



4/7/2026

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

11:30 AM

1. CALL TO ORDER

2. ATTENDANCE

3. PUBLIC COMMENT

4. POLICE CLAIMS

Summary of claims for signature.

- a. Summary of Claims for Signature

5. NEW BUSINESS

- a. Treasurer's Report: February 2026
- b. Police Member #15 Weight Management Prescription Reimbursement Request
- c. Fire Member #10 SSA Medicare retro Reimbursement discussion

6. UNFINISHED BUSINESS

- a. Disability Board Policy Rules and Regulations Draft Revisions Status
- b. Member At Large Vacancy Status

7. BOARD COMMENTS/DISCUSSION

8. ADJOURNMENT

NEXT MEETING DATE: May 5, 2026

MEETING DATE: 4/7/2026

DISABILITY BOARD - POLICE

BUDGET NO. J2517210 . 520012

Member #	Date of Claim	Claim Type - Category	Code	Provider	TOTAL
15	1/9/2026	Prescription	1040	Elk Drug	\$ 10.84
15	1/23/2026	Prescription	1040	Elk Drug	\$ 10.84
15	2/6/2026	Prescription	1040	Elk Drug	\$ 10.84
15	2/20/2026	Prescription	1040	Elk Drug	\$ 10.84

\$ 43.36

JIM KRAFT, POLICE REPRESENTATIVE

DENNIS WATERS, FIRE REPRESENTATIVE

KATHRYN ARMSTRONG, MEMBER AT LARGE

MAYOR

CHUCK TORELLI, MAYOR PRO TEM

LEOFF I - CERTIFICATION CLAIM FORM - Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.

I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; I am enclosing the required explanation of benefits; and that I am eligible for reimbursement under the following plan(s):

Asuris [] Medicare [] Other [] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
1-9-2026	Pill Pak	Elk Drug	10.84	10.84
1-23-2026	Pill Pak	Elk Drug	10.84	10.84

TOTAL: 21.68

Print Name: _____ Signature: _____ Date: 1-27-2026

Board Use Only

RECEIVED

1/30/26

Sale



509-382-2536

Elk Drug

176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [Redacted]
Date: 01/23/26 10:14AM
Cashier: LACY
Register: POS Lane2
Customer: [Redacted]

Item	Flags	Qty	Price	Value
Rx [Redacted]	RF			\$0.00
Rx [Redacted]	RF			\$0.00
Rx [Redacted]	RF			\$0.00
Bubble PK 2 WK	T	1x	\$10.00	\$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:3
Retail count:1
Total count:4

Rx Total:\$0.00
Retail Total:\$10.00

Subtotal \$10.00
Standard Tax on \$10.00 \$0.84

Total \$10.84

Tender Cash \$11.00

Change \$0.16

Change Due: \$0.16



Customer Copy

Sale



509-382-2536

Elk Drug

176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [Redacted]
Date: 01/09/26 11:29AM
Cashier: Danielle
Register: POS Lane2
Customer: [Redacted]

Item	Flags	Qty	Price	Value
Rx [Redacted]	RF			\$0.00
Bubble PK 2 WK	T	1x	\$10.00	\$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:1
Retail count:1
Total count:2

Rx Total:\$0.00
Retail Total:\$10.00

Subtotal \$10.00
Standard Tax on \$10.00 \$0.84

Total \$10.84

Tender Credit (#8282) \$10.84

Mastercard Card - Approved

Amount:\$10.84

Mastercard:**** [Redacted]

Transaction:CREDIT

Approval: [Redacted]

Response Code:0

Entry Method:Contactlessicc

MASTERCARD: [Redacted]

Trace Code [Redacted]

Cryptogram:ARQC FB7BED0D4642DE8D



Customer Copy

LEOFF I - CERTIFICATION CLAIM FORM - Police

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.

I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; I am enclosing the required explanation of benefits; and that I am eligible for reimbursement under the following plan(s):

Asuris [] Medicare [] Other [] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
<i>Feb 6 - 2026</i>	<i>Pill Pak</i>	<i>Elk Drug</i>	<i>10.84</i>	<i>10.84</i>
<i>Feb 20 - 2026</i>	<i>Pill Pak</i>	<i>Elk Drug</i>	<i>10.84</i>	<i>10.84</i>

TOTAL: 21.68

Print Name: _____ Signature: _____ Date: *Feb 27 - 2026*

Board Use Only

RECEIVED

MAR 05 2026

CITY OF KENNEWICK
Accounts Payable

Sale



509-382-2536

Elk Drug
176 E. Main Street
Dayton, VA 99328
Ph : 509-382-2536

Receipt: [REDACTED]
Date: 02/20/26 10:50AM
Cashier: LACY
Register: POS Lane2
Customer: [REDACTED]

Item	Flags	Qty	Price	Value
Rx [REDACTED]	RF			\$0.00
Rx [REDACTED]	RF			\$0.00
Rx [REDACTED]	RF			\$0.00
Rx [REDACTED]	RF			\$0.00
Rx [REDACTED]	RF			\$0.00
Bubble PK 2 WK	T	1x	\$10.00	\$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Rx count:5
Retail count:1
Total count:6

Rx Total:\$0.00
Retail Total:\$10.00

Subtotal \$10.00
Standard Tax on \$10.00 \$0.84

Total \$10.84

Tender Credit [REDACTED] \$10.84

Mastercard Card - Approved

Amount:\$10.84
Mastercard:*****[REDACTED]
Transaction:CREDIT
Approval:00942S
Response Code:0
Entry Method:Contactlcc
MASTERCARD:[REDACTED]
Trace Code [REDACTED]
Cryptogram:TC DD34B83F856792B0



Customer Copy

Sale



509-382-2536

Elk Drug
176 E. Main Street
Dayton, WA 99328
Ph : 509-382-2536

Receipt: [REDACTED]
Date: 02/06/26 01:53PM
Cashier: LACY
Register: POS Lane2

Item	Flags	Qty	Price	Value
Bubble PK 2 WK	T	1x	\$10.00	\$10.00

Flags: T=Taxable F=FSA R=Rx P=Promo A=Auto Refill

Item count:1

Subtotal \$10.00
Standard Tax \$0.84

Total \$10.84

Tender Credit [REDACTED] \$10.84

Mastercard Card - Approved

Amount:\$10.84
Mastercard:*****[REDACTED]
Transaction:CREDIT
Approval:09165S
Response Code:0
Entry Method:Contactlcc
MASTERCARD:[REDACTED]
Trace Code: [REDACTED]
Cryptogram:TC 41D7447D711B9879



Customer Copy

CITY OF KENNEWICK
OTHER POST EMPLOYMENT BENEFITS
TRUST FUND

Preliminary Financial Statements

February 28, 2026

CITY OF KENNEWICK

Other Post Employment Benefits Trust Fund

Balance Sheet
February 28, 2026

	Current Year	Prior Year
<u>Assets</u>		
Equity in Pooled Cash & Investments	\$ 5,967,182	\$ 5,629,182
Investments	-	-
Interest Receivable	-	-
Total Assets	\$ 5,967,182	\$ 5,629,182
 <u>Liabilities</u>		
Accounts Payable	\$ 14,367	\$ 14,330
Total Liabilities	14,367	14,330
 <u>Fund Balance</u>		
Committed Fund Balance	5,952,815	5,614,853
Total Fund Balance	5,952,815	5,614,853
Total Liabilities and Fund Balance	\$ 5,967,182	\$ 5,629,182

CITY OF KENNEWICK

Other Post Employment Benefits Trust Fund

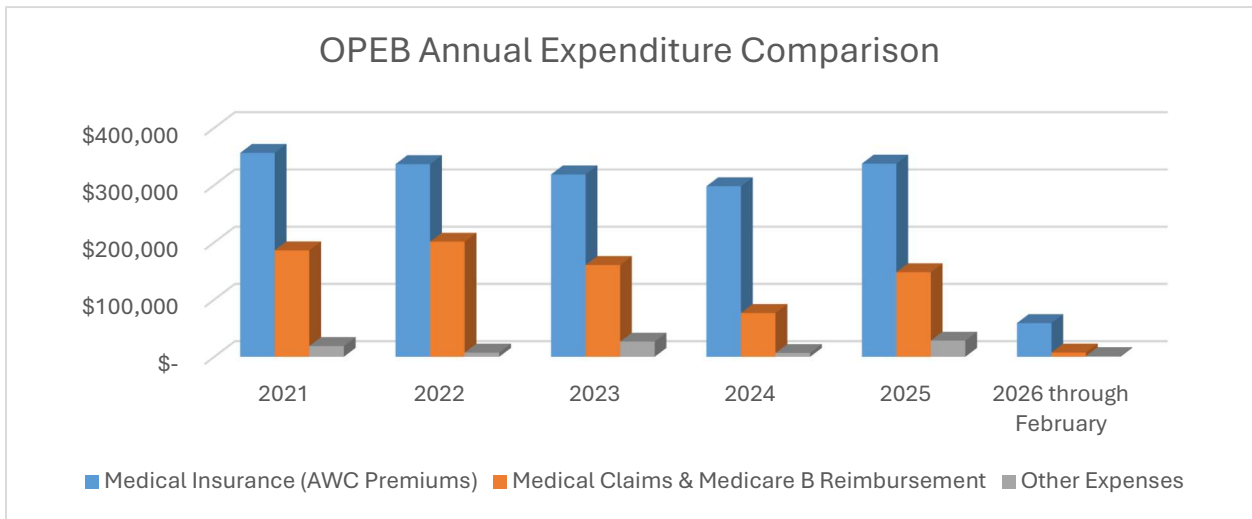
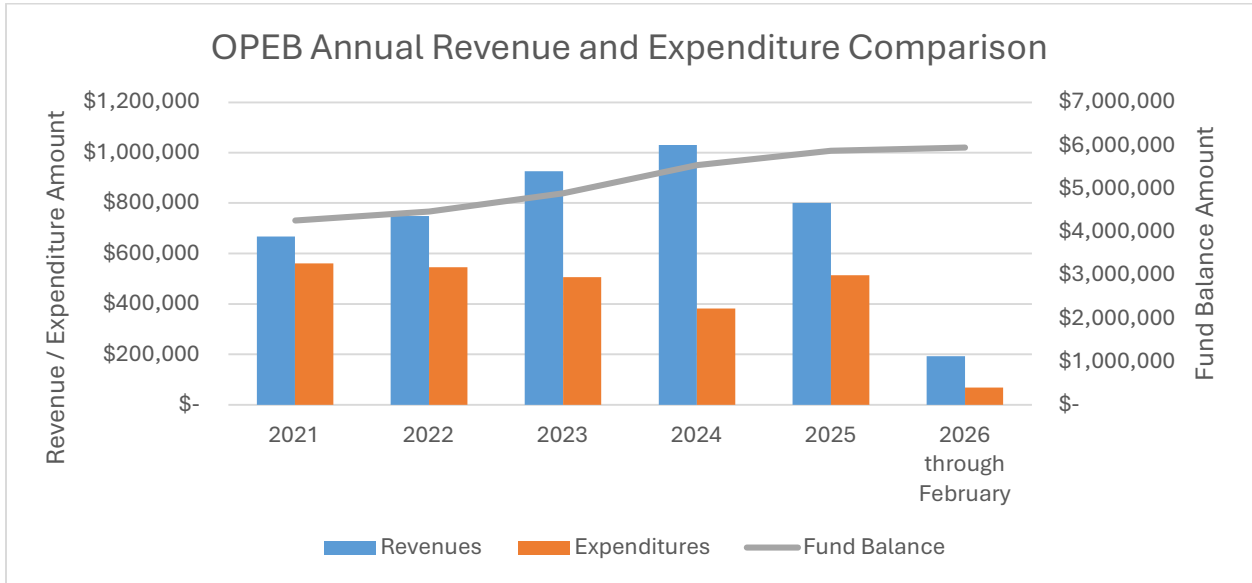
Income Statement

February 28, 2026

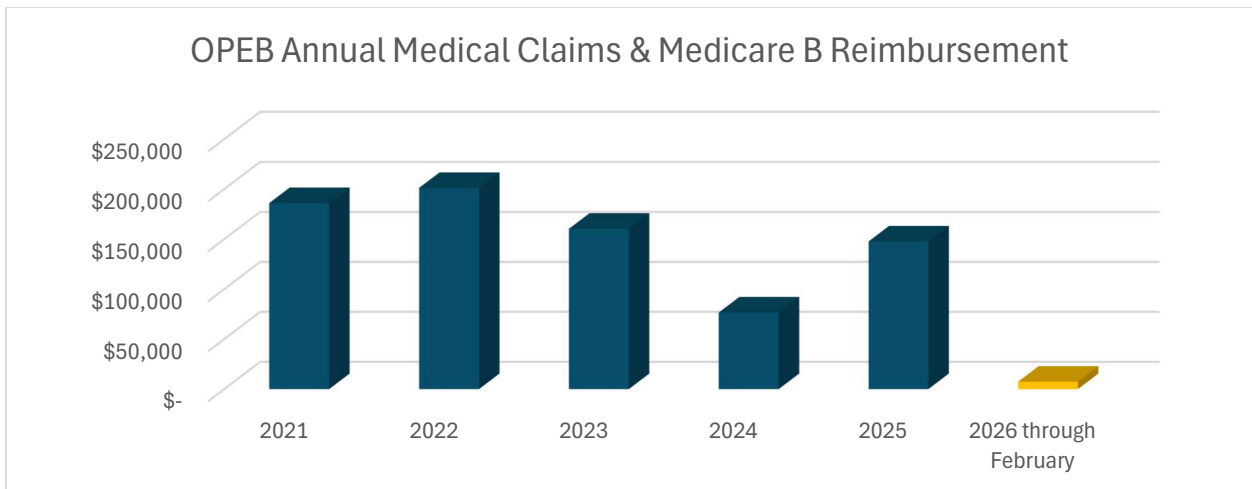
	2026 Budget	Year To Date	Over (Under) Budget	Prior Year To Date
<u>Revenues:</u>				
Water and Sewer Utility Tax	\$ 590,000	\$ 118,299	\$ (471,701)	\$ 119,215
Investment Interest	163,500	33,067	(130,433)	33,412
Expense Reimbursements	-	40,687	40,687	-
Total Revenues	753,500	192,053	(561,447)	152,627
<u>Expenditures:</u>				
Medical Insurance	348,500	59,054	(289,446)	57,319
Medical and Prescriptions	205,000	7,413	(197,587)	21,570
Disability Board Secretary	2,000	-	(2,000)	-
Office Supplies	50	-	(50)	-
Postage Expense	300	-	(300)	21
Travel and Training	2,000	-	(2,000)	-
Contractual/Consulting Services	12,500	1,232	(11,268)	-
Copier Charges	18	-	(18)	-
Total Expenditures	570,368	67,700	(502,667)	78,911
Net Income (Loss)	183,133	124,353	(58,779)	73,716
Beginning Fund Balance	5,828,461	5,828,461	-	5,541,137
Ending Fund Balance	\$ 6,011,594	\$ 5,952,815	\$ (58,779)	\$ 5,614,853

City of Kennewick
Other Post Employment Benefits Trust (OPEB) Fund
February 28, 2026

Revenues and Expenditures

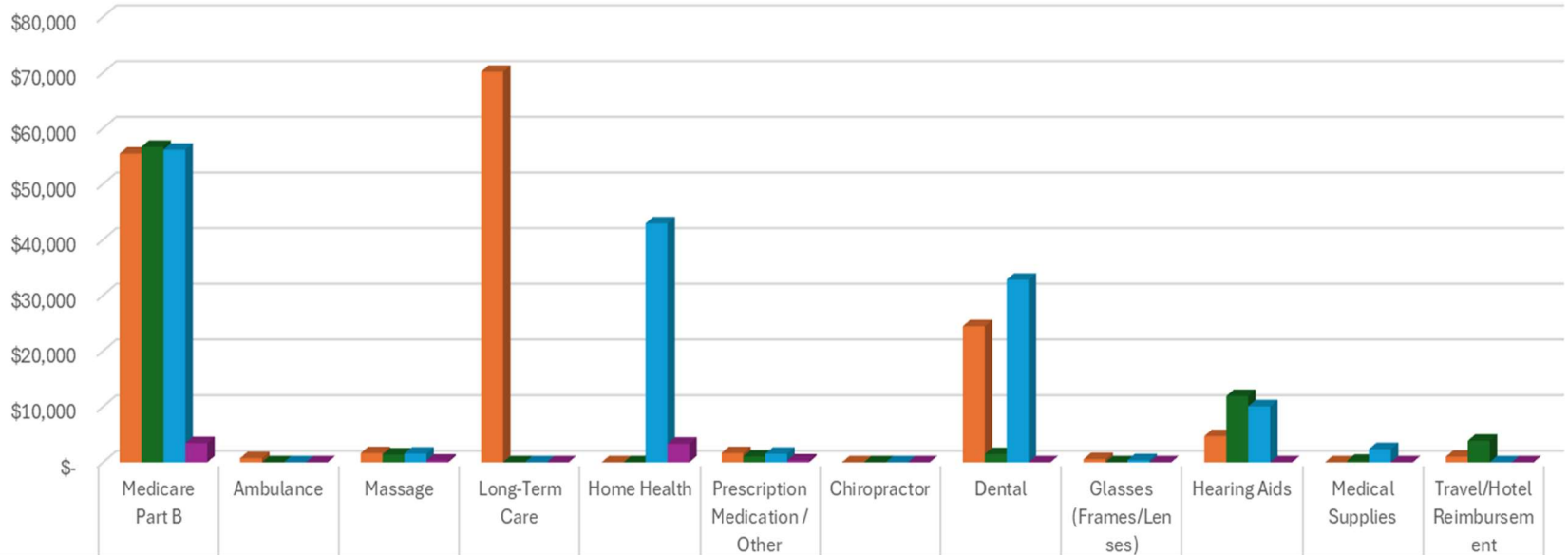


Medical Claims & Medicare B Reimbursement



**City of Kennewick
Other Post Employment Benefits Trust (OPEB) Fund
February 28, 2026**

OPEB Annual Medical Claims & Medicare B Reimbursement Comparison



LEOFF I – CERTIFICATION CLAIM FORM – POLICE

I hereby certify under penalty of perjury that this is a true and correct claim for necessary medical expenses incurred by me, and that no payment has been received by me on account thereof.

I further certify that I am an active/retired member of the Kennewick Police Department; that the following claim was required by an allowable provider; **I am enclosing the required explanation of benefits**; and that I am eligible for reimbursement under the following plan(s):

Asuris [] Medicare [] Other [] _____

Date of Service	Condition or Illness Or Prescription Name	Provider of Service	Bill Charged	Co-pay Amount
10-13-25	Zepbound	Lilly Direct/Dr. Allgaier	349.00	349.00
11-10-25	"	" "	349.00	349.00
12-2-25	"	" "	449.00	449.00 *

TOTAL: 1147.00
 * 2 month supply
 1-26-26
Date

Print Name [Redacted]

Signature [Redacted]

Board Use Only

RECEIVED
 2/3/26

COMPLEX CARE CENTER

December 11th, 2025

969 Stevens Drive, Suite 3A
Richland, WA 99352
Ph; 509-713-1315
F: 877-673-0795

To whom it may concern,

Based on the patient's medication list showing obesity-related comorbidities (hypertension requiring multiple agents, BPH, and heart failure given dual loop diuretics), Zepbound (tirzepatide) is medically necessary. The FDA has approved tirzepatide for weight management in adults with obesity or overweight with at least one weight-related comorbid condition, and this patient has multiple qualifying conditions. The letter below will document the medical necessity with supporting evidence from clinical guidelines and trials.

I am writing to document the medical necessity of tirzepatide (Zepbound) for the above-referenced patient under my care. This patient has obesity with multiple weight-related comorbid conditions that significantly impact their health and quality of life.

Clinical History and Comorbidities:

The patient has documented obesity with the following weight-related comorbid conditions:

Hypertension requiring triple therapy (losartan 50 mg daily, propranolol ER 60 mg daily, and dual loop diuretics)

Heart failure (evidenced by requirement for both torsemide 10 mg and furosemide 40 mg daily for volume management)

Benign prostatic hyperplasia requiring combination therapy with tamsulosin and finasteride

The patient's current medication regimen demonstrates the severity of their cardiometabolic disease burden and the need for aggressive weight management intervention.

Medical Necessity:

Tirzepatide is FDA-approved for chronic weight management in adults with obesity or overweight in the presence of at least one weight-related comorbid condition. This patient clearly meets these criteria with multiple documented comorbidities.

The American Association of Clinical Endocrinology recommends tirzepatide as a highly effective treatment option for obesity, particularly in patients with cardiometabolic complications. In the SURMOUNT clinical trial program, tirzepatide demonstrated superior efficacy compared to other weight loss interventions, with mean weight reductions of 20-22.5% at the highest dose (15 mg weekly), and nearly 40% of participants achieving 25% body weight loss. Importantly, SURMOUNT-2 demonstrated that even in patients with type 2 diabetes (who typically have attenuated weight loss responses), tirzepatide achieved 12.8-14.7% weight reduction.

Expected Clinical Benefits:

Weight reduction with tirzepatide is expected to provide substantial benefits for this patient's multiple comorbidities:

Cardiovascular disease: Tirzepatide has demonstrated improvements in blood pressure, visceral adiposity, and circulating triglycerides. Weight loss may allow reduction in the patient's current complex antihypertensive regimen and reduce heart failure burden.

Heart failure management: The SUMMIT trial demonstrated tirzepatide's efficacy in treating heart failure with preserved ejection fraction, and weight reduction may decrease the need for aggressive diuretic therapy.

Overall metabolic health: The Obesity Society guidelines recognize tirzepatide as the most effective currently approved anti-obesity medication, with a weight loss differential of up to 17.8% compared to placebo.[3]

Safety Profile:

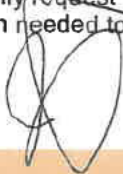
Tirzepatide has been extensively studied with a well-established safety profile. The most common adverse events are gastrointestinal (nausea, diarrhea, decreased appetite), which are typically mild to moderate and often remit with slow dose titration. The medication demonstrates a low risk of hypoglycemia when used without insulin or insulin secretagogues.

Conclusion:

Given this patient's obesity with multiple serious weight-related comorbidities including hypertension requiring triple therapy and heart failure requiring dual diuretic therapy tirzepatide represents a medically necessary intervention supported by robust clinical evidence and professional society guidelines. Weight reduction with tirzepatide is expected to improve cardiovascular outcomes, potentially reduce medication burden, and significantly enhance overall health and quality of life.

I respectfully request approval for tirzepatide (Zepbound) for this patient and am available to provide any additional information needed to support this request.

Sincerely



Jeffrey Allgier, MD

Please note, coverage for the requested drug cannot be provided. For this reason, we cannot review this drug for any other request (for example, Tier Exception or Quantity Limit).

You can have a free copy of all documents we have in your appeal file. You can request these copies by contacting us at 1 (844) 765-6823 (TTY: 711), 24 hours a day/7 days a week. This call is free.

A Reconsideration Form has been attached to this letter for your convenience.

You have the right to appeal this decision

You have the right to ask for an independent review (appeal) of our decision. You must appeal within 65 calendar days after the date on this notice. You, your prescriber, or someone you name to act for you (your representative) can ask for the appeal.

How to ask for an appeal

You can ask for an appeal by mail or electronically. Include your name, address, member ID number, the reasons you're appealing, and any evidence you want to attach. If someone other than you or your doctor or prescriber is asking for the appeal, that person must submit a document showing their authority to act for you. This could be a power of attorney, a court order, or an Appointment of Representation form.

If your appeal is about a decision to deny coverage for a drug that's not on our list of covered drugs (formulary), or if you're asking for an exception to a prior authorization (PA) or other utilization management (UM) requirement, your doctor or prescriber must submit a statement with your appeal request indicating that all the drugs on any tier of our formulary (or the PA/UM requirement) wouldn't be as effective to treat your condition as the requested drug, or would harm your health.

Submit your appeal request to the independent reviewer in one of these ways:

Electronically via the Part D QIC Portal: c2cinc.com//Appellant-Signup

Fax:

For Standard Appeals: (833) 710-0580
For Expedited Appeals: (833) 710-0579

Standard mail:

C2C Innovative Solutions, Inc.
P.O. Box 44166
Jacksonville, FL 32231-4166

FedEx, UPS or courier:

C2C Innovative Solutions, Inc.
301 W. Bay St., Suite 1110
Jacksonville, FL 32202
Phone: (833) 919-0198



Model Redetermination Notice of Denial of Medicare Drug Coverage

Date: 10/08/2025

Enrollee name: [REDACTED]

Enrollee ID Number: [REDACTED]

Plan Name: Regence MedAdvantage + Rx (PPO)
Formulary ID: [REDACTED]

Contract ID: [REDACTED]
Plan ID: [REDACTED]

This notice is to let you know we agree with our initial coverage determination: we're denying coverage for the following prescription drug(s) that you, your doctor, or prescriber asked for: MOUNJARO 2.5MG/0.5ML SOLUTION AUTO-INJECTOR

We're denying coverage because:

This request for coverage was based on our Glucagon-Like Peptide-1 (GLP-1) Agonists Prior Authorization criteria. It cannot be approved at this time. You must meet our criteria for this drug to be covered by your plan.

Drug-Dosage-Strength	Request Type	Outcome
Mounjaro Subcutaneous Solution Auto-injector 2.5 MG/0.5ML	Part D Eligibility	Denied

Medicare Part D rules limit coverage of drugs. They limit it to those that are being used for a Part D eligible medically accepted condition. These rules are found in the Medicare Prescription Drug Benefit Manual, Chapter 6 Section 10.6. Medically accepted conditions are based on Food and Drug Administration (FDA) labeling and/or Medicare-approved drug references.

Drug-Dosage-Strength	Request Type	Outcome
Mounjaro Subcutaneous Solution Auto-injector 2.5 MG/0.5ML	Prior Authorization	Denied

- You must have a diagnosis of type 2 diabetes mellitus. This is a condition that affects the blood sugar.
Please note: The requested drug cannot be covered under Medicare Part D when used for weight loss alone. This is based on Medicare rules. These rules are found in the Medicare Prescription Drug Benefit Manual, Chapter 6 Section 20.1.



Y0062_2025_RX009_C





Thank you for your order!

We've received your payment and your order is being prepared for delivery. While you wait for your prescription, visit [this page](#) for resources on how to store the product once it arrives.

Order Summary

Created 10/13/25
02:59:35 PM
Prescribed by JEFFREY
ALLGAIER
NPI: 1659300374

ZEPBOUND \$349.00

2.5

MG/0.5ML

SUBCUTANEOUS

SOLUTION

VIAL (2.5MG)

NDC:

00002015204

Rx#

Fill Date:

October 14th,

2025 05:33

INJECTION \$5.00
SUPPLIES

Tax \$0.00
Subtotal \$354.00

Total Paid \$354.00

Card ending
in [REDACTED]

Shipping Information

[REDACTED]

If you have any questions,
please [chat with a](#)
[Gifthealth patient care](#)
[representative](#) during
business hours.





Thank you for your order!

We've received your payment and your order is being prepared for delivery. While you wait for your prescription, visit [this page](#) for resources on how to store the product once it arrives.

Order Summary

[REDACTED]
Created 11/10/25
07:30:23 AM
Prescribed by JEFFREY
ALLGAIER
NPI: 1659300374

ZEPBOUND \$349.00

2.5

MG/0.5ML

SUBCUTANEOUS

SOLUTION

VIAL (2.5MG)

NDC:

00002015204

Rx# [REDACTED]

Fill Date:

November 11th,

2025 10:24

INJECTION \$5.00
SUPPLIES

Tax \$0.00
Subtotal \$354.00

Total Paid \$354.00

Card ending
in [REDACTED]

Shipping Information



If you have any questions,
please [chat with a](#)
[Gifthealth patient care](#)
[representative](#) during
business hours.





Thank you for your order!

We've received your payment and your order is being prepared for delivery. While you wait for your prescription, visit [this page](#) for resources on how to store the product once it arrives.

Order Summary

[REDACTED]
Created 12/02/25
02:13:21 PM
Prescribed by JEFFREY
ALLGAIER
NPI: 1659300374

ZEPBOUND ~~\$599.00~~ \$449.00

7.5

MG/0.5ML

SUBCUTANEOUS

SOLUTION

VIAL (7.5MG)

NDC:

00002121404

Rx# [REDACTED]

Fill Date:

December 3rd,

2025 10:17

INJECTION SUPPLIES	\$5.00
Tax	\$0.00
Subtotal	\$454.00
Total Paid	\$454.00

Card ending
in [REDACTED]

Shipping Information



If you have any questions,
please [chat with a
Gifthealth patient care
representative](#) during
business hours.

