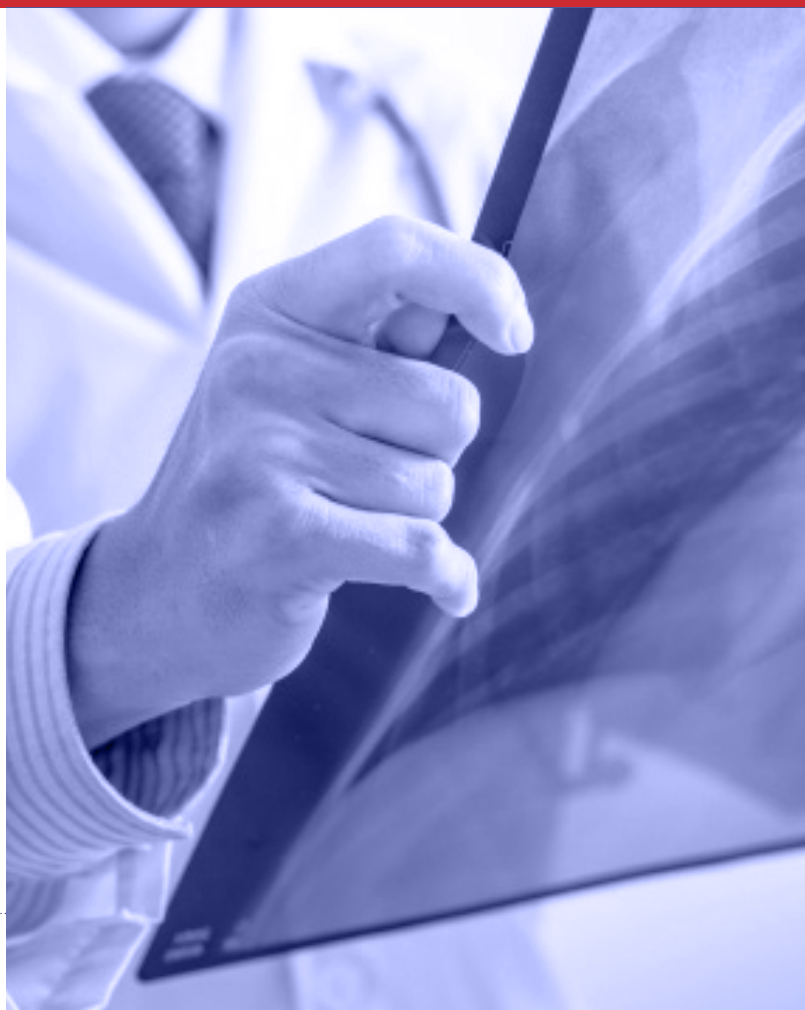
Local 27 Guide to Injuries, Illness and Disability

Updated Summer 2024



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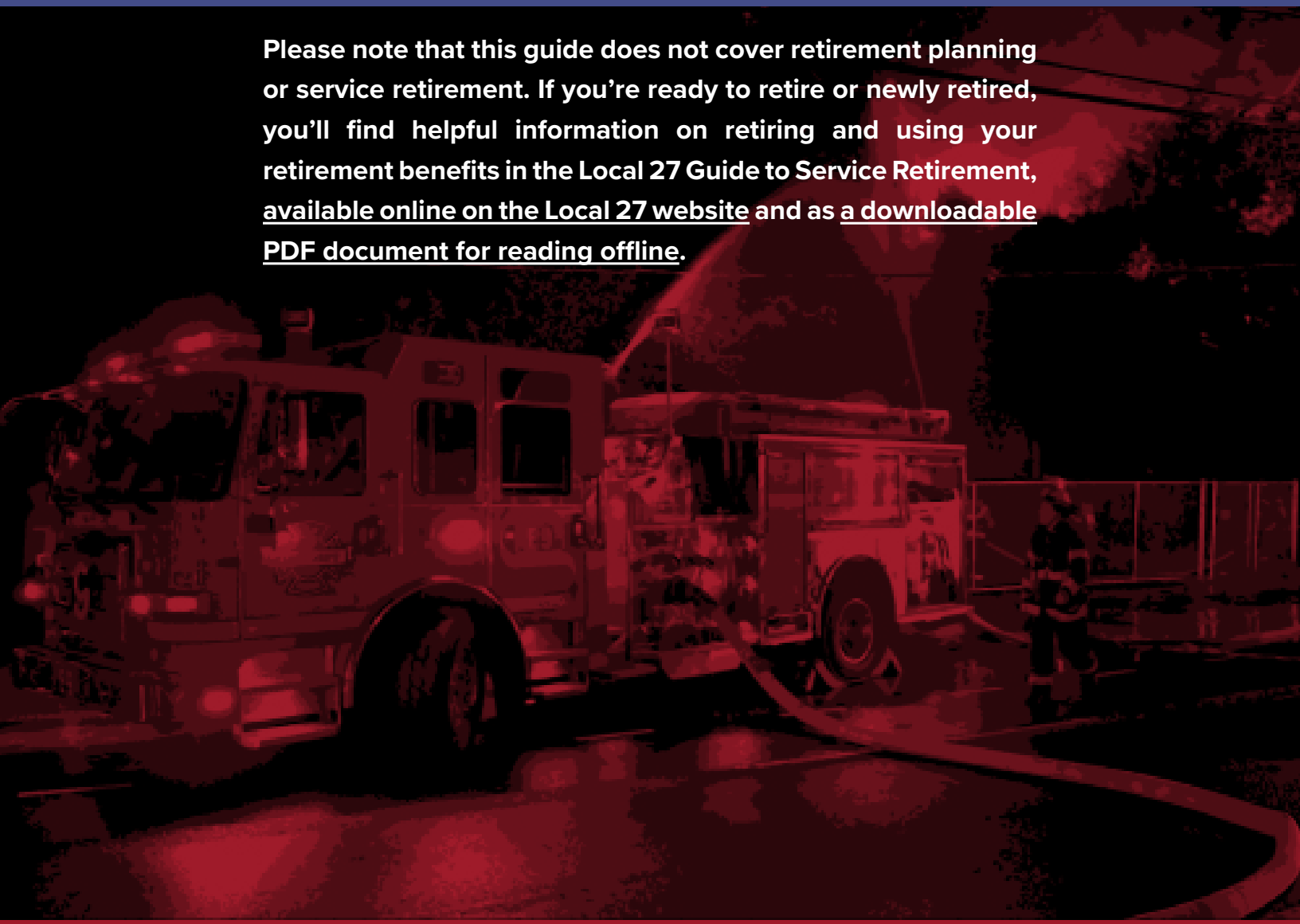
About This Guide

This quick guide is designed to answer common questions about dealing with on-the-job and off-duty injuries, illnesses, health problems (including exposure), and dependent care. The guide will help you address your immediate injury or illness-related questions and issues, understand workers' compensation, file your claim, collect applicable long-term disability benefits, return to work if you're able, and—if you're unable to return to work—understand your disability retirement options.

Please note that this guide does not cover retirement planning or service retirement. If you're ready to retire or newly retired, you'll find helpful information on retiring and using your retirement benefits in the Local 27 Guide to Service Retirement, available online on the Local 27 website and as a downloadable PDF document for reading offline.



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City of Seattle

The City of Seattle is Self-Insured

The City of Seattle does not participate in the employee insurance program managed by the State of Washington. Like many public and private employers, the City of Seattle is self-insured, meaning that the city is responsible for covering the costs of on-the-job injuries and related health problems. The city's self-insurance program is regulated by the Washington Department of Labor & Industries (L&I). This means that even though the city is self-insured, you have the same rights and responsibilities as other workers in Washington State.

The fact that the City of Seattle is self-insured has two noteworthy advantages: first, the cost of our workers' compensation coverage is less than the cost of the similar coverage managed by the state. Second, the fact that our claims are managed locally (instead of being managed by a team in Olympia) has been advantageous. Most of our members find their claims are quickly approved, without the friction that sometimes occurs when you're dealing with a remote bureaucracy. You'll find more on the claims process, how to manage your claims, and how to advocate for yourself in this guide.

Occupational vs. Non-Occupational Injuries and Health Problems

Throughout this guide you'll see references to "occupational" and "non-occupational" injuries and health problems. It's important to understand the difference between these two types of health issues. Your benefits, how you manage your claim, your responsibilities, and your options depend on whether the injury or health problem was sustained while participating in a job-related activity or while you were off-duty.

Occupational injuries and illnesses (also referred to as "On Duty" injuries and illnesses) are sustained while participating in activities directly related to the occupation of firefighting and related apparatus travel. These activities include, but are not limited to, emergency activity; training activity, including organized physical fitness programs; inspection activity; apparatus, station, and ground maintenance; and business that is necessary to maintain Fire Department operations. Illnesses that are included in this category are those obtained while in the process of performing Fire Department duties due to contact with smoke, poisons, toxic agents, dust, and infections such as hepatitis.

Non-occupational injuries and illnesses (also referred to as "Off Duty" injuries and illnesses) are injuries and illnesses that do not meet the definition of "occupational" and are sustained while off duty. Illnesses in this category are those such as flu, common colds, bronchitis, strep throat, and others of questionable origin even though symptoms might not appear until while on duty.

About Disability Retirement

Unlike Service Retirement, which is a planned retirement, Disability Retirement is usually unplanned—which makes it even more stressful than a Service Retirement. While we can't eliminate all of the stress that comes with an unplanned retirement, this guide is designed to help reduce some of the stress—especially the stress that comes from not understanding the process and/or not knowing your options.

As fire fighters, we grapple with risk every day, but we tend to focus on the immediate risks that come with the job—particularly incident related physical injuries. But as we all know, there are other long-term risks that we also face, including injuries and illnesses that develop over time, including exposure related illnesses. We are all also becoming more aware of the long-term risks to our mental and emotional health. Like the physical wear and tear that builds up over time, and one day suddenly becomes unbearable, the impacts of our work on our mental and emotional health can also creep up on us—and suddenly become a crisis.

We are raising these issues because we all need to broaden our thinking about our own health. We need to move beyond just focusing on our physical health and become better at assessing the health and well being of our full selves—our physical, emotional, and mental selves. Concerns about the health of any one of these three aspects of our whole selves is a reason to seek medical care—and may lead to an eventual disability retirement. While a disability retirement is always an unwelcome event, our goal is to ensure that you're covered, regardless of the nature of the injury or illness that's the cause of your unplanned retirement.

2 I Have an Occupational Injury, Illness or Health Problem: What Do I Do?

Get Medical Care

If you've been injured—on the job or off duty—get medical care right away. The most important thing is to attend to your injury! If you have a health problem, see a healthcare professional as soon as you can. As a fire fighter, you have healthcare coverage for your immediate needs as well as a variety of long-term disability benefits, but nothing is more important than getting the care you need right away. Like an unattended fire, injuries and persistent health problems only get worse when they aren't taken care of as soon as possible.

Your doctor will:

- Attend to your immediate medical needs.
- Examine you and provide their opinion on the most likely cause of your injury/illness.
- Recommend any further treatment you may need.
- Fill out the Physician's Initial Report (PIR) for your initial injury/illness visit.
- Fill out the Activity Prescription Form (APF), including the Key Objective Findings section.
- Work with you to decide when you can return to work.

When you see your doctor, make sure you clearly communicate the circumstances that led to your injury—and that the injury is fully documented. This will help ensure that your injury claim is properly reviewed, processed, and approved.

If you are unable to work as a result of your injury or occupational disease, you may qualify for time-loss compensation. These benefits are paid if you are unable to work for more than the three shifts (ten work days for members working an admin schedule) immediately following the date of your injury. To qualify, your health-care provider must notify the City that your condition is work-related and that you are unable to work. Your provider must also provide objective findings to support their certification.

More information about time-loss compensation can be found under Section 5 of this guide, "What Is Workers' Compensation?"

Occupational Injury Claim Checklist

Once you've attended to your immediate healthcare needs, you need to report your duty injury to your supervisor and begin filing the forms required to initiate your healthcare claim.

This checklist will help you manage your claim. Additional information on these steps, your benefits, and filing claims follows below and in the other sections of this guide.

- ☐ Get medical care promptly (within 24 hours for an occupational injury or illness).
- ☐ Report your injury or exposure to your officer, the Disability Officer, or chain of command as soon as possible.
- ☐ Complete and file the required documentation for your type of injury. (Details follow below.)
- ☐ Communicate with your health-care providers and make sure they have filed a Providers Initial Report (PIR) and Activity Prescription Form (APF) for your injury or illness.

- [ ] Stay in frequent contact with the Disability Officer and your case analyst at the City of Seattle Workers' Compensation Division. If you can, update them on your progress on a weekly basis, preferably by email so that everyone involved has an ongoing record of your case.
- [ ] Follow your treatment plan.

Report Your Injury or Exposure to Your Officer, Chain of Command, or the Disability Officer

You must report your occupational injury or exposure as soon as possible to your officer, chain of command, or the Disability Officer. If you'd like to maintain your privacy regarding your injury or exposure, you have the option to report it directly to the Disability Officer (skipping your officer and chain of command). The Disability Officer is aware of personal medical privacy rights issues and will do their best to protect your privacy. If you intend to file an occupational claim, the Disability Officer must be informed about your occupational injury or exposure.

Collect, Complete, and File the Required Documentation

You and your physician must complete and file the following required documentation of your occupational injury or exposure within six (6) calendar days of your visit to your physician or layoff:

Form	Where to find it
Occupational Injury/Illness Report (Form 78)	This online form is available on Orion.
Provider's Initial Report (PIR)	This form is available on the Hub.
Self-Insured Form (SIF-2)	This is a paper form. It's available in your fire station.
Activity Prescription Form (APF)	This form is available on the Hub.
Communicable Disease Exposure Form (Form 407)	This form is available on the Hub.

Additional information on each of these forms follows below.

The following table will help you determine which forms you need to submit for your injury or exposure:

Type of submission	What it means	Required forms due within 6 days
Precautionary	I don't need to see a Dr. or miss work, but want to document this.	Form 78
No Time Loss	I need to see a Dr., but I don't need to miss work.	Forms 78, PIR, SIF-2, APF
Time Loss	I need to miss work. A Doctor, LRNP, or PA needs to authorize any time loss.	Form 78, PIR, SIF-2, APF, and form 407 if your time loss is due to Exposure
Exposure without time loss	I was potentially exposed to a contagious disease (such as COVID-19, TB, Hepatitis, or Bacterial Meningitis); was exposed to excessive smoke, by-products of combustion, or noise.	Form 78, Form 407

Complete the Right Forms and Get the Right Signatures

This section will help you make sure you're completing the right forms and get them signed by the right people. It will also help you make sure you're submitting each form to the right person/organization.

Form Descriptions

Occupational Injury/Illness Report (Form 78)

This online form is available on Orion.

The Occupational Injury/Illness Report (Form 78) is used to document occupational injuries and illnesses, including exposures. It provides a way for your Supervisor to investigate, review and comment on the specifics of an incident in an attempt to recognize accidents that may be prevented in the future. It must be completed for all occupational injuries, illnesses, and exposures.

The online form is available on Orion. It must be completed and submitted electronically. You must complete the Member section within one (1) year of the date of your injury, or two (2) years from the initial date of your illness. Once the form is submitted through Orion, your officer and the Disability and Safety Officers will receive an email asking for their review and signature of the form.

Note that the "case number" box should be left blank: the case number will be assigned by the Orion system.

The Provider's Initial Report (PIR)

This form is available on the Hub.

The Provider's Initial Report (PIR) is completed by you and your physician. You should complete your section of the form before your initial visit to your physician. Your physician will complete their section of the form during your visit. The completed Provider's Initial Report form establishes your claim with the City of Seattle.

Send your completed PIR to the Disability Officer as soon as possible after your initial visit.

Self-Insured Form (SIF-2)

This is a paper form. It's available in your fire station.

The Self-Insured Form (SIF-2) is required by the Workers' Compensation Unit for occupational injuries, illnesses, and exposures whenever a physician is seen regardless of time loss or no time loss. The Workers' Compensation Unit uses the SIF-2 to open your claim. Once your claim is established, it serves to document the injury, illness, exposure, or health problem to enable the proper payment of medical bills as well as payment to you for time loss from work.

Be sure to thoroughly fill out and sign the Worker section. Your signature releases your medical records to the Fire Chief, his designees, and the City of Seattle's Workers' Compensation Unit.

The Employer section (including the signature and date at the bottom) is only to be filled out by the Disability Officer. Make sure that your officer or chain of command does not add their signature to the Employer section.

You'll find your claim number in the top, right-hand corner of the SIF-2. The mailing address of the Workers' Compensation's unit is in the top, left-hand corner of the form.

You will need to give your claim number and the mailing address of the Workers' Compensation Unit to your physician and/or medical establishment for billing purposes.

Keep the pink copy of the SIF-2 form for your records and submit the remaining copies to the Disability Officer. Do not leave this form at the physician's office.

Activity Prescription Form (APF)

This form is available on the Hub.

The Activity Prescription Form (APF) is completed by you and your physician. The form must be completed and submitted to the Disability Officer within six (6) calendar days of the injury. The Disability Officer will forward it to the City of Seattle Workers' Compensation Unit.

Communicable Disease Exposure Form (Form 407)

This form is available on the Hub.

This form is available on the Hub in the Lists section. If the device you're using has access to the Hub, click here to get the form.

Completing and Routing Your Forms

Use the tables below to make sure you're completing the right forms and submitting them to the right person or department.

Precautionary Submission		
Forms Required	**Completed By**	**Submit To**
Occupational Injury/Illness Report (Form 78)	• You • Your officer, the Disability Officer, or chain of command	• Your officer, the Disability Officer, or chain of command

No Time Loss Submission		
Forms Required	**Completed By**	**Submit To**
Occupational Injury/Illness Report (Form 78)	• You • Your officer, the Disability Officer, or chain of command	• Your officer, the Disability Officer, or chain of command
Self-Insured Form (SIF-2)	• You	• The Disability Officer
Physician's Initial Report (PIR)	• Your Physician	• The Disability Officer
Activity Prescription Form (APF)	• You • Your Physician • Your officer, the Disability Officer, or chain of command • Your Disability Officer	• The Disability Officer

Time Loss Submission		
Forms Required	**Completed By**	**Submit To**
Occupational Injury/Illness Report (Form 78)	• You • Your officer, the Disability Officer, or chain of command	• Your officer, the Disability Officer, or chain of command
Self-Insured Form (SIF-2)	• You • Your officer, the Disability Officer, or chain of command	• The Disability Officer
Physician's Initial Report (PIR)	• Your Physician	• The Disability Officer
Activity Prescription Form (APF)	• You • Your Physician • Your officer, the Disability Officer, or chain of command • Your Disability Officer	• The Disability Officer

Exposure Submission (With time loss)		
Forms Required	**Completed By**	**Submit To**
Occupational Injury/Illness Report (Form 78)	• You • Your officer, the Disability Officer, or chain of command	• Your officer, the Disability Officer, or chain of command
Self-Insured Form (SIF-2)	• You • Your officer, the Disability Officer, or chain of command	• The Disability Officer
Physician's Initial Report (PIR)	• Your Physician	• The Disability Officer
Activity Prescription Form (APF)	• You • Your Physician • Your officer, the Disability Officer, or chain of command • Your Disability Officer	• The Disability Officer
Communicable Disease Exposure Report (Form 407)	• You	• The Disability Officer (usually at the end of each calendar year)

Stay In Touch With Your Team

Update your team on your progress weekly if you can, including the Disability Officer and your case analyst at the City of Seattle Workers' Compensation Division. Frequent contact leads to better outcomes. It's best to keep in touch via email so that everyone involved has an ongoing record of your case.

Notify the City of Seattle immediately if your address changes to avoid delays in receiving benefit checks or other claim related correspondence.

Follow Your Treatment Plan

Cooperate with all reasonable requests from your healthcare provider, the City of Seattle, and others authorized to assist in your treatment and recovery.

You'll find information on Workers' Compensation, returning to work, long-term disability, and disability retirement in other sections of this guide.

3 I Have a Non-Occupational Injury, Illness or Health Problem: What Do I Do?

Non-Occupational Injuries, Illnesses, and Health Problems

If you have a Non-Occupational injury, illness, or other health problem, you can use your sick leave benefits. The sick leave program pays your wages if you must be absent from work because of a personal medical appointment, illness, injury, or disability, which makes you temporarily unable to perform your job. You are eligible to use available sick leave hours after your first 30 days of employment.

The program also pays your wages when you are absent because of a medical appointment, illness, injury or disability of your spouse or domestic partner, parent, grandparent, sibling, grandchild or dependent child.

You can also use sick leave for the non-medical care of a newborn or child recently placed for adoption, foster care or legal guardianship, closure of your worksite or your child's school or place of care by a public health official, and for reasons related to domestic violence, sexual assault or stalking.

This section is focused on using your City of Seattle Sick Leave benefits. The following section, "Your Family and Medical Leave Benefits" covers your other family and medical leave benefits from the State of Washington and the City of Seattle.

If you are sick or injured and are concerned that you could be off work for more than three weeks you should also file for Long-Term Disability (LTD) benefits. See Section 7, "Long-Term Disability" for more information on using your Long-Term Disability benefits.

Using Sick Leave

Sick leave is a paid leave benefit. You accrue sick leave based on the number of regular hours worked. Full-time employees earn 96 hours of sick leave per year. You may carry over your unused sick leave from year-to-year. There is no maximum accumulation.

Local 27 has also ensured that you earn sick leave on your overtime hours consistent with the City Ordinance, but it is at a lower accrual rate and the rules are different than our Collective Bargaining Agreement (CBA) sick leave accrual. The rules are based on total hours worked, so if you take any time off for any reason, those hours are deducted. In addition, the accrual is calculated on a calendar year basis, not on a pay period basis.

Return to Work Form

The Return to Work (RTW) form is only required if more than 48 hours or two shifts will be missed due to a non-occupational injury/illness or dependent care related absence. (For admin members, the RTW form is required if more than 32 hours will be missed). The form must be completed by your healthcare provider and submitted upon your return to duty, unless you will miss work for more than six calendar days, in which case you are required to submit the form to the Disability Office on or by the sixth calendar day.

If the RTW form designates that you are able to return to full duty, you must submit it to your officer or chain of command for review upon reporting for duty. The initial RTW must be completed no later than the date when the 48th hour is missed for Ops members, or the 32nd hour for admin members.

4 Your Family and Medical Leave Benefits

Local 27 members are eligible for family medical and leave benefits from both the State of Washington and the City of Seattle. This section provides an overview of the Federal Family and Medical Leave Act (FMLA), the Washington State's Paid Family and Medical Leave Program, and the City of Seattle's Paid Family Care Leave Program.

This section does not include a comprehensive list of the benefits available to you from the State of Washington and/or the City of Seattle. It is focused on the **primary** medical and family leave benefits from these two entities.

The Federal Family and Medical Leave Act (FMLA)

The Federal Family and Medical Leave Act (FMLA) entitles employees of covered employers to take **unpaid**, job-protected leave for specified family and medical reasons with continuation of your group health insurance coverage under the same terms and conditions as if the employee had not taken leave. This includes:

- Twelve workweeks of leave in a 12-month period for:
  - the birth of a child and to care for the newborn child within one year of birth;
  - the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
  - to care for the employee's spouse, child, or parent who has a serious health condition;
  - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
  - any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or
- Twenty-six work-weeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

The FMLA guarantees your right to unpaid leave for specified family and medical reasons, but does not provide you with any **paid** family or medical leave benefits. Local 27 members have **paid** dependent care benefits for both family members and newborns available from the State of Washington and the City of Seattle. If you have exhausted your available **paid** family care benefits from the State and City, you can use your accrued paid leave benefits to care for your qualifying dependents.

Washington State's Paid Family & Medical Leave Program

Washington State's Family Care Act allows workers to use their choice of **any paid leave they have earned** while caring for qualifying family members with a serious health condition, or to care for a child with a serious health condition. Local 27 members have paid dependent care benefits for both family members and newborns available from the State and the City.

In addition to the dependent care benefits available from the State and City, the Family Care Act allows you to use the following earned paid leave benefit for dependent care leave, including:

- Paid sick leave
- Vacation
- Paid time off
- Personal holidays
- Merits
- Certain specific short-term disability plans

Under the act, however, leave cannot be used for a worker's personal medical condition.

Note that you **can** use leave covered under the Family Care Act to care for a child exposed to coronavirus (COVID-19) who must be isolated from school or their place of care, even if the child does not have any symptoms of the illness.

Qualifying for the State's Paid Leave Benefit

To qualify for the state's Paid Leave benefit, you must have worked for 820 hours in your qualifying period, which is normally the first four of the last five completed calendar quarters.

Visit the "Qualifying Period Definition" page on the Washington Paid Family & Medical leave website for more information.

Who Counts As a Qualifying Family Member?

Who counts as a "qualifying family member" when it comes to family leave? The Washington Paid Family & Medical Leave program allows you to take paid time off to care for a family member with a serious health condition, or if you're bonding with a new baby or child in your family. You may use family leave to care for:

- Spouses and domestic partners
- Children (biological, adopted, foster or stepchild)
- Parents and legal guardians (or spouse's parents)
- Siblings
- Grandchildren
- Grandparents (or spouse's grandparents)
- Son-in-law and daughter-in-law
- Someone who has an expectation to rely on you for care—whether you live together or not

The state may require documentation about your relationship to the person or certification of their medical need.

Visit the "What is family leave?" page on the Washington Paid Family & Medical leave website for more information.

Applying for Paid Family & Medical Leave from the State

To apply for paid family and medical leave from the state, you must:

1. Notify the department at least 30 days before you plan to take leave (if the event is foreseeable).
2. Experience a qualifying event.
3. Apply for leave (wait to apply until after your qualifying event).
4. Receive a determination letter in the mail.
5. Complete your waiting week (exceptions: bond leave or military exigency don't have a waiting week)
6. File your weekly claims to get paid (you may have an unpaid waiting week)

Visit the "Apply Now" page on Washington Paid Family & Medical leave website for more information on applying.

Visit the "File Your Weekly Claim" page on Washington Paid Family & Medical leave website for more information on filing your weekly claim.

How Much Time Do I Get?

Within your claim year, you can take:

- ***Up to 12 weeks of medical leave or family leave.*** Medical leave is for recovering from or getting treatment for a serious health condition. Family leave is for taking care of a qualifying family member who has a serious health condition, for bonding with a new child or for certain military events.
- ***Up to 16 weeks of combined medical and family leave*** if you have more than one qualifying event in the same claim year. This could include medical leave for pregnancy or to recover from giving birth, then family leave to bond with your baby. Or you could qualify for family leave to care for a family member, then medical leave for yourself within the same year
- ***Up to 18 weeks of combined medical and family leave*** if you experience a condition in pregnancy that results in incapacity, like being put on bed rest or having a C-section. There is a checkbox on the Certification of Serious Health Condition form where your healthcare provider should certify that your serious health condition is related to pregnancy.

Using Your Paid Leave

You do not have to take your Paid Leave all at once. But you must claim eight consecutive hours of leave each week, or claim zero hours if taking intermittent leave. For example, you can take one day off a week to care for a family member undergoing chemotherapy treatment. Or you can take your leave in full weeks to recover from your own major surgery.

How Much Will I Get Paid?

When you take paid leave, you can receive up to 90% of your weekly pay—up to a maximum of $1,327 in 2022. Use our calculator to find out about how much your pay could be if your leave starts in 2022.

Use the state's payment calculator to estimate your weekly pay.

Job Protection

The department is not required to keep your job for you if any of the following is true:

- You've worked for the City for less than a year
- You've worked less than 1,250 hours (about 24 hours a week) for the City in the year before you took leave

For More Information…

Visit the Washington Paid Family & Medical Leave Program website for more information on the state's program.

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Your City of Seattle Paid Family and Medical Leave Benefits

This section covers your City of Seattle **paid** family and medical leave benefits. Local 27 members receive these benefits *in addition to* the paid benefits listed above provided by the State of Washington.

Paid Family Leave

The City provides eligible employees up to four weeks (160 hours) of paid leave to care for a qualifying family member with a serious health condition under an approved Family and Medical Leave (FML). Hours are pro-rated for part-time employees.

Employees become eligible for paid family care leave after completing six consecutive months of employment in a benefit-eligible position or temporary assignment and if they have not exhausted their FML entitlement hours. The use of Paid Family Care Leave counts against FML entitlement hours.

To apply for this leave, please contact the Department's City of Seattle Human Resources representative.

Paid Parental Leave

The City of Seattle's Paid Parental Leave program provides eligible employees up to 12 weeks of paid leave to bond with their new child. These hours are prorated for part-time employees. Employees become eligible for this leave after completing six months of employment in a benefit-eligible position and if they experience one of the following qualifying events:

- Birth of a child
- Placement of a child for adoption
- Placement of a child for foster care
- Placement of a child for legal guardianship

The employee must submit a completed and signed Family and Medical Leave Request Form and a record of birth or placement to the City. The employee must use the leave by the first anniversary of the child's birth or placement.

To apply for this leave, please contact the Department's City of Seattle Human Resources representative.

Funeral and Bereavement Leave

In the event of the death of a family member or close relative, you are eligible for paid funeral leave to attend or make arrangements for a funeral. The guidelines for funeral leave are as follows:

- Members assigned to a forty-hour average work week are eligible to receive one shift off duty with pay, or two shifts in instances where a total travel distance of 200 miles or more is necessary.
- Twenty-four hour shift members are eligible to receive one shift off duty with pay.

Members notified of a death in the family while on duty may be immediately excused from work for the balance of the shift, as funeral leave, if necessary. This time off with pay is in addition to the applicable benefit above. A member working on an overtime basis will be allowed to leave work, but will be paid only for hours actually worked. Time worked for less than twenty (20) consecutive hours does not count as an overtime shift worked.

Bereavement leave is an approved use of your sick leave benefits for up to two shifts. You may also be able to use vacation days or merits for bereavement leave for family members and close relatives, consistent with article 10 of the Local 27 Collective Bargaining Agreement.

For more information, see Personnel Rule 7.8: Bereavement Leave.

To use funeral or bereavement leave, please choose it from the options listed while laying off.

Your City of Seattle Unpaid Family and Medical Leave Benefits

This section covers your City of Seattle **unpaid** family and medical leave benefits.

Unpaid Family and Medical Leave

The City provides up to 90 calendar days of unpaid Family and Medical Leave per rolling 12-month calendar year. Hours are pro-rated for part-time employees. Employees are eligible to use the leave after six months of employment. Eligible employees can elect to utilize their accrued paid leave such as vacation, sick leave, floating holiday, etc. during an approved City FML leave period. City FML leave is a protected leave, allowing for job restoration, continued health insurance benefits, and protection against retaliation.

When you use Family and Medical Leave for the non-medical care of your newborn child or for a child who has been placed with you for foster care or adoption, you must provide 30 days advance notification, when possible. Any use of intermittent Family and Medical Leave for the non-medical care of your new child must be by mutual agreement between you and your supervisor. You must submit a record of birth or placement attesting to the date of the child's birth or placement with you.

When you use Family and Medical Leave for your own serious health condition or to care for the serious health condition of an eligible family member, you must provide as much notification as possible. You must also submit a health condition certification form that certifies your or your family member's serious health condition. The form is filled out by your family member's healthcare provider.

- View and download the form required to certify *your* serious health condition.
- View and download the form required to certify *your family member's* serious health condition.

Additionally, if you are taking Family and Medical Leave for your own serious health condition, you will need your healthcare provider's release to return to work.

To apply for this leave, please contact the Fire Department's Disability Officer or the Department's City of Seattle Human Resources representative.

Voluntary Relief

In rare cases, Local 27 members can be kept on paid status while other members of the department voluntarily work their shifts for them. This "voluntary relief" is made available on a case by case basis with the agreement of the Fire Chief and the Local 27 President. Voluntary relief shifts are coordinated through the Local 27 office and communicated by the Local to the Department.

Pregnancy Disability Leave

Pregnancy Disability Leave (PDL) is an unpaid leave available for a period of sickness or temporary disability related to pregnancy or childbirth following the exhaustion of the employee's accumulated sick leave. Pregnancy disability leave must be granted in addition to the employee's entitlement to Family and Medical Leave if the employee so chooses.

Lactation Breaks/Breastfeeding

Lactation breaks are reasonable paid break times that employees who are nursing may take to express breast milk in addition to their legally required paid and unpaid breaks.

For more information, see Personnel Rule 7.2 — Pregnancy Disability Leave and/or contact the Department's City of Seattle Human Resources representative.

Leave of Absence

A Leave of Absence is an unpaid leave for a period not to exceed 12 months that is available to employees who need time off due to personal (non-medical) reasons or due to family or medical reasons that are not eligible for City Leaves, such as Family Medical Leave and is only available at the discretion of the Fire Chief.

For more information, see Personnel Rule 7.3 — Leave of Absence and/or contact the Department's City of Seattle Human Resources representative.

Other Benefits Available to You Through the City of Seattle

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides confidential counseling and mental health support for issues such as stress, family relationship concerns, work-related problems, financial issues, eating disorders, and alcohol and drug problems.

Confidential, professional help is available for you and your household members 24/7 online and by phone through Resources for Living. Services also include childcare referral, eldercare information, and financial and legal consultation. No enrollment is necessary.

Employees and household members can receive six visits per issue per year. You choose in-person counseling, phone counseling, or virtual counseling via Talkspace. Talkspace services include text, chat, and televideo counseling. A week of text correspondence counts as one of six visits.

Employees may use six paid, non-leave hours per year for EAP visits. (Contact Human Resources to schedule time if you want to use paid time.)

For more information on the Employee Assistance Program, visit the program summary page on the City's Human Resources website.

To explore the program's services or get started with counseling, visit the Resources for Living website. To login to the website:

- Enter the username "city of seattle"
- Enter the password "city of seattle" (all lowercase letters, with the spaces)
- You can also call Resources for Living at 1-888-272-7252 or TTY 1-888-879-8274.

Accidental Death & Dismemberment Insurance (AD&D)

Employees may purchase Accidental Death and Dismemberment insurance (AD&D) within 30 days of their hire date, the date they become eligible or during any open enrollment period. The City offers AD&D policies through Securian Financial at competitive group rates for coverage increments of $25,000. Employees pay 100 percent of the monthly premium through payroll deduction.

Employees may choose to cover themselves, or themselves and their dependents. The amount of benefits dependents have will be a percentage of the employee's amount of benefit.

Benefits will be paid in the event of accidental death, subject to some exclusions such as suicide, military service and war.

For more information, including information on premiums, see the Accidental Death and Dismemberment program summary on the City's Human Resources website.

Sick Leave Transfer

The City has a sick leave transfer program. You may request to receive up to 560 hours of donated sick leave for any single qualifying incident from other employees if you meet all the following conditions:

- You have exhausted or will exhaust in the current pay period, your paid leave balances due to a personal illness, injury, impairment, or physical or mental condition which is likely to cause you to go on leave without pay, or to leave City employment.
- You provide a medical certification from your health care provider verifying the nature and expected duration of your condition and the need to be off work.
- You have used your sick leave balance judiciously.
- You are not eligible for benefits under SMC Chapter 4.44 or under the State Industrial Insurance and Medical Aid Acts.

You may also donate eight or more sick leave hours to an approved recipient employee, provided the donation will not cause your sick leave balance to fall below 240 hours.

For more information, see Personnel Rule 7.7 — Sick Leave and Sick Leave Transfer and/or contact the Department's City of Seattle Human Resources representative.

5

What Is Workers' Compensation?

Injured fire fighters are entitled to no-fault accident and disability coverage. This coverage, known as "workers' compensation" covers medical expenses and pays a portion of the wages you lose while you recover from a work-related injury, illness or occupational disease. If you are injured at work, you will be covered by the City's self-insured Workers' Compensation program. You are covered as soon as you start work.

Your Workers' Compensation Benefits

Healthcare Services

When your claim for a work-related injury or occupational disease is approved, the city will pay your medical bills while you recover.

What health-care services and costs are covered?

All health-care provider, hospital, surgical, pharmacy, and other health-care services necessary for treatment of your work-related injury or occupational disease are paid directly by the city. Health-care services are provided until your work-related injury has stabilized and reached a point where further recovery is not expected.

Other services may include, but are not limited to, emergency ambulance service, special or home nursing care, dental repair, convalescent center care, glasses, hearing aids, crutches, braces, and prostheses. Workers receiving a prosthesis (an artificial limb, for example) also receive lifetime prosthesis maintenance, including replacements needed because of normal wear and tear of the prosthesis or related physical changes.

May I choose my health-care provider?

The first time you see a doctor, you may choose any health-care provider who is qualified to treat your injury or disease. For ongoing care, you must be treated by a doctor in the L&I Medical Provider Network. You'll find a list of network providers at www.lni.wa.gov/findadoc.

If you are receiving medical care out of state, your provider does not need to be in the network.

Qualified providers include: medical, osteopathic, chiropractic, naturopathic and podiatric physicians; dentists; optometrists; ophthalmologists; advanced registered nurse practitioners; and physician assistants.

May I change health-care providers once my claim is filed?

Yes. You may change health-care providers or ask for a consulting opinion from another provider if you feel you are not making progress with your current provider. However, to ensure proper payment of medical bills, you must get approval from the City of Seattle Workers' Compensation Unit before changing providers or seeking another opinion.

Note: If you transfer care to a new provider or seek a consulting opinion, you still need to see a provider who is a part of the L&I Medical Provider Network. You'll find a list of network providers at www.lni.wa.gov/findadoc.

Who pays my medical bills?

Healthcare providers should send their bills to the City of Seattle's Workers' Compensation Unit for payment.

Usually, there are no out-of-pocket expenses to you. However, if your eligibility for benefits is in doubt, a provider may bill you. In that case, keep a copy of your invoice and receipt. If your claim is approved, the provider must reimburse you the amount you paid and seek payment from your employer or their representative.

Time-Loss Compensation

If you are unable to work as a result of your injury or occupational disease, you will be paid a portion of your regular wages tax free.

- If your marital status is single, 60% of your regular wages will come in the form of a check, mailed to you from the City of Seattle Workers' Compensation Unit.
- If you are married, this adds 5%, and 2% is added for each dependent up to 5; for a total maximum replacement of 75% of regular wages.
- You will receive another benefit concurrently with the workers' compensation benefits, which will get you to 80% of your regular wages, paid by the City from Ordinance Hours which lasts for 2,376 hours of worked time.
- After Ordinance benefits drop, you'll receive only your workers' compensation portion (60-75% of your regular wages depending on marital and dependent status).
- You can refer to the Department of Labor and Industries Claims Adjudication Guidelines for more information on this and other benefit calculations at Claims Adjudication Guidelines (wa.gov).

How do I qualify for time-loss compensation?

Your health-care provider must notify the City that your condition is work-related and that you are unable to work. Your provider must also provide objective findings to support their certification.

How long do I have to be off work to qualify for time-loss compensation benefits?

These benefits are paid if you are unable to work for more than three days immediately following the date of your injury. Injured workers are not compensated for those first three days unless they are still unable to work on the fourteenth day (tenth day for members working an admin schedule) following the injury. (You may be eligible to receive time-loss benefits for the first three days, if you returned to work, found you could not continue working, then remained off work through the fourteenth day.)

It is important to note that the city will still take three shifts of sick leave (four if you have a debit day), but you will also be paid by Workers' Compensation, meaning you are essentially being paid double for the first two weeks of your disability claim. You may make arrangements to buy that sick leave back after your return to work, if desired.

When will I get my first benefit check?

The city must pay you within 14 days of being notified of your claim and receiving information that you have missed time from work due to an industrial injury.

How long will I receive time-loss compensation benefits?

You will receive time-loss payments twice a month or every two weeks as long as your healthcare provider verifies that your condition prevents your return to any work. You and your provider must keep the City informed of your progress. Without this information, your time-loss compensation check could be delayed or stopped.

Will I ever have to return time-loss compensation benefits?

If your claim ultimately is rejected because the city found that your injury or disease was not work-related or if new information shows your check should have been for a lower amount, you will be required to refund all or part of the money you received. Also, time-loss compensation must be refunded if it is later found that you were able to work or did work days for which you received benefits.

In most cases, the city has one year from the date of the incorrect payment to notify you that you must make repayment. If you are not notified within one year, you are not required to repay the overpayment. This time limit does not apply if your claim has been rejected.

How time-loss compensation is calculated

The amount of your time-loss benefit check is 60 to 75 percent of your total wages and certain benefits, depending on your family status and number of dependents you have when you are injured. These benefits cannot exceed specified

limits and are based on a standard formula established by law.

Establishing your gross income

The following is taken into account to establish your gross income at the time of injury:

- Your wages earned before taxes, including income from a second job.
- The city's contribution to your medical, dental, and vision benefits.
- The reasonable value of room and board, housing, fuel or similar considerations received from the city as part of your income.
- Any bonus you received as a part of the contract of hire with the city at the time of injury.
- Tips you reported to your employer for federal income tax purposes.

If you have established a history of overtime, those wages can be included in your calculation.

Possible effects of Social Security benefits

You should report to your employer any Social Security payments you receive as this can affect your workers' compensation benefits.

Other Occupational Injury Related Benefits

Refunds for traveling to a health-care provider or job-training appointment

When the city authorizes you to travel, you can be reimbursed for out-of-pocket expenses.

You will be reimbursed for all miles traveled for:

- An independent medical examination or other examination scheduled by the city.
- Vocational services
- Vocational retraining

If you must travel more than 15 miles from home (one way) for an authorized trip to get treatment or for the fitting of a prosthetic device, you will be reimbursed for all mileage except the first 15 miles from your home and the last 15 miles of your return trip.

Out-of-pocket expenses for approved travel can include mileage, food and lodging. They will be reimbursed at rates set by L&I. These rates may be less than your actual cost. You can also be reimbursed for other transportation costs, such as parking or bridge or ferry tolls. Receipts may be required.

To ensure you receive reimbursement, make sure the city pre-approves your travel. Contact the City in advance to request pre-approval and to find out what documentation they need in order to process your request for reimbursement. You must send your request for reimbursement to the city within one year of the trip and clearly indicate the date, destination and reason for the travel.

Property damage refunds

In some cases, your benefits may cover the cost of personal property that is damaged or lost because of a workplace injury. The same is true if those items are damaged or lost because of emergency treatment offered on the scene. Receipts for repair or replacement of articles are required. Copies of receipts and your request for reimbursement should be sent to the city or the city's representative.

Motor vehicle modification

The costs of modifying a motor vehicle may be covered for workers suffering amputation or paralysis. Dollar limits apply. The modification must be necessary to meet the worker's need for safe transportation. Any vehicle modifications must be pre-approved by the city or their representative.

Home modification

The costs of modifying a home may be covered for workers suffering catastrophic injuries. Dollar limits apply. Some examples of catastrophic injuries are brain injury, paralysis, loss of arm(s) or leg(s), and severe or progressive lung or heart disease. The modifications must be necessary to meet the worker's needs for safety, mobility, or activities of daily living. Any home modifications must be pre-approved by the city or their representative.

6

I'm Able to Return to Work: What Do I Do?

The best possible outcome following an injury or illness is that you're ready and able to return to your regular position. But while you may be ready and able to return to work following an injury or illness, medical restrictions may prevent you from returning to your regular job. In this case, it may be possible to return to work in a different, light duty capacity while still receiving medical benefits. Research shows the sooner you return to work, the more likely you'll preserve future income and health.

Below you will find information on returning to your regular position and returning to a lighter duty job.

Returning to Your Regular Position

In order to return to work, you must have your physician complete and submit an updated Activity Prescription Form (APF) form stating that you're fit for duty and can return to work with no restrictions.

If you've been off for more than six months, you'll need to fulfill the Department's return to work requirements. The program is coordinated by the Training Division at the Joint Training Facility (JTF).

Returning to a Lighter Duty Job

Light duty is work the Department may offer within your medical restrictions for you to perform while you recover. Light duty doesn't have to be directly related to the work you were performing at the time of injury.

Light-Duty Jobs

Depending on the severity of your injury and/or the type of work you do, you may have difficulty returning to work right away. If there is a need in the Department that accommodates your physician-determined limitations, the Department shall provide you with a modified duty job. When your physician determines it's medically necessary, you may have the option of performing the job on a part time basis.

Note that your physician directed physical therapy can be performed as a part of your light duty schedule.

Issues that will be considered to determine whether a modified job is feasible for you include:

Can your regular job be temporarily modified?

In some cases, the physical demands of your job can be changed temporarily to accommodate physical restrictions. This may include part-time or lighter-duty work. Note that this option is not available to Operations personnel.

Light duty or transitional work could be:

- Working shorter hours.
- Doing some of your original duties part time and gradually increasing to full-time work
- Performing different duties with lighter physical demands and grow into your original duties.
- Adjusting your job or worksite to meet your physical limitations by providing tools, equipment, or appliances.

Can you return to a new job with the department?

A different permanent job, in keeping with your physical restrictions, is sometimes available with the department or City.

Collaborate with the City and Department

The City and L&I require you to actively participate in all return-to-work activities while you are receiving benefits. When the City offers you light duty or you talk to them about work you can do, you are collaborating in your healing process. Some injuries are so severe that you can't go back to work right away. With most injuries, however, an early and medically-approved return to work makes sense. While working a modified duty position you continue to earn service credits. Working 45 hours per pay period of modified duty will earn you full service credits.

It is common to have concerns about returning to work and the impacts on your claim. Don't let these concerns stop you from talking to the department's Disability Officer. You can continue to receive treatment for your accepted work-related conditions until you've reached maximum medical improvement.

Talk with the Disability Officer about work you may be able to perform while you heal.

Employability Assessments

Some fire fighters have injuries that make it impossible to return to work with the department or City. If this is the case, the City may refer you to a vocational counselor for an employability assessment. The counselor will evaluate your skills and abilities.

The City uses this assessment to determine whether:

- You are employable in your area's job market and not eligible for further vocational services,

  OR

- You are eligible for further vocational services. A vocational counselor then will develop a vocational plan with the goal of helping you become employable,

  OR

- You are not able to work and are not eligible for further vocational services.
- You may be found employable in or be retrained in an occupation that pays less than what you made when you were injured. Your time-loss payments cannot continue if you are employable (unless you are participating in a vocational plan). L&I's Self-Insurance Section will approve or disapprove your employer's decision about your employability.

Vocational Benefits

Vocational benefits are discretionary. They are aimed at helping a worker who cannot return to their old job due to the effects of their injury and does not have the training or skills for a different job to become employable. Vocational benefits may include approved training plans.

Vocational Plans

If vocational assistance is necessary to assist you in becoming employable, your employer will provide a vocational counselor who will work with you to develop a training plan for L&I's approval.

A vocational retraining plan includes a job goal based on your skills, interests, and medically documented limitations. The plan can include schooling or on-the-job training and cannot exceed two years' duration.

When a vocational retraining plan is approved, you can select one of two options: begin the approved plan with the assistance of the vocational expert, or an alternative that allows you to pursue training independently.

Disputing Decisions About Vocational Benefits

L&I's Self-Insurance Section approves or disapproves your employer's decisions about your employability or your vocational plan. If you disagree with the decisions L&I makes, you have the right to dispute. If you decide to take this step, you must send a written dispute to:

The Vocational Dispute Resolution Office
Department of Labor & Industries
PO Box 44880
Olympia, WA 98504-4880

You must write to L&I within 15 days after receiving the notice with which you disagree. Explain your concerns in detail. The Vocational Dispute Resolution Office will investigate your complaint and help resolve the dispute. Its recommendations then will go to the director of L&I, who will make the final decision.

Note that your City of Seattle claims analyst can assist you with this process.

7 Long-Term Disability

An injury or illness that leaves you unable to return to work is challenging—physically, emotionally, psychologically, logistically, and financially. Those who've suffered career ending disabilities will tell you that you have to begin this new, unexpected phase of your life by being kind to yourself. It's a difficult transition.

Your Long-Term Disability Benefits

As a member of Local 27 you are automatically enrolled in the Union's Group Long-Term Disability (LTD) Insurance plan. The plan provides benefit coverage for work related disabilities after a 180-day waiting period, and coverage for non-occupational disabilities after a 30-day waiting period. Your maximum benefit amount is $7,000 before reduction by your deductible income.

The LTD plan will help you preserve your sick leave if you are off for more than 8 shifts in non-occupational cases or more than 180 days in occupational claims. You should file a claim as soon as possible if you think you may be unable to work for an extended period of time. This will help ensure that you do not incur a gap in your pay if you are off for more than 8 shifts. If you don't use the available benefits, the claim will expire.

Contact the Disability Officer to initiate the LTD claims process.

For more information on your Long-Term Disability benefits and help filing a claim, contact the Department's LTD insurance broker:

Douglas Evans
R. L. Evans Company, Inc.
3535 Factoria Blvd SE, Suite 120
Bellevue, WA 98006
Phone: 425.455.0501 ext 111
Email: douge@rlevansco.com

You can also contact the claim's department at Standard Insurance Company (the insurance carrier) at 800-368-1135.

Long-Term Rehabilitation

Our Long-Term Disability policy does not cover rehabilitation, however it does include other benefits that may be useful during rehabilitation:

- The policy includes a Reasonable Accommodation benefit of up to $25,000 payable to the City to reimburse the expenses they incur making the accommodations necessary to enable you to return to work. This usually includes things like specialized keyboards, chairs, or other required workplace equipment.
- The policy also includes a Return to Work incentive. During the first 24 months following a covered disability, the coverage allows a member who returns to work part-time to keep their Return to Work earnings and their LTD benefit—up to the point that when both are added together, they don't exceed 100% of the member's pre-disability earnings.

For more information on these benefits and other potentially applicable LTD benefits, contact the Disability Officer and/or Doug Evans.

8 Disability Claims and Retirement

If you are a LEOFF Plan 2 member and you become disabled, you might be entitled to a disability benefit. This section describes your LEOFF 2 disability retirement benefits and how to apply for them. The Department of Retirement Systems (DRS) recommends you contact a DRS Retirement Specialist if you plan to apply for a LEOFF disability retirement.

Are You Fixed and Stable?

If you've suffered a major injury or illness, you're likely to hear the term "fixed and stable." If you're "fixed and stable," it means you've reached the point when your disability is unlikely to be significantly improved by further medical treatment and you're not reasonably expected to be able to return to duty. In other words, your disability is permanent.

Deciding to Try to Continue to Work or Retire

A debilitating injury/illness is life changing. Deciding whether to try to continue to work or retire isn't easy. There are many factors to consider, including your current physical limitations, your current emotional and mental state, your living situation, your finances, your family obligations, and more. Most people in this difficult situation need the help of one or more trained professionals to work through the options.

We strongly recommend that you assemble a team of professionals you trust to help you, especially as you consider your financial situation. There's no single blueprint for rebuilding your life after a debilitating injury/illness. The team you assemble can help you map out a plan that works for you and your family. You don't need to face this unexpected and difficult transition alone.

Am I Eligible for a Disability Retirement Benefit?

If you are totally incapacitated for continued employment with the department and/or City and you leave that employment as a result of your disability, you might be eligible for a disability retirement benefit.

You do not need a minimum amount of service credit to be eligible for a disability benefit.

You must file an application with DRS before you can qualify for a disability benefit. DRS will determine whether you are capable of carrying out the duties of the job you performed at the time of the disability or any other LEOFF-eligible employment you are qualified to perform. DRS will also determine whether your disability occurred in the line of duty. You are responsible for scheduling and paying for independent medical examinations to prove you qualify for disability retirement.

Each benefit has its own eligibility requirements. The four types of disability benefits are:

- Temporary duty disability
- Non-duty disability
- Duty disability
- Catastrophic duty disability

Temporary Duty Disability

If you do not earn full service credit because of leave associated with a duty disability, you have the option to purchase up to 24 months of service credit for each covered duty disability.

Utilizing the Fire Fighter Supplement that your union fought for, you can use your sick leave hours to purchase your lost service credits due to an occupational injury or illness. This is a good way to get 100% value from your sick leave that will continue to pay dividends for the rest of your life.

To establish service credit, you must meet the following criteria:

- Your disability must have occurred in the line of duty.
- You must have received your injury on or after July 1, 2002, and be eligible to receive workers' compensation benefits.
- You and your employer must make employer and member contributions on the compensation you would have earned had you been working. If the payments are made for a retroactive period, interest is charged. If your employer offers a disability leave supplement or similar benefit, your first six months of service credit are interest free.

Non-Duty Disability Claims

If your disability didn't occur in the line of duty, you might receive a monthly benefit calculated as follows: 2% x FAS x service credit years.

Final Average Salary (FAS) is the monthly average of your 60 consecutive, highest-paid service credit months.

Your monthly benefit will be reduced to reflect the difference between your age at the time of your disability retirement and age 53.

If you are age 50 and have 20 years of service credit, the reduction is 3% per year (prorated monthly) from age 53.

Duty Disability Claims

If your disability occurred in the line of duty, you may choose between a nontaxable:

- One-time payment equal to 150% of your eligible retirement contributions
- Minimum monthly benefit of at least 10% of your FAS

If you have fewer than 60 service credit months when you become disabled, the average will be based on your actual total of service credit months.

If the normal retirement benefit calculation rule yields a monthly benefit greater than 10% of your FAS, you will receive the higher benefit amount. However, only the amount equal to 10% of your FAS is nontaxable.

Contributions made to restore service credit after the deadline are refunded at 100% only.

Catastrophic Duty Disability Claims

If your disability occurred in the line of duty and is so severe it prevents you from performing substantial gainful activity or substantial gainful employment in any capacity in the future, you might be entitled to receive a catastrophic duty disability benefit.

The catastrophic duty disability benefit is another important legislative improvement that Local 27 fought for and got passed after the catastrophic injury to Seattle Fire Fighter, Mark Jones.

The Social Security Administration defines "substantial gainful employment" as working in a position whose average earnings are more than a set dollar amount each month, a figure it updates annually.

Your catastrophic duty disability benefit can be calculated in three ways:

- 70% of your FAS
- 100% of your FAS, offset by Social Security disability and workers' compensation disability payments
- <2% x FAS x service credit years

In addition to your monthly benefit, you will be reimbursed for premiums you pay for employer-provided health insurance, COBRA, and Medicare Parts A and B.

If you are entitled to Medicare, you must enroll and maintain enrollment in both Medicare Parts A and B to remain eligible for the reimbursement.

These premium reimbursements are not taxable.

Medical insurance reimbursements are available for current, past and eligible COBRA enrollees. Reimbursement for these members is never greater than the COBRA coverage they are eligible for.

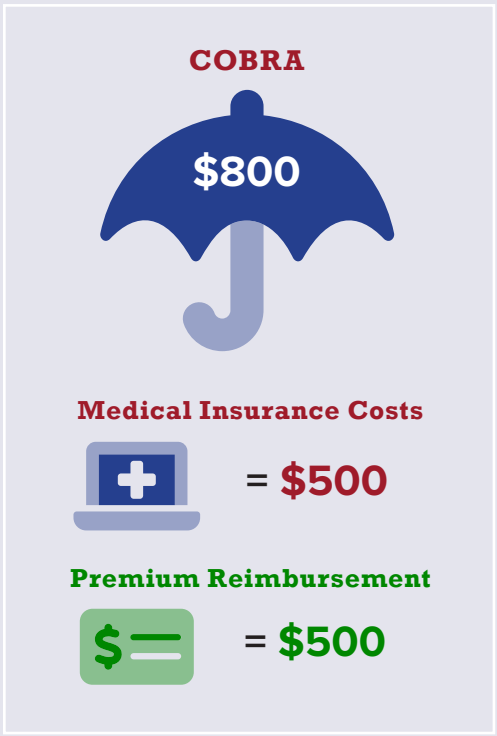
Example

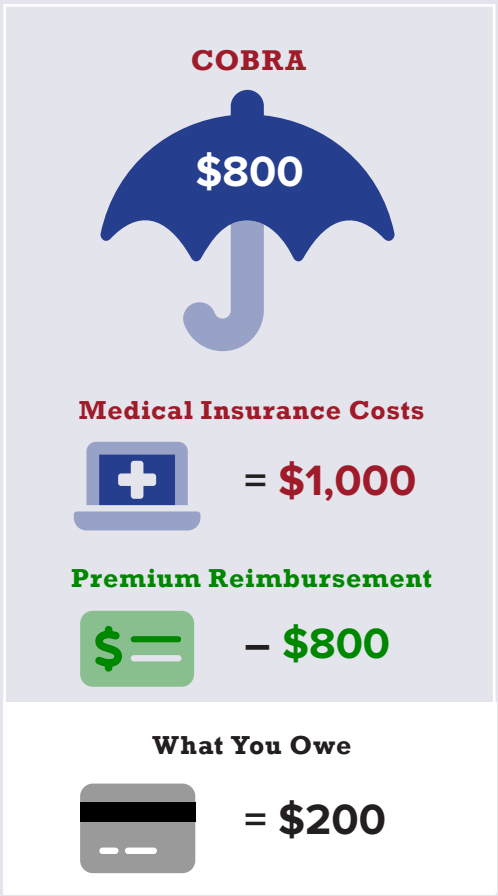
COBRA covers you up to $800. You have medical insurance costs of $500. Your premium reimbursement is $500.

If your medical insurance costs are $1,000, your total reimbursement is $800—the entire COBRA coverage you are entitled to. You will not be reimbursed for the additional $200 owed toward your medical insurance.

If you are receiving a catastrophic duty disability benefit and you are capable of performing substantial gainful activity or substantial gainful employment or your average earnings exceed the monthly limit, your benefit will automatically convert to a duty disability benefit and you'll no longer be reimbursed for your medical premiums.

If you are able to perform in a LEOFF-eligible position, your benefit will be stopped.





Disaster Response Disability Claims

There are certain circumstances, when you might qualify for disaster response benefits and service credit. In the two situations listed below, your disability must have occurred while you were in eligible federal service providing eligible emergency management services.

- **Working for a LEOFF 2 Plan employer:** You might qualify for a disability benefit if you leave the department to provide a disaster response for another LEOFF 2 Plan employer and you become disabled. Your benefit won't be reduced if you retire early. The benefit will be a minimum 10% of your Final Average Salary.
- **Working in eligible federal service:** You might qualify for service credit for a leave of absence if you become disabled when you leave the department to provide a disaster response for an eligible federal agency.

How to Apply for a Disability Retirement

The DRS recommends you contact a DRS Retirement Specialist if you plan to apply for a LEOFF 2 disability retirement. Call the DRS and request an official estimate of your disability retirement amount. It takes about three to four weeks for the DRS to calculate your benefit. The DRS will then mail you a packet with the estimate and a three-part form. You, the City, and your doctor will need to complete all three forms in the packet.

Once the DRS receives your completed application and all supporting documentation, it usually takes about four to six weeks to determine your eligibility for a disability retirement.

Note that if you are awarded a disability retirement, 10% of your pension will be tax free.

How Long Will It Take for a Determination to be Made?

An initial determination can be made within four to six weeks of DRS receiving all three parts of the application as well as all the needed support documentation.

Please send the following documentation with your disability application:

- All medical records, reports and charts pertaining to your disabling condition
- Complete physician information, especially if you are being treated by more than one doctor
- Clarification from your employer regarding your job specification information
- Department of Labor and Industries or self-insurer file documentation, such as the Report of Accident, Independent Medical Examinations and vocation records
- If you are applying for catastrophic disability, also send DRS a copy of your Social Security Administration disability award letter and any additional medical information the Social Security Administration provides

You may apply for disability retirement from DRS before separating from employment. If you have already separated, you may still apply for disability retirement as long as you were disabled at the time of your separation.

What is the Lump Sum Payment Option?

If your monthly benefit will be less than $50, you may choose between a monthly benefit and a lump sum payment.

If you choose the lump sum payment, you are considered retired from LEOFF. If you choose a monthly benefit, you cannot take a lump sum payment at a later date.

What Happens Once I Receive a Determination from DRS?

If you receive a denial: You may petition for a review within 120 days of receiving your denial letter. If your petition is denied, you will be informed of appeal procedures. You will have 60 days to appeal the decision.

If you are approved: DRS will mail you an approval letter with additional information. You must separate from employment to begin receiving your monthly disability benefit.

If you have not separated from employment within 90 days of your approval date, DRS will rescind its approval. If that happens, you must reapply and submit current medical evidence to be considered for a disability benefit.

Your retirement date is the first of the month following your date of separation. For example, if your application is approved May 4, and you separate from service May 15, your retirement date is June 1 and you will receive your first monthly benefit on the last working day of June.

Could I Be Eligible for Other Disability Benefits Outside DRS?

You might also be eligible for disability-related benefits from the Department of Labor and Industries (workers' compensation benefits), Department of Social and Health Services, the Social Security Administration, your employer, and disability insurers.

Except for catastrophic duty disability, the benefits you receive from the Social Security Administration, Department of Labor and Industries, or other disability insurers do not affect your benefit amount with DRS. However, the benefit from DRS could affect other benefits.

For more information, contact these organizations directly.

For More Information on Your LEOFF 2 Disability Benefits...

Visit the Disability Benefits section of LEOFF Plan 2 website for information on your disability benefits, the application process, payments, and more.

9

Closing Your Claim: Disability Awards, Pensions, and Settlements

Several factors must be considered before your claim is closed, including:

- Your medical condition.
- Your ability to work based on your injury.
- Whether you have any permanent impairment due to your injury.

Some duty injuries and occupational diseases involve additional financial compensation – an award, pension, or settlement.

Permanent Partial Disability Awards

If your injury or occupational disease caused permanent loss of bodily function, you may be entitled to a permanent partial disability (PPD) award. The degree of a partial loss of function is determined by a disability rating. These ratings are conducted either by the health-care provider who treated you (the attending provider), or by one or more independent medical examiners (IMEs) using established medical standards and guidelines. Normally, ratings are performed after your condition is medically stable, and no further treatment is needed. The award is intended to cover all future costs related to the claim. The amount you receive for any physical loss does not include compensation for pain and suffering.

Once the PPD is awarded, your claim will be closed. If there is a future injury to the exact same body part, any additional PPD award will be based on a newly calculated disability rating and will only cover the newly incurred, more severe permanent loss of bodily function. For example, if the first PPD award is based on a two percent closing rating and the second injury results in a four percent closing rating, the second PPD award will only be for the two percent over the previous rating and not for the full four percent.

You will not jeopardize a permanent partial disability award by working. You should return to your job as soon as your provider releases you for work. Any permanent partial disability award you receive is based on the degree of impairment suffered, not on whether you can work.

Visit the L&I Permanent Partial Disability website for information on Permanent Partial Disability award schedules, including PPD down payment amounts and maximum award amounts for specific disabilities.

Permanent Total Disability Pensions

If your accident results in the loss or total paralysis of both legs or arms, one leg and one arm, or a total loss of eyesight, you are eligible for a pension by law, even if you are able to return to work.

If vocational and medical evaluations determine that your injury prevents you from ever becoming gainfully employed, you may be entitled to a pension. Pension benefits are paid monthly. As with time-loss compensation benefits, the amount you are eligible to receive depends on factors such as your wages, family status, number of dependents, employer-provided health-care benefits, Social Security benefits, the state's average wage at the time of your injury and your pension option choice. Previously paid permanent partial disability awards reduce your pension benefit amount.

While pension benefits will come directly from L&I, the City is responsible for funding the benefits. More information will be provided to you at the time a pension is determined.

Visit the L&I Permanent Total Disability Pensions website for information on pension benefits and payments, as well as information on how your Federal Social Security benefits may affect the amount of your State disability pension payments.

Structured Settlement Agreements

A structured settlement is an agreement between a worker and the employer to resolve a claim. The agreement generally resolves all future benefits except medical. Workers are still eligible to receive medical treatment for conditions allowed on their claim.

In most structured settlements, the claim is closed. The worker is paid a set amount ofcompensation in a series of payments spelled out in the agreement.

To be eligible, an injured worker must:

- Be age 50 years of age or older, and
- Have an allowed workers' compensation claim in Washington, and
- Wait at least 180 days after the self-insured employer received the claim.

The City may initiate a structured settlement discussion with you; however, structured settlements are voluntary and must be agreed upon by all parties and be approved by the Board of Industrial Insurance Appeals.

Visit the L&I Structured Settlement website for more information on Structured Settlements, or to begin a structured settlement discussion.

10 Your Legal Rights and Responsibilities

Disputing a Decision About Your Disability Claim

Every decision about a claim requires the use of judgment, and you may not always agree. If you believe a decision made by the City is wrong, first contact your City of Seattle Workers' Compensation Unit claim analyst. If you are unable to resolve the issue, you may ask for help from the Department of Labor & Industries.

You can write a letter to:

Department of Labor & Industries Self-Insurance Section
PO Box 44892
Olympia, WA 98504-4892

Or, report your dispute online at www.Lni.wa.gov/SIClaimProblems

Requesting a Penalty If Benefits are Delayed

If there is an extended delay in the payment of your benefits, such as your time-loss compensation or medical bills, you can ask L&I to decide if the City should pay a penalty. These penalties are not automatic; L&I may discover legitimate reasons for the delay. However, if L&I does approve a penalty, it will be payable to you — $500 or 25% of your delayed benefit, whichever is greater.

To request a penalty, write a letter to L&I explaining your reasons, attach any supporting documents, and mail your letter to the address above.

Protesting or Appealing a Legal Order and Notice

Formal decisions about your claim will be communicated to you in a legal document called an Order and Notice. If you disagree with a decision in an Order and Notice:

- **Protest to the Department of Labor & Industries** – Within 60 days of receiving the Order and Notice with which you disagree, you must send a written protest to L&I or submit a protest online. (See mailing and web addresses above.) For some vocational decisions, you may have a shorter timeframe to reply: be sure to review the timeframes in the document you've received. Explain in detail why you think the decision is unfair and supply any additional information you think may help them in their evaluation.

  They will review your claim and send you an Order and Notice in response to your protest.

- **Appeal to the Board after Protest to Labor & Industries** – If you disagree with the Order and Notice sent in response to your protest, you may appeal in writing to the Board of Industrial Insurance Appeals. You must send your appeal to the Board within 60 days of receiving this Order and Notice.

You can write a letter to:

Board of Industrial Insurance Appeals
2430 Chandler Ct. SW
PO Box 42401
Olympia, WA 98504-2401

Or, submit your appeal online at
www.BIIA.wa.gov

The Board's phone number is
360-753-6823 or 1-800-442-0447
(in-state toll-free line).

The Board, which is independent of L&I, conducts hearings on claim issues that cannot otherwise be settled to the satisfaction of you, your employer, or the department. The Board issues a written decision about your case after personal arguments and testimony have been taken. This decision may be appealed to a Washington State Superior Court. For more detailed information, ask the Board for its pamphlet, Your Right to be Heard.

- **Pay During Appeal** – If you have appealed an L&I order that awarded benefits to you, in most cases the City must continue paying benefits during the appeal. Payment must continue until the Board of Industrial Insurance Appeals formally allows the City to stop payment during the appeal, or makes a decision on the appeal.
- If the Board of Industrial Insurance Appeals decides that the benefits should not have been awarded to you, you may have to repay them. If you want to stop the payment of benefits to you during the appeal, send a written request or email to the city's Workers' Compensation Unit (WCU), the state L&I division, and the Board of Industrial Insurance Appeals (BIIA).
- If you have questions about what benefits should be paid during the appeal, please contact your City of Seattle WCU claims analyst.

If You Need Legal Assistance

You are not required to have an attorney to protest any L&I decision. However, you may want an attorney's advice before appealing an L&I decision to the Board of Industrial Insurance Appeals.

Attorney fees are limited by law to a maximum of 30 percent of any increased benefit you receive as a result of your protest. Attorney fees for a Structured Settlement Agreement are limited to 15 percent of the settlement amount. Because this maximum fee may not always be reasonable, either L&I or the Board will set a reasonable fee for your attorney's services upon request.

To request a fee review from L&I, write to:

Director of Labor & Industries
PO Box 44001
Olympia, WA 98504-4001

To request a fee review from the Board, write to:

Board of Industrial Insurance Appeals
2430 Chandler Ct. SW
PO Box 42401
Olympia, WA 98504-2401

Reopening a Claim

You may apply at any time to reopen your claim. If objective medical evidence shows the condition caused by your injury or disease has worsened and requires additional health-care attention, your claim may be reopened. In most cases, we will decide whether to reopen your claim within 90 days of receiving your application.

If your claim is reopened, any benefits will be payable beginning 60 days prior to L&I's receipt of your reopening application. If more than seven years have passed since the date your claim was first closed (or 10 years for an eye injury), you may not be eligible for time-loss compensation or permanent partial disability benefits. However, you will still be eligible to receive medical benefits.

The application form to reopen your claim is available through your health-care provider's office: "Application to Reopen Claim Due to Worsening Condition." If your provider doesn't have the form, you can request one by contacting an L&I office. You'll find telephone numbers for these offices at the end of this booklet.

Complete the reopening application form and promptly mail it to:

L&I Self-Insurance Section
PO Box 44892
Olympia, WA 98504-4892

When to Reopen a Claim, When to File a New Claim

In most cases, it's better to open a new claim when you have a new injury rather than reopen an existing claim.

- If you've injured a body part that you previously injured, but the injury occured from a new event, you should file a new claim.

The difference between filing a new claim versus reopening an old claim is that you are compensated based on the wage you were earning on the date of injury. Cost of living adjustments are included, but those adjustments rarely keep up with Local 27 negotiated wage and step increases.

If you're unsure how to proceed, consult an attorney.

Rights Cannot Be Waived

An injured worker may not waive his or her rights under the Workers' Compensation Act.

Protection from Employer Discrimination

If you believe your employer has discriminated against you because you filed a claim, or expressed an intent to file, you can submit a discrimination complaint by writing to:

L&I Investigations
PO Box 44277
Olympia, WA 98504-4277

You must act within 90 days of the incident.

Requesting Copies of Files

The City or the City's representative maintains a complete copy of your claim file. You can request a copy of the file. You must submit your request in writing. The City or the City's representative has 15 days from the day they receive your written request to provide a copy to you. The first copy will be provided free of charge to you or your representative.

To request new or updated material, you must submit another written request. All new material, not previously provided, also will be provided free of charge. However, the City is entitled to charge a fee for copying any materials already provided.

You may review the information that L&I has in your claim file by using the online Claim & Account Center at www.lni.wa.gov/claims/for-workers/check-the-status-of-my-claim.

Consequences of Knowingly Giving False Information

Any person claiming benefits under the Workers' Compensation Act who knowingly gives false information relating to a claim of $500 or more will be guilty of a Class C felony. When the claim involves less than $500, a person knowingly giving false information will be guilty of a gross misdemeanor.

When Injuries Are Caused By a Third Party

In Washington, you cannot sue your employer or coworkers when a work-related injury or disease occurs. However, you can sue another company or individual if they are responsible. An example might be a company that manufactured a defective product that caused your injury. Such an individual or company is called a third party.

In these cases, you may choose to initiate legal action yourself to recover damages. If so, you may wish to consult an attorney. Or, you may have the City initiate action on your behalf. In either case the City may recover their claims costs from the settlement.

Your injury may increase the City's insurance costs. For this reason, the City may decide to take legal action even if you don't.

Initiating third-party legal action will not jeopardize your right to workers' compensation benefits. You'll receive all the benefits for which you qualify, regardless of the outcome.

If you believe a third party may have been responsible for your injury or occupational disease, contact the Department's City of Seattle Human Resources Representative.

11 Getting Help with Claim Related Problems

City of Seattle

The Workers' Compensation Unit (WCU), housed within the Seattle Department of Human Resources, is responsible for administering claims for potentially work-related injuries and illnesses for City of Seattle employees. The City is self-insured and self-administered. For more information and help with claims, contact Workers' Compensation at (206) 684-7855.

You can also view and download the City's Guide to Workers' Compensation Benefits for information.

State Department of Labor & Industries (L&I)

Your claim is managed by the City of Seattle. If you have a problem with a claim, your first point of contact should be the City, or their administrator. However, if you have been unable to resolve your problem with the City, L&I is responsible for overseeing how claims are managed. If you have a problem with a claim, you can contact L&I by:

- Phone: 360-902-6901
- Fax: 360-902-6900
- Mail: **Department of Labor & Industries**
  Self-Insurance Section
  PO Box 44892
  Olympia WA 98504-4892

Online Customer Service

You can also use L&I's online system to report problems related to time-loss compensation, medical care, or other issues. L&I's customer service website can also be used by health-care providers, attorneys, or individuals authorized to act on your behalf. The customer service site is at www.Lni.wa.gov/SIClaimProblems.

How L&I Works with Employers

L&I staff can often resolve problems by working with an employer. However, in some cases, they may not be able to resolve your problem, or at least not immediately. Telling L&I about problems with claims is still very important. Each customer service issue is tallied and, if there's a pattern, they will take action to improve how the employer manages claims.

If you do not want the City to see your report about your problem, contact the independent Office of the Ombuds instead of using our website. More information on the Office of the Ombuds follows below.

Revealing of Mental Health Conditions and Treatment

Your employer has the right to access your claim file, including mental health information. An employer can only reveal your mental health conditions or treatment to people who are authorized to access the information.

Examples of authorized people your employer can communicate with about your claim are:

- You or your representative.
- The City or their representatives.
- Medical providers treating or examining you.
- Vocational Rehabilitation Counselors.
- Authorized L&I personnel.

Privacy is your right as a patient. L&I understands the need to keep your mental health information confidential, and Washington state law (Chapter 51.28.070 RCW) helps protect the privacy of your claim file.

If the City reveals information about your mental health conditions or treatment to an unauthorized person, without written consent, the City is subject to a civil penalty of $1,000 per occurrence. All complaints regarding this violation must be investigated to determine if the City or their authorized representative violated the law.

Example 1: The City sends an electronic correspondence to three people unauthorized to receive claim information. The correspondence shares your mental health condition from the claim file. Since the information was sent through one electronic correspondence, the City will be charged for one occurrence.

Example 2: One of the unauthorized people in Example 1 forwarded the electronic correspondence to an unauthorized person the next morning. Later that afternoon, that same person sent an additional correspondence to another unauthorized person. Since the unauthorized person sent the mental health information to other unauthorized people on two separate occasions, the City will be charged for two additional occurrences.

Example 3: On three separate occasions an authorized representative verbally shares mental health information from your claim file with three different unauthorized people. Since the information was shared in three separate conversations, the City will be charged for three occurrences.

If you believe your confidential mental health information has been shared with unauthorized people, please let L&I know at www.lni.wa.gov/claims/for-workers/injured-what-you-need-to-know/confidentiality.

L&I Service Locations

Visit www.lni.wa.gov/agency/contact/#office-locations for a list of service locations throughout Washington State.

The Office of Ombuds—an Independent Advocate

The Office of Ombuds operates independently of L&I to advocate for injured workers employed by self-insured businesses. The Governor appoints the Ombuds.

The office is available to answer questions about workers' compensation and explain your rights and responsibilities under the law. The office investigates workers' compensation complaints and works with your claims administrator, and/or L&I, to resolve claim-related issues.

How to File a Complaint with the Ombuds

You may contact the Ombuds' Office in writing or by phone. If you file a complaint by mail or fax, please include your name, contact information, claim number and a brief description of your issues.

Confidentiality

The files and records of the Ombuds' Office are confidential. Your information will not be disclosed without your authorization.

Contact the Ombuds

- **Office of the Ombuds for Injured Workers of Self-Insured Employers**
  950 Broadway Suite 200
  Tacoma WA 98402
- Phone: 1-888-317-0493 (toll-free)
- Fax: 253-596-3885
- For more information, visit http://ombuds.selfinsured.wa.gov

Project HELP

Project HELP provides information to educate and counsel those engaged in workers' compensation claims. The project's goal is to assist in early and successful claims resolution, ensure that all rights are preserved and protected, and reduce unnecessary litigation. Project HELP offers workshops, seminars, and one-on-one counseling. All services are provided free of charge.

The project works in partnership with the Washington State Labor Council, AFL-CIO, and the Washington State Department of Labor & Industries.

Learn more about Project HELP's services at www.projecthelpwa.com. You can also call Project HELP toll free at 1-800-255-9752.

12 When to Seek Advice From a Qualified Attorney

While most member workers' compensation claims are handled without the services of an attorney, from time to time members require the services of an attorney to resolve their claim. You may need an attorney because your claim is unusual and/or complex, or because you're not satisfied with the benefits and/or compensation you've received.

If you choose to engage an attorney, make sure you choose a qualified attorney—one who has proven experience handling workers' compensation claims. It's also important to understand how attorneys get paid in these types of cases.

Attorney Fees

The attorney fees at most legal firms that handle workers' compensation claims are based on a contingent fee agreement. Contingent legal fees mean that you do not have to pay attorney fees up front. It also means that if you don't win your case, you don't pay any attorney fees at all. If you win your case then you pay a percentage of the recovery.

Lawyers offer to handle an L&I claim on a contingent basis when they believe in the case and the client. If and when you get paid, attorney fees are a percentage of the money the attorney recovers for you. If you are offered a contingent fee agreement it will be in writing, read it. No matter how much you trust your new lawyer, be sure to carefully read any fee agreement put in front of you. Ask questions. Know what the deal is.

Limits on Attorney Fees

There are legal limits on attorney fees in L&I cases. Attorney fees either before L&I or at the Board of Industrial Insurance Appeals are limited in three ways: by statute, by reasonableness, and by best practices.

- **Statutory attorney fees** – By statute L&I attorney fees are limited to 30% of the increase in award secured by attorney services.
- **Reasonableness** – Pursuant to the statute and the Washington State Bar Association, attorney fees must be reasonable.
- **Best Practices** – Attorney's informally set additional limits on their own fees based on what they believe is fair. For example, for time loss benefits secured by attorney services, 30% of past due time loss and 15% of ongoing time loss is considered fair by most attorneys. However, 30% of ongoing time loss is probably not fair in most cases. Have a discussion with your attorney. If your current attorney or the attorney you are thinking of hiring charges you too much, say something.

Case Costs

Case costs are different from attorney fees. Case costs are expenses incurred in the handling of your case. For example, an injury case needs medical records. We order your medical records, we review the records, and we use these records as part of your case; we do not charge for that. The doctor however charges for a copy of the records, that charge is a case cost. The client is responsible to eventually pay this case cost.

Some lawyers want clients to pay costs in advance, some want costs paid as the case proceeds, and some will advance costs until the end of the case when money is awarded.

If you hire a lawyer, the fee agreement presented to you will provide the specifics about attorney fees and case costs. Read it with care. Ask questions.

Sharpe Law Firm

We recommend injured members seeking advice from a qualified workers' compensation attorney contact Sharpe Law Firm. Christopher Sharpe has a long history with us and has helped many fellow members with the claims. You can reach Chris at:

Website and contact form: sharpelawfirm.org

Phone: 206-456-2700

Mailing address:
Sharpe Law Firm
2775 Harbor Avenue SW, Suite D
Seattle, WA 98126-2138

The Sharpe Law Firm website is a valuable resource for information on L&I benefits, workers' compensation claims, and finding and working with an attorney. Portions of the content in this section are courtesy of Sharpe Law Firm.

Key Contacts for Fire Fighters and Retirees

City of Seattle, Department of Human Resources

Website: seattle.gov/human-resources
Contact Name: David Blackmon
Email: david.blackmon@seattle.gov
Phone: 206-684-7928

City of Seattle, Workers' Compensation Unit (WCU)

Phone: 206-684-7855

Deferred Compensation Program (DCP)

Website: drs.wa.gov/plan/dcp
Phone: 888-327-5596

Nationwide

Website:
seattledcp.com/rsc-web-preauth/index.html
Contact: Ms. Susan Wilson
Email: wils931@nationwide.com
Office: 206-447-1924
Mobile: 206-399-8367

Office of the Ombuds

Website: ombuds.selfinsured.wa.gov
Phone: 888-317-0493

Project HELP

Website: projecthelpwa.com
Phone: 800-255-9752

Resources for Living

Website: resourcesforliving.com
Login info:
Username: city of seattle
Password: city of seattle
Phone: 888-272-7252

R.L. Evans Company

Website: rlevansco.net
Contact Name: Doug Evans
Email: douge@rlevansco.com
Phone: 425-455-0501 ext 111

Retirement Security Fund (RSF) Ameriflex Retiree HRA

Website:
https://participant.myameriflex.com/#/login/
Phone: 888-868-3539
Email: service@myameriflex.com

For help with RSF eligibility and contributions, contact the HealthCare Trust.

Seattle Fire Department

Website: seattle.gov/fire
Contact Name: Dori Trower
Title: Personnel Specialist, Supervisor
Email: Dori.Towler@seattle.gov
Phone: 206-386-1471

Seattle Fire Fighters Healthcare Trust (SFFHCT)

Website: sffu.simon365.com
Email: sffhct@vimly.com
Phone: 206-859-2693

Key Contacts for Fire Fighters and Retirees *(continued)*

Seattle Fire Fighters Local 27

Email: info@iaff27.org
Phone: 206-285-1271

Sharpe Law Firm

Website: sharpelawfirm.org
Contact Name: Christopher Sharpe
Email: info@sharpelawfirm.org
Phone: 206-456-2700

Standard Insurance Company

Website: standard.com
Phone: 800-368-1135

WA State Department of Labor & Industries

Website: lni.wa.gov

Self-Insurance Section
Phone: 360-902-6901

Vocational Dispute Resolution Office
Website: lni.wa.gov/SIClaimProblems

WA State Department of Retirement Services (DRS)

Website: drs.wa.gov
Email: recep@drs.wa.gov
Phone: 360-664-7000 or
toll-free 1-800-547-6657

Glossary of Healthcare Related Acronyms and Terms

Allowed Amount
Maximum amount on which payment is based for covered healthcare services. This may be called an "eligible expense," "payment allowance", or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

APF
Activity Prescription Form

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-Insurance
Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-Payment
A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible
The amount you owe for healthcare services that your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include equipment and supplies such as oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

EAP
Employee Assistance Program

Emergency Medical Condition
An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EOB
Explanation of Benefits

Excluded Services
Healthcare services that your health insurance or plan doesn't pay for or cover.

FMLA
The Federal Family and Medical Leave Act

Form 407
Form number for the Communicable Disease Exposure Form

Form 78
Form number for the Occupational Injury/Illness Report

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all your healthcare costs in exchange for a premium.

HMO
Healthcare Maintenance Organization

Home Healthcare
Healthcare services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

HRA
Health Reimbursement Arrangement

In-Network Co-Insurance
The percentage (for example, 20%) you pay of the allowed amount for covered healthcare services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-Network Co-payment
A fixed amount (for example, $15) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

LEOFF
Law Enforcement Officers and Firefighters

LTD
Long-Term Disability

Medically Necessary
Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

MERP
The Medical Expense Reimbursement Plan

Network
The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-Insurance
The percentage (for example, 40%) you pay of the allowed amount for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-Payment
A fixed amount (for example, $30) you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

OOP
Out of Pocket

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or healthcare your health insurance or plan doesn't cover. Some health insurance or plans don't count all your co-payments, deductibles, co-insurance payments, out-of-network payments, or other expenses toward this limit.

PCY
Per Calendar Year

Physician Services
Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

PCY
Per Calendar Year

PIR
Physician's Initial Report (PIR)

PPO
Preferred Provider Organization

Preauthorization
A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of healthcare services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Rehabilitation Services
Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

RSF
Retirement Security Fund

SBC
Summary of Benefits and Coverage

SIF-2
Self-Insured Form

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Trust Office
The contract administrator hired by the SFF Board of Trustees to administer day to day operations of the SFF HealthCare Trust

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

VEBA
Voluntary Employees' Beneficiary Association