Fire Pension Board Meeting Agenda

September 18, 2024, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for August 21, 2024

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$720,000.00	
July 2024	$58,556.20	
Remaining budget	**$276,522.83**	**38.41%**
MEDICAL CLAIMS		
Budgeted amount	$1,792,000.00	
July 2024	$79,428.45	
July 2024 HMA fees	$14,088.48	
Remaining budget	**$901,852.44**	**50.33%**

3.) Action Item:

Member #9	Request for reimbursement for GCM Sensor Dexcom (Diabetes Supply) in the amount of $240.
Member #5	Request for reimbursement for crown and bridge replacement in the amount of $1091.
Member #81	Request for reimbursement for partial denture in the amount of $3,700.

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: Insulin dependent typ1 diabetes
2. Prognosis: life long treatment
3. Type of Treatment(s) or Procedure: CGM Sensor DEXCOM G6
4. Cost of treatments/service: $ 240.00
5. Request to the board for this specific treatment or procedure:

Diabetes Supply has billed for balance that was impacted by deductible.
Have paid $240.00 via visa credit card on 6/10/24

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

NEW

Patient Portal

- Register and manage your account online
- View and pay invoices securely
- Track your payments

adapthealth

Pay online at: **Diabetessupply.hmebillpay.com**

Account Number: [redacted]

Patient Name: [redacted]

Due by:
May 14, 2024
Patient owes:
$240.00

Date Mailed: Apr 24, 2024

Invoice 1933230

DATE	DESCRIPTION	AMOUNT
01/26/2024	(MEDI) CGM SENSOR DEXCOM G6 3/BX	$240.00

Your balance has been impacted by a deductible

Total: $240.00

Pd by Credit (VISA) on 6/10/24

[redacted]

Pay online at:
Diabetessupply.hmebillpay.com

Important Messages

- You can now LIVE CHAT with a member of our billing team, visit www.AdaptHealth.com during our normal business hours.
- If your insurance is on file, a claim has been submitted and the balance on the invoice is your ESTIMATED financial responsibility.
- If AutoPAY is enabled, no action is required. Your default payment method will be charged on the due date. IF AUTOPAY IS NOT ENABLED, PLEASE LOG IN AND ENABLE IT TODAY.

Insurance on File

NORIDIAN ADMIN SERVICES

HEALTHCARE MANAGEMENT ADMIN

Billing Questions

(402) 399-8444

Monday - Friday
8:00 am - 6:00 pm

Invoice Total		Previously Billed		Total Due
$240.00	+	$0.00	=	$240.00

140421-MINV-1-7942-2083

PLEASE DETACH HERE AND RETURN BOTTOM PORTION

Late after: **May 14, 2024** Patient owes: **$240.00**

Amount Enclosed: $ _____

Payments not accepted at this address
Diabetes Supply
PO Box 1259 Dept # 140418
Oaks, PA 19456

Diabetessupply.hmebillpay.com

Account [redacted] Invoice(s): 1933230

Mail Payment to:

Diabetes Supply
PO Box 743708
Los Angeles CA 90074-3708

[redacted]

0012 028251

1 of 1

61 0000431650 001933230 000000024000 0424242

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name [redacted]
(please print)

1. Diagnosis: crown & bridge on (R) rear mouth
2. Prognosis: fit crown & bridge to replace missing tooth
3. Type of Treatment(s) or Procedure: _____
4. Cost of treatments/service: $ 4026.00
5. Request to the board for this specific treatment or procedure:

reimburse # 1091 out of pocket

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

STATEMENT OF SERVICES RENDERED

Ruddell Road - Light Dental
Studios
5720 Ruddell RD SE STE A
Lacey, WA 98503-6401

NEXT APPOINTMENT 05/06/2024 08:00 AM

GUARANTOR / RESPONSIBLE PARTY

[redacted]

PLEASE PAY THIS AMOUNT	AMOUNT ENCLOSED
$0.00	

BILLING DATE	DUE DATE
04/15/2024	05/15/2024

To ensure proper recording of your payment, please detach and return this portion of the statement with your payment

Please retain this portion of the statement for your own records

DATE	DESCRIPTION	PATIENT NAME	AMOUNT	BALANCE
04/14/2024	**Balance Forward**			0.00
04/15/2024	D0220 - Intraoral Periapical Images	[redacted]	0.00	
	D0230 - Intraoral Periapical Add'l		0.00	
	D6740 - Bridge Abut Crown - porcelain/ceramic Th: 29 **		1,342.00	
	D6245 - Pontic - Full Porcelain/Ceramic Th: 30 **		1,342.00	
	D6740 - Bridge Abut Crown - porcelain/ceramic Th: 31 **		1,342.00	4,026.00
04/15/2024	Primary dental insurance claim City of Everett [$4026.00] Claim status: UNPAID			
04/15/2024	Cash Payment $1091.00		-1,091.00	2,935.00

(*) = Payments have been split between more than one visit. (**) = Pending insurance payment.

BALANCE 0-30 DAYS	BALANCE 31-60 DAYS	BALANCE 61-90 DAYS	BALANCE 90+ DAYS	TOTAL BALANCE	-	ESTIMATED INSURANCE	=	PATIENT PORTION
2,935.00	0.00	0.00	0.00	2,935.00		2,935.00		0.00

Statement Message

Thank you [redacted] good to see you today, take care.
receipt #774677

chit

We do our best to provide accurate patient estimates prior to the scheduling and completion of treatment. Occasionally insurances may pay different than expected resulting in a patient balance.

While we do our best with the information provided by your insurance, it is ultimately the PATIENT'S responsibility to be familiar with their plan coverage, limitations and copays, etc. We advise that you follow-up with your insurance carrier on any claims unpaid after 60 days from date of service. CLAIMS THAT ARE NOT PAID FOLLOWING 90 DAYS FROM DATE OF SERVICE may become patient responsibility in FULL and billed accordingly. We will always help advocate for our patients in such circumstances; providing any necessary documentation to help resolve the matter with your insurance carrier and assist in reimbursement to you.

If you have any questions regarding this statement or the status of your account, please contact our office. We appreciate your prompt payment.

STATEMENT OF SERVICES RENDERED

Ruddell Road - Light Dental
Studios
5720 Ruddell RD SE STE A
Lacey, WA 98503-6401

NEXT APPOINTMENT 05/06/2024 08:00 AM

GUARANTOR / RESPONSIBLE PARTY

[redacted]

PLEASE PAY THIS AMOUNT	AMOUNT ENCLOSED
$0.00	

BILLING DATE	DUE DATE
04/15/2024	05/15/2024

To ensure proper recording of your payment, please detach and return this portion of the statement with your payment

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04/14/2024	**Balance Forward**	[redacted]		0.00
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	D0230 - Intraoral Periapical Add'l		0.00	
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2,935.00	0.00	0.00	0.00	2,935.00	-	2,935.00	=	0.00

Statement Message

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If you have any questions regarding this statement or the status of your account, please contact our office. We appreciate your prompt payment.

RECEIPT

DATE 4-15-24 No. 774677

RECEIVED FROM [redacted] $1,091.00

One thousand and ninety-one dollars only DOLLARS

○ FOR RENT
✕ FOR Bridge TX

ACCOUNT	$1,091.00
PAYMENT	1,091.00
BAL. DUE	0

✕ CASH
○ CHECK
○ MONEY ORDER
○ CREDIT CARD

FROM _____ TO _____

BY Chf E.

3-11

EVERETT
WASHINGTON

City of Everett
Police and Fire Pension Boards

Request to the Board

To be completed by LEOFF 1 member (or family) for submittal to the board.

Member Name
(please print) [redacted]

1. Diagnosis: _____

2. Prognosis: _____

3. Type of Treatment(s) or Procedure: _____

4. Cost of treatments/service: $ _____

5. Request to the board for this specific treatment or procedure:

Possible Reimbursement?
Can't figure this out!!!
Damage from Dental Work caused me to have to Replace Partial Plate @ 3700.00

(Examples can be found at everettwa.gov/pensionboards)

Return to:
City of Everett
Police and Fire Pension Boards
2930 Wetmore Ave, Ste 1-A
Everett, WA 98201
Leoff1@everettwa.gov

Proposed Treatment Plan

2/15/2024

Beautiful Smiles Dental, LLC

www.BeautifulSmilesllc.com
22833 Bothell Everett Hwy #146
Bothell, WA 98021
(425)487-1551 (425)487-1551

[redacted]

ID: 6021

Phase	Date Plan	Appt	Provider	Service	Tth	Surf	Fee	Ins.	Pat.
	2/15/2024		HUD	05213 Partial Denture Upper-Metal	UA		$3,700.00	$0.00	$3,700.00
				Subtotal:			$3,700.00	$0.00	$3,700.00

Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

Total Proposed:	$3,700.00
Total Completed:	$0.00
Total Accepted:	$0.00
Proposed Insurance:	$0.00

Insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

By signing I am verifying that all prescribed treatment and financial estimates have been explained to me. I also understand that all payments are due at time of service.

Patient or Guarantor's Signature [redacted] Date 2-15-24

BEAUTIFUL SMILE DENTAL
STE 146
BOTHELL, WA. 98021-9372
000

SALE

REF#: 00000002

Batch #: 344

03/05/24 12:36:29

APPR CODE: 05062G

Trace: 2

VISA Chip

**********8809 **/**

AMOUNT **$3,700.00**

APPROVED

VISA CREDIT
AID: A0000000031010
TVR: 80 80 00 80 00
TSI: 68 00

THANK YOU

CUSTOMER COPY

Monroe Smiles, Inc.
14650 N Kelsey St, #104-105
Monroe, WA 98272-1456
(360)794-8580

STATEMENT

05/28/2024

Account Number 18213

Amount Due	Date Due	Amount Enclosed
0.00	Upon Receipt	

[redacted]

CREDIT CARD TYPE _____

_____

3 DIGIT CSV _____

EXPIRES _____

AMOUNT APPROVED _____

NAME _____

SIGNATURE _____

PLEASE DETACH AND RETURN THE LOWER PORTION WITH YOUR PAYMENT

Total:	$1,835.00
-Ins Estimate:	$1,835.00
=Balance:	**$0.00**

0-30	31-60	61-90	over 90
1835.00	0.00	0.00	0.00

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
02/14/2024	[redacted]	D0180		comprehensive periodontal evaluation - new or established patient	160.00		160.00
02/14/2024		D0274		bitewings - four radiographic images	103.00		263.00
02/14/2024		D0350		2D oral/facial photographic image obtained intra-orally or extra-orally	0.00		263.00
02/14/2024		D0431		adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	37.00		300.00
02/14/2024		D1110		prophylaxis - adult	167.00		467.00
02/14/2024		D1206		topical application of fluoride varnish	65.00		532.00
02/14/2024		PC		PERIO PROBING AND CHARTING	0.00		532.00
02/14/2024		D0220	7	intraoral - periapical first radiographic image	49.00		581.00
02/14/2024		D0230	10	intraoral - periapical each additional radiographic image	42.00		623.00
02/14/2024		D0230	24	intraoral - periapical each additional radiographic image	42.00		665.00
02/14/2024		Pay		Credit Card $499.80 Payment Number: 221156		499.80	165.20
02/14/2024		Pay		Patient Refund ($191.10) Payment Number: 221158		-191.10	356.30
02/14/2024		Claim		Pri Claim $665.00 HMA Healthcare Management Administrators Received 03/27/2024 Payment: $665.00			
03/06/2024		Pay		Credit Card $150.00 Payment Number: 221493		150.00	206.30
03/27/2024		InsPay		Insurance Payment for Claim 02/14/2024		665.00	-458.70
05/22/2024		D4341		UR- periodontal scaling and root planing - four or more teeth per quadrant	407.00		-51.70
05/22/2024		D4999		Cervitec	65.00		13.30
05/22/2024		LSRQ		UR- laser bacterial reduction per quadrant (No Bill Ins)	53.00		66.30

Date	Patient	Code	Tooth	Description	Charges	Credits	Balance
05/22/2024	[redacted]	LSRQ		LR- laser bacterial reduction per quadrant (No Bill Ins)	53.00		119.30
05/22/2024		D4342		periodontal scaling and root planing - one to three teeth per quadrant #32	314.00		433.30
05/22/2024		Claim		Pri Claim $786.00 HMA Healthcare Management Administrators Sent Estimated Payment Pending: $564.00 Est. Patient Portion: $222.00			
05/28/2024		D4341		LL- periodontal scaling and root planing - four or more teeth per quadrant	407.00		840.30
05/28/2024		D4999		Cervitec	65.00		905.30
05/28/2024		LSRQ		UL- laser bacterial reduction per quadrant (No Bill Ins)	53.00		958.30
05/28/2024		LSRQ		LL- laser bacterial reduction per quadrant (No Bill Ins)	53.00		1,011.30
05/28/2024		D0220	15	intraoral - periapical first radiographic image	49.00		1,060.30
05/28/2024		D2740	15	crown - porcelain/ceramic	1,781.00		2,841.30
05/28/2024		D4342		periodontal scaling and root planing - one to three teeth per quadrant #14,15	314.00		3,155.30
05/28/2024		Pay		Credit Card $531.50 Payment Number: 222618		531.50	2,623.80
05/28/2024		Pay		Credit Card $788.80 Payment Number: 222619		788.80	1,835.00
05/28/2024		Claim		Pri Claim $2,616.00 HMA Healthcare Management Administrators Waiting to Send Estimated Payment Pending: $1,271.00 Est. Patient Portion: $1,345.00			
05/28/2024		Stmt		Statement-InPerson			

THIS IS NOT A BILL

SUMMARY OF ACTIVITY

This covers claims processed between 04/01/2024 - 04/15/2024

Total Billed Amount	$4,365.00	This is the total amount of charges during this period.
Discount & Adjustments	$0.00	Healthcare Management Administrators negotiates discounts with health care professionals and facilities to help you save money.
Amount Not Covered	$3,700.00	This is the portion of your bill that is not covered by your plan. You may or may not need to pay this amount. We'll cover that information for you in the Detailed Claim Breakdown.
What Your Plan Paid	$665.00	This is the total amount your plan paid during this period.
What You Pay	$3,700.00	This is the amount you owe after your discount and what your plan paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. **You may or may not have already paid this amount.**
You Saved	$665.00	This is a total of your discount and what your plan paid.