RESOLUTION NO. 288

WHEREAS, Section 5-306(e) of the Fire and Police Disability, Retirement and Death Benefit Plan (Plan) permits the Board of Trustees to require Plan Members with medical conditions attributable to service-connected or occupational injuries or illnesses to obtain hospital and medical services from providers who have fee arrangements with the Board, and

WHEREAS, the Board is desirous of implementing a policy of requiring Plan Members to seek medical and hospital services from providers who have fee arrangements with the Board, effective December 1, 1995, and

WHEREAS, the implementation of such a policy requires an amendment to the Plan's Administrative Rules, and the Rules Committee recommends that the amendments reflected herein be adopted.

NOW, THEREFORE, BE IT RESOLVED by the Board of Trustees that Subsection I., Reimbursement for Expenses Attributable to Service-Connected or Occupational Disease of Section III, BENEFITS, of the Administrative Rules be and hereby are amended and shall hereafter read as follows:

I. Reimbursement for Expenses Attributable to Service-Connected or Occupational [Disease] Injury or Illness.

Reimbursement for actual, [and] reasonable and necessary expenses, as determined by the Board, incurred by a Member as a result of a service-connected or occupational injury or illness shall be paid as provided below:

(1) Members shall be reimbursed for the actual, [and] reasonable and necessary medical expenses they have incurred. Payment by the Board directly to the medical care provider shall be deemed to be reimbursement of the Member.

(2) Actual, [and] reasonable and necessary costs for travel, prescriptions and other necessary expenses paid by the Member will be reimbursed upon request by the Member.

(3) All requests for reimbursement shall be made on forms provided by the Board and accompanied by itemized documentation which supports the request. For example, requests for reimbursement for prescriptions must be accompanied by a receipt from the provider identifying the prescription and its price and requests for

mileage reimbursement must be accompanied by a statement reflecting the actual mileage traveled.

(4) Reimbursement for the cost of meals, lodging, public transportation or use of a private vehicle shall be at the rate of reimbursement paid to City employees when incurring such expenses.

(5) Reimbursement for the cost of meals, lodging, or travel exceeding 50 miles will be paid only if such expenses are pre-approved by the Fund Administrator.

(6) Expenses incurred for public transportation or the use of a private automobile will be reimbursed based on the most direct route between the Member's home and the facility where the service is to be performed.

(7) All requests for reimbursement for expenses paid by the Member must be submitted to and received by the Board within 60 days of incurring the expense for which reimbursement is sought.

(8) Medical or hospital service providers that have fee arrangements with the Board.

A. Notwithstanding the provisions of subsection (1) above, effective December 1, 1995, Members who are covered under Article 3 of the Plan must obtain hospital and medical services for service-connected or occupational injuries or illnesses from providers who have fee arrangements with the Board, except in those circumstances described in subparagraph C. of this paragraph 8. A listing of such providers shall be on file in and available from the Fund Administrator's office.

B. Transitional Rules.

1. In the case of ongoing, continuous claims involving an injury or illness which occurred or commenced before December 1, 1995, a provider having no fee arrangement with the Board who was the Member's treating physician for such injury or illness before December 1, 1995, may continue to treat the Member for such injury or illness on and after December 1, 1995. However, if at any time on or after December 1, 1995, the Member chooses to change providers, or the provider who was the Member's treating physician prior to December 1, 1995 has not treated the

Member for a period of one year, the Member must obtain treatment from a provider who has a fee arrangement with the Board.

2. In the event that a Member requires treatment for a recurrence or aggravation of a condition which is attributable to an illness or injury occurring before December 1, 1995, the Member may choose to be treated by a provider who has no fee arrangement with the Board if the provider has treated the Member for such condition during the preceding year. If it has been more than a year since such provider has treated the Member, the Member must select a provider who has a fee arrangement with the Board.

C. Members may obtain and will be reimbursed for the actual and reasonable costs of necessary medical or hospital services received from providers who do not have fee arrangements with the Board, in the circumstances described in this subparagraph C. below. Payment directly to the provider will be considered to be reimbursement to the Member.

1. The Member has a life-threatening emergency requiring immediate medical care at the nearest emergency facility. Life-threatening emergencies include, but are not limited to, situations such as profuse bleeding, loss of consciousness, breathing difficulty or sudden severe head trauma.

2. The Member is traveling in an area in which there are no providers who have a fee arrangement with the Board and a service connected or occupational injury or illness requires immediate medical treatment.

3. The Member is referred by either the Bureau of Police or the Bureau of Fire, Rescue and Emergency Services to a provider with whom the Bureau has made arrangements for vaccinations or evaluation and treatment for on-the-job exposures to blood borne pathogens or hazardous materials.

4. The Member is referred by the Police Chaplain to a provider who does not have a fee arrangement with the Board.

5. A provider who has a fee arrangement with the Board refers a Member to a provider who has no fee arrangement with the Board or a provider who has no fee arrangement with the Board is serving as an "on-call" provider who is covering for a provider who does have a fee arrangement with the Board.

6. There are no providers who have fee arrangements with the Board who can provide the services required by the Member.

7. Other exceptions specifically authorized by the Fund Administrator or his or her designee. The Fund Administrator or his or her designee may waive the requirement that a Member seek hospital or medical services from a provider who has a fee arrangement with the Board upon a showing by the Member that it is a necessity that the Member be treated by another provider or that it would cause an undue hardship on the Member to require that he or she seek treatment only from a provider who has a fee arrangement with the Board.

D. Initial determinations under this subsection I.(8) shall be made by the Fund Administrator or the Fund Administrator's designee. Members shall be advised, in writing, of any adverse determination. In the event that a member is adversely affected by a determination of the Fund Administrator or the Fund Administrator's designee, the Member may appeal such determination by filing with the Fund Administrator a written notice of appeal requesting a hearing before the Board. However, a hearing shall not be granted unless the notice of appeal is received by the Fund Administrator within 60 days after the mailing of the adverse determination, unless the Member can establish good cause why the notice of appeal was not received within the required 60 days.

ADOPTED by the Board of Trustees on 9.12., 1995.

Edwin L. Freeman
Fund Administrator

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