Fire Pension Board Meeting Agenda

May 15, 2024, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for April 17, 2024

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$720,000.00	
March 2024	$71,420.23	
Remaining budget	**$505,739.31**	**70.24%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
March 2024	$96,038.35	
March 2024 HMA fees	$14,422.01	
Remaining budget	**$1,356,451.34**	**75.69%**

3.) Special Bills for Board Review:

Member #134	Reimbursement request for unpaid/unsubmitted Medicare payments from 2022 in the amount of $4082.40 (tabled from 4/17/2024 meeting)
Member #144	Reimbursement request for eye glass repair in the amount of $69.00

4.) Other:

- HMA Claims

To: LEOFF 1 Pension Board

From: William Langus Retired Everett Firefighter

Address: [redacted]

RE: Medicare Reimbursement

Date: March 20, 2024

To whom it may concern:

Thank you for reimbursing my 2023 Medicare payment. I was asked to write a letter requesting my 2022 payment because I was very late in requesting it. The reason I did not ask for the monies is because I simply forgot. I had surgery on Jan 3rd and the surgery went sideways. I was laid up for a couple three months and I just forgot to ask for my reimbursement.

Please consider looking at this issue and hopefully, sending me a check to cover the Medicare Part B donation. It is substantial.

If you've any questions, feel free to call. [redacted]

Thank you,

Bill Langus

[redacted]

FORM SSA-1099 – SOCIAL SECURITY BENEFIT STATEMENT

2022 • PART OF YOUR SOCIAL SECURITY BENEFITS SHOWN IN BOX 5 MAY BE TAXABLE INCOME.
• SEE THE REVERSE FOR MORE INFORMATION.

Box 1. Name	Box 2. Beneficiary's Social Security Number
WILLIAM C LANGUS	[redacted]

Box 3. Benefits Paid in 2022	Box 4. Benefits Repaid to SSA in 2022	Box 5. Net Benefits for 2022 *(Box 3 minus Box 4)*
$28,314.40	NONE	$28,314.40

DESCRIPTION OF AMOUNT IN BOX 3		DESCRIPTION OF AMOUNT IN BOX 4
Paid by check or Direct deposit	$24,232.00	NONE
Medicare Part B premiums deducted from your benefits	$4,082.40	
Total Additions	$28,314.40	
Benefits for 2022	$28,314.40	

Box 6. Voluntary Federal Income Tax Withheld

NONE

Box 7. Address

WILLIAM C LANGUS
2209 5TH ST
EVERETT WA 98201-1102

Box 8. Claim Number (*Use this number if you need to contact SSA.*)

[redacted]

Form **SSA-1099-SM** (1-2023) **DO NOT RETURN THIS FORM TO SSA OR IRS**

CITY OF EVERETT
POLICE & FIRE
2930 WETMORE
EVERETT, WA 98201
(425) 257-7024

MEDICAL CLAIM

PENSION BOARD APPROVAL:
I certify that the named patient is authorized to receive the described medical care at the expense of the City of Everett Uniformed Personnel Pension Fund. Payment is approved by board action this date. I am authorized to authenticate and certify said claim.

City Clerk or Secretary of Board | Date

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME [redacted] | ☐ ACTIVE ☑ RETIRED | [redacted] | [redacted] | ☐ POLICE ☑ FIRE

COMPLETE HOME ADDRESS | SOCIAL SECURITY NO. | ☑ MALE ☐ FEMALE

THIS SPACE FOR OFFICE USE ONLY

ACCOUNT NUMBER	VOUCHER NO.	VENDOR NO.	DESCRIPTION	AMOUNT
☐ 6375380000250 ☐ 6385380000250	48100		☐ MED SERV ☐ RX ☐ CHIRO SERV ☐ REIMB ☐ OTHER	

I certify that the information and charges here shown are true and correct, and that these services and/or medications were received by me and that I am liable for these charges. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish the Fire/Police Pension Board with full information regarding treatment rendered (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish the Fire/Police Pension Board with information regarding benefits to which I may be entitled. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby assign benefit to the supplier/vendor below.

DATE 8-30-23 | EMPLO [redacted]

STATEMENT OF ATTENDING PHYSICIAN OR OTHER

DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIANGOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED (IF CODE OTHER THAN CPT ★★ USED, GIVE NAME)	CHARGES
8-30		EYE GLASS REPAIR		69.00
		PAID		
		SEE	ATTACHED	

DO NOT WRITE IN THIS SPACE

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

TOTAL CHARGES $ 69.00

TOTAL PAYMENTS $

DATE 8-30-23 | SUPPLIE [redacted]

[redacted]

ZIP CODE

PENSION BOARD

Customer Contact
[redacted]
Phone # [redacted]
Ship To

PAID
08/30/2023

Invoice #
17678
Date
8/30/2023

Description	Qty	Rate	Amount
TEMPLES		69.00	69.00
Walmart Surprise on Bell Road		0.00	0.00T

L / R LENSES SCRATCHED ____ L / R CHIPPED ____

Subtotal	$69.00
Sales Tax (3.0%)	$0.00
Total	$69.00

I have been told and understand that my eyewear may not be amendable to repair. If I order ALL AMERICAN EYEGLASS REPAIR to attempt repair, I hereby release ALL AMERICAN EYEGLASS REPAIR from any liability for the appearance of, or distortion to the frame. I agree to pay the total cost of any repair upon receipt of the mended frame. ALL AMERICAN EYEGLASS REPAIR guarantees to pay for any pair of glasses lost or otherwise not returned to the customer whose value does not exceed $300.00.

Not responsible for the outcome of eyewire bonds. Not responsible for the chipping of lenses on rimless frames. Not responsible for the distortion of lenses during stripping of anti-reflective coating.

ALL REPAIRS GUARANTEED FOR 90 DAYS EXCEPT PLASTIC EYEWIRE BONDS. NO REFUNDS. ALL CLIP-ON SUNGLASSES GUARANTEED 1 YEAR. ALL SUNGLASS SALES FINAL. NO RETURNS. NO REFUNDS.

I AGREE TO ALL TERMS AND CONDITIONS SET FORTH HEREIN:

SIGNED: X _____

ANY REPAIR LEFT OVER 90 DAYS WILL BE USED FOR PARTS.

ALL AMERICAN EYEGLASS REPAIR - PHOENIX (602)589-0401, 3505 WEST DUNLAP AVE PHOENIX AZ, 85051

STORE HOURS: MON - FRI: 10AM - 6PM / SAT: 10AM - 2PM / SUN: CLOSED

OTHER AZ LOCATIONS: MESA (480)655-1161, EAST MESA (480)654-8242, PARADISE VALLEY (602)953-2799, CHANDLER (480)838-9741, PEORIA (602)933-9011, TUCSON (520)795-7363

RECEIVED
OCT 03 2023
CITY OF EVERETT
HUMAN RESOURCES DEPT.

HMA

Member Reimbursement Claim Form

Patient Information

First Name [redacted]

Mailing Addres[redacted]

City [redacted] State [redacted] ZIP Code [redacted]

Phone Number [redacted] Member ID Number[?] [redacted] Date of Birth [redacted]

Group/Employer Name CITY OF EVERETT Group Number[?] 020188

Patient's Relationship to Policyholder ◯ Self ◯ Spouse ◯ Dependent

[?] *This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".*

Other Insurance Information

Does the patient have insurance coverage from any other health plan?

◯ No (skip to next section)

◉ Yes (if you haven't provided us with your other insurance information in the past year, please fill out and submit the **Other Health Insurance Coverage Form** (located at https://www.accesshma.com/news-and-resources/member-forms)

Claim Information

Provider Name ALL AMERICAN EYEGLASS REPAIR Date(s) of Service 08/30/2023 Total Charges 69.00

Address Where Services Were Rendered PEORIA 602 933 9011

Have the Charges Been Paid in Full? ◉ Yes ◯ No

Diagnosis/Symptoms Requiring Treatment BROKEN PIVOT -

Description of Service(s) You Received REPLACED TEMPLES

Provider's Status[2] ◯ In Network ◯ Out of Network ◯ I Don't Know

Provider's NPI Number (If Known)[3] Provider's Tax ID Number (If Known)[4]

Accident Information

Is This Claim Due to an Accident? ◯ No (skip to next section) ◯ Yes (fill out this section)

Accident Date Accident Location ○ Home ○ Work ○ School ○ Auto ○ Other

How Did the Accident Happen?

Are You Filing a Claim with Labor & Industries (L&I), Homeowner/Auto Insurance, or Any Other Party? ○ Yes ○ No

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1 If your mailing address has changed, please notify your Human Resources (HR) department so they can update the eligibility information they provide to us.
2 You can look up your provider on https://www.accesshma.com/find-a-provider to find out if they are in network or out of network. Please note that you might not be reimbursed (in full, in part, or at all) by your health plan for out of network services. As such, it is recommended that you always verify your provider is in network.
3 This number is often located on receipts from the provider. National Provider Identifier (NPI) is a unique ten-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, we will attempt to look it up. However, please note that your claim might be denied if we are unable to verify your provider.
4 This number is often located on receipts from the provider. Tax Identification Number (TIN) is also known as an Employer Identification Number (EIN). A TIN/EIN is a unique nine-digit identification number issued to an organization by the IRS.

HMA

Member Reimbursement Claim Form

Instructions

Within this form, the terms "you" and "your" refer to the member. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator.

Use this form for all medical, dental, and vision services covered by HMA. For prescription claims, contact your pharmacy benefits manager (PBM). You need to fill out this form only if your health care professional isn't filing the claim for you. Your health care professional can still file the claim for you if they are out-of-network with your policy; however, they are not required to do so.

Please include itemized receipt(s) with your completed claim form. Each receipt must include the following, at minimum:

- Patient name
- Date(s) of service
- Healthcare provider's information - full name, credentials, full mailing address, and phone number
- Procedure code(s) - this is usually a five-digit number that describes the services/products provided
- Diagnosis code(s), in ICD format - this is the reason for your healthcare treatment
- Total charge for each service rendered

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Any questions? We are here to help! Contact Customer Care at 800-869-7093.

Submission Information

Please provide the information in this form to us using one of the methods below (pick any option that works for you)**:**

Electronic Submission Options

✓ **Option 1: DocuSign**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the DocuSign option under **Member Reimbursement Claim Form**
3. Fill out and submit the form in DocuSign

✓ **Option 2: HMA Member Portal**:

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Click on the PDF option under **Member Reimbursement Claim Form**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat (it is not recommended to try filling out the form in a web browser or on a mobile device, as the form may not work correctly)
4. Login to the member portal at https://accesshma.com/for-members
5. On the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts

Paper Submission Options

✓ **Option 1: Fax** the completed form to: 866-458-5488

✓ **Option 2: Mail** the completed form to:
HMA
Attn: Claims Department
PO Box 85008
Bellevue, WA 98015-5008

HMA

Member Reimbursement Claim Form

Reimbursement Information

Claim Reimbursement Should Go to: ☑ Me (the patient listed above) ○ The provider listed above

Note: Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will remit payment to the provider, even if you indicate you want reimbursement to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, be sure to provide your providers with your insurance card so they can bill your Plan directly.

Attachments

SEE ORIGINAL REQUEST

Please be sure to include all relevant material (such as receipts) with your submission. Otherwise, your claim might be delayed or denied.

[redacted]

Signature

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

By signing below, I indicate the following:

- I certify that the information I provided on this form is true and complete to the best of my knowledge.
- I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

[redacted]

Printed Name (First and Last)

SELF

Relationship to Patient (If you are the patient, put "Self")

[redacted]

Signature

9/28/23

Date