CITY OF BOTHELL

LEOFF I DISABILITY BOARD

POLICIES AND PROCEDURES

TABLE OF CONTENTS

		Page
PREAMBLE		6
SCOPE		6
EFFECT OF RULES AND REGULATIONS		6
PART 1.	**DEFINITIONS**	**(7)**
1.1 - 1.10		7
PART 2.	**THE BOARD**	**(8-10)**
2.1	Powers of the Board	8
2.2	Board Composition	8
2.3	Board Term of Election/Appointment	8
2.4	Election of the Firefighter/Law Enforcement Representative	8
2.5	Chair	8
2.6	Voting	9
2.7	Absence	9
2.8	Board Compensation/Reimbursement	9
2.9	Board Clerk-Secretary	9
2.10	Delegation of Authority	9
2.11	Board Physician	9-10
PART 3.	**GENERAL PROVISION OF BOARD MEETINGS**	**(10-13)**
3.1	Meetings, Agenda	10
3.2	Meetings Minutes	10
3.3	Amendment of Rules	10
3.4	Parliamentary Guide	11
3.5	Examination of Records	11
3.6	Oral Proceedings/Transcripts	11-12
3.7	Subpoenas	12-13

PART 4.	**PROCESSING APPLICATIONS AND CLAIMS**	**(13-14)**
4.1	Submission of Claims	13
4.2	Reconsideration of Board Decisions	13
4.3	Appeal Procedure	14
PART 5.	**DISABILITY LEAVE AND RETIREMENT/ GENERAL PROCEDURES**	**(14-15)**
5.1 - 5.7	General Procedures	14-15
PART 6.	**OBLIGATION OF MEMBERS WHILE ON LEAVE**	**(15-17)**
6.1	Authorization to Return to Active Service from Disability	15-16
6.2	Member Cooperation in Board Evaluation	16
6.3	Member's Address	16
6.4	Determination of Fitness	16
6.5	Treatments	17
6.6	Activities of Members while on Disability Leave	17
PART 7.	**DISABILITY RETIREMENT**	**(17-19)**
7.1	Granting Retirement	17
7.2	Alternate/Available Assignment	18
7.3	Denial of Retirement	18
7.4	Voluntary Waiver of Leave	18
7.5	Periodic Re-examination of Retiree	18-19
7.6	Discontinuation of a Retirement Allowance, Notice of	19
7.7	Decision, Findings and Conclusions	19
7.8	Re-entry from Retirement	19
PART 8.	**MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS**	**(19-21)**
8.1	Medical Services	19-20
8.2	Forms	20
8.3	Time for Filing	20
8.4	Third Party Payments and Subrogation	20
8.5	Criteria for Authorizing Reimbursement	20
8.6	General Provisions	20-21

PART 9.	**CLAIMS FOR REIMBURSEMENT OF CERTAIN MEDICAL TREATMENT/PROCEDURES**	**(21-31)**
9.1	General Rule	21
9.2	Special Approval	21
9.3	Emergency Treatment	21-22
9.4	Continuous or Periodic Treatment Services	22
9.5	Treatment Plans	23
9.6	Chiropractic Treatment/Services	23-24
9.7	Mental Health Services of a Psychologist, Social Worker, or Licensed Mental Health Counselor	24-25
9.8	Substance Abuse Services	25-26
9.9	Vision Benefits	26
9.10	Medical Equipment and Supplies	27-28
9.11	Dental Benefits	28
9.12	Long Term Care	29-30
9.13	Miscellaneous	30-31
PART 10.	**REVIEW OF BOARD RULES: AMENDMENTS, REVISIONS PER STATE RETIREMENT SYSTEMS**	**(31-31)**
10.1	Periodic Review	31
10.2	Application	31
10.3	Review Action (Chronology of Board Rules Revision Action)	31-32

PREAMBLE

The purpose of these rules is to establish the general operating procedures and reduce to writing the administrative policies and procedures of the City of Bothell Disability board. The Board recognizes that conditions may exist or come into existence, which are not properly encompassed by these rules. In such cases, the Board reserves the right to take whatever action is necessary to properly deal with that situation consistent with RCW 41.26, WAC 415-104 and WAC 415-105.

SCOPE

These Policies and Procedures shall be applicable to all members hired before October 1, 1977, covered by chapter 41.26 RCW 'LEOFF I", whether Firefighter or Police Officer, unless specifically provided herein.

EFFECT OF RULES AND REGULATIONS

Upon adoption of these Policies and Procedures, each City of Bothell LEOFF-I member shall be provided a copy of such rules by certified mail. All members shall be subject to the policies and procedures contained herein to the extent consistent with applicable State statutory provisions and shall at all times follow the procedures contained herein to avoid possible loss of benefits. In the event any policy or procedure as applied to the particular member shall be held to be contrary to State law, such member shall not be relieved of any other requirement contained herein and any such finding shall not relieve the member from the responsibility to comply with all other procedures and policies contained herein.

A member's failure to follow these procedures may subject her/him to the loss of benefits otherwise due under RCW 41.26.

The Board has reserved the right to amend, modify or deviate from these rules at its discretion. Copies of amendments to the rules shall be mailed to each member at their last registered address and posted at the Police and Fire stations. Failure to receive copies of these rules or any amendment thereto shall not be a defense for failure to comply with the required procedures. Each member is expected to be familiar with the Board's processes. Inquiries regarding these rules, any amendments or the Board's procedures may be made in writing to:

LEOFF I Disability Board Clerk Secretary
Bothell LEOFF-I Disability Retirement Board
18415 101st Ave NE
Bothell, WA 98011

1 DEFINITIONS

1.1 "Application" means a filed request by a member for Board approval of disability leave or retirement.

1.2 "Board Physician" means a duly licensed and practicing physician appointed by the Board to serve as its consultant pursuant to WAC 415-105-030.

1.3 "Claim" means a filed request by a member to the Board for approval of reimbursement of expenses incurred for medical services or treatment; or the pre-approval of any services requiring pre-approval by the Board

1.4 "Conditional return" is a return to duty by a member for the purpose of determining whether the member's disability persists.

1.5 "Consulting Physician" see "Board Physician".

1.6 "Designated Physician" means a physician named by the Board to provide medical diagnosis, treatment, on-going evaluation and/or final assessment of an individual member.

1.7 "Disability" means the existence of a physical or mental (psychological) condition that 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 the regular duties of any available position to which a member or his grade or rank is normally assigned, with average efficiency, the member is not considered disabled. Nothing in these rules shall be deemed to limit or amend the rights and obligations of any disabled person and the City of Bothell under the provisions of the Washington Law Against Discrimination or the Americans with Disabilities Act.

1.8 "Disability Leave Allowance". Disability leave allowance is not granted for any specific amount of time. Such leave may encompass a period of one hour to a maximum of six months. During this time, the member is to receive an allowance equal to his regular salary on the first day of such leave [Per AGO No. 78.8] or the applicable portion thereof, from his employer.

1.9 "In the line of duty" means that the member's disability occurred as a direct result of the performance of the member's duties.

1.10 "Member" means a current or retired law enforcement officer or firefighter eligible for benefits provided under RCW 41.26.

2 THE BOARD

2.1 Powers of the Board

The Board shall have the powers granted by the State legislature or necessarily implied from such grant of powers in RCW 41.26 and WAC chapters 415-104 and 415-105.

2.2 Board Composition

The City of Bothell LEOFF-I Disability Retirement Board shall consist of the following five members: Two Members of the City Council to be appointed by the mayor, one active or retired Firefighter to be elected by the Firefighters employed by or retired from the City, one active or retired law enforcement officer to be elected by the law enforcement officers employed by or retired from the City and one member from the public at large residing within the City to be appointed by the other four members.

Only those active or retired firefighters or law enforcement officers who are subject to the jurisdiction of the board have the right to elect per RCW 41.26.110(1)(a)

2.3 Board Term of Election/Appointment

Each member, elected and appointed, shall serve a two year term with service beginning in January. The member at large shall serve a two year term with service beginning in March. In the event of a vacancy, a successor shall be appointed or elected in the same manner as with an original appointment or election to serve the remainder of the unexpired term. Nothing herein prohibits members from being re-elected or reappointed.

2.4 Election of the Firefighter/Law Enforcement Representative

Nominations and election commence every two years and are conducted by the Board Clerk-secretary.

2.5 Chair

The members of the Board shall elect a Chair and, when necessary, a chair pro tempore to serve in the absence of the Chair. The chair pro tem shall assume the duties and powers of the Chair in the Chair's absence.

The Chair shall preside at all meetings and hearings of the Board and may call special meetings. The Chair shall have the privilege of discussing matters before the Board and voting thereon except where doing so constitutes a violation of an appearance of fairness doctrine or a conflict of interest. The Chair 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 Board.

2.6 Voting

Each Board member shall have one vote, which must be cast by that member in person. Three members shall constitute a quorum.

2.7 Absence

Each Board member is expected to notify the Chair or Clerk-secretary prior to a scheduled meeting if that member will not be able to attend the meeting. All attendance at meetings shall be recorded in the minutes of the meeting. An excused absence shall be the determination of the Board. Three unexcused absences in a one year period shall be cause for review and possible removal from the Board by a majority vote of the Board.

2.8 Board Compensation/Reimbursement

The members of the City Disability Board shall not receive compensation for their service upon the Board but shall be reimbursed for all expenses incidental to such service as to the amount authorized by law. Time spent on Board activities by active members of the Bothell Police or Fire Departments shall not be considered "on duty" time.

2.9 Board Clerk-secretary

The City Human Resources Director or her/his designee shall serve as Board Clerk-secretary.

2.10 Delegation of Authority

The City of Bothell Disability Board delegates to the Board Clerk-secretary the authority to instigate investigative activities, including gathering, collating and presenting of fact regarding matters within the scope of the Board's authority. These matters include, but are not limited to, areas of disability leave, pensions, medical expenses and activities relevant to them.

2.11 Board Physician

A. The Board as specified in WAC 415-105-030 shall appoint a duly licensed and practicing physician. 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 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.

B. 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 Board shall furnish to the examining physician the job and/or position description of the applicant.

3 GENERAL PROVISIONS OF BOARD MEETINGS

3.1 Meetings, Agenda

A. The Board shall meet regularly, the second Wednesday of the month at 5:00 p.m. in Bothell City Hall Conference Room #127. If necessary, special meetings may be called by the Chair or a majority of the Board. Regular meetings may be canceled if there is no business pending before the Board.

B. The meetings of the Board shall be open to the public in accordance with the provisions of the Open Meetings and Record act. The Board, in its discretion may close meetings or portions of meetings or records relating to:

1. The consideration of a specific application, claim or appeal regarding the application of the member as exempted by RCW 42.30.140(2) where such consideration may include discussion of sensitive personal information relating to the member or

2. Where the Board in its discretion deems that evidence, discussion or release of records might violate either a member's right to privacy under the provisions or RCW 42.56 or would violate the right of confidentiality regarding a disability of a member under the provisions of the Americans with Disabilities Act.

3.2 Meeting Minutes

The Board Clerk-secretary shall take or cause to be taken minutes of regular meeting minutes and be responsible for distribution to Board members, Human Resources Director, City Manager and others designated by the Board.

3.3 Amendment of Rules

The policies and procedures of the Board may be amended at a regular meeting of the Board by a majority vote of members attending provided that such amendment or amendments are submitted in writing to each member of the Board at least twenty (20) days prior to the meeting at which they are to be considered by the Board and provided that nothing herein shall preclude amendment of the rules without prior notice upon the unanimous consent of every member of the Board to waive such notice if the same is present during a regular or special meeting where at the amendment comes before the Board for consideration.

3.4 Parliamentary Guide

Robert's Rules of Order shall govern the conduct of all Board meetings, unless otherwise provided in these rules.

3.5 Examination of Records

Information relating to a member's claim or application shall be released under the following conditions:

A. Only as required by RCW 42.56, by court order, or written permission of the member. Upon request to the Board Clerk-secretary, members may examine their disability file at the Board office during times scheduled by the Board Clerk-secretary. As provided under subsections (3.5 (B) below, a member may submit a written request for copies of her/his disability file or portions thereof.

B. A person requesting examination of Board records, minutes or agendas must submit a written request and arrange with the Board Clerk-secretary an appointed time for viewing the materials. Requests for examination must comply with the Public Information Act. If a request would violate a member's privacy rights, all identifying details in the information must be deleted or the member's written permission must be obtained before release of the information.

C. A copy of a record of proceedings, minutes, agendas, Board action, disability file records (with member's written permission), or any part thereof will be furnished to a requesting party upon request and payment thereof of copy fees charged pursuant to RCW 42.56.120 except that a member will not be charged for copies of records in Board files pertaining to that member.

3.6 Oral Proceedings/Transcripts

The Board may hold a full hearing on any matter when deemed necessary or on a motion for reconsideration under Board rules. At such a hearing:

A. Any person testifying before the Board may have his/her attorney present.

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

C. Unless precluded by law, informal disposition may also be made of any contested case by stipulation, agreed settlement, consent order or default.

D. The record of a hearing shall include:

1. All pleadings, motions, intermediate rulings;
2. Evidence received or considered;
3. A statement of matters officially noticed, if any;
4. Questions and offers of proof, objections and ruling thereon, if any;
5. Proposed findings and exceptions, if any;
6. Any decision, opinion or report by the Disability Board.

E. All oral proceedings before the Board shall be recorded and tapes and evidence maintained by the Board Clerk/Secretary.

F. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

G. The Disability Board may:

1. Administer oaths and affirmations, examine witnesses and receive evidence;
2. Issue subpoenas as provided below;
3. Rule upon offers of proof and receive relevant evidence;
4. Take or cause to be taken depositions pursuant to rules promulgated by the Board;
5. Regulate the course of the hearing.

3.7 Subpoenas

The Board may compel the attendance of a witness at any hearing as follows:

A. The Board may issue a subpoena on its own motion or on the request of any party;

B. If an individual fails to obey a subpoena, or obeys a subpoena but refuses to testify when requested concerning any matter under examination or investigation at the hearing, the Board may petition the Superior Court for enforcement of the subpoena. The petition shall be accompanied by a copy of the subpoena and proof of service and shall set forth in what specific manner the subpoena has not been complied with and shall ask an order of the court to compel the witness to appear and testify before the Board.

C. Witnesses subpoenaed to attend such a hearing shall be paid the same fees and allowances, in the same manner and under the same conditions as provided for witnesses in the courts of this State by RCW 2.40 and by RCW 5.56.010, as now or hereafter amended. Provided, that the Board shall have

the power to fix the allowance for meals and lodging in like manner as is provided in RCW 5.56.010, as now or hereafter amended, as to courts. Such fees and allowances and the cost of producing records required to be produced by its subpoena, shall be paid by the Board, or by the party requesting the issuance of the subpoena.

4 PROCESSING APPLICATIONS AND CLAIMS

4.1 Submission of Claims

All applications and claims shall be submitted to the Board Clerk-secretary:

A. On forms provided by the Board;

B. Be submitted to the Human Resources Department; who will then forward the completed forms to the Board Clerk-secretary;

C. Be submitted to the Board Clerk-secretary at least ten (10) calendar days prior to a scheduled meeting to be placed on the current meeting agenda. Untimely submitted or incomplete material will be considered at the discretion of the Board or placed on the next available agenda. The Board reserves the right to request additional supporting documentation if the Board questions the official nature of the material submitted for a claim. Illegible material will not be considered.

4.2 Reconsideration of Board Decisions

The Board's decision to approve or deny applications or claims may be made without a full hearing solely on the basis of the written information submitted to the Board. Any member aggrieved by a decision made without a full hearing may file with the Board a request for reconsideration and receive an opportunity for a full hearing.

A. Such a request must be filed in writing within 14 days of notification of the decision. Upon receipt of such a written request, the Board will set a hearing date and time at the next available Board meeting. Notice will be sent to the member at least fourteen (14) days prior to the hearing.

B. At a scheduled hearing, a member and/or a representative will be afforded approximately 15 minutes to present information or testimony before the Board. In addition to, or in lieu of, verbal testimony, any written material must be submitted to the Board office seven (7) days before the hearing date to be included with the regular agenda. Written material submitted at the time of a hearing will be considered at the discretion of the Board.

4.3 Appeal Procedure

A. Any member aggrieved by an order of the City Disability Board has the right of appeal to the State Retirement Systems director pursuant to the provisions of RCW 41.26.200.

B. If the final determination is outside the jurisdiction of the State Retirement Systems director, motion for review is to be filed with the superior court pursuant to RCW 41.26.211 and RCW 34.05.514.

C. In accordance with RCW 41.26.125(3) the State Retirement Systems does not review a Board finding that a disability retirement was/was not incurred in the line of duty. Direct review, however may be sought from the United States Department of the Treasury, Internal Revenue Service, concerning any federal tax consequences of a Board finding that a disability was not incurred in the line of duty.

5 DISABILITY LEAVE AND RETIREMENT/GENERAL PROCEDURES

5.1 Applications for disability leave shall be submitted on forms provided by the Board together with all supporting information required on that form.

5.2 All applications for disability retirement shall be submitted on forms provided by the Board, together with statements from two (2) physicians and the Department's statement and report on the application for disability retirement, and:

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

B. If the disability claimed was incurred in the line of duty, proper evidence must be submitted substantiating this claim, per WAC 415-104-155: "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."

5.3 Where the duration of a disability leave is uncertain the Board will estimate the duration of the leave when considering the application. In such cases the Board may later act to modify the duration of the leave allowed.

5.4 Each application for disability retirement shall be deemed to be an application for disability leave not to exceed six months and disability retirement benefits, unless otherwise provided.

5.5 Where the Board receives an application for a disability retirement, arrangements shall be made to have the applicant examined before the sixth month of leave by a physician designated by the Board. The report of the designated physician as well as all information submitted by the applicant, shall then be reviewed by the Board's

consulting physician and he shall submit an analysis, either orally or in writing, of the applicant's condition to the Board.

5.6 Applicants for disability retirement will be reexamined by a physician during the fifth or the sixth month of disability leave in order to determine their eligibility for disability retirement, except in conditions where:

A. The Board physician assures the Board that the applicant's condition is continuous and unrecoverable, such that it has not and will not be corrected before the end of the sixth month, whereby the above rule will not necessarily apply, or

B. The applicant establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and voluntarily waives all or any portion of disability leave.

No applicant will be granted a disability retirement unless the procedures outlined in sections 5.1 through 5.6 are followed.

5.7 The Board may, at its discretion, postpone any decision and request additional information or a hearing.

6 OBLIGATIONS OF MEMBERS WHILE ON LEAVE

6.1 Authorization to Return to Active Service from Disability

A. It shall be incumbent upon all members granted disability leave to seek authorization from their physician and Department to return to active service at the earliest possible time. In the event the Board finds that a member has not sought authorization from her/his physician and Department to return to active service immediately upon cessation of disability, the Board shall require the member to report to a Board appointed physician to determine the member's ability to return to work. If the Board appointed physician finds that the member's disability had ceased prior to the examination, the Board may retroactively cancel the member's disability leave allowance for the period in question.

B. In the event the medical and other relevant evidence is inconclusive regarding the continued existence of a disability or reasonable likelihood of a recurrence of the disability, the Board may specify, in a written order, a reasonable period for a trial return to service to determine the member's fitness for active duty. The reasonable length of such a trial period shall be supported by medical evidence. The original claim form signed by the member will serve as an agreement the a trial 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 period of service, he/she is then found to be still disabled.

C. If, at the end of the trial return period, the employee is performing her/his duties with average efficiency, the trial return period will cease. The member or Department will contact the Board at the end of the trial return period. If the member has not been able to perform her/his duties with average efficiency during the trial return period, the member will notify the Board. The Board will then make its decision on the member's retirement or may extend disability leave pursuant to Board Rule 5.3.

6.2 <u>Member Cooperation in Board Evaluation</u>

A. While on disability leave, the member shall be obligated to comply with the directives of the Board. Such directives may include, but are not limited to, requests for medical or psychological evaluation(s) or testing; requests for submittal of other relevant reports; and orders to appear before the Board. If the Board finds compliance with such a request was within the control of the member and he/she failed to comply, it will presume compliance with the request would have shown the member to have recovered. This presumption can be overcome by competent medical evidence provided by the member to the Board.

B. Each member shall, as a condition precedent to returning to active service or being placed on disability retirement, sign a sworn statement that all information provided to the Board is truthful. Any person knowingly making a false statement to the Board shall be guilty of a felony, pursuant to RCW 41.26.300.

6.3 <u>Member's Address</u>

A member shall keep the Board advised of her/his current address. Any travel expenses incurred to appear before the Board or its designated physician shall be the responsibility of the member.
In the event the retired member is residing at a location more that one hundred (100) miles from the location of the Disability Board, the Board at its discretion may authorize examination by a physician in her/his immediate area. The physician shall be first approved by the Board and prior to such evaluation be apprised of the basis upon which the examination is to be conducted and the issues to be addressed within the evaluation report.

6.4 <u>Determination of Fitness</u>

Any medical standards designed to set minimum health qualifications before a firefighter or law enforcement officer is hired, issued by the State Department of Retirement Systems or used by an Department, are not the applicable standards for determining eligibility for disability leave or retirement benefits.

6.5 Treatments

During the period of leave, the Board shall have the authority to inquire of any examining physician as to what physical, medical or therapeutic treatments might be employed to rehabilitate the member and, based upon such evaluation, to direct the member to participate in rehabilitation. If the member fails or refuses to submit to such treatments, the Board may terminate the member's disability benefits.

6.6 Activities of Members while on Disability Leave

A member who engages in any activity while on disability leave which results in an injury or illness, may needlessly compound the issues. Therefore, in the event a member, while on disability leave, is found to be engaged in an activity, deemed by the Board to be potentially detrimental to his returning to full duty status, he/she may be directed by the Board to cease that activity. Failure to follow such direction may result in loss of benefits.

7 DISABILITY RETIREMENT

7.1 Granting Retirement

If evidence shows to the satisfaction of the Board that the member is disabled and that the disability will be continuous from the date of commencement of disability leave for a period of six months, the Board shall enter its written decision for disability retirement and order which shall contain the following presented in clear and concise terms:

A. Findings of fact supported by substantial evidence in the record that support the grant of a disability retirement allowance. Findings of fact shall also include:
   1. Whether the disability was incurred in other employment, if applicable.
   2. Dates encompassing disability leave, waiver of disability leave and/or dates relating to approved conditional return to duty, and the factual basis of such decision.
   3. Whether applicant waived disability leave under Board rules.

B. Conclusions of law on the basis of the facts in the case.

C. A finding of whether or not the disability was incurred in the line of duty.

D. Such written decision and order with supporting documentation shall thereafter be forwarded to the State Retirement Board for review.

7.2 Alternate/Available Assignment

No member shall be entitled to a disability retirement allowance if the Department Chief 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 the member is capable of discharging the duties of the position with average efficiency. (WAC 415-105-060(2)) Nothing herein shall be interpreted to limit the rights or obligations of the City or disabled employee under the terms of the Washington Discrimination Act or the Americans with Disabilities Act.

7.3 Denial of Retirement

If an application for disability retirement is denied, the Board shall enter a written decision and order which shall contain findings of fact and conclusions of law. The applicant and Department will be promptly notified of the decision and of the applicant's rights to request for reconsideration to the Board, if applicable, or to appeal to the State Retirement Board. (see Rule 4.3)

7.4 Voluntary Waiver of Leave

If a member establishes that the disabling condition is continuous and unrecoverable for the duration of six months leave and longer, the member may voluntarily sign a written waiver of her/his rights to all or part of the six month disability leave in order to have her/his disability retirement application acted on at an earlier date than would otherwise be permitted.

When the Board receives an application for a disability retirement where the applicant voluntarily waives her/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.

7.5 Periodic Re-examination of Retiree

Each member placed on disability retirement who is under 49.5 years of age is subject to periodic review, to include a medical examination and completion of the Board's re-evaluation questionnaire, approximately every six (6) months, to determine whether disability retirement should be continued.

A member shall keep the Board advised of her/his current address. Any travel expenses incurred to appear before the Board or its designated physician shall be the responsibility of the member.

In the event the retired member is residing at a location more than one hundred (100) miles from the location of the Disability Board, the Board at its discretion may authorize examination by a physician in her/his immediate area. The physician shall be first approved by the Board and prior to such evaluation be apprised of the basis upon which the examination is to be conducted and the issues to be addressed within

the evaluation report. The retirement allowance of any member who fails to submit to medical examination as provided above shall be discontinued or suspended until the required medical information to justify continuation of a retirement allowance is provided by the member. In the event such refusal continues for one (1) year, her/his retirement allowance shall be canceled. Failure of the member to affirmatively respond to the request for reexamination shall be deemed a continuing refusal.

7.6 Discontinuation of a Retirement Allowance, Notice of

Where a periodic reexamination determines that the retired member may no longer be disabled or the member requests to return to duty, the member shall be notified, by mail, of the Board's proposed action to discontinue or cancel her/his retirement allowance. The notification shall contain notice of the time, place and nature of a hearing to be held to determine whether the member continues to be disabled.

7.7 Decision, Findings and Conclusions

Every decision and order revoking a disability retirement shall be in writing or stated in the record and shall be accompanied by findings of fact and conclusions of law. The member shall be notified of the decision and order in person, by phone and by first class or certified mail. The member shall be entitled to a hearing before the Board pursuant to RCW 41.26.140(2). The hearing shall be held unless the retiree waives such hearing before cancellation of a disability retirement allowance.

7.8 Re-entry from Retirement

If the Disability Board shall determine that the member is not so incapacitated her/his retirement allowance shall be canceled and he/she restored to duty in the same civil service rank, if any, held by the beneficiary at time of retirement or if unable to perform the duties of said rank, then, at her/his request, in such other like or lesser rank, as may be or become open and available, the duties of which he/she is then able to perform. In no event, shall a beneficiary previously drawing a disability allowance be returned or be restored to duty at a salary or rate of pay less than the current salary attached to the rank or position held by the said beneficiary at the time of her/his retirement for disability. If the Board determines the beneficiary is able to return to service he/she shall be entitled to notice and hearing as provided in Board rule 7.6.

8 MEDICAL EXPENSE CLAIMS, PROCEDURES AND GENERAL PROVISIONS

8.1 Medical Services

Medical services are defined in RCW 41.26.030(19) to be the minimum services legally required to be furnished or authorized by the Board. Medical services not listed in that section, may, at the discretion of the Board, be considered for authorization on a case by case basis and according to these rules. The Board, at its discretion, may authorize administrative approval of claims which clearly meet standards described by these rules.

A. The Board authorizes staff administrative approval of claims as designated above at up to $1500.

8.2 Forms

Claims for payment of medical services shall be submitted on forms provided by the Board together with any supporting information.

8.3 Time for Filing

All claims must be submitted within six (6) months of the billing date, unless the employee can demonstrate that the delay was beyond her/his control. If a legal holiday observed by the City occurs at the end of the six month time period, the claim(s) may be submitted on the next working day. No claim will be allowed before the expenses are actually incurred, except in such cases where preauthorization is required herein.

8.4 Third Party Payments and Subrogation

A. Payment of claims shall be reduced by any amount received or eligible to be received under workmen’s compensation, social security, Medicare, insurance provided by another Department, pension plan or other similar source in accordance with RCW 41.26.150(2).

B. Members possessing insurance benefits covering the expenses of necessary medical services, which would otherwise be the obligation of the Department, shall first present the claim to the appropriate insurance carrier and, only thereafter, make claim to the Board for those costs which are not paid by the insurer.

C. The City shall have the subrogation rights described in RCW 41.26.150(3). The City may provide for the payment of approved medical claims by insurance, self-funded medical benefit plan, enrollment of the member in an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) or any other method chosen by the City.

8.5 Criteria for Authorizing Reimbursement

For each claim, the Board shall determine if the criteria listed in the Board Rules 4.1 and 8.6 and any applicable provision of these rules are met. If there is a doubt as to the reasonableness of a medical service charge, the burden is upon the claimant to establish reasonableness.

8.6 General Provisions

The following rules apply to all claims for medical services as defined in RCW 41.26.030(19) and as authorized under these rules.

A. The Board will allow claims under the conditions set forth in RCW 41.26.150 and RCW 41.26.030(19). Claims for medical services will be approved only if they meet the following conditions:

1. The sickness or disability for which services are rendered was not brought on by dissipation or abuse.
2. The medical services are necessary.
3. The charges are reasonable, unless a provision in these rules provides for reimbursement of a lesser amount.
4. If the member belongs to a pre-paid health plan, he/she could not have obtained reasonable equivalent services at no additional charge through such plan. The Board will decide which services are reasonably equivalent.

B. The City may provide any information which it believes will assist the Board in determining whether the criteria set forth above and any applicable provision of these rules are met for any medical claim submitted to the Board. Such information may include the reasons for denial of a claim or limitations on a member's coverage by a third party payer.

C. The Board will not allow claims for interest on delinquent accounts or charges for missed appointments.

D. Pursuant to the authority granted to the Board under 41.26.150(1) to designate medical services payable by the City in addition to those listed in RCW 41.26.030(19), the Board designates in Chapter 9 additional medical services subject to the conditions and limitations set forth in these rules and given statutes.

9 CLAIMS FOR REIMBURSEMENT OF CERTAIN MEDICAL TREATMENT/ PROCEDURES

9.1 General Rule

The Board will approve payment of claims for all medical services defined in RCW 41.26.030 under the conditions set forth in RCW 41.26.150 and stated in Chapter 8.

9.2 Special Approval

A quorum of the Board may, at other than regular Board meetings, approve payment of claims.

9.3 Emergency Treatment

Charges for emergency services and treatment not covered by the member's insurance provider will be approved in full, in cases of sudden, acute medical

emergencies or accidental injuries for 24 hours or for such time reasonably required to come under the care of a participating physician, provided claims are processed as required in Rule 8.3.

9.4 Continuous or Periodic Treatment/Services

Treatment/services of psychological counseling and/or substance abuse and chiropractic services, and other remedies, requiring consecutive treatment, are subject to provisions set forth herein. Claims for such treatment must be submitted for prior approval before a member undertakes treatment. A claim for reimbursement of the cost of treatment taken without the Board's prior approval by a member's own volition, will be considered at the Board's discretion.

A. Members with a Health Maintenance Organization

When the member is covered by a comprehensive-group health insurance provider, such as Group Health, the member should first seek medical services from their own health insurance provider since they are known to have medical staff/specialists.

If this health insurance provider's physician certifies that specific medical services are unable to be provided through their facility/registry, the member should seek a referral by their health insurance provider's physician to a physician/specialist outside of that group-plan health facility. When there is a referral, such group-plan health insurance provider is required to pay up to an aggregate maximum dollar amount per contract year for specific services. If a physician of a group-plan health insurance provider refuses to make such a referral, the reasons for the refusal should be reported in writing to the Board since the reasons could bear upon the issue of the necessity of such services. If such a referral is not provided with a claim, the Board will construe the medical services provided outside of a member's group-plan health facility as elective on the part or the member and may deny such claim.

B. Members with Other Insurance Coverage

When the member is covered by a health insurance provider, the member is required to submit claims to this provider for payment or rejection. [Certain health insurance providers, such as Regence Blue Shield, Blue Cross or like insurance providers, will pay for medical services up to a specified amount subject to the contract year entitlement.] Once medical service costs exceed the contract year's entitlement, the uncovered portion rejected by a health insurance provider may be submitted to the Board for their consideration. (see 9.4(C) below)

C. In the event the cost of specific medical services exceeds the aggregate contract year entitlement provided by a health insurance provider, the claimant should submit a proposed treatment plan for the Board's pre-approval, prior to receiving services over and above the designated contract

maximum.

1. <u>Medical treatment services found unreasonable.</u> If such treatment plan or charges thereof is found to be unreasonable, excessive or continuous, such that a member elects to continue treatment for relief of pain symptoms only, the Board will require a member to undergo specific medical examination and provide a medical evaluation from a physician or specialist. If a member fails to undergo such an examination, the Board will construe such services as elective on the part of the member and may deny such claim.

2. <u>Unrelated or additional medical service/treatment.</u> If the aggregate contract entitlement has been reached and medical services are sought for treatment of an injury/condition, not related to the reason for which original medical services were rendered, the member may have two visits to a physician or specialist for such injury/condition prior to submitting a treatment plan for such additional services to the Board for prior approval. Treatment/services in excess of two must be approved in advance by the Board.

9.5 <u>Treatment Plans</u>

The service provider is required to submit an initial individualized treatment plan which was prepared within one (1) month of commencement of treatment or upon request of the Board or where stated otherwise in the rules. The Board will review the progress reports and treatment plans to determine whether charges for such treatment should continue to be approved for payment.

Components of the Treatment Plan: A treatment plan is required as an individualized program to meet the unique treatment requirements of the member. The treatment plan shall include, but not be limited to the following:

- ✐ Current medical diagnosis;
- ✐ Significant history;
- ✐ Description of treatment/therapy or medication (treatment modality, frequency, length of treatment session, estimation of duration, approximate recovery time, criteria used to indicate progress, and names and activities of other professional who participate in the treatment);
- ✐ Description how the condition being treated affects the member's ability to perform required regular day-to-day duties of the job and or tasks of daily living with average or better efficiency.
- ✐ Approximate cost per treatment.

9.6 <u>Chiropractic Treatment/Services</u>

Claims for chiropractic services are subject to the provisions set forth above. [Refer to Rule 9.4]

A. Certain health insurance providers, such as Regence Blue Shield will pay for chiropractic services up to a specified amount subject to the contract year entitlement. Once chiropractic service costs exceed the contract year's entitlement, the uncovered portion rejected by a health insurance provider may be submitted to the Board for their consideration.

B. When a member is covered by a comprehensive-group health insurance provider such as Group Health, the member should first apply to their own health insurance provider since they are known to have chiropractors on staff. If this health insurance provider's chiropractor certifies that services are unable to be provided through their facility, the member should seek a referral by their health insurance provider's physician outside of that group health facility. When there is a referral, such group health insurance provider is required to pay up to an aggregate maximum dollar amount per contract year for chiropractic services. If that group health provider physician refuses to make such a referral, the reasons for the refusal should be reported to the Board since the reasons could bear upon the issue of necessity of such services. If such a referral is not provided with a claim, the Board will construe such services were elective on the part of the member and may deny such claim.

   In the event the cost of chiropractic services exceeds the aggregate contract year entitlement provided by a health insurance provider, the claimant should submit a proposed treatment plan for the Board's pre-approval, prior to receiving services over and above the designated contract maximum.

C. If such treatment plan or charges thereof is found to be unreasonable, excessive or continuous, such that a member elects to continue treatment for relief of pain symptoms only, the Board will require a member to undergo medical examination and provide a medical evaluation from an orthopedic specialist/or physician.

D. If the aggregate contract entitlement amount has been reached and chiropractic services are sought for treatment of an injury/condition not related to the reason for which original chiropractic services were rendered, the member may have two (2) visits with a chiropractor prior to submitting a treatment plan for such services to the Board for prior approval. Treatments/services in excess of two (2) must have been approved in advance by the Board.

9.7 <u>Mental Health Services of a Psychologist, Social Worker, or Licensed Mental Health Counselor.</u>

Claims for psychological/counseling services are subject to the provisions set forth in Rule 9.4 concerning coverage by a member's health insurance provider.

Payments for mental health counseling services provided to a member by a psychologist or social worker, during a continuous 12-month period, will be approved

only under the following conditions:

A. The member's physician or Department Chief has:

1. recommended such services prior to the time services were provided and

2. provides a written statement, to be submitted with the medical claim, confirming the recommendation and setting forth the date the recommendation was made.

B. The mental health services are provided by a psychologist licensed by the State of Washington or a clinical social worker licensed by the State of Washington or a licensed Mental Health Counselor.

C. The service provider submits an initial treatment plan which was prepared within one month of commencement of treatment and reports the progress of the member at least once every six (6) months if treatment continues for six months or more. If the member will be under treatment for more than 12 months, a second treatment plan must be submitted within 13 months after commencement of treatment. The Board will review the progress reports and treatment plans to determine whether costs for such treatment should continue to be paid.

D. Nothing in this rule relieves a member from complying with the requirement that claims be submitted within six (6) months of the member's receipt of the original billing.

9.8 Substance Abuse Services

Claims for substance abuse/counseling services are subject to the provisions set forth in Rule 9.4 concerning coverage by a member's health insurance provider.

The Board will approve a member's treatment cost for substance abuse (alcoholism or drug abuse) in a program, either outpatient or inpatient, if the service provider is approved by the Bureau of Alcohol and Substance Abuse, State of Washington per WAC 248-26, up to a maximum cost of $2000 per year for three (3) consecutive years, provided that the following conditions are met:

A. The member's physician has:

1. recommended such treatment, and
2. provided a written statement, to be submitted with the claim, confirming the recommendation and stating when the recommendation was made.

B. The service provider submits to the Board a written treatment plan which was prepared within five (5) business days of the member's admission to such program. The plan must include a recommendation concerning the required length of time that the member remain in the facility/program.

The plan will be used by the Board in determining whether the conditions set forth in these rules are met for these services. The plan must be submitted with the member's claim for payment of such medical services. Nothing in this rule relieves a member from complying with the rule that all claims be submitted within six (6) months of the member's receipt of the original billing.

C. Subject to the dollar limitation set forth above, the member remains in the program for the recommended length of time and the service provider submits to the Board a written statement confirming this. If the member leaves the program against medical advice or before the recommended length of treatment, the Board will approve reimbursement of only a pro rata portion of the reasonable costs of such program based on the time the member spent in the program.

The $2000.00 limitation on allowable costs shall apply to all costs for treatment of substance abuse except those for hospital, physician and nurse services and drugs and supplies which are allowable under RCW 41.26.030(19)(a) and (b) and applicable Board rule.

9.9 Vision Benefits

Payments for eyeglasses and contact lenses, plus the reasonable costs of necessary eye examination services of a licensed ophthalmologist or optometrist, will be approved pursuant to the authority granted to the Board under RCW 41.26.250, if eyeglasses are prescribed by an ophthalmologist or optometrist. Frames must be of average quality and serviceability unless other frames are prescribed.

The Board will approve payment for eyeglasses and contact lenses prescribed to correct vision when required for a new prescription, in accordance with the following schedule, which may be revised periodically.

A. **Eyeglass lenses**: Lenses covered up to $200.00 every 12 months for single vision, lined bifocal, lined trifocal, progressive, scratch coating, anti-reflective and rimless mounting.

B. **Eyeglass frames**: $120.00 maximum during any 24-month period.

C. **Contact lenses**: Covered up to $200.00 every 12 months, in lieu of glasses, to cover the cost of contact lenses and fitting.

D. **Replacement**: None

E. **No reimbursement** will be made for tinting, coloring, photosun or other options.

F. **No reimbursement** will be made for a spare pair of glasses or contact lenses.

9.10 Medical Equipment and Supplies

In addition to the rental of durable equipment provided for in RCW 41.26.030(19)(b)(iii)(E), the Board will approve claims for the purchase of durable, medical equipment and supplies under the following conditions:

A. **Hearing Aids**: Payment for hearing aid purchase will be allowed without prior Board approval if the claim meets the following conditions and includes necessary documentation as required herein.

1. Conditions for Approval of Hearing Aid Purchase: Requests for the reimbursement of hearing aid(s) purchase must meet the following conditions:

a) Examination by a physician or hearing specialist documenting the medical necessity for hearing aid(s);

b) Results of audiological evaluations (e.g., audiogram);

c) Report stating the member's hearing loss is progressive, permanent and/or not likely to improve with other treatment (e.g., medication, surgery, etc.);

d) A maximum cost not to exceed $3,000.00/per hearing aid or $6,000.00 per pair during any 36-month period;

e) The Board may ask for additional medical information to determine medical necessity of equipment charges.

2. Replacement of Hearing Aids: The Board will consider approval of payment of member's replacement hearing aid expenses not more frequently that once every 36 months under the following conditions:

a) Member must provide the Board with documentation of the medical necessity for the replacement.

b) Replacement of hearing aid(s) will be approved if the loss or damage is duty-related or due to an accident.

3. Repair of Hearing Aids: members requesting payment for repair of hearing aid(s) must document why the devices are no longer serviceable. (Exception: Payment will be approved for costs of regular maintenance and batteries at reasonable cost on submission of appropriate medical expense claim forms.)

4. Schedule of Limits of Approval of Payment:

   a) Reasonable charges/fees for services of licensed physician or licensed audiologist for examination will be allowed.

   b) Invoices or billing for payment for hearing aid(s) must first be submitted to the member's health insurance. The Board will then consider approval of the balance not covered by insurance or third party payor.

   c) Any payment by the employer will be limited to the net balance after any insurance reimbursement or other settlement is deducted.

   d) The maximum amounts allowable will be the cost of a hearing aid of average quality and serviceability. Any difference between the amount allowed by the Board and the cost of the hearing aid purchased by the member shall be the responsibility of the member.

5. Member Compliance to Submit Claims: Nothing in this rule relieves the member from complying with the requirement of Rule 8.3 in the claims must be submitted within six (6) months of the member's receipt of the original billing from the provider.

B. **Other**: The Board will not approve any claims for equipment or supplies which have a non-medical use or function.

9.11 Dental Benefits The Board will allow claims for the following:

A. Preventative Care: covers two annual dental exams, cleanings and x-ray's up to $500.00 per year. The City will evaluate the rate each January.

B. Dental expenses incurred by a member who sustains an accidental injury to her/his teeth and commenced treatment within 90 days after the accident, or said treatment can be justified by way of curing or correcting an existing health problem. An accidental injury does not include teeth broken, or damage caused by the act of normal chewing or biting, or by the neglect of dental hygiene.

C. Dental expenses incurred by a member for routine dental and periodontal work shall be covered up to $2,500 per calendar year. Cosmetic dental procedures determined to be medically necessary by a dentist, orthodontist, or oral surgeon will be decided on by the Board on a case-by-case basis. Except in the case of medical emergency, payment for cosmetic procedures will not be authorized without prior approval by the Board.

9.12 Long Term Care

The City will provide Long Term Care Insurance to cover services in an assisted living facility, a long term care facility and in-home care should they become medically necessary. This could include visiting nurse coverage, resident attendant care and/or payment to a family member who must quit work to care for the infirm member. It is the member's responsibility to fully complete and return to the insurance provider any forms, medical reports or other information the provider may request. Failure to comply with such requests can result in the member or his/her heirs being financially responsible for the costs that would have been covered by this insurance coverage.

All claims must be submitted to any other insurance prior to submission to the Board. Any requests for long-term care nursing assistance shall be submitted to the LEOFF Disability Board for approval through a treatment plan.

Charges for services associated with long-term care must be substantiated by a physician's report as medically necessary. The Disability Board has a right to request additional examinations by the Board's physician in order to obtain needed information regarding any request for payment for services.

A. Monthly Benefit:

1. The Board shall only reimburse for services rendered; the Board will not make advanced payment for any charges.

2. Request for payment shall be made on a Reimbursement of Medical Expenses form. All explanations of benefits, insurance documentation showing the amount paid and/or rejected and any physician documentation necessary to support the claim, including itemized statements or billings must be attached.

3. Payment by other insurance coverages, including UNUM, Medicare and private nursing home insurances, are primary to this policy.

4. The amount paid for nursing home confinement will not include non-medical charges such as hair care, personal toiletries, recreational events, etc.

5. The Long Term Care insurance company (UNUM) the City uses to provide Long Term Care benefits to active and retired LEOFF I employees has closed the plan to new enrollment. Therefore, effective January 1, 2008, active and retired LEOFF I employees hired after the plan closed need only to submit claims to Medicare or other private nursing home insurances prior to the City reimbursing the cost for a Nursing Facility as well as in home care at the same benefit rate as the current plan.

   a) LEOFF I's not covered on the current policy will need to meet the same benefit eligibility criteria as those covered on the

policy to receive the benefit. Please refer to current Long Term Care certificate for eligibility criteria

9.13 Miscellaneous

A. Smoking Cessation: The Board will approve reimbursement of medical expenses, over insurance coverage, on a case-by-case basis, one-time only, following successful completion of a smoking cessation program and upon maintenance of program goals for one (1) year.

Members are required to submit a description of the smoking cessation program selected and a treatment plan to the Board for prior approval.

B. Well-Physical Exams and Immunizations: the Board will allow claims for Well-Physical Exams and Immunizations. Invoices or billing for payment must be submitted to Medicare and/or other health insurance prior to City reimbursement.

C. Experimental, Educational, Research Procedures/Drugs, Shiatsu, Biofeedback: The Board will approve on a case-by-case basis medically prescribed experimental, educational, research procedures/drugs, Shiatsu and/or Biofeedback. The member must submit a treatment plan to the Board prior to commencement.

D. Acupuncture/Acupressure: Claims for acupuncture/acupressure services are subject to the provisions set forth in Rule 9.4. Payments for acupuncture/acupressure provided to a member by an acupuncturist/massage therapist during a continuous six (6) month period will be approved under the following conditions:

1. Services have been prescribed by a licensed physician;
2. Services are provided by a certified acupuncturist (C.A.), including a MD or a D.O., as well as other providers awarded a diploma of acupuncture by the National Commission for the Certification of Acupuncturists (N.C.C.A.).
3. Member/provider first submits a claim for payment to the member's insurer or third party payor, as directed in member's health insurance contract;
4. If treatment is to be continuous (more than two (2) visits for the same illness or condition) an evaluation and proposed treatment plan must be submitted to the Board for pre-approval as required by Rule 9.4.
5. Claims for acupuncture/acupressure expenses must be filed with member's employer within six (6) months of the member's receipt of the original billing as required by Rule 8.3.

E. Vasectomies and cosmetic surgery (other than post-trauma reconstructive

surgery) are not considered necessary medical services. Tubal ligations are approvable if determined to be medically necessary by two Board Physicians at least one of which is an OB-GYN.

F. In determining whether the expenses of membership in weight loss programs, physical fitness clubs, health spas, or other programs of this nature are allowable, the Board will consider whether programs are prescribed by a physician and where reasonable equivalent benefits from such programs could be obtained at equivalent less expensive facilities. Such programs are not considered necessary medical services.

10 REVIEW OF BOARD RULES: AMENDMENTS, REVISIONS PER STATE RETIREMENT SYSTEMS

10.1 Periodic Review

The City of Bothell Disability Board rules and regulations shall be accordingly reviewed and revised, periodically or as necessary, subject to the recommendations of the State Retirement Systems usually provided in their annual pension seminar, to assure that:

A. Provisions herein remain to conform with Washington statutory and administrative codes.

B. Dollar amounts specified in schedule of benefits reflect current and reasonable average charges in the local area.

C. Provisions herein reflect current philosophy and intent of the Board.

10.2 Application

Member claims are subject to the last revised rulings adopted and exceptions will not be made. Any newly revised rulings and statutes supersedes previous policies and makes obsolete any prior existing rule or statute, therefore claims may not be made to apply to obsolete policies.

10.3 Review Action (Chronology of Board Rules Revision Action)

1992 Formation of City of Bothell Disability Board Policies.

1992 Rule 3.1: Amended to change meeting time from 5:30 p.m. to 6:30 p.m.

1994 Rule 8.1: Amended to authorize to administratively approve claims to $1,000 pursuant to provisions of RCW 41.26.030(22).

1995 Rule 8.4: Amended to authorize Long Term Care Insurance for LEOFF-I employees.

2005 Rule 9.12. Amended to include authorization of in-home care.

2006	Rule 3.1 Amended to change the meeting day from the second Thursday of the month to the second Wednesday of the month.
2007	Rule 9.9, A, B, C, and D; Rule 9.11, A; Rule 9.13, B. Amended to recognize increase in health expenses.
2009	Rule 9.12. Amended to allow LEOFF I employees hired after the plan closed to new enrollment to maintain the same benefit as those currently covered on the Long Term Care Policy.
2010	Rule 9.11. Amend to increase dental benefits in regards to preventative care.
2017	Complete administrative revisions of Board Rules.
2017	Rule 1.3. Revise definition of a “Claim”.
2017	Rule 2.2. Amended to state only those subject to the board rules have the right to elect.
2017	Rule 2.3. Delete letter “A” and amended to include member-at-large term begins in March. Delete contents in “B” as it is no longer applicable.
2017	Rule 3.2. Updated meeting minutes distribution list.
2017	Rule 9.7. Added Licensed Mental Health Counselor.
2017	Rule 8.1, A. Amended staff approval of administrative claims.
2017	Rule 9.10. Amended need for prior approval, increased maximum amount for reimbursement, eliminated the need for additional cost estimates.
2017	Rule 9.11. Increase maximum amount for reimbursement of routine dental and periodontal expenses.
2017	Rule 9.12. Delete sentence “To qualify for benefits…”, delete A and B, delete C,4, (a) Nursing Home, (b) Assisted Living, and (c) In-Home Care. Amended C,5. Deleted C,5,b.
2017	Rule 9.13. Amended B to require submission of claims to other health insurance prior to reimbursement.