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In the Matter of Arbitration Between:)
)
ARCELORMITTAL USA)
East Chicago, IN.)
)
and)
)
UNITED STEELWORKERS,)
Local 979.)
)
****

Grievant: Miller
Issue: S & A Benefits
Arbitrator Docket No. 180210

CASE 88

BEFORE ARBITRATOR JEANNE M. VONHOF

INTRODUCTION

The undersigned Arbitrator was appointed according to the rules of the applicable collective bargaining agreement. The hearing was held on March 6, 2018, in Cleveland, OH.

Mr. Christopher Kimbrough, assisted by Mr. Josh Pelettier, Labor Relations Representatives, represented ArcelorMittal USA, Cleveland, hereinafter referred to as the Employer or the Company. Ms. Janet Jordan, Manager, Labor Relations; Mr. Steven Toth, Lead Representative, Employee Benefits; Ms. Deborah Santora, Labor Relations Representative; and Ms. Ashley Caron, Account Coordinator with Reed Group, testified on behalf of the Employer.

Mr. Patrick Gallagher, District 1 Sub-district Director, represented United Steelworkers Local 979, hereinafter referred to as the Union or the Local. Mr. Ricky Miller, Grievant; Mr. Mike Mormile, the Union's Contract Coordinator for Benefits; and Mr. Pete Trinidad, the Union's Contract Coordinator for ArcelorMittal contract negotiations, testified on behalf of the Union.

Each party had a full and fair opportunity to present evidence at the hearing. Both parties made closing arguments at the hearing.

ISSUE:

Did the Company violate the Agreement and the Program of Insurance Benefits by denying the Grievant S & A benefits, and if so, what shall the remedy be?

RELEVANT PORTIONS OF THE INSURANCE AGREEMENT AND THE PROGRAM OF INSURANCE BENEFITS

RELEVANT PORTIONS OF THE PROGRAM OF INSURANCE BENEFITS SUMMARY PLAN DESCRIPTION

INTRODUCTION

This booklet is the Summary Plan Description ("SPD") for employee life and accidental death and dismemberment insurance, sickness and accident benefits, and prescription drug benefits of the ArcelorMittal USA LLC Program of Insurance Benefits (PIB) (the "Plan") for United Steelworker represented wage employees of ArcelorMittal USA LLC that are covered under bargaining units defined in Exhibit A.

The Plan provides employee life insurance and accidental death and dismemberment insurance and sickness and accident coverage for you only and it provides prescription drug services for you and your eligible family members.

...

The eligibility provisions defined in this SPD apply to employees and their eligible dependents for employee life and accidental death and dismemberment insurance, sickness and accident benefits, prescription drug benefits, and medical, dental, mental health and alcohol/substance abuse services and vision benefits provided from the [Steelworkers Health and Welfare] Fund.

...

SECTION 4. – SICKNESS AND ACCIDENT BENEFITS

Eligibility

4.0 If you become totally disabled as a result of an illness, injury, or accident so as to be prevented from performing the duties of your employment and an authorized provider certifies thereto, you will be eligible to receive sickness and accident benefits...

...

Filing a Sickness and Accident Benefit Claim

4.1 You, or someone on your behalf, will be required to file your sickness and accident benefit claim with the Company, or appropriately designated sickness and accident benefits claim administrator, and provide information concerning your medical condition including the name, address, and telephone number of your authorized provider and the expected duration of absence. You will also be required to complete and return an authorization for the release of medical information regarding the disability for which you are claiming sickness and accident benefits.

....
You are encouraged to provide prompt notice of your claim for sickness and accident benefits so that the evaluation of the claim, including any necessary investigation of medical and other factual aspects of it, can be made in an expeditious manner. This provision shall not be used to deny a claim for Sickness and Accidents Benefits.

...
Administration of Benefits

4.9 The payment of sickness and accident benefits is an obligation of the Company, but the Agreement with the Union permits the Company to provide the payment in accordance with the policy with an insurance company. The Company performs important administrative functions in connection with the handling of claims, including the issuance of benefit checks. In the typical case, such handling is routine and a claim is paid within two weeks after it is reviewed by the Company. The Company is authorized to make benefit payments on claims without prior approval of the insurance company when Company personnel engaged in claims work determine the claim meets the standard established by the Company and/or the insurance company. If you have a claim which does not meet these standards, the sickness and accident benefits administrator or the insurance company may take reasonable steps to investigate the medical and other factual aspects of the claim.

SECTION 7. CLAIM PROCEDURES

Claim Procedures

7.0 The following definitions have special meaning when used in this Plan in accordance with claim procedures.

A "Claim" is any request for a Plan benefit or benefits made by you or your authorized representative in accordance with the Plan's procedures for filing benefit claims.
...
1. Initial Benefit Determination

If you file a Claim in accordance with the provisions of the Plan, you will receive an Explanation of Benefits (EOB) from the third-party administrator that will tell you if your Claim has been paid or denied, or if additional information is needed to process your Claim. If additional information is requested, it is your responsibility to provide it, along with a copy of the EOB, to the third-party administrator, so that your Claim can be processed with the additional information. If your Claim is denied, the EOB will tell you the reason for the denial and how you can have the decision reviewed.

Under normal circumstances a decision on your Claim for benefits will be made within 30 days after receipt of your properly filed Claim with the appropriate third-party administrator... These periods may be extended, however, one time by the third-party administrator for up to... 15 days... provided that the administrator determines that such an extension is necessary due to

matters beyond their control and notifies you, prior to the expiration of the initial notification periods, of the circumstances requiring the extension of time and the date by which the administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least… 45 days … from receipt of the notice within which to provide the specified information.

…

If your Claim for benefits is wholly or partially denied, the appropriate third-party administrator will notify you in writing. This written notice will tell you the reason for the denial, the provisions of the Plan on which the denial is based, and what additional information is needed, if any, that could change the decision.

2. Claim Review Process

If you receive a written notice denying your Claim for benefits, in whole or in-part, and you do not agree with such determination, you can have your Claim reviewed. If you want your Claim reviewed, you, or your authorized representative, must file a written request for review with the appropriate party within 180 days after you receive the written notice of denial of your Claim for benefits.

…

Under normal circumstances, you will be notified of a decision on your request for review within 30 days after receipt.

…

3. Appeal Process

If you want to appeal (in whole or in part) the decision made on your request for review, you, or your authorized representative, must file a written appeal with the Plan Administrator within 180 days after you received the written notice of denial of your request for review of your Claim.

….

The Plan Administrator will make the appealed determination.

…

Under normal circumstances, the Plan Administrator will render a decision on your appeal within 30 days after receipt of your appeal.

…

SECTION 8. OTHER INFORMATION

8.0 This Summary Plan Description ("SPD") is the official Plan document that has been established pursuant to the Insurance Agreement dated September 1, 2015, and subsequent amendments as agreed to between ArcelorMittal USA LLC ("the Company") and the United Steelworkers ("the Union") … If there is a conflict between this document and any other description of the Plan, the text of this Plan and/or Agreement controls. The Company intends that the terms of the Plan, including those relating to coverage and benefits, be legally enforceable. The Plan is maintained for the exclusive benefit of the bargaining unit employees of the Company.

ERISA Information (Employee Retirement Income Security Act of 1974, as Amended)

...
The Plan Administrator for employee life and accidental death and dismemberment insurance, medical, sickness and accident, dental, vision, and prescription drug benefits is the ArcelorMittal USA LLC Manager, Employee Benefits. The day-to-day operation of the Plan is handled by the claims administrators.

The Plan Administrator has the responsibility to the Plan to make and enforce any necessary rules for the Plan, and to interpret the Plan provisions uniformly for all employees. If it is necessary for you to communicate with the Plan Administrator or appeal a claim, you should submit your written comments or requests to the Plan Administrator, in care of ArcelorMittal USA LLC at the following address:

Manager, Employee Benefits
3210 Watling Street
East Chicago, Indian 46312
...

SECTION 9. INSURANCE GRIEVANCES

9.0 If a difference relating to the Plan arises between you and the Company and such difference is not resolved by discussion with a representative of the Company at the location where it arises, the difference may be processed as an insurance grievance directly into Step 3 of the provisions of the Basic Labor Agreement applicable to the adjustment of grievances.
...

9.1 Insurance grievances will be scheduled for arbitration at the earliest practical date and not later than 45 days from the date the grievance was filed. Costs of arbitration to be divided equally between the Company and the Union.

EXHIBIT A

Following are the groups of employees, and their locations, in bargaining units to which the Insurance Agreement is applicable.

...
Cleveland, Ohio

BACKGROUND

The Company offers a variety of benefits under its Insurance Agreement with the Union, including a Sickness and Accident (S & A) disability benefit. An employee is entitled to S & A benefits if the employee becomes "totally disabled as a result of an illness, injury, or accident so as to be prevented from performing the duties of [the employee's] employment." The Plan requires that an authorized provider certifies the disability. The Company's Manager of Employee Benefits is the Plan Administrator, and the Company utilizes Reed Group to perform some of the administrative functions of the Plan. The parties negotiate the terms of the Program of Insurance Benefits (PIB), as described in its Summary Plan Description (SPD), the most recent of which became effective January 1, 2017.[1]

The Grievant submitted a claim via telephone to the Reed Group for S & A disability benefits on December 5, 2017, requesting benefits for an injury period beginning December 1, 2017, and lasting until January 13, 2018. The Grievant provided information regarding his medical provider and Reed Group faxed an Attending Provider Statement to the Grievant's doctor on or about December 6, 2017. According to the record of the Third Step grievance meeting, a Nurse Case Manager called the Grievant on December 8, 12, and 21 of 2017. The Nurse did not speak to the Grievant, but left messages advising him that the Attending Provider Statement was due back to Reed Group by January 4, 2018.

On December 26, 2017, the Grievant called Reed Group to check on the status of his paperwork and was advised that no form had been received from his doctor by that point in time. He requested that another Attending Provider Statement be faxed to his doctor. According to the grievance meeting minutes, the request was faxed to the doctor the same day.

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[1] Witnesses used the terms PIB, the Plan, the Program and SPD interchangeably in their testimony and their use of terms is reflected in this Award.

On January 4, 2018, the Grievant called Reed Group to check on the status of his claim again, and, according to the Third Step minutes, "was advised that his medical provider was faxing the paperwork on 1/4/18." On January 5, 2018, Reed sent a letter to the Grievant stating that his S & A claim had been "denied." The reason given for the denial was "Administrative" and later, the form states, "Proof of Claim for your time off work from 12-01-17 through Return to Work has not been received." Under "Medical documents reviewed," the form states, "No medical documentation was received." The letter states that in order to "perfect your claim for benefits… And to demonstrate that the requested disability benefits are payable, you would have [to] request an appeal in writing within a (sic) 180 days from this letter and furnish us with information that has not already been submitted…" The letter goes on to describe certain kinds of medical records as examples that would be used to support a claim of disability. The letter also lists an appeal address for Reed Group.

The evidence demonstrates that the Grievant's doctor faxed medical documentation to Reed Group on January 9, 2018. The Union filed this grievance on January 12, 2018. The grievance states that the Company, acting through their agent Reed Group, had denied payment to the Grievant because Reed Group decided that the Grievant's doctor's information was untimely and they closed his claim. The grievance states, "the language specifically states that it shall not be used to deny benefits." It became clear at arbitration that this statement in the grievance was a reference to language contained in Section 4.1 of the SPD. The remedy requested is for the Company to cease and desist the practice of closing claims and denying benefits to the Grievant and all Employees and to pay the benefit to the Grievant as soon as possible along with all "trailing benefits."

The Company denied the grievance, arguing that although the initial filing notice requirement of 21 days was removed in the current PIB, this did not remove the employee's responsibility to submit paperwork to verify that he or she is totally disabled and eligible for the benefit. In its grievance response the Company stated that the PIB requires the Company to respond to a claim with an initial determination of benefits within 30 days of the filing of the claim. The Company stated that the Grievant failed to provide supporting documentation for his disability claim within that time period, despite reminders to do so, and failed to pursue his appeal rights with Reed Group.

Mr. Steven Toth testified that he has been the Company's Lead Representative, Employee Benefits for the past ten years, and has worked in Benefits since 1987. He testified that S & A program is covered under ERISA (Employment Retirement Income Security Act) as an employee benefit plan and must comply with all ERISA requirements. At arbitration he presented regulations under ERISA which require a plan administrator to notify an employee within 45 days of the filing of a claim if their claim has been denied. He testified that he participated in drafting the current PIB and noted that the parties here have negotiated a shorter 30-day period for claims decisions, under Section 7.

Toth testified that under the former PIB there was a 21-day filing deadline under Section 4, which was eliminated in the current PIB. He said that there is a difference between Section 4, which governs the initial filing of a claim, however, and Section 7, which sets forth the procedures for evaluating a claim. He testified that if a claim cannot be determined within 30 days, it is closed, and the claimant must file an appeal to the third-party administrator. He testified that other claimants have had their claims closed when there was not adequate medical information provided within 30 days, and that some of these claimants have appealed these

decisions. He stated further that the Union has not objected to this procedure before this grievance.

Under questioning from the Union, Toth said he believed that the Company has granted S & A benefits to employees in situations where they did not submit full medical documentation within 30 days. He also acknowledged that the PIB specifically permits grievances over the application of the PIB, and that under the PIB, the Reed Group appeals process is not the only mechanism for an employee to dispute a decision on a claim. He acknowledged further that the Program is self-funded by the Company, and that the Company can make a decision to pay a claim, in some situations, without the prior approval of the third-party administrator.

The Union presented emails between Toth and the Union in 2014 in which the Union took issue with form letters provided by Reed Group. These letters included a space for a date to be included by which an employee is required to provide medical documentation. Toth assured the Union at that time that the letters and forms could be configured to their specific plan's provisions. With regard to spaces left to include specific dates for documentation to be returned, he said, "Since our plan does not have this language it would not be included in the letter."

In response to the Arbitrator's question, Toth testified that the Plan Administrator for the S & A Plan is the Company's Division Manager for Employee Benefits, Mary Richardson. He pointed to language in the Insurance Agreement stating that the Plan shall be administered by the Company "or through arrangements provided by it." He testified that claims processing has been delegated to Reed Group.

Ms. Ashley Caron is an Account Coordinator with Reed Group. She handles escalated issues involving Arcelor benefits and investigates whether claims have been handled properly. She examined this case and determined that the proper procedures were followed. Reed Group

follows the provision of the PIB which requires that an initial determination be made within 30 days. This deadline means that the claimant must produce adequate documentation to substantiate the claim within that 30-day period, according to Caron. Because the Grievant failed to provide substantiation of his claim within 30 days, it was denied. From a practical point of view, she stated, employees could not be permitted an unlimited amount of time to provide information on a claim, because such a procedure would be unmanageable and would likely violate the ERISA deadline.

Caron acknowledged that Reed Group received the Grievant's documentation on January 9, 2018. She also acknowledged that there was a request for an extension of time in this case, but said that once Reed Group denies a claim, no extension is possible for S & A benefits. She also testified that Reed Group cannot reopen a claim if they receive late medical documentation, unless there is an appeal or direction from Arcelor to do so. She confirmed that Arcelor may direct Reed Group to pay benefits for an employee.

Ms. Deborah Santora testified that she has worked as a Labor Relations Representative since March of 2010 and has worked for the Company since 1974. Santora testified that she saw that the Grievant's S & A benefit claim had been denied. She said that she talked with the Grievant to make sure that he knew he had to file an appeal within 180 days. Santora testified that he told her that the Union told him not to file an appeal with Reed Group. She acknowledged that there is a provision of the PIB which provides for the filing of grievances over insurance Plan disputes.

Mr. Mike Mormile testified that he has worked for the Company or its predecessors since 1970. He serves as the Union's Contract Coordinator assigned to Benefits, and has been involved in all negotiations, especially over benefits, since 2002. He stated that nothing in the negotiated

PIB allows the third-party administrator to deny a claim for S & A benefits as an administrative denial. He testified further that there have never been time limits in the PIB for closing a claim, and that the parties never agreed to a 30-day time limit for submitting medical documentation. Mormile noted that the employee has no control over when his doctor sends in medical documentation to the Company or its third-party administrator, and testified that this is why the Union has not agreed to time limits for submitting documentation. He pointed to Section 4.1 of the PIB and testified that the intent behind it was to encourage prompt submission of medical documentation so that the employee can get paid quickly. He testified that the intent was not to deny benefits if submission of the medical documentation took longer than normal.

Mormile testified further that as a member of the Joint Benefits Committee, he normally reviews all letters that are to be sent to employees by the Reed Group, and that he never reviewed a letter about an internal appeals process at Reed Group. He testified that under Section 7 of the PIB, appeals are supposed to be submitted to Ms. Mary Richardson, the Company's Benefits Manager, and therefore the Reed Group appeals process is not proper. He testified that he would have stepped in to stop the process if he had been aware of it. Mormile testified that prior to 2017 he was not aware of claims being denied because medical documentation was not submitted within 30 days. He testified further that the Company has granted benefits without medical documentation being submitted within 30 days. He said that the Company has not approached the Joint Benefits Committee to ask for a modification of the PIB regarding the submission of medical documentation. He said that it is only the employee claimant, not the Company, who is harmed if the medical documentation is delayed.

Mr. Peter Trinidad, the Union's Contract Coordinator for ArcelorMittal negotiations, testified that he has been involved in negotiations since 2003. He also sits as a Member of the

Joint Benefits Committee. He testified that during negotiations there has never been an agreement between the parties that there would be a 30-day limit on providing medical information. He agreed that medical documentation is necessary to process a claim, and said that Reed Group can recommend to the Company that a claim be denied for lack of such documentation. He stated, however, that Reed Group does not have the authority to administratively deny a claim. On rebuttal, Mr. Toth testified that the Union never requested an override on the Grievant's claim.

Ms. Janet Jordan testified that she has served as the Manager of Labor Relations since 2002. She said that she was familiar with the two cases raised by the Union in which the Company had overridden denials of claims by the third-party administrator and paid the benefits. She said that if there are extenuating circumstances, the Company will request that the benefit be paid so that the employee is not waiting too long for the benefit. She testified that the situation involving the Grievant in this case was not an example of extenuating circumstances.

THE COMPANY'S POSITION

- At issue in this dispute is the Company's right to a reasonable procedure for administering S & A benefits.
- When the Company is notified of a claim, it takes every reasonable step to ensure that the claim is evaluated and the mandates of the PIB and ERISA are followed.
- The Company's broad authority and duty to administer S & A benefits is outlined in both the Insurance Agreement and the PIB. The PIB has been agreed to by both parties and is incorporated into the Insurance Agreement.
- The parties spent about 15 months negotiating the current PIB and both parties agreed to eliminate the 21-day period for filing the initial claim for S&A benefits. Section 4.1 of the PIB deals specifically with the deadline for the initial notice of a claim, and that provision is not in dispute between the parties.

- The notification requirements of a claim are separate requirements from the claim determination process. The Company's determination of a claim is governed by Section 7 of the PIB. The parties did not make any changes to this portion of the PIB in 2015 and no changes to these procedures have been made in the last 15 years.

- Before this case, the Union has never raised an objection to the claims procedure or the appeal process, since the claims procedure went into effect. This Union agreed to follow the claims procedure set forth in Section 7 of the PIB, and until now had been using the appeals procedure when a claim was denied for failure to provide medical information.

- ERISA requires that the Company must establish and maintain reasonable claims procedures. These procedures are applied uniformly to every plan participant, in compliance with federal law.

- Under ERISA, once a claim has been received, the administrator is given a maximum of 45 days in which to render a decision.

- The parties have agreed to a shorter time period in their PIB, and the Company must make a determination within 30 days, under Section 4.1.

- Reed Group used reasonable diligence in order to collect the medical information it needed from the Grievant. When he failed to provide the information by 30 days after receipt of his initial claim, Reed Group denied the claim in writing and informed the Grievant of his right to appeal, in accordance with the PIB and federal law.

- The Union's argument that the parties agreed to eliminate time limits for submitting medical information is unfounded. There are no provisions within Section 4.1 which establish how a claim should be determined, and the discretion to administer the program is left to the Company, subject to ERISA law.

- The Union's reliance on Section 4.1 is misplaced and its arguments that the elimination of the 21-day period has, in effect, removed all time limits associated with S & A claims is mistaken. If the parties had intended to eliminate all time limits, they would have done so with clear language.

- The parties could not have agreed to a longer time period for submission of medical documentation, because it would violate ERISA law.

- The employee has the responsibility to file an appeal in writing to Reed Group. The Grievant has refused to file an appeal with Reed Group and claimed that he was advised not to do so because of the filing of the grievance. Reed Group cannot take future action on his claim until he appeals.

- In support of its position, the Union has claimed that claims have been granted outside of the 30-day period for determination. The Company presented testimony that claims

deadlines are only overridden under extraordinary circumstances. The Grievant's claim presented normal circumstances and the Union never presented a case for exceptional circumstances.

- The Union is requesting that the Grievant be treated differently than other similarly-situated plan participants. Reed Group continues to honor the Grievant's appeal rights, but he has refused to file an appeal.

- The Company has a right to administer its plan with reasonable requirements, including the right to request medical information from a claimant. This right has been upheld in arbitration.

- In the Grievant's case, after 30 days Reed Group did not have sufficient information to substantiate his claim that he was totally disabled, and his claim was properly denied.

- The Union has failed to meet its burden of proof that the Company violated the collective bargaining agreement or the PIB. Therefore, the Company respectfully requests that this grievance be denied.

<u>THE UNION'S POSITION</u>

- The arbitration decisions cited by the Company in its closing argument are not relevant. They are quite old and were decided under different PIB's and different Employers.

- The Company has the right to administer the PIB, but they are obligated to administer it in conjunction with the agreements which have been made between the parties in the PIB.

- The question here is whether the third-party administrator can establish time limits for submission of medical documentation for S & A benefits filed under the PIB.

- The parties never negotiated these time limits. The PIB does not contain any time limits for presenting medical documentation.

- The Grievant submitted all of the documentation necessary to be granted the benefits. The Company has admitted that they had the Grievant's medical documentation. The PIB does not provide for denial of a claim by the third-party administrator.

- Section 7 of the PIB does not contain a drop-dead thirty-day limit for submission of medical documentation. The first words of the Section state, "under normal circumstances."

- The Company through its third-party administrator is trying to introduce terms into the program that were never agreed to by the parties.

- The Reed Group appeals procedure is not the exclusive avenue for the appealing a denial of a claim.

- Both Union and Company witnesses agreed that there are other avenues to challenge a denial besides the third-party appeals process. The grievance procedure is available for a denied claimant to file a grievance, through Section 9 of the PIB.

- The Company claims that they must be able to administer the program reasonably. However, an employee claimant cannot control when his doctor responds to a request for information. It is not reasonable to hold him responsible, especially when the information goes directly from his doctor to the Company.

- The Reed Group sent several similar letters to the Grievant here, requesting the same medical documentation which they had already received.

- The Company has the authority to direct Reed Group to grant claims. The Company has admitted that the Grievant's medical documentation was received, and was adequate, but that they refused to direct Reed Group to grant his claim. It would have been reasonable for them to do that.

- The testimony at arbitration does not establish that there was an agreement between the parties for a 30-day drop-dead deadline for submission of medical documentation by a claimant. The Company is trying to achieve something in this case through arbitration which they did not achieve in contract negotiations.

- The Union requests that the grievance be sustained and the Grievant be paid his S & A benefits and any trailing benefits to which he is entitled.

FINDINGS AND DECISION

This is a case involving the operation of the Company's Sickness and Accident benefits program. In order to claim S & A benefits an employee must substantiate, through medical documentation, that he or she has suffered an illness or injury that has disabled the employee from working during the benefit period. The program is operated under the terms of the Program of Insurance Benefits, which has been negotiated between the Union and the Company, pursuant to the Insurance Agreement. The Summary Plan Description is the official document provided to employees describing the benefits that have been established under the PIB. The Company's

S & A program is self-funded, and the Plan Administrator is the Company's Manager of Employee Benefits. A third-party administrator, the Reed Group, evaluates claimants' medical documentation, and performs other claims administration functions on behalf of the Company.

As described above, the Grievant applied for S & A benefits through the Reed Group. When medical documentation substantiating his claim was not received from his doctor within 30 days, Reed Group notified the Grievant that his claim had been denied for "administrative" reasons, and that he could appeal this denial to Reed Group. The Union filed a grievance over the denial of the Grievant's claim—and the requirement that he file an appeal with Reed Group.

The issue here is whether the action taken by the third-party administrator on behalf of the Company meets the terms of the parties' agreements. As a threshold matter, the parties have agreed that the Program of Insurance Benefits "shall be administered by the Company or through arrangements provided by it." As Impartial Umpire Ralph T. Seward stated in *Bethlehem Steel Corp. Decision 2929*,

> "In the Insurance Agreement, Section 7 [the parties] have granted to the Company the right to administer the PIB. (Indeed, they have given it the duty and obligation to do so)."

He concluded in that case that the Company's institution of a reenrollment program to verify dependent status for dependents claimed by employees was a proper exercise of the Company's administrative authority. Similarly, in *Bethlehem Steel Corp. Decision 3670* this Arbitrator concluded that,

> "The parties have agreed... that the Company has both the right and the obligation to administer the Sickness and Accident Program...The Company's duty to administer the Sickness and Accident program is stated in broad general terms, in both the Insurance Agreement and the PIB booklet...In the exercise of this discretion the Company may employ reasonable procedures to administer the

> program, as long as the measures do not violate the terms of the parties' agreements."

In that Decision I found that the institution of a program of requesting additional substantiating information from employees after benefits had begun to be paid did not, on its face, violate the parties' agreements.

Similar, if not identical language appears in the controlling agreements in this case, demonstrating a similar intent by the parties to give the Company the authority to administer the Program. However, both Bethlehem Decisions 2929 and 3670 make clear that a procedure instituted by the Company to administer a benefit may be reasonable and comply with the parties' agreements generally, and yet a particular application of the procedure may conflict with the agreements. Chairman Seward noted that problems inevitably may arise when the general requirements of the PIB are administered through specific procedures and forms. When such problems arise, Chairman Seward stated that they can be resolved "when it is realized that it is always the language of the agreement between the parties which governs."

The Union argues here that the denial of the Grievant's claim for failure to meet a 30-day requirement for submitting documentation – and the requirement than any appeal of the denial must be made to the Reed Group -- violates the parties' agreements. The Summary Plan Description does not contain a 30-day limit – or any time limit -- for employees to file medical documentation in support of an S & A claim. The Company relies upon language in Section 7, stating that, "Under normal circumstances a decision on your Claim for benefits will be made within 30 days after receipt of your properly filed Claim with the appropriate third-party administrator." The Company contends that this language means that the Plan must make a decision on a claim for benefits within 30 days of its filing, and therefore, the employee must provide medical documentation substantiating the claim within that 30-day period as well.

The grievance cites language from Section 4.1, particularly the last sentence of that section. During the most recent negotiations over the PIB, the parties agreed to eliminate from Section 4.1 a 21-day time limit for filing a claim. Instead, the Parties have substituted the current language, which states,

> You are encouraged to provide prompt notice of your claim for sickness and accident benefits so that the evaluation of the claim, including any necessary investigation of medical and other factual aspects of it, can be made in an expeditious manner. This provision shall not be used to deny a claim for Sickness and Accidents Benefits.

The parties disagree about whether the language of Section 4.1 is relevant to this grievance. It is not entirely clear from the language whether the last sentence stating that "this provision shall not be used to deny a claim for Sickness and Accident Benefits" relates only to the claimant providing "prompt notice" of a claim or also to the "necessary investigation" of medical and other facts referenced in the previous sentence. However, the Section is entitled, "Filing a Sickness and Accident Benefit Claim" and thus the primary purpose of the paragraph is to establish reasonable parameters for filing a claim. The "necessary investigation" of medical and other facts (to substantiate a claim) is mentioned as the reason for the claimant to file promptly: so that the overall processing of the claim, and the final decision on the payment of benefits can be made expeditiously. A delay in filing the claim initially means that the employee will be without disability benefits for that period of time, followed by the standard time needed to evaluate the claim.

The language of Section 4.1 does not directly address delays in receiving medical documentation once the processing of a claim has begun. The Union introduced convincing testimony that the reason for changing Section 4.1, and eliminating the 21-day filing period, was to prevent the denial of claims which had occurred in the past because of employees not meeting

this filing deadline. Considered in light of this testimony, the language of the last sentence of Section 4.1 ensures that such denials of claims will not continue to occur under the more open-ended parameters for filing claims "promptly" in the revised language.

However, even if Section 4.1 does not directly address the issue here, the elimination of the 21-day filing period coupled with the last sentence of Section 4.1 clarifies that the intent of the parties is that deadlines applied to claimants' actions, even if they are intended to "move the process along," should not be used to deprive employees of benefits. The Grievant is entitled to benefits if he establishes that he is disabled for the period in question, and the Company is required to pay those benefits. Section 8.0 of the Summary Plan Description states that, "[T]he Plan is maintained for the exclusive benefit of the bargaining unit employees at the Company."

It is reasonable to notify employees that if the Plan is to render a decision on a claim within 30 days, documentation must be received within that time period. These are the "normal circumstances" referred to in Section 7. The question in this grievance is whether appropriate action was taken when the documentation was not received within 30 days, and Reed Group notified the employee that his claim had been immediately denied and that he would have to appeal it through Reed Group. The Company does not argue with the fact that the Grievant's doctor substantiated that he is eligible for benefits, several days after the 30-day time limit. The Company argues that all the Grievant needs to do to obtain his benefits is to file the appeal with Reed Group. The Union argues that this process has not been agreed to by the parties as the exclusive method for obtaining benefits for an employee in the Grievant's situation. The Arbitrator concurs, for the following reasons.

First, the SPD states at Section 9.0 that an employee may file a grievance under the Basic Labor Agreement over "a difference" between the employee and the Company arising under the

PIB. This dispute is clearly a difference arising between the Grievant and the Company over the terms of the Plan. Several Company Witnesses acknowledged that Section 9.0 provides another means for an employee to appeal a denial of benefits or to process other insurance disputes, besides a third-party administrator's appeals process. It may be faster for an employee to file a grievance and use the discussions in the grievance procedure to resolve a claim where the medical documentation is a few days late, as in this case, rather than wait for the third-party administrator's more bureaucratic appeals process to conclude.

Secondly, it is clear from the testimony of Company and Union Witnesses at arbitration that the Company may provide benefits under this self-funded Plan, even if the third-party administrator advises that the claim should be denied. There is convincing evidence in the record that the Company has paid S & A benefits in the past for employees who did not meet requirements of the third-party administrator, in order to expedite payment of their benefits. Company Witness Jordan testified that this is only done in "extraordinary" circumstances, but she did not explain what the Company considers "extraordinary" or why the Grievant's case does not fall within this category. Once an employee's claim does not fit into the "normal circumstances" of providing documentation and obtaining a decision on the claim within 30 days, it is not clear why the claim would not fit into the "extraordinary circumstances" category and still be considered for quick payment, if substantiated.[2]

Thirdly, it is not clear how the appeals process established by the third-party administrator comports with the appeals process agreed to by the parties in Section 7. It is not clear that the parties intended for the appeals process in Section 7 to be delegated to the third-

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[2] This evidence undercuts any argument that there has been a consistent past practice of requiring all claimants to go through the appeals process of the third-party administrator before receiving benefits, or that the Union acquiesced in such a past practice.

party administrator, since the SPD states that written appeals are to be made to the Plan Administrator, who is identified in the SPD as the Company's Manager of Employee Benefits. The section also states that the "The Plan Administrator will make the appeal determination."[3] If the "administrative denial" and appeal to the third-party administrator are considered as a separate intermediate procedure before the denial and appeal referred to Section 7, the procedure – and the delay it encompasses – are at odds with the appeal process agreed to by the parties in Section 7. For all of these reasons, the Arbitrator concludes that the parties did not intend the third-party administrator's appeal process to be the sole and exclusive method for the Grievant to appeal the administrative denial of his claim.

The Employer argues that claims should not be granted without substantiating documentation and that employees should not be permitted an unlimited amount of time to present such documentation after filing a claim. The Arbitrator does not understand the Union to be advocating either position. The Union is not requesting that the Grievant be provided benefits without substantiation, or that he should have been permitted an unlimited amount of time in which to present such documentation. The Union is requesting only that documentation received a few days late should not result in a denial of a claim and a mandatory requirement to participate in the third-party administrator's appeals process.

This is not a case where the Grievant had the information and refused to provide it to the third-party administrator or the Company. Here the Grievant provided Reed Group with information about his doctor immediately after filing the claim. Although he did not respond to

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[3] It is not clear that the "administrative denial" issued by the third-party administrator constitutes a final denial of benefits as contemplated by the Program, that would trigger the appeals procedure of Section 7. However, in any case the grievance here constitutes a legitimate method of appeal, and the filing of the grievance meets the 180-day time limit for appeal.

several calls from Reed Group, he did check with them 21 days later to determine if they had received the information. When he discovered that they had not received it, he requested that the Company send the request for information to his doctor again. He checked in again on the 30th day and was told that his doctor was providing the information that day. His doctor provided the information a few days later. He was waiting for his doctor to send the information directly to Reed Group, which is the normal method of providing this information. There was no basis for the third-party administrator or the Company to conclude that the Grievant had filed a claim and then abandoned it, or that he had obstinately refused to provide any substantiation for the claim. Only the Grievant is harmed by a delay in providing substantiating information and has a natural incentive to see that the information is submitted promptly in order to have his or her claim decided as quickly as possible.

In evaluating the procedures established by the Company or the third-party administrator, it is important to consider the overall intent of the Program: to provide benefits for employees who are entitled to them, and to do so as quickly as possible. Providing S & A benefits in a timely fashion is particularly important to employees who are not receiving a regular paycheck during the disability period. The primary purpose of the 30-day requirement is to ensure that the Program does not unnecessarily delay the decision to issue benefits, once the substantiating documentation has been received. The 30-day language is intended as a shield for employees to protect them against delay by the Company in issuing benefits which they are due, and it should not be used as a sword to deny or delay legitimate claims.

The Company also relies upon language in the ERISA regulations, which requires an employer to notify a claimant of an adverse decision on a claim within 45 days. The documentation for the Grievant's claim was received in sufficient time to render a decision that

would have met the 45-day ERISA standard. Thus, the ERISA regulations are not immediately relevant to this case. However, the ERISA deadline also operates primarily as a shield to prevent unnecessary delays in providing benefits, and not as a sword to cut them off. ERISA provides reasonable extensions of time for an employer to render a decision on a claim when there is a good reason for not issuing it within 45 days. The regulations specifically mention not receiving full documentation substantiating the claim as a legitimate reason for such an extension. They permit the employee an additional 45 days, if necessary, to present such documentation, so that the employee does not lose out on a legitimate claim for benefits, due to the 45-day language. The PIB here contains similar time extension language, which is clearly based upon the ERISA language.

The Company is authorized to develop reasonable procedures for processing claims, and to delegate functions of claims processing to a third party. However, the Company must do so in a way which does not violate the parties' agreements. The parties have agreed to a provision which sets 30 days as a standard for rendering a decision on a claim "under normal circumstances." The SPD does not contain language that mandates a decision on every claim within 30 days. Most importantly the SPD does not contain language requiring that all medical information be provided within 30 days, and does not require a denial of a claim and a mandatory appeal through the third-party administrator for every claim for which medical substantiation is not submitted within 30 days. The parties have established a Joint Committee on Benefits which may help resolve claims such as the Grievant's, which fall outside the "normal circumstances" of a 30-day decision.

The Company's administration of the Program as applied to the Grievant's claim violated the terms of the parties' agreements. The Company has not disputed that the

documentation the Grievant provided was sufficient to substantiate a claim. Therefore, the evidence establishes that he is entitled to the S & A benefits. The grievance is sustained and the S & A benefits for the initial claim are to be granted, as well as any attendant benefits.

AWARD

The grievance is sustained. The Grievant's claim for S & A benefits filed on December 5, 2017 is granted. Any attendant benefits, including later claims that may have denied because of the denial on the initial claim, are also granted, as long as they reasonably comply with the Program's requirements. The Arbitrator will retain jurisdiction solely over the remedy portion of this Award.

Jeanne M. Vonhof
Labor Arbitrator

Decided this 15th day of June 2018.