



Seattle Firefighters Pension Board

**2026
Benefits and Policy
Manual**

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Introduction

EFFECTIVE DATE: January 1, 2026
TO: LEOFF 1 Seattle Firefighters
FROM: Seattle Firefighters Pension Board

Seattle Firefighters Pension Board Policies and Procedures

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

If you have any comments or questions about the enclosed Policies and Procedures, please contact the Fire Pension Office at (206) 625-4355 or by email at SeattleFirePension@seattle.gov. You can also visit our website for information at www.seattlefirepension.org.

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Section One - Benefits

See “Section Two – Procedures” for instructions for reimbursement and pre-authorization.

ALL PHYSICIANS MUST ACCEPT MEDICARE AS MEMBERS PRIMARY INSURANCE. STATE LAW RCW 41.26.150 (2)

Acupuncture

- Acupuncturist must have a valid State License.
- Coverage is limited to one treatment per day, maximum of \$145 per day.
- Limited to actual acupuncture treatment, does not cover additional procedures without prior Board approval.

Appliances and Non-Durable Medical Goods

- Medicare covers items like oxygen and oxygen equipment, wheelchairs, walkers, and hospital beds among other devices. Check with the provider to determine if the item is covered, the Pension Board will reimburse for portion not covered by Medicare. Should you have questions please call the Fire Pension office.
- Devices must be approved by the Pension Office prior to purchase, even when prescribed by a physician.
- The Pension office has an authorized medical equipment vendor that should be used for the purchase of medical appliances.
- The authorized vendor will be used for out-of-area needs as well.
- For all appliances or non-durable medical goods costing less than \$250.00, present the authorized prescription and itemized invoice to the Pension Office.
- Pre-Authorization from the Pension Office and a letter from your primary physician are required for appliances and non-durable goods which exceed \$250.00.
- For all items purchased, submit the itemized receipt for the item and if under \$250 an authorized prescription or if over \$250 a letter from your primary care physician to the Pension office for reimbursement.
- Pension office may authorize appliances up to \$2,500.00. A letter from the prescribing physician stating the medical necessity must accompany the request for approval.

- Some items such as walkers, wheelchairs and hospital beds may be available through the Pension office directly, contact the office for further information.
- Allowable limits with prior approval apply for the following items:
 - A. Lift chairs \$1,250.00
 - B. Mobility scooters \$2,000.00
 - C. Lifts/ramps for scooters or wheelchairs \$2,250.00

Chiropractic Treatment

- Provider must be a licensed Chiropractor.
- Coverage limited to fee schedule adopted by the Board (current \$80.00 per adjustment)
- Maximum of 26 treatments per calendar year, one treatment per day (may be altered per Pension Board Review.)
- X-rays are a covered expense to a maximum of two sets of x-rays per year.
- Plan will reimburse for adjustments only, additional chiropractic costs are not reimbursable.

Cosmetic Surgery

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

Counseling

- Counseling is covered under the direction of a state-licensed psychologist, psychiatrist, or counselor upon a letter from your primary care physician.
- A diagnosis and prognosis report must be submitted to the Pension Office after the original examination.
- The specialist will submit a monthly progress report to the Pension Office.
- Outpatient treatment for counseling will be subject to a maximum calendar year limit of 26 visits.

- After 26 visits the member's progress will be reviewed by your primary care physician and a pension board physician to determine if continuing care is warranted.
- Inpatient treatment in a state-licensed facility is a covered benefit.
- Marriage counseling is not considered a necessary medical expense and is not reimbursable.
- If disability leave is incurred, it will be considered non-duty until medical and/or other relevant evidence substantiates a duty-caused disability.

Dental

- It is typically in the best interest of the member to see a dentist that is contracted with Premera Blue Cross. Premera Blue Cross has negotiated discounts, and therefore members could receive a higher level of payment for their services if they ensure Premera is an in-network dentist. This means member dental benefit coverage will likely cover more of the cost and there will be less, if any, out of pocket expense.
- Dental coverage is limited to \$3,800.00 per year. To determine amount of remaining annual coverage, contact Premera Blue Cross using the number on the back of your Premera Blue Cross card (1-800-722-1471.)
- Dental work deemed medically necessary by a physician is not limited by the annual care cap.
- For standard dental services, use the Blue Cross card, no other paperwork is required.
- If the dentist is a Premera Blue Cross provider, the dentist will bill Premera Blue Cross directly and no paperwork or payment is required.
- If the dentist is not a Premera Blue Cross provider, the member or dentist will need to submit the invoice directly to Premera Blue Cross, and Premera Blue Cross will pay the dentist directly.
- If dentist requires upfront payment for services, member will submit the statement to Premera Blue Cross with an itemized statement and receipt showing what has been paid by the member. Reimbursement will be paid directly to the member. If the dentist is a Premera Blue Cross provider, then payments are required to be made to the dentist office directly.
- Treatment for accidental injury to teeth must commence within 90 days of the injury and must be administered by a licensed dentist. Contact Pension Office to ensure coverage before any treatments are rendered.
- For an injury, the dentist must provide a letter to the Pension Office detailing services provided and stating that the services were the result of an injury.

- Treatment for an injury to teeth incurred in the line of duty, to include bridgework, is covered and not subject to the \$3,800.00 annual limit.
- Oral surgery, including implants, may be covered if determined to be medically necessary by a licensed physician.
 - Implant limit is \$6,000.00 per tooth lifetime benefit.
 - The \$6,000.00 per tooth implant benefit is to include procedures that pertain to the implant process. If the cost of the implant exceeds the \$6,000.00 benefit, members may use their \$3,800.00 standard dental benefit toward the cost of the implant. Once the \$3,800.00 dental benefit is utilized you may not use the implant benefit toward any dental work that isn't part of the implant procedure. Any dental work outside of work needed for the implant process that exceeds the \$3,800.00 dental benefit is the member's responsibility.
 - To clarify the \$3,800.00 dental benefit can be used toward implant cost if it exceeds the \$6,000.00, but the implant benefit cannot be used toward any other dental care except implants and procedures to prepare for implants. When receiving implant treatment, it is the member's responsibility to notify the dentist of this policy.
 - The Board is committed to helping members utilize their full benefits when procedures are followed.
- Premiums for other dental insurance coverage are not reimbursable.
- For dental work performed outside of the country, contact the Pension Office prior to having the work done for information on the proper procedures to ensure reimbursement allowed.

Eyeglasses and Eye Care

- Eyeglasses are provided when medically necessary subject to \$700 maximum limit every 24 months.
- Examinations and treatment must be provided by a licensed physician/optometrist
- Prescribed eyeglasses may be obtained from any source of the members' choice.
- Eyeglass lenses, frames and/or prescription sunglasses are covered.
- Additional enhancements (scratch resistance, tinting, etc.) are covered.
- An exception to the 24-month period exists when there is a prescription change or accidental damage.
- Contact lenses are covered as a necessary medical expense.

CORRECTIVE EYE SURGERY

- Ocular corrective lenses, as a component of cataract surgery, are a covered medical expense limited to \$5,000 per eye.
- The procedure must be provided by a licensed physician/ optometrist
- Appliances and equipment must be FDA approved, and performed in the United States
- LASIX surgery is a covered medical expense limited to \$1,400 per eye.

Hearing Aids

- If audiology test determines hearing aids are medically necessary, hearing aids are covered at \$4,000 per ear once every 36 months.
- Cost must include insurance covering repairs and batteries for three years from date of purchase.
- Extended-wearing hearing devices (e.g. Phonak Lyric or equivalent) are covered at \$3,800 per year when medically necessary.

Immunizations

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

Laboratory Services

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

Long-Term Medical Care

- Nursing/Adult Family Home/ In-Home/Hospice/Assisted Living/Memory Care (generically referred to herein as Long-Term Care) will be covered if deemed medically necessary by a primary care physician.
- Contact pension office for coverage amounts.

- Certified caregivers are NOT allowed to receive money or gifts of any kind from the members they care for. Any knowledge of this policy not being followed could result in a reevaluation of benefits received.
- A state-required assessment of the member must be performed by an independent agency or primary care physician.
- The intent is to provide care for members when they are unable to care for themselves in an independent living situation and their only other option would be a Skilled Nursing facility.
- Facilities must provide medical care twenty-four hours a day, seven days a week (24/7).
- The published daily costs for the facility are intended to cover most medical items the member may need and should be provided by the facility.
 - Lifts
 - Special commodes
 - Hospital beds
 - Other standard items
- Items covered in addition to the daily facility amounts include items such as:
 - Adult diapers
 - Specialized wheelchairs
 - Special items deemed necessary.
 - The medical menu items are limited to a maximum coverage of \$150.00 per day and require a letter from a member's primary care physician specifying which items are medically necessary.
- Transportation for non-emergency events for members confined to a long-term care environment are reimbursable as follows:
 - Requires a claim form stating the pickup location and the drop off location of each transport.
 - Three round-trip transports per month at a maximum cost of \$200.00 per transport.
 - Coverage is for doctor's appointments, transportation to hospitals for tests, and other situations deemed medically necessary.
- Payment is authorized to Long-Term Care Facilities to hold a bed for a member who has been temporarily transferred to another facility for a period of no more than 30 days.
- Special Procedures

- The member or their legal representative must first obtain a letter from the member's primary care physician stating the need for long-term care.
- The member or their legal representative must obtain contact the Pension Office prior to placement for an explanation of specific requirements from the physician and the prospective care providers. The payment process and coverage will also be explained at this time.
- A copy of the long-term care provider's license, W9 and member assessment to the Pension Office for review.
- The Pension Office will review the request with the members or their representative to assist them with any questions they may have.
- The goal of the Board is to help the members through the process during this difficult time.
- The pension staff will review the request and under guidelines set forth by the Board, will notify the members or their legal representative of what coverage will be provided.
- Care must be provided only by state-licensed providers under applicable state guidelines approved by the Board.
- Long-term medical care by family members
 - Services or supplies furnished to member by a provider who is an immediate relative are not reimbursable.
 - "Immediate relative" is defined as a spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent, or spouse of grandchild.

Massage Therapy

- A therapist must be state licensed.
- The maximum number of massage therapy treatments allowed per year is twenty-six (26).
- The maximum dollar amount is \$110.00 per treatment.
- Coverage is limited to one (1) treatment per day.

Medications (Prescription and Over-the-Counter)

- PRESCRIPTION MEDICATIONS:
 - Blue Cross provides prescription medications through participating pharmacies or by mail order. Present authorized prescription and Blue Cross card to participating pharmacy or utilize the mail order program.

- Prescriptions purchased under emergency conditions are reimbursable. Submit the prescription and itemized receipt for purchase to the Pension Office for reimbursement.
- Reimbursement for prescription copays requires only the receipt from the pharmacist, provided it shows the physician's name, and the item prescribed.
- **PRESCRIBED OVER-THE-COUNTER MEDICATIONS:**
 - Over-the-counter drugs, when prescribed prior to purchase and deemed medically necessary, are reimbursable.
 - The only reimbursable over-the-counter drugs are those prescribed for treatment of specific medical conditions, pain medication, acid reflux medication, etc.
 - General supplements are not covered unless identified by the member's primary care physician for a specific medical condition.
 - Submit the prescription, claim form and the itemized receipt to the Pension Office for reimbursement.

Naturopath Medicine

- The provider must be state licensed.
- Naturopathic Physician care is provided when a letter from a primary care physician is received by the Pension Office stating that medical care from a Naturopathic Physician is part of an overall medically necessary treatment plan for a specific illness.
- The primary care physician will re-evaluate the progress of the patient to determine the effectiveness of the treatment.
- Medically necessary lab work requested by the Naturopath will be reimbursed only if performed at labs meeting the following requirements:
 - Have a state business license.
 - Are licensed by the Department of Health
 - Have been assigned a Medicare number.
- The maximum allowable payment for a visit to a Naturopath is \$150.00.
- Coverage is limited to one visit per day.

Organ Transplants

- A letter is required from your primary care physician.

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

Orthotics

- A \$500.00 maximum reimbursable amount per year regardless of the number of pairs received.

Physical Examinations (Annual)

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

Physical Fitness

- The Board encourages and supports physical fitness for firefighters and is aware of its importance in the prevention of injuries and disease.
- Physical fitness is the individual member's responsibility. Reimbursement is not provided for fitness programs, this includes but is not limited to, club memberships, fitness equipment, home spas, and dietary aids.
- Weight Loss Programs:
 - To qualify for a weight loss program, members will require a physician's medical exam resulting in confirmation of a BMI of over 30 and a medical condition related to obesity. A qualifying letter needs to be sent to the Fire Pension office.
 - Food and supplements are NOT covered.
 - Prior approval from the Pension Board is required.
 - An annual letter from your primary care physician with updated information is required and should be sent to the Fire Pension office.
 - Physician prescribed medications for weight loss are covered if prior approval is received.

Physical Therapy/Rehabilitation

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

Smoking Cessation

- Treatment is covered for smoking cessation through a structured, medically supervised program.
- Reimbursement is subject to a \$1,500.00 annual limit (12 months).
- Treatment programs that exceed the annual limit must have prior approval. Contact the pension office for additional information.
- A letter must be obtained from a primary care physician prior to treatment and submitted for reimbursement.

Sterilization and Sexual Dysfunction

- Sterilization (which is not the result of injury or organic disorder) is not considered a necessary medical expense and is not reimbursable.

- Treatment for sexual dysfunction is covered when considered medically necessary by the member's primary care physician and requires a letter from your physician.

Substance Abuse

- Treatment for substance abuse must be provided by a state-licensed facility.
- The primary care physician will determine the suitability of the treatment program.
- Treatment may consist of inpatient or outpatient treatment with the approval of primary care physician.
- Reimbursement for substance abuse treatment is subject to a maximum lifetime limit of \$25,000.00.
- A member's primary care physician must provide a letter identifying the selected facility or organization and stating the need for the prescribed treatment.

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Section Two – Procedures

Premera Blue Cross

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

Procedures

- Always present Premera Blue Cross ID card for all medical services, dental services, and prescriptions.
- Claim Forms must only be submitted by the member to the Pension Office for the following:
 - Prescribed over-the-counter medications and transportation for non-emergency events.
- Letters from Primary Care and Attending Physicians are only required for specific treatments and services and can be found in section one of these Policy and Procedures. The following will require a letter:
 - Appliances and non-durable medical goods, counseling, long-term care, organ transplants, smoking cessation, sterilization and sexual dysfunction, substance abuse, weight loss programs, and specialized medical treatments.
 - Contact our office if you need clarification.
- Members with other insurance must first submit all bills to the other insurance, including Medicare, for payment. *See details in Other Insurance below*
- If bills are received at the member's home, contact the provider and ensure provider is using the correct Premera Blue Cross ID number.
 - Members should NOT use their Social Security Number.
- Contact Premera Blue Cross directly to inquire about the status of a bill (1-800-722-1471).
- If Premera Blue Cross does not have a record of the bill, mail a copy to the Premera Blue Cross office.

- Premera Blue Cross, P.O. Box 91059, Seattle, WA 98111-9159
- Pending Claims – contact the Premera Blue Cross office to determine claim status.

Reimbursement

- Reimbursement for medical services, dental services, prescriptions, will require the following items being submitted with the itemized receipt of payment for service(s):
 - An itemized bill for service(s).
 - An Explanation of Benefits (EOB), if the member has other coverage.
 - Prior approval from the Pension Office with a letter from the primary care or attending physician authorizing service.
 - A claim form.
- Reimbursement for prescriptions requires three items being submitted together:
 - An itemized receipt for the prescribed item
 - The prescription from the physician
 - A claim form
- Reimbursement for co-payments or any other electronically prescribed prescriptions requires the receipt from the pharmacist showing the physician's name and the item prescribed.
- Reimbursement for medical insurance premiums;
 - Medicare Part B – instructions to obtain the Medicare Part B Refund form from the Pension Office are as follows:
 - To receive your standard Medicare part B premium you will need to sign the form that is sent out in January with the information packet and include one of the following:
 - If member is receiving Social Security payments, they will receive a copy of the SSA-1099 form showing the cost of the plan's premium, enclose that document with the Medicare Part B Refund form and send to Pension Office.
 - If member is not receiving Social Security payments, request a copy of form SSA-2458 from the Social Security office. Send that document with a Medical Part B Refund form to the Pension Office.
 - Part B Medicare premiums will only be reimbursed on an annual basis.
 - Other insurance premiums:

- When a member is eligible for Medicare, the pension office will no longer reimburse for other medical coverage. Member may continue to carry other coverage but will not be reimbursed for the premiums.
 - If you have special circumstances, contact the Pension Office.
- Reimbursements for medical expenses received by the Pension Office more than one year from the date of service may be denied.
- Medical treatments performed outside the United States are not reimbursable.
- Emergency medical treatment performed outside the United States will be reviewed by the Board on a case-by-case basis.

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Section Three – Policy

Reference

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

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

Board Authority/Responsibility

- The granting of disability leave, retirement and other benefits; and the cancellation of disability leave/retirement and subsequent return of members to duty, is the statutory duty of the Board.
- Previously granted disability benefits may be denied by the Board, with just cause, by a motion to rescind.

Policy

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

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

Other Health/ Benefit Form

- Annually, members are required to submit an Other Health Benefits Form to the Pension Office. The Pension Office will mail the form to members.

Medicare

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

Medical Coverage from Pension Fund

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

- Must use the designated medical services or referral system.
- FIRE FIGHTERS UNDER PRIOR ACT, RCW 41.18, AS AMENDED.
 - Members are covered for medical expenses attributable to service connected medical conditions, or service connected medical conditions that surface after retirement. The proof of service connection needs to be conclusive and requires the written concurrence of a Primary Care Physician.
- ALL physicians MUST accept Medicare as members' primary insurance.
- The Board's Policy and Procedures, as well as applicable State laws, must be followed by all fire fighters entitled to medical coverage in order to obtain proper medical treatment and/or payment of medical bills.
- A member entitled to receive pension, disability and/or medical benefits from the fund, must maintain a current address on file in the Seattle Fire Fighter's Pension Office.
- Primary care physician
 - Members may choose a physician of their choice as their primary care physician. The following procedures must be followed in order to obtain proper medical treatment and/or payment of medical bills.
 - The physician of the retired member's choice becomes the member's primary care physician. This physician now has the authority to refer a member for testing or to see a specialist.

Medical Coverage from Other Source

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

LEOFF – PLAN I

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

PRIOR ACT RETIREES – RCW 41.18

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

Medical Care from family members, exclusion policy

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

Transportation

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

Death of a Retired Fire Fighter, Procedures

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

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

Phone: (206) 625-4355

Active Firefighters should contact the Fire Pension office with any questions at 206-625-4355.

Section Four –Abbreviations, Definitions

Abbreviations

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

Definitions

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

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

Contact Information

Pension Office Phone	(206) 625-4355
Pension Office Address	2200 – 6 th Ave., Suite 820, Seattle WA 98121
Pension Website	www.seattlefirepension.org
Pension Email	SeattleFirePension@seattle.gov
Pension FAX	(206) 625-4521
Pension Contacts	<div> Alaina Gill alaina.gill@seattle.gov Sue Daves sue.daves@seattle.gov Steve Todd steve.todd@seattle.gov Office Email seattlefirepesnion@seattle.gov </div>
Premera Blue Cross Phone	(800) 722-1471
Premera Blue Cross Address	PO Box 91059, Seattle, WA 98111
B.S.I. Trust	(800) 203-0544
City Credit Union	(206) 398-5500
IAFF Local 27	(206) 285-1271
Medicare	(800) 633-4227
Poison Control	(800) 222-1222
SFD Alarm Center	(206) 386-1494
SFD Business Office	(206) 386-1400
SFD Relief Association	(206) 285-7651
Social Security	(800) 772-1213

