Fire Pension Board Meeting Agenda

June 17, 2026, 9:30 a.m. via Microsoft Teams

1.) Approval of minutes for May 20, 2026

2.) Bills and Pension Rolls:

PENSION ROLL		
Budgeted Amount	$704,000.00	
April 2026	$88,770.48	
Remaining budget	**$455,712.44**	**64.73%**
MEDICAL CLAIMS		
Budgeted amount	$2,240,000.00	
April 2026	$224,922.33	
April 2026 HMA fees	$13,431.15	
Remaining budget	**$1,601,412.09**	**71.49%**

3.) Action Item:

Member #118	Request for reimbursement of $1,026 for dental crown.

Fire Pension Board Minutes
City Of Everett
May 20, 2026

DRAFT

The regular meeting of the Fire Pension Board was called to order at 9:33 a.m. on May 20, 2026. Board Members Vitalich, Jorve, Neyens, and alternate Oas were present. Board Members Franklin and Schwab were excused. Ana Mechler, Human Resources; Ramsey Ramerman, Deputy City; and Rick Gray, Finance were also present.

APPROVAL OF MINUTES

The minutes of the meeting of April 15, 2025, were approved.

BILLS AND PENSION ROLLS

PENSION ROLL		
Budgeted Amount	$704,000.00	
March 2026	$52,239.18	
Remaining budget	**$544,482.92**	**77.34%**
MEDICAL CLAIMS		
Budgeted amount	$2,240,000.00	
March 2026	$83,757.82	
March 2026 HMA fees	$14,006.79	
Remaining budget	**$1,839,765.57**	**82.13%**

Moved by Vitalich, seconded by Neyens, to approve the pension rolls as presented.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

Moved by Vitalich, seconded by Jorve, to approve the medical claims as presented.

Discussion ensued regarding other insurance providers, Ana Mechler, HR, stated she would investigate.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

DRAFT

ACTION ITEMS

Member # 101 Request for reimbursement of $348.27 for Eliquis for AFib while out of the country (HMA only covered 60% since foreign claim).

Moved by Vitalich, seconded by Neyens, to approve the request for Member #101.

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

Member #35 Request for reimbursement of $13,123.37 for three-night stay in hospital while out of the country for diverticulitis (HMA only covered 60% since foreign claim).

Moved by Vitalich, seconded by Neyens, to approve the request for Member #35

Roll was called with all members voting yes, except Board Members Franklin and Schwab who were excused.

Motion carried.

OTHER

Member William Kingston passed away.

Discussion ensued regarding member payment timing.

The Board meeting adjourned at 9:46 a.m.

_____
Marista Jorve, Board Secretary

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: Dental Procedure

2. Prognosis: _____

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

4. Cost of treatments/service: $ 1,026.00

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

Fire member #118 is requesting reimbursement after a dental procedure. HMA denied this claim due to dental maximum benefit already met.

(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

HMA

Member Reimbursement Claim Form

Instructions

Please use this form if requesting reimbursement for claims related to all medical, dental, and vision services covered by Healthcare Management Administrators (HMA), your third-party Health Plan Administrator. For prescription claims, contact your pharmacy benefits manager (PBM). You will need to complete and submit 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 a copy of your itemized receipt, bill, and/or invoice with your completed claim form. Your submission must contain all necessary information based on the type of service for which you're requesting reimbursement. The minimum necessary information for each type of service is described below in the "Attachments" section.

☐ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

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 choose one of the following methods below for submitting your claim reimbursement request (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. Scroll to **Member Reimbursement Claim Form** and click **Complete Online**
3. Complete and submit the form and a copy of your itemized receipt, bill, and/or invoice through DocuSign

✓ **Option 2: HMA Member Portal**:

1. Login to the member portal at https://memportal.accesshma.com/login
2. In the member portal, click on **Manage Claims & Deductibles**, click on **Submit a Claim**, and follow the prompts - be sure to upload a copy of your itemized receipt, bill, and/or invoice

Paper Submission Options

1. Go to https://www.accesshma.com/news-and-resources/member-forms
2. Scroll to **Member Reimbursement Claim Form** and click **Download pdf**
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) or print out the form and fill it out by hand
4. Use one of the submission options below:

   ✓ **Option 1: Fax** the completed form and a copy of your itemized receipt, bill, and/or invoice to: 866-458-5488

   ✓ **Option 2: Mail** the completed form and a copy of your itemized receipt, bill, and/or invoice to:
   HMA
   Attn: Claims Department
   PO Box 85008
   Bellevue, WA 98015-5008

HMA

Member Reimbursement Claim Form

Patient Information

First Name [redacted]

Date of Birt [redacted]

Group/Employer Name City of Everett **Group Number**[1] 020188

Service Type

Please select the type of service for which you're requesting reimbursement. If more than one service type applies, you must submit a separate claim form for each. If you're completing this form electronically, your selection here drives which information will be marked as required in the "Attachments" and "Claim Information" sections below.

Service Type Select... Dental Reimbursement

Attachments

Please include all relevant documentation (such as an itemized receipt, bill, and/or invoice) with your submission. The checkboxes below indicate which information your documentation must contain for each service type. **Failure to provide the requested information may cause your claim to be delayed or denied.**

☑ **Required for all service types:** Date(s) of service and total amount you were billed for each service rendered / equipment purchased

☑ **Required for all service types *except* durable medical equipment (DME) purchased through a store (not purchased through a certified DME vendor):** Patient name, provider full name and mailing address, including city, state, and ZIP code, procedure codes such as CPTs or HCPCs, and one or both of the following: Provider's national provider identifier (NPI) number, provider's tax ID number (TIN)

☑ **Required for all service types *except* DME purchased through a store and massage therapy:** Diagnosis code(s), in ICD format

Claim Information

Please enter all necessary information below or ensure it's listed on the documentation you're attaching with your submission such as an itemized receipt, bill, and/or invoice. **Failure to supply all the required information may cause your claim to be delayed or denied.**

↓ Check each applicable box below if you're including an attachment that contains this information. If so, no need to also write the information below.

☐ **Date(s) of Service**[2] 12/09/2025

☐ **Total Billed Amount** 1026.00

☐ **Provider Name** Stanwood Advanced Family Dentistry

☐ **Provider Mailing Address** 9628 271st St. NW

City Stanwood **State** Wa **ZIP Code** 98292

☐ **Procedure or Service Codes (such as CPTs or HCPCs)**[3]

☐ **Diagnosis Codes (in ICD format)**[4]

☑ **Provider's NPI Number**[5] **and/or Tax ID Number (TIN)**[6] 1689694143 / 85381983

1 This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".

2 For DME you purchased through a store, this is the purchase date.

3 Procedure/Service Code (CPT/HCPC) is usually a five-digit number that describes the services/products provided.

4 Diagnosis Code (ICD) is usually a three- to seven-character alphanumeric code that indicates the reason for your healthcare treatment.

5 National Provider Identifier (NPI) is a unique 10-digit ID issued to U.S. healthcare providers by the Centers for Medicare and Medicaid Services (CMS). If you don't know your provider's NPI, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

6 Tax Identification Number (TIN) is a unique 9-digit ID issued by the IRS. If you don't know your provider's TIN, please contact your provider to obtain it before submitting your claim for reimbursement. If you submit your claim without this information, it might be denied if we're unable to verify your provider.

HMA

Member Reimbursement Claim Form

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

Signature

Note: It's 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.
- ☐ I understand that my claim for reimbursement might be delayed or even denied if I haven't provided all the information needed to process my claim.

[redacted] Self

Printed Name (First and Last) **Relationship to Patient (If you are the patient, put "Self")**

[redacted] 12/23/25

Signature **Date**

STATEMENT OF SERVICES RENDERED

Stanwood Advanced Family Dentistry
9628 271st St NW
Stanwood, WA 98292-8096

(360)629-4597

CHART NO.	PAGE NO.
023888	1

BILLING DATE
12/09/2025

GUARANTOR NAME AND MAILING ADDRESS

[redacted]

PATIENT	TOOTH	SURF	DESCRIPTION	CHARGE	CREDIT
[redacted]			Personal Check at Service Ch # 2146		-1026.00

PRIOR BALANCE		CURRENT CREDITS		CURRENT CHARGES		NEW BALANCE		DENTAL INS. EST.		PLEASE PAY
1026.00	-	1026.00	+	0.00	=	0.00	-	0.00	=	0.00

PATIENT	DATE	TIME	REASON
[redacted]	Wednesday - February 25, 2026	9:00 am	N20, ProphyAd

 LWLK 1

SINGLE PATIENT LEDGER

Stanwood Advanced Family Dentistry

Date: 12/09/2025 **Page:** 1

Patient Name: [redacted] **Chart Number:** 023888

Billing Type: 1

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
/22/2025		Patient Balance Forward	[redacted]		-8066.00	-8066.00
/23/2025		Personal Check at Service			-1489.00	-9555.00
23/2025		Professional Discount			-165.00	-9720.00
/23/2025	30	Prefab abutment-incl placement		800.00		-8920.00
/23/2025	30	Abtmt supp porc fused to hi-nob		1880.00		-7040.00
30/07/2025	30	Crown Delivery		0.00		-7040.00
* 08/20/2025		Personal Check at Service			-359.00	-7399.00
* 08/20/2025		Professional Discount			-40.00	-7439.00
* 09/03/2025		Dental Ins Payment - HMA			0.00	-7439.00
* 10/08/2025		Personal Check at Service			-1407.00	-8846.00
* 10/08/2025		Professional Discount			-156.00	-9002.00
* 11/13/2025		Dental Ins Payment - HMA			0.00	-9002.00
12/09/2025		Personal Check at Service			-1026.00	-10028.00

TOTAL PATIENT BALANCE AS OF 12/09/2025: -10028.00

ocedures that have been placed in History.

SINGLE PATIENT LEDGER

Stanwood Advanced Family Dentistry

Date: 02/11/2026 **Page:** 1

Patient Name: [redacted] **Chart Number:** 023888

Billing Type: 1

DATE	TEETH	DESCRIPTION	PATIENT	CHARGE	PAYMENT	BALANCE
07/22/2025		Patient Balance Forward	[redacted]		-8066.00	-8066.00
* 07/23/2025		Personal Check at Service			-1489.00	-9555.00
* 07/23/2025		Professional Discount			-165.00	-9720.00
* 07/23/2025	30	Prefab abutment-incl placement		800.00		-8920.00
* 07/23/2025	30	Abtmt supp porc fused to hi-nob		1880.00		-7040.00
* 08/07/2025	30	Crown Delivery		0.00		-7040.00
* 08/20/2025		Personal Check at Service			-359.00	-7399.00
* 08/20/2025		Professional Discount			-40.00	-7439.00
* 09/03/2025		Dental Ins Payment - HMA			0.00	-7439.00
* 10/08/2025		Personal Check at Service			-1407.00	-8846.00
* 10/08/2025		Professional Discount			-156.00	-9002.00
* 11/13/2025		Dental Ins Payment - HMA			0.00	-9002.00
* 12/09/2025		Personal Check at Service			-1026.00	-10028.00

Proc code

6056

6059

$1654.00 = -1489.00 -165.00

800.00 + 1880.00 = $2680.00

TOTAL PATIENT BALANCE AS OF 02/11/2026: -10028.00

* We do not use ICD 9 codes

$2680.00
- 1654.00
$1026.00

Stanwood Advanced FAMILY DENTISTRY

Tony Hewlett, DDS
General Dentist

9628 271st St NW | Stanwood, WA 98292
ph: 360-629-4597
info@hewlettdental.com

* Procedures that have been placed in History.