeable batteries and charging stations. Board consideration on a case-by-case basis with required documentation for hearing aids more than $5,000 or prior to 36-month period.
	Hearing tests (audiograms) covered by medical plan. Hearing aids reimbursed up to $2,500 per aid or $5,000 per pair during a 36-month period accompanied by supporting documentation for a licensed physician or hearing specialist. In addition, Board will reimburse for cost of batteries, including rechargeable batteries and charging stations. Board consideration on a case-by-case basis with required documentation for hearing aids more than $5,000 or prior to 36-month period.
	Pre-approval required. Exam by MD/DO or Audiologist. Max $6,000. Replacement/3yr. $50 for batteries.
	Pre-approval required. Dr or Audiologist required. Board will reimburse for one or both h/a every 5 years, submit to board within one year of billing date.
	Exam by Dr or hearing specialist/audiogram and report. $3,000 per ear/36 months. Replacement 1x/36 months w/documentation. Repair-documentation why. Except regular maintenance and batteries.
	$1,800 per ear every five years; repair reimbursement up to $600 accumulative.
	Aids/Exam up to $6,000 every 3 yrs.
	Exam covered. $1,600/aid/36-months for basic amplifier hearing aid. $2,600/aid/5-years for digitally programmable analog; $2,800/aid/5-years for programmable digital; batteries and necessary repair/replacement.
	Pre-approval required. Two estimates required. Charges limited to that necessary to achieve functional corrections. Replacement: pre-approved on case by cast, limit to reasonably necessary costs.
	Evaluation w/otolaryngologist then audiologist to include a 2 yr warrant and audiogram/aid recommendation. 1 pair every 5 years. Repair/Maint: exceed 2 yr warranty at reasonable cost. Repair/Replace: claim form/information 1x every 5 yr 5-year replacement. Two estimates required. - $1,200/per aid. Maintenance/batteries/loss not covered.
	1 hearing test/3 years. Costco current rates or pre-approval if no Costco/will cover Annual membership if member is not. Repairs/replacement 36 months. Batteries covered.
	$4,300/ 24 mos; by licensed Audiologist. All claims to HMA.
	Audiogram covered. Prior approval required. Active members only, unless hearing deficiency was reason for retirement and was duty-incurred. Battery replacement excluded. 6-year replacement.
	Case by case pre-approval by board, medical necessity. Two bids by two vendors. Max $1750 ea/$3500 year on 5-year basis. Maintenance/repair case by case
	$2,500/aid/5 years. Reasonable cost of batteries and repairs covered. Would be considered case-by-case.
	$3,000/aid/5 years. Pre-approval required.
Kennewick	Pre-approval required. Exam by board designated provider. Every 5 years. Necessary repairs, no routine maintenance, or batteries.
[redacted]	$2,000/aid plus 50% of balance to $3,000/aid/3 years. Necessary repairs, routine maintenance and batteries covered.

Hearing Aids

Jurisdiction	Policy Summary
[redacted]	$2,500/aid/5 years. 2-year warranty required. Regular maintenance and batteries.
	$2,500 per aid/36-months by qualified medical provider or audiologist. 2-year warranty required. Reasonable battery cost. Replacement allowed but not more than every 3 years.
	$5,000/aid/5 years, warranty and batteries not covered.
	$6,500/3 years. Batteries and repairs covered.
	Exam by Dr/hearing specialist; Audiogram, report. Max $4,400/pair/48 months. Replacement if line duty or accident. Maintenance/batteries allowed.
	Exam by Md or ENT. Dr statement. Aid's must be issued by licensed fitting dispenser or licensed audiologist. Submit to insurance first. Case by case basis.
	Pre-approval required. Medical necessity, two bids. Repair statement why/repair vs replacement, Replacement on case-by-case basis
	Prior approval. Audiology report, device recommendation w/cost estimate. Replacement requires new support.
	$2,600/ear/5 yrs; $100 allowed towards handheld remote control. Damage due to negligence and batteries are covered.
	Pre-approval required for first time. $1,600/aid/36-months.
	$3,000/3 yrs, includes 2-yr warranty, maintenance, batteries, and reasonable repairs. Exam covered if not covered by medical insurance. Effective 9-1-15, reimburse minimum Costco membership fee when hearing aids are purchased at Costco, if not already a member.
	Pre-approval required.
	Pre-approval required. $1,000/aid/5-years. 2-yr warranty required. Maintenance and batteries not covered.
	Pre-approval required. Charges necessary to achieve functional correction. 3-yr warranty required. Necessary repair and batteries allowed.
	Charges necessary to achieve functional correction. $2,500/aid/ 60-months.
	$1,500/aid/36-months. Batteries not covered.
	Preauthorization. Medical necessity by licensed audiologist.
	$1,875/aid/5 years. Batteries and reasonable repairs covered.
	Two options/without prior approval evaluation by Audiologist $6,000 pair/4 years. Audiologist evaluates/audiogram and recommendations estimates for two aids/fittings/adjustments and costs of aids including 2 yr warranty. Lost/broken or damage no replacement if negligent or abuse.
	Pre-approval required. Reasonable charges based on current rate charged by Costco/3-yrs/2-yr warranty required. Batteries & maintenance covered only when included in purchase price.
	Pre-approval required. $2,500/aid/4-years. 2-year warranty required. Cost of maintenance and batteries eligible.
	$2,500/aid/36-months digital analog; $2,800/aid/5 years digitally amplified; Batteries covered; Repairs need board approval
	$2,500 per aid. Batteries at member's expense. Replacement considered after 5 years on case by case/information by Audiologist.
	$1,800/aid. Every 5/yrs Licensed Audiologist. Replacement batteries not covered. Repairs/per Audiologist.
	Pre-approval required.

Hearing Aids

Jurisdiction	**Policy Summary**
[redacted]	Medically necessary, $3800/ear/36 months cost include warranty & batteries 100% hearing tests. Digital $3,500/aid/3 years. Prescribed and dispensed through licensed Audiologist only. Repair, reprogramming, maintenance, and batteries covered. $2,600/aid/36-months. Regular maintenance and batteries covered. Costs of Wa St L&I standards aids every 5 years. Damage/Responsibility of member. $5,000/pair. Batteries $40/year. $4,000/5 years. Batteries covered. Repair/replacement case by case. $4,000/set, claim accompanied by documentation of Licensed Otolaryngologist of medical requirement of disorder. Batteries/$75/year. Repair/ Case by case. Digital aids through TPA; Cleanings/Repair paid in full/5 years; batteries covered $2,000/aid/3-years. Batteries $75/12-months. Repair considered. $1,750 per ear or $3,500 per pair, replacement every 5 years w/ prior approval, repairs $250 per aid w/ prior approval Otorhinolaryngologist or Md. Reasonable expenses. Hearing Aids (Cont.)
Jurisdiction	***Policy Summary***
[redacted]	Pre-approval required. Charges necessary to achieve functional correction. 3-year warranty required. Batteries not covered. Pre-approval required. $1,500/aid/36-months analog; $2,500/aid/60-months digital. $25 deductible for regular maintenance and batteries. Prior approval required. $2900/aid/36-months. Regular maintenance/repair and batteries eligible for reimbursement. Replacement of lost aids not covered. $3,000/aid/5-years. 2-year warranty required. Regular maintenance and batteries covered. $1,600/aid/5-years. Repairs considered. Maintenance/batteries not covered. $1,800 ea aid. With preapproval and 30-day trial period. Repairs & batteries 100%. Pre-approval required if cost $500 to repair. $2,000/aid/5 years. Repair/loss only in line of duty. Cleaning/service/batteries excluded. Pre-approval required. $1,800/aid/5 years. Batteries and repairs 100% reasonable cost. 30-day trial period required. Reasonable costs for repairs and batteries.

HIPPA

Jurisdiction	**Policy Summary**
[redacted]	Documents kept in Pension files. All routine claims are de-identified. Minutes show board action only. Documents redacted of member's identity in items considered during executive session. Documents kept in Pension files. All routine claims are de-identified. Minutes show board action only. Documents redacted of member's identity in items considered during executive session. Members assigned random number; discussions refer only to number. 3rd-party administrator process claims. Documents kept in Disability Board files. Send a form to Auditors office for payments and keep all claims and receipts in Pension Files for HIPAA purposes. Employer provided with a form authorizing payment. Summary of medical claims (not including provider) sent to the jurisdictions for payment. All back-up paperwork stays in Pension office. Documentation kept in Pension Board files. Employer provided with form authorizing payment. Documentation kept in pension board files.

HIPPA

Jurisdiction	Policy Summary
[redacted]	Provide an authorization to pay. Original documentation is kept in Pension files. Only Pension Office see documents. All others see only voucher numbers, payee, and amount. Board documents redacted of members identity. Documents maintained in Board files. Payment requisition sent to accounting stating that documentation is on file in the Pension office. Send a form to AP for payment and keep all claims in Pension files. Have a HIPAA policy listing who in the auditor's office will be handling these documents and where they are stored. Documentation remains in Board files. Authorization to pay provider sent to employer for payment. Requisition includes statement that documentation is kept in disability board files. Documents kept in Police Pension Office. All others see only voucher numbers, payee, and amount. Minutes show Board action only, specifics considered in executive session. Send form to AP for payment and keep all receipts in Pension files. The Boards, entire Retirement Department, and Risk Management staff are HIPAA and EPHI compliant. Employer provided with a form authorizing payment. Documentation kept in Board files.Yakima Co Board Secretary sees details. All others see only voucher numbers, payee, and amount. Records kept locked in Human Resources.

Hot Tubs

Jurisdiction	Policy Summary
[redacted]	Request denied. Request denied as spa could be used by others. Approved purchase in 2001 ($4,460.75). No requests but have paid for physical therapy that included therapeutic hot tub. Have approved bathtub attachments that would serve as a therapeutic hot tub. and subscriptions to health type clubs that offer hot tub/pool. Request denied. Request denied. Request denied as hot tub could be used for and by others for non-necessary medical reasons and treatments could be provided in a clinical setting.

Immunizations

Jurisdiction	Policy Summary
[redacted]	Covered by insurance plan. Immunizations not covered by Medicare may be submitted to the Board for reimbursement if they are prescribed by a physician. Immunizations not covered by Medicare may be submitted to the Board for reimbursement if they are prescribed by a physician. Insurance prior to any reimbursement Covered if prescribed by medical doctor for specific medical condition. Covered by medical plan. Vaccinations covered. Covered by insurance plan Flu/pneumonia/shingles vaccinations covered.

Immunizations

Jurisdiction	Policy Summary
[redacted]	Shingles, Pneumococcal, Prevnar 13
	Covered if prescribed by medical doctor.
Kennewick	Flu/pneumonia vaccinations covered.
[redacted]	Flu/pneumonia/shingles vaccinations covered.
	Up to the amount the city pays for flu shots.
	Flu/pneumonia/shingles vaccinations covered.
	No policy.
	Have paid shingles vaccinations.
	Flu/pneumonia/shingles vaccinations covered.
	Flu 1/year. All other vaccinations must be Physician prescribed.
	If Physician prescribed would likely approve.
	None.
	Covered if physician verified necessity.
	Flu vaccinations covered.
	Flu 1/year. All others must be physician prescribed. No travel.
	Covered if recommended and administered by physician.
	Flu/pneumonia/shingles vaccinations covered.
	Vaccinations covered.
	Covered same as active employees.
	Flu, Shingles, and pneumonia.
	Annual flu, H1N1, HepB including boosters; One time shingles/pneumonia or by doctor prescription.Richland Fire Annual flu, H1N1, HepB including boosters; One time shingles/pneumonia or by doctor prescription.
	Covered w/Premera.or submit to Premera. No travel immunizations.
	Flu/pneumonia/shingles vaccinations covered. No travel immunizations.
	Shingles vaccine covered.
	As prescribed by physician.
	Have paid shingles vaccinations.
	Vaccinations covered.
	Pneumonia vaccine covered.
	Covered by Medicare/Regence BlueShield
	Flu/pneumonia/Hepatitis vaccinations covered.
	Flu/pneumonia vaccinations covered. Inoculations suggested/required to travel outside US and/or other inoculations related to specific medical conditions or exposures.
	Every 2 years: TB, Hepatitis B; other as needed
	None
	Flu vaccines are covered.
	Flu/pneumonia/shingles vaccinations covered.
	Shingles 100% 60 plus years of age.
	Flu/shingles vaccines are covered.

Insurance

Jurisdiction	Policy Summary
[redacted]	Self-insured through Premera - no spouse/dependent coverage for retirees.
	Medicare Advantage PPO plan (Humana), LEOFF Vision plan (VSP), dental costs reimbursed by Pension Board. Medical/vision premiums paid by Board. Members not eligible for Medicare are covered on City plan.
	Medicare Advantage PPO plan (Humana), LEOFF Vision plan (VSP), dental costs reimbursed by Pension Board. Medical/vision premiums paid by Board.

Insurance

Jurisdiction	Policy Summary
[redacted]	City provides insurance.
	County provides health insurance. Spouse coverage available at member's cost.
	Cities provide medical insurance.
	Health/dental insurance for spouses/dependents may be purchased.
	Member pays dependent portion of premium.
	Annual deductible for medically necessary services
	Self-insured. No spouse/dependent coverage available.
	County pay health insurance composite rate and $1,250 deductible.
	Each entity has insurance policies - none cover spouse/dependent.
	Insured through WA Counties Insurance Fund - 1 spouse purchased coverage.
	Provide health insurance. Dependent premium paid by member.
	Cover premium for active members. Self-insured - spouse (to 65)/dependent (to 25) at own expense.
	Provide health insurance. Dependent premium paid by member.
	Medical insurance for members.
	Retirees covered by same carrier as active until Medicare.
	Employee only portion of medical & dental for active; full medical premium for retirees.
	Not self-insured - 4 different plans - spouse/dependent coverage at own expense.
	Fire: Medicare & Supp, HMA with Rx & Vision included, Delta Dental supplemental Police: Medicare & Supp, Regence w/ Rx & Vision incl, Dental handled by board.
	Members covered with city plan
	LEOFF Trust plan.
	Fire: Contact labor first, NWFFT, Davis Vision, Epic Hearing. Police: Med/advantage/Kaiser, VSP/vision
	County provides health insurance. Cities are responsible for their members.
	Do not reimburse premiums. Self-insured - no spouse/dependent coverage available.
	Pay employee contribution to insurance, co-pay, deductible, or co-insurance. Self-insured (TPA-Regence) - spouse (to 65)/dependent (to 25) at own expense.
	Cover insurance premium until Medicare. Self-insured. Member may purchase spouse/dependent coverage via city's plan at retirement only.
	Self-insured - no spouse/dependent coverage available.
	Self-insured - no spouse/dependent coverage available.
	Medical/Dental premiums paid by the Board.
	Medical/dental premiums will be paid for board approved plans.
	Reimbursement for premiums by employers/spouse employer for primary coverage.
	Self-insured - spouse/dependent at own expense.
	County insurance - spouse/dependent at own expense (widow may continue).
	Spouse-dependent at member's expenses, deducted from retirement check.
	Pay premium for active employees; reimburse retired members for Medicare Parts A and B. Self-insured through Premera - no spouse/dependent coverage.
	Bargaining unit employees covered through LEOFF Welfare and Trust.

Insurance

Jurisdiction	Policy Summary
[redacted]	Self-insured. Coverage may be purchased for spouse (to 65)/children (to 23).
	Employer pays insurance premium.
	Spouse/dependents coverage available for purchase (offered COBRA if member dies).
	No coverage allowed for spouses.

Insurance

Jurisdiction	Policy Summary
[redacted]	AWC insurance carrier. No spouse coverage available. Do not provide insurance. 100% of medical premiums. No reimbursement for outside employer premiums. May purchase spouse coverage (until 65) at time of retirement only. May purchase spouse/dependent medical-dental insurance

July 41.18 Increase

Jurisdiction	Policy Summary
[redacted]	Seattle CPI-W from BLS. July COLA given regardless of when retiree passed away. Seattle CPI from BLS. Seattle CPI-U from BLS. July COLO given regardless of when retiree passes away. CPI Jan 1-Dec 31 previous year with 2% Minimum Seattle CPI-U from BLS. July COLA given regardless of when retiree passed away. July COLA given as due regardless of when retiree passed away. July COLA determined by CPI-W Sea/Bel/Tac regardless of when retiree passed. July COLA given as due regardless of when retiree passed away July COLA given as due Use same as DRS April 1st COLA Use same as DRS April 1st COLA. CPI from L&I

Legal Counsel

Jurisdiction	Policy Summary
[redacted]	City Attorney City Attorney City Attorney City Attorney Pension Board Attorney Grays Harbor Co Deputy Prosecuting Attorney Kennewick City Attorney City Attorney City Attorney Prosecuting Attorney City Attorney City Attorney Deputy Prosecuting Attorney City Attorney City Attorney City attorney County Prosecuting Attorney Snohomish Co Deputy Prosecuting Attorney Prosecuting Attorney Deputy City Attorney Deputy Prosecuting Attorney Assistant City Attorney Prosecuting Attorney Appointed Attorney

Jurisdiction	Police Summary	Long Term Care
[redacted]		No insurance. Home health physician prescribed, licensed/state certified provider. Caregiver residing in member's home or family member not eligible. Not to exceed average daily cost of nursing home care. Hospice in DSHS certified/Medicare-approved program. Adult family home, assisted living facility, boarding home or nursing home at minimum required service. Max daily rate/Genworth determined. Carry insurance for members aged 65 and over.
		Pre-approval required. Not to exceed nursing care under the City's existing LTC insurance. Non-medical charges not covered.
		Pre-approval by Board. Medical necessity by member's physician or licensed aging agency assessment required. Nursing home, assisted living, in-home care based on Genworth rates.
		Pre-approval by Board. Medical necessity by member's physician or licensed aging agency assessment required. Nursing home, assisted living, in-home care based on Genworth rates.
		Medical necessity required. Assisted living - one bedroom. Nursing home - semi-private room. Upgrades and excess charges only if medically necessary. Max determined w/Genworth cost or 120% for area member resides. In home care/assisted living preferable to nursing home care. In home care capped at Nursing Home rate. See room limitations.
		UNUM for LTC coverage. Will not include non-medical charges. Nursing Home - average daily amount for semi-private room, Assisted Living - average for studio room; In-Home Care average daily amount of local nursing facility for semiprivate room (custodial or housekeeping services included).
		Nursing home (semiprivate) or home health care based on Genworth rates. Assisted living for medical necessity. Hospice covered with insurance, Dr review.
		Reimbursement for out of pocket limited to $7,859.81-month semi-private room in nursing home. In home/Asst Liv $4000 monthly. Licensed in WA State
		No insurance. Medical necessity. Assisted living (studio). Nursing home (semiprivate room). Upgrades and excess charges only if medically necessary. 120% of latest Genworth costs for area member resides. In home care/assisted living preferable to nursing home care. Hospice care covered with Dr review.
		Pre-approval exceeding 45 days. Care outside Clark County not to exceed care in Clark County by 10%
		Skilled nursing: Dr ordered w/tx plan updates every 6 months, services w/licensed agency, max cost not exceed avg daily of nursing home through USHHS. Hospice: admission to licensed facility or program w written plan by Dr. Facilities: Dr ordered. Licensed facility, submit to insurance/TPA, prior approval, case by case basis.
		Pre-approval required. Max $ based on average local facilities for semiprivate room. In home and assisted living limit same max as nursing. Licensed agency.
		Skilled nursing: case by case basis, board review/pre-auth; Rehab 36 visits/year 100# allowable/Board review for additional.
		Average rate for Franklin County. Non-medical not covered.
		Prior approval required. Adult daycare/Nursing home care when cost not exceed 10% average cost in Grant Co. Licensed facility. Written care plan. In home/Asst living or liv/group home medically necessary by licensed agency, itemized billing; supplies services medically necessary, physician re-eval/6 mos if board requests.
		Carry John Hancock for most, one is covered through UNUM.
		Average cost of semi-private room in defined geographic area.
Kennewick		Pre-approval required. Reasonable expenses authorized/determined medically necessary, prescribed by Dr not to exceed median daily or monthly rate for semiprivate room based on Genworth COC. Custodial care/Asst Liv-case by case basis. Hospice: reasonable expenses licensed certified program.

Jurisdiction	Police Summary	Long Term Care
[redacted]		Pre-approval required, Semi-Private Room $354 • Private Room $414; Respite/Daycare: 14 days/yr max.
		Home Health Care /Hospice Care physician prescribed, licensed/state certified provider. Not to exceed average cost of nursing home care in County where provided. Long-Term Care in state licensed facility.
		Capped amount based on Genworth in home care, nursing, adult family home. Costs reviewed annually
		Capped amount 120% based on MetLife/Genworth. In home care, adult daycare, assisted living, memory care, nursing home semiprivate room and hospice.
		By order of physician. Nursing Home max $220/day. Home care pre-approval required/max $130/day. No housekeeping. Non-medical charges not covered.
		Hospice admission to DSHS certified/Medicare approved program
		Provide long term care coverage.
		Pre-approval required. Home health, Hospice, Skilled Nursing, Rehab less costly than inpatient confinement, plan review periodically. Tx plan by Dr;
		Preauthorization required. Medical necessity. Licensed agency/facility. Max monthly based on average of three local facilities; 24 hr. care, semi private room.
		Medical necessity. Board approval required. Average of three facilities in South Snohomish/North King Counties. Semiprivate. Custodial/non-medical charges not covered.
		Medically necessary (including assisted living facility and in-home care).
		No insurance. Pre-approval required. Average of 3 facilities in geographic area for semi-private room. No payment for non-medical services.
		Pre-Authorization required. Physicians report/medical necessity. In home preferred to Nursing home. Board review costs periodically/costs up to amount of Panorama Rehab/Convalescent Center in Lacey. Semiprivate room/24 hrs. No custodial care. .
		Prior approval required. $2,000/mo assisted living/in-home; $3,883.20/mo nursing home.
		Medical necessity. Custodial/housekeeping not covered. Assisted living/skilled nursing, average in geographic area. Provider must be bonded/licensed.
		Pre-Authorization by board mandatory. Physician Ordered. Max monthly per day for 24 hr care in facility or home care $170 per day. No custodial care.
		No insurance, some agencies under Board use UNUM. Pre-approval requested. In-home up to allowed nursing home care. Nursing home average rate for semiprivate. Non-medical charges excluded. Do not pay deposit.
		No custodial care. Home healthcare/Dr prescribed max daily not exceed average daily nursing home care; Nursing Home/Hospital Extended and other facilities/Dr. ordered, State licensed, if 6+ months updated tx plan. Case by case basis.
		Hospice/Dr ordered. Care is part of written plan for continuous care.
		Individual policies. All other insurance primary to Board. Medical necessity, preapproval required. Approval based on latest annual MetLife Market survey of Nursing Home, Assisted Living, Adult Day Svcs & Home Care Costs. Only services provided by bonded & licenses providers considered. No custodial services.
		Nursing/Home care COC Genworth; Private room Nursing Home; State Licensed.
		Home care/no family/RN or otherwise defined by Genworth
		Pre-approval required. In-Home/Hospice/Skilled Nursing state licensed facility.
		Adult day-care, home healthcare, rehab, assisted living and nursing home facilities: Use Cost of Care/authorized payment. Case by case.

Jurisdiction	Police Summary	Long Term Care
[redacted]		Adult day-care, home healthcare, rehab, assisted living and nursing home facilities: Use Cost of Care/authorized payment. Case by case.
		Medically necessary. Pre Auth required. Assessment. Facilities 24/7 care. No care by immediate family members is reimbursable.
		Medical necessity required. May limit to Seattle area average daily rate for nursing home.
		No insurance. Physician prescribed; provider licensed. DSHS certified/Medicare approved facility. Pre-approval required. Home Health provided by Dept of Health licensed agency.
		Nursing home - average of 3 facilities in Columbia Gorge geographic area for semi-private; Assisted Living - average of 3 facilities in Columbia Gorge geographic area for studio apartment. Custodial/housekeeping and non-medical charges not covered.
		Physician ordered. Medically necessary.
		Pre-approval required.
		Washington State Medicaid daily rate allowed for nursing home/adult family homes/assisted living and/or home health. Custodial/housekeeping not covered. Have covered one deposit.
		Homecare/Hospice/prescribed by physician, written plan, provided by professional licensed agency or professional. Max cost not to exceed daily nursing home care in county by Genworth COC/Studio or semi-private room. No Custodial care. Adult home/nursing, Board preapproval required, placement by physician, Licensed facility, Genworth COC /semiprivate/studio. No custodial care.
		Pre-approval. Nursing/Home care through TPA, no custodial care. Medical necessity. Doctor ordered. Home health 150% of Genworth COC. Asst Living/Studio. Nursing Home, Preapproval or w/in 72 hrs. of emergency; Hospice care.
		Pre-approval required for home care, assisted living and skilled nursing care. Not to exceed average rate for semi-private room based on annual Genworh Survey. Non-medical charges excluded. Do not cover deposits or move-in fees.
		No policy. Have covered adult day-care, in-home care, and respite care.
		No insurance. Pre-approval required, if possible. Medical necessity. Not to exceed average semi-private room for nursing home in Washington State. Miscellaneous expenses not covered. Home Health care/Assisted Living by licensed-bonded providers only.
		Carry Transamerica Life Insurance.
		Pre-approval required. Home/Health Care physician prescribed, provider registered nurse or Board-approved nursing assistance. Not to exceed that of nursing home. Hospice Care for DSHS-certified/Medicare-approved program.
		Average of 3 nursing facilities in Greater Wenatchee area for semi-private room. $4,000/month in-home care provided by bonded/licensed provider.
		Pre-authorization required. Physician prescribed, licensed professional, home care/long term care/nursing/hospice. Review after 6 months. All case-by-case basis. Reasonable expenses incurred in facility with 100 miles of member's residence. Non-medical charges not covered. Custodial care considered case-by-case. Home Health Care not to exceed allowed rate for Skilled nursing home.
		No insurance. 100% of average basic rate for room and meals, which may include misc. housekeeping services of nursing homes or assisted living facility, in regional area services provided plus 100% of reasonable charges for medically necessary services. Home health limited to amount allowed for nursing home.
		Medically necessary. Prior approval required. Nursing Home $220/day; In-home Skilled Nursing $130/day; Assisted Living $3,000/month.
		Nursing home/Assisted Living. 100% reasonable charges. Medical Report/request for Long Term Care is required.

Massage Therapy

Jurisdiction	Policy Summary
[redacted]	Physician prescribed, provider licensed massage therapist.
	Physician prescription required. 25 visits/year
	Physician prescription required. 25 visits/year
	Insurance submission then any self-pay can be submitted.
	Must be prescribed annually by medical doctor.
	Covered by insurance if prescribed by doctor.
	Physical/massage therapy physician prescribed, performed by licensed therapist.
	Treatment plan after 45 days.
	May be covered under physical therapy benefit. Pre-approval over 45 days.
	Tx beyond insurance requires tx plan in a month w/updates every 12 mos.
	Physician prescribed/licensed massage therapist. 6 sessions or 1 month.
	Case by case, pre-approval by board w/physician's statement required.
	Physician prescribed, licensed massage therapist. Treatment plan after 2 visits.
	Prior authorization required. Physician prescribed, licensed therapist.
	6 sessions or 1 month. Dr ordered. 6+ preapproval by board required.
	35 visits/year Tx prescribed.
	None
	Not covered
	Licensed Massage Therapist, Dr or Chiro ordered. Short tx: 6 sessions or 6 months/first. Updated Rx if exceeding limit. Long tx/chronic. 1 yr tx. Dr ordered. Board review by board dr.
	Physician prescribed/medically necessary.
	Case by case – if medically necessary.
	Covered in plan 25/yr Massage/Acupuncture; to exceed needs preapproval
	$25/visit, maximum 2 visits/month unless ordered by physician. Pre-approval required for more than two per month.
	State Licensed. 26/year @ $70 per tx/1x day.
	100% of billed charges with physician's prescription.
	Prescribed by physician provided by licenses massage therapist. Evaluation and treatment plan required beyond 2 visits.
	Physician prescribed as medically necessary. Pre-approval over 4 visits.
	$750 per year/lifetime/one condition/$3000 for tx. Includes Naturopathy, acupuncture, massage, chiro and other holistic or alternative choice.
	Covered by Regence BlueShield
	Dr letter required. Licensed Massage Therapist. No more than six sessions or one month. Limits can be exceeded with Dr Reports/board approval.
	Not covered
	Physician prescribed, certified massage therapist. Treatment plan over 2 visits.
	Services must be provided by licensed massage therapist. Pre-approval of treatment plan for continuous care.
	Case by case basis with medical documentation.

Meal Supplements

Jurisdiction	*Policy Summary*
[redacted]	Does not cover weight loss products.
	Board consideration if medically necessary with supporting documentation.
	Board consideration if medically necessary with supporting documentation.
	Not covered
	Not covered
	Not covered

Meal Supplements

Jurisdiction	***Policy Summary***
[redacted]	Not covered
	Has reimbursed Glucerna but not Medi fast
	Has reimbursed Glucerna for diabetic members, but not Medi fast.
	Not covered
	Not covered
	Not covered
	$1,500 lifetime maximum for weight loss programs.

Medical Alert

Jurisdiction	***Policy Summary***
[redacted]	Board pre-approval required. Covered at average cost per region
	Board pre-approval required. Covered at average cost per region
	Have covered
	Have covered
	50% monthly fee, must be pre-approved
	Covered as medically necessary with prescription.
	have paid ($35-40/month)
	Have covered

Medicare

Jurisdiction	**Policy Summary**
[redacted]	Part B premiums reimbursed; enrollment required. Premiums for Medicare supplicant insurance reimbursed. Do not pay Part D premiums.
	Part B premiums reimbursed. Do no pay Part D premiums.
	Base Medicare premium reimbursed. No penalty for failure to sign up is reimbursed.
	Part B & D premiums reimbursed.
	Part B & D premiums reimbursed.
	Part B premiums reimbursed. Medicare required/if fail to obtain any service will be reduced by amount member entitled to.
	Part B premiums reimbursed. Do not pay Part D premiums.
	Mandatory enrollment
	Part B premiums reimbursed. Enrollment required.
	Part B premiums reimbursed. Enrollment required.
	Part B premiums reimbursed.
	Part B premiums. Enrollment required
	Part B premiums reimbursed.
	Part A/B premiums reimbursed. No Part D premiums.
	Part B premiums reimbursed. Do not pay Part D premiums. Enrollment required.
	Part B premiums reimbursed. Pay Medicare supplement.
	Part B premiums reimbursed. Enrollment required.
	Part B premiums reimbursed (pay full premium)
	Part B premiums reimbursed.
Kennewick	Part B premiums and supplemental reimbursed. Enrollment required.
[redacted]	Premiums reimbursed; enrollment required.
	Part B premiums reimbursed.
	Part B premiums reimbursed; enrollment required. Do not pay Part D premiums.
	Part B premiums reimbursed.

Medicare

Jurisdiction	Policy Summary
[redacted]	Part B premiums reimbursed.
	No. Member responsible to enroll to avoid reduction in benefits.
	Part B premiums reimbursed.
	Part B premiums reimbursed. Part D if member required to pay premium
	Part B premiums reimbursed. Mandatory enrollment.
	Part B premiums reimbursed; Medicare is required.
	Part B premiums reimbursed.
	Part B premiums reimbursed.
	Part B premiums reimbursed.
	Part B premiums reimbursed; enrollment required. Medical plan pays prime on providers that opt-out of Medicare.
	Part B premiums reimbursed; enrollment required.
	Do no pay Medicare Part B or Part D premiums.
	Part B premiums reimbursed; Quarterly. Enrollment required.
	Part B premiums reimbursed by all jurisdictions except Sheriff's Department. Members strongly urged to enroll. If member does not enroll benefits reduced by amount Medicare could have paid.
	Part B premiums reimbursed.
	Part B premiums reimbursed.
	Part B premiums reimbursed. Enrollment required. No part D.
	Part B premiums reimbursed. Quarterly reimbursements.
	Part B premiums reimbursed.
	Part B premiums reimbursed w/verification. No IRMA reimbursement.
	Part B premiums reimbursed.
	Part B premiums reimbursed
	Part B premiums reimbursed. Part A reimbursed if members do not qualify.
	Part A/B premiums reimbursed. Mandatory enrollment.
	Part B premiums reimbursed. If member chooses to utilize provider that opted out of Medicare, member pays the portion that Medicare would have paid.
	Part B premiums reimbursed. Medicare required.
	Part B premiums reimbursed (plus late enrollment penalty, but not additional based on income); part A reimbursed if member has no SS benefits. Enrollment required.
	Part D covered through medical plan. If member chooses to utilize provider opted out of Medicare, member pays portion Medicare would have paid.
	Part B premiums reimbursed. Enrollment required.
	Part B premiums reimbursed
	Part B premiums reimbursed (except penalty for late enrollment); enrollment required.
	Part B premiums reimbursed; enrollment required. Part A reimbursed if ineligible. Medicare required. Part B reimbursed
	Part B premiums reimbursed; enrollment required. Part A not reimbursed.
	Part B premiums reimbursed for actual rate paid
	Part B premiums reimbursed.
	Part B premiums reimbursed; enrollment required. Do not pay Part D premiums.
	Part B premiums reimbursed.
	Part B premiums reimbursed; enrollment required.
	Part B premiums reimbursed.; Supplemental premium $250 month/members not covered by city plan.
	Part B premiums reimbursed, no reimbursement for penalty for late enrollment. Reimbursement in March

Miscellaneous Medical

Jurisdiction	Policy Summary
[redacted]	Surgical procedures and devices for birth control are not considered medically necessary. Fitness program at members own expense. Organ transplants need pre-approval.
	Charges and services not covered by the medical plan considered on a case-by-case basis with documentation.
	Charges and services not covered by the medical plan considered on a case-by-case basis with documentation.
	Have paid dental claims from Mexico
	Experimental, research, drugs procedures/biofeedback are case by case.
	Have paid claims from Canada
	Pain Therapy covered when physician prescribed, by licensed practitioner.
	Swim fees if Everett Parks/submit to board office. Genetic testing, obstetrics, blood transfusions, ambulance, contraception 100% allowable charges.
	Members required to use insurance contracted provided. Prior authorization required for experimental treatments and preventative medicine.
	$750/year exam/filling, root canal/crown/bridge/dentures. Max $1200 full or partial denture every 5 yrs. Ortho only if medically necessary.
	Non-emergency air ambulance service excluded. Vitamins not prescribed by a physician excluded.
Kennewick	Board must be advised 1 month prior to surgical procedure (except in emergency).
[redacted]	Physical therapy/12 visits yr through licensed RPT.
	Medical necessity required.
	Charges must be reasonable and considered usual and customary.
	Routine physical exam will be covered. Subrogation recovery rights.
	Claims must utilize any available insurance/Medicare etc; claim submission up to 1 year. Svc's beyond primary insurance require prior authorization.
	Charges reasonable and considered usual and customary unless a provision in these Rules provides for reimbursement for a lesser amount.
	Pain therapy tx when given by licensed practitioner; board discretion. Podiatry reasonable expenses, Dr prescribed, case by case. Orthotics 2 pair/one year.
	Residence access ramps preapproval required, reasonable expenses, primary and secondary ramps, future maintenance, or repair/members responsibility. Three bids.
	Claims not covered by insurance require pre-approval.
	Only medical services deemed reasonable and necessary shall be paid.
	Cover out of country claims.
	Missed appointments not covered. Physical therapy over 45 days must be preapproved.
	Medical Recommendation/Colonoscopy. Bone Density - age 70/$350 every two years.
	Reasonable cost of necessary medical care or services.
	No mileage/food or lodging except as pre-authorized by board.
	Insurance covers Mexico, foreign travel. Naturopathy policy allows $2,500/yr inclusive of any amounts paid by insurance.
	Have paid claims from Mexico.
	Naturopathic not covered. Physical Therapy/city plan then Dr letter w/plan submitted to board.
	Meal expenses/business travel for board business only; Physical Therapy/Insurance benefit, if +insurance must be pre-approved by Board. Death benefit $1,000 per RCW.

Miscellaneous Medical

Jurisdiction	Policy Summary
[redacted]	Naturopath State licensed. Letter from Primary. See lab restrictions. $150 per visit/1 x day; Organ transplants. Letter required. Reasonable expenses/reasonable donor expenses, federal licensed facility. Orthotics $450 one time/year; Dental coverage and limitations through Delta Dental plan, all members premiums paid through office. No cosmetic. If physician outside group plan requires referral from group plan physician. Pre-authorization for any necessary medical expense not covered by insurance. Out of country claims must be pre-approved. Travel for tx must be pre-approved. Member only. If problem, can be corrected locally/no coverage. Physical therapy: above insurance requires prior approval. $750 per year/lifetime/one condition/$3000 for tx. Includes Naturopathy, acupuncture, massage, chiro and other holistic or alternative choice. Denied administrative fees. Pain therapy. Licensed facility. Use of non-Kaiser facilities by Kaiser members requires pre-approval. Have paid Administrative Fee for LTC. Have covered dental & glasses from Mexico. Naturopathic $2,500/Year Insurance covers out of country claims.

On-Line Policies

Jurisdiction	Policy Summary
[redacted]	www.bellevuewa.gov (Boards and Commissions/LEOFF 1 Disability Board/Policies and Procedures www.ci.bothell.wa.us www.bremertonwa.gov www.clallam.net (Co Laws & Policies/Co Administrative Policies/Section 200: Personnel/295: Disability Board www.co.grays-harbor.wa.us (departments, disability board)
Kennewick	www.ci.kennewick.wa.us (City Managers Web Page in Navigation Pane- Disability Board
[redacted]	http://olympiawa.gov/city-government/advisory-committees/leoff-disabilityboard.aspx www.rentonwa.gov (City Departments and Services/Human Resources/LEOFF Policies and Procedures www.cityoftacoma.org/leoff Podiatry/reasonable expenses; Orthotics not to exceed two pair in one year http://www.cityofvancouver.us/hr/page/leoff-1-police-and-fire-pension-boards www.whatcomcounty.us/2445/Leoff-1-Disability-Board

Physicals

Jurisdiction	Policy Summary
[redacted]	Annual well visits are covered by the medical plan in accordance with age, gender, and frequency guidelines. Annual well visits are covered by the medical plan in accordance with age, gender, and frequency guidelines. $300/year. Allowed annually. Cover costs not covered by other insurance.

Physicals

Jurisdiction	Policy Summary
[redacted]	Once every two years for members over 40. More frequent require pre-approval.
	Once annually.
	$300 annually
	Once annually.
	Pay co-pay.
	Allowed as preventative.
	$350/24 months, except annual pap spear or prostate examination.
	$350 per year.
	Cover co-pays.
	Yes
	$350/year Any additional procedures prescribed by Dr shall also be paid.
	Not covered.
	$350/year.
	Covered
	$350/year.
	Not covered.
	Not covered.
	Covered
	Covered
	$400/year.
	$400/year. Charges exceeding to be brought before the Board for consideration
	Reimbursable and encouraged
	One a year, under medical plan.
	Annual physical exam covered.
	$250/year.
	Covered
	$200/year. Billed to insurance plan first.
	1/year
	1/year
	1/yearWalla Walla 2 years age 36-50 to include medical history/exam, complete blood count, urinalysis, chemistry profile, PSA, mammography, pap smear (yearly), hemoccult, complete cholesterol profile. Every 4 years beginning at age 36: chest x-ray, exercise treadmill test, spirometry, audiogram. Every 5 years beginning at age 50: flexible sigmoidoscopy.
[redacted]	Covered
	$350/year for routine physical exams and immunizations.
	Covered annually. Request members use preferred network when possible.

Preferred Provider

Jurisdiction	Policy Summary
[redacted]	Use of network providers not required, but benefits reduced for non-preferred providers.
	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Primary care physician must be network provider, may refer to non-network providers.
	Do not require use of preferred providers - Medicare doctors required.
	Members required to use in network provider when possible. If out of network reimbursed to member for difference of in network provider, not full amount.
	Do not require use of preferred providers.
	Do not require use of preferred providers.

Preferred Provider

Jurisdiction	Policy Summary
[redacted]	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Encourage use of preferred providers, may consider by pre-approval.
Kennewick	Do not require use of preferred providers.
[redacted]	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Do not require preferred providers, reduced benefits for non-participating providers.
	Do not require use of preferred providers.
	Do not require, but request use of preferred providers.
	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Do not require, but request use of preferred providers.
	In network encouraged.
	Encouraged to utilize preferred and Medicare. If not, may not be 100% covered.
	Encourage member utilize participating providers.
	Do not require preferred providers but reduce benefit for non-participating providers.
	Do not require use of preferred providers; member must obtain services through prepaid health plan.
	Do not require use of preferred providers.
	Require use of Regence BlueShield preferred providers
	Do not require use of preferred providers.
	Do not require use of preferred providers.
	Do not require, but request use of preferred providers.
	Members encouraged to use preferred provider

Prescriptions

Jurisdiction	Policy Summary
[redacted]	Medically necessary erectile dysfunction 4 doses/month. Pre-authorization required.
	Max $100/month; should submit monthly-must submit quarterly March, June, September, and December.
	Erectile dysfunction paid as any other prescribed medication.
	Covered through medical plan. Prescription copays reimbursed with documentation. OTC Rx and E/D Rx covered with doctor prescription.
	Covered through medical plan. Prescription copays reimbursed with documentation. OTC Rx and E/D Rx covered with doctor prescription.
	Prescriptions exceeding medical plan reviewed case-by-case.
	Insurance first. OTC by order of note or Rx by Dr.
	OTC covered with physician's prescription.
	Covered in medical plan. Erectile dysfunction 6/month.
	Co-pay covered. Erectile dysfunction paid as any other prescribed medication. OTC available without note or prescription is not covered.
	E/D Rx limited 6/month.
	Physician prescribed for medical necessity.
	OTC medications available without a prescription are not covered. E/D same as any other Rx.
	Co-pays covered by board. Any E/D cap $250/yr with physician’s prescription
	100% to Treatment/diagnosis illness/injury. Erectile dysfunction 6/month.
	OTC and vitamins covered with physician's prescription.
	Rx by licensed Dr.

Prescriptions

Jurisdiction	Policy Summary
[redacted]	OTC covered with Dr. prescriptions. Sexual dysfunction 8/month or 96/yr
Kennewick	E/D 8 pills/month medical necessity documentation required
[redacted]	Sexual dysfunctions are determined to be reimbursable.
	Physical prescribed for medical necessity
	OTC and E/D (limit 6 doses/month) with physician's prescription. Any Rx to be reduced by insurance first.
	Must use Mail order as part of plan when available. OTC covered with physician's prescription.
	OTC covered with physician's prescription. Generics encouraged. E/D $500 12 months/case by case showing medical necessity.
	Two-year term Ballots and Nominations in February every other year
	Erectile dysfunction 6/month; OTC covered with physician's prescription.
	OTC covered with physician's prescription.
	OTC covered with physician's prescription.
	Physician prescribed for organic diagnosis, up to 6 tablets per month.
	Only when prescribed by a physician.
	Unless approved by board/Rx to be purchased from local Pend Orielle County area.
	OTC covered with physician's prescriptions. Up to 8 doses/month for Erectile dysfunction (other drugs for same purpose).
	100% when physician prescribed/medically necessary.
	If Rx requires pre auth by FDA, member required to follow City's benefit provider; E/D as prescribed by Dr.
	If Rx requires pre auth by FDA, member required to follow City's benefit provider; E/D as prescribed by Dr.
	Covered with Premera at pharm/mail order. Copay's reimbursable when medically necessary for specific conditions.
	OTC covered with Rx; E/D limit/12/month
	Erectile dysfunction not considered medically necessary.
	OTC covered with physician's prescription.
	E/D 6 doses/month if shown medically necessary.
	Only drugs and medicines that require a physician's prescriptions.
	Require use Regence BlueShield participating pharmacy
	OTC covered with physician's prescription.
	Erective dysfunction paid as any other prescribed medication.
	OTC covered with a physician's prescription. Erectile dysfunction 13/quarter.
	OTC covered with a physician's prescription.
	Erectile dysfunction when prescribed to treat organic diagnosis. 75% of charge.
	Erectile dysfunction not considered medically necessary.
	Erectile dysfunction paid as any other prescribed medication.

Smoking Cessation

Jurisdiction	Policy Summary
[redacted]	Covered under Regence Plan
	As covered through Medicare Advantage PPO plan.
	As covered through Medicare Advantage PPO plan.
	Insurance coverage, any out of pocket on case by case/1x only following successful completion and 1/yr maintenance.

Smoking Cessation

Jurisdiction	Policy Summary
[redacted]	Exceeding insurance to specified amount, 1x only following completion for one year.
	part of regular coverage.
	Hypnotherapy to stop smoking excluded.
	$300 one-time-only for patches.
	$250 once-only following successful completion and 1-yr maintenance of goals.
	Covered as Physician prescribed. Pre-approval required.
	80% of remaining balance not paid by insurance. One lifetime benefit.
	Paid 100%.
	Smoking cessation, pre-approval required.
	Letter from Primary. $1000 limit/exceeding limit must have prior authorization.
	Smoking cessation treated as other illness/injury.
	$300 once-only following completion and 1-year maintenance of program goals.
	Prescriptions limited to 90-days per lifetime
	Pre-approved by board/lifetime max $500.
	$250 once-only following completion and 1-year maintenance of program goals.
	$250 once-only following completion and 1-year maintenance of program goals.
	$250 once-only following completion and 1-year maintenance of program goals.
	$50 lifetime maximum for Nicorette

Travel

Jurisdiction	Policy Summary
[redacted]	Travel costs not covered.
	Travel costs not covered.
	Travel costs not covered.
	Have allowed mileage for doctor's appointments and to pick up prescriptions.
	No personal mileage, food, or lodging.
	Transportation to medical facility if service not available locally. Have paid cabulance from nursing home to doctor visit.
	Have paid medical transportation to healthcare providers. Subject to preauthorization.
	Travel for medical pre authorization required, max/per diem rates for lodging, meals and incidentals and IRS mileage rate using private vehicle.
	Have paid - case-by-case.
	Would consider if no other options in local area or upon physician's necessity.
	Case-by-case; generally, not approved.
	Would have to be necessary medical expense.
Kennewick	With physician referral case-by-case.
[redacted]	For out-of-area treatment for member only. Prior approval would be required.
	Only when member required to submit to an evaluation requested by the Board.
	Case-by-case.
	No
	No
	Must be proven medically necessary unless doctor visit requested by Board.
	Has paid airfare for member out of country to allow treatment in the states.
	Current city travel policy. Preauthorization required for board or medical tx.
	Cabulance to treatment. Travel for out-of-area treatment not covered.
	No
	No
	Have paid travel and meals – case-by-case.

Travel

Jurisdiction	Policy Summary
[redacted]	No covered. Have covered personal assistance including transportation to medical appointments. Have paid transportation from massage. to nursing facility and doctor's appointments from nursing facility. Would cover travel only if Board directed a member to an out-of-area physician. If no other options or upon physician's recommendation. Pre-authorization required. Have paid cabulance/medical taxi; have paid mileage for home health care provider to transport member to doctors; case-by-case basis if same services not available in Yakima. Only reimbursed if Board issued for IME purposes.

Vision

Jurisdiction	Policy Summary
[redacted]	$325/lenses and frames/24-months. $200/contact lens/24-months. Pre-approval required. $200 max/2 yrs. Glasses may be purchased at Costco, city card if needed. $270/year for frames and lenses; exam covered by medical. $1,000 per eye for Radial Keratotomy or laser eye surgery in lieu of glasses in 2 calendar years. 2 sets of lenses plus $200 for frames/24-months. $400 for laser/refractive eye surgery instead of hardware. If vision conditions uncorrectable by any other means and member precluded from performing duties of his/her position greater amount may be considered case-by-case. Routine exam/hardware covered under city Vision Plan. Laser max amount to cost of contact lenses. One-time payment only. Coverage provided through the City's LEOFF Vision Plan. Annual exam, frame/lenses/contacts covered every calendar year. Coverage provided through the City's LEOFF Vision Plan. Annual exam, frame/lenses/contacts covered every calendar year. 2 sets of lenses plus $200 for frames/24-months.$400 for laser/refractive eye surgery instead of hardware. Allowance of $1,000 in conjunction w/dental per year Lenses $200/12-months. Frames $120/24-months. Tinting, coloring, photo sun, other options or a spare pair not covered. 100% exams; $190/year for eyewear - laser surgery $760 in lieu of 4 yrs eyewear benefit. Exams covered; corrective lenses covered to $400/24 months. No Rx sunglasses. Laser surgery to $4,000, no other vision benefits for 5 years. Annual exam. $500/2 years lenses/contacts/glasses. Refractive/laser surgery medically necessary. Treatment for glaucoma, cataracts, macular degeneration, tear ducts, etc. are covered. 1 Exam and 1 pair glasses/contacts each year. Reimbursement for services is based on listed fee schedule Lenses-annually; Frames -. every 2 years. Limit $500 every 2 years when purchasing 2 pairs of glasses at tone time. Laser surgery allowed at 50%. Untreated/un-tinted lenses (either eyeglass or contact lenses) 2 pairs/24 months. $260/2 years for contact lenses. Member pays $20% co-pay for lenses. Frames $100/pair. 1 pair frames/24-months. 100% of examination; lenses/frames $150; contact lenses $100. 1 exam and 1 pair of glasses or contacts/12-months.

Vision

Jurisdiction	Policy Summary
[redacted]	1 exam/year. $300 annually. Police coverage-VSP. Fire coverage-Humana. First to insurance, then seek reimbursement.
	1 exam/12 months. $300/12 months for lenses, frames and/or contact lenses. Replace due to breakage in the line of duty. Refractive Keratotomy Surgery for myopia/astigmatism not considered necessary medical. Corneal Laser Surgery require pre-approval. Annual exams and $375/yr for corrective lenses or contact lenses. Tinting/progressive lenses if prescribed. Sunglasses only for specific condition. Replacement only in line of duty. Total cost for corrective lenses/excluding exam $300 max/1 every two years.
	$250 one paid of lenses/frames or contacts per year. Replacement when damaged in line of duty. Annual eye exam covered. $600 glasses/frames/lenses and or contacts.
	1 per year; exam/refraction/glaucoma testing/OptoMap $100/single $125/bifocal $160/trifocal $210 progressive $300/polycarb $75/high index $300/protective coating $40/transitions $120/anti-reflective $140/frames $250/corrective surgery $500 per eye. 1 exam/year. $400/year for lenses and frames or contact lenses. Replacement on case by case. Toric or Multifocal cataract $1500 lifetime. $450/2 years for lenses and frames or contact lenses, including tinting and Refractive/Laser Eye Surgery. 1 exam/year. Annual exam and one pair lens, include anti-scratch/glare) tint, transition max $150/frames year. Sunglasses/1x year only Dr prescribed for medical condition. Contact Lenses/$200/year. Insurance first if applicable; exam and one pair lens, include anti-scratch/glare) tint, transition max $150/frames year. Sunglasses only Dr prescribed for medical condition. Contact Lenses/$200/year. Broken frames/lenses no replacement. Exam and tx, Rx by Dr. Frames/lenses/sunglasses 24/mos. Lens enhancements are allowed w/i limits. One pair single vision $550; bifocal $580; trifocal $645. Change in Rx/12 mos single $310; bifocal $335 Trifocal $405. Lasik/Licensed Ophthalmologist. FDA approved. Performed/USA. One time $1400/eye.
	Annual exam. $800/year for hardware (frames/lenses) w/prescription change. Laser eye surgery/keratotomy and blepharoplasty (eyelid) surgery if medical necessity. Refractive Keratotomy Surgery to $1400/eye/lifetime by licensed ophthalmologist. Corneal Laser Surgery prescribed for medical condition. Glasses/frames $400 every two years or sooner if correction is required. Special Rx due to circumstance on case-by-case basis.
	1 pair eyeglass or contact lenses/12 months. $250/pair lens; $100/frames; $200/pair contact lens. No over-sizing, tinting, coloring, photosun, or other options, special requests, unless medically necessary. Pre-approval required for laser corneal surgery. 1 exam/year; $250 for 1 set of frames/2 years; $300 for 1 pair lenses/year; laser eye surgery required preapproval. Contacts/$300. Replacement: breakage/loss on duty. Laser surgery preapproval $1,000/eye w/no hardware/2 years.

Vision

Jurisdiction	Policy Summary
[redacted]	1 exam/year. $200/frames and $300/lenses every 2 years.
	1 exam/year; hardware $500/2 years, Lasik $2600 per lifetime.
	Lasik through TPA/lenses for glasses allowed w/i 6 months after Lasik.
	$150/2 years unless medical necessity requires change sooner. Laser: Medical necessity are only options for adequate vision or safety of employee.
	Exam and $500 for eyewear per calendar year through Vision Service Plan (VSP)
	One exam/2 yrs. Lens covered 100%/2yrs; Frames $100/second pair glasses or contacts 25% total cost. Contacts $130/2 years
	1 exam and 1 pair of glasses or contact lenses/12-months, except replacement if broken in line of duty, or as needed for specific medical condition. Exam $80;
	$250/year hardware (lens, frames, coatings, contacts, etc.) plus $20 for UV protection. Charges for sunglasses, photo gray or contact lenses in excess of allowance, only pre-approved medical necessity. 1-year hardware allowance may offset the cost of laser surgery unless vision cannot be corrected by glasses and/or contacts.
	Vision premiums paid on a composite basis. Expenses not paid by insurance covered, excluding hardware.
	$240/pair lenses/12-months. $100/frames/24-months. $240/pair contact lens/12-months. Over-sizing/tinting/coloring/photosun or spare pair not allowed. Refractive Keratotomy Surgery to correct myopia and/or astigmatism not covered. Pre-approval required for prescribed laser corneal surgery.
	Annual eye exam. $500 for corrective lenses every 2-years. Refractive keratotomy surgery or laser surgery not considered medical necessity.
	$800/frames and lenses/12 months
	$75/year exam; frames/lenses/contacts $500 per two years. No laser vision correction
	Annual exam. Frames $200/year. No maximum on lenses. Disposable contact lens $200/year. Tinting, special coatings rolled and/or polished edges, oversized lenses or prescription sunglasses not covered.
	Eye exam 100%; $500 max every two years lenses/frames/contacts; The $500 can be applied toward cost of corrective vision surgery.
	Annual exam. $275/2 years for lenses and/or frames and/or contact lenses. $275 lens allowance can be applied toward cost of corrective vision surgery.

W-2 for Disability

Jurisdiction	Policy Summary
[redacted]	2 pay codes (non-duty disability taxable and duty disability non-taxable).
	duty & non-duty disability same pay code. W-2 adjusted to reflect actual taxable amount.
	no active members.
	2 pay codes (non-duty disability taxable and duty disability non-taxable).
	2 pay codes (non-duty disability taxable and duty disability non-taxable).
	no active members.

Weight Loss

Jurisdiction	Policy Summary
[redacted]	Physical fitness no covered.
	$500/one-time-only, for prescribed weight loss program for at least 60 pounds.
	Board consideration on a case-by-case basis with documentation of medical necessity.

Weight Loss

Jurisdiction	Policy Summary
[redacted]	Board consideration on a case-by-case basis with documentation of medical necessity. Weight loss programs, physical fitness/health spas, considered when prescribed. No requests for surgery. Not covered. Physical fitness not covered. Weight Loss program if prescribed. No requests for surgery. Case by case, Dr. Monitored. Swim Fees of Everett Parks, submit to Pension Board. Considered if prescribed by physician and approved by Board Physician. Prior approval required. Weight loss programs/physical fitness/health spas must be medically necessary. Pre-approved one lap-band surgery. If medically necessary if reasonable equivalent benefits could not be obtained for less.
Kennewick	Necessary medical costs. No food supplements, membership in weight loss programs, physical fitness clubs or health spas. Will cover counseling by licenses psychologist/psychiatrist or dietician/nutritionist.
[redacted]	May approve weight loss program prescribed/monitored by physician one-time only, exclusive of food supplements/replacements. Not covered unless medical necessity and equivalent treatment could not be obtained for less. No gym or spa memberships. Covered for medical necessity and equivalent treatment could not be obtained for less. Not covered. Weight-loss programs/physical fitness/health spas not covered unless medical necessity and equivalent treatment not available for less. Access through insurance and no reimbursement Weight loss programs/physical fitness/health spas not covered unless medically necessary. Weight-loss programs/physical fitness/health spas not covered unless medical necessity and equivalent treatment not available for less. Weight loss program prescribed one-time-only. Board will pay 50%, exclusive of food. If applicant demonstrates goal completion and maintenance for 2 years, Board may provide further compensation. Complete city's health care before any plan submission to Board. Dr prescribed/1x per person/case by case. 50% excludes food/other parts as determined prior to start. After two years/w goals/maintenance the board may provide up to full amount. Medical necessity/BMI <30 limited $1,000. Food/supplements not covered. Prior authorization required. Doctor letter required. 100% excluding supplements/nutritional products. Upon physician's prescription do pay 100% for physical fitness facilities for members with chronic wasting diseases. Prescribed/monitored by physician, one-time-only (excludes food supplements). Pre-approval required. Physical fitness programs no covered. No requests for surgery. 50% one-time only, exclusive of food and other parts of the program. After 2 years may pay up to full amount upon maintenance of goals. Exercise/fitness programs not covered. Health club memberships case-by-case in lieu of physical therapy for medically necessary rehabilitation following surgery. Case-by-case for medical necessity. $500/year for prescribed dietary counseling, up to $1,500 for one condition.

Weight Loss

Jurisdiction	Policy Summary
[redacted]	Would require pre-approval for any procedures. Have approved one surgery. Physical fitness program not covered. Pre-approval for weight loss program prescribed/monitored by physician, one-time-only, excludes food supplements/replacements. No requests for surgery. One-time only when medical necessity, physician prescribed/monitored, when proven cost savings long term. One-time-only when physician prescribed/monitored, excludes food supplements/replacements. Physician prescribed/monitored, one-time-only, excludes food supplements. Preapproval required. No requests for surgery. Have covered surgeries deemed medically necessary.

*This is a general comparison list only and should not be used to confirm, verify or determine any benefit(s) from your Pension Board. Please contact your Pension Board directly for any of your needs.

Rev: March 25, 2025