IN THE MATTER OF THE ARBITRATION)
)
Between)
)
ARCELORMITTAL USA)
BURNS HARBOR)
)
and)
)
UNITED STEELWORKERS,)
LOCAL 6787)

OPINION AND AWARD

RONALD F. TALARICO, ESQ.
ARBITRATOR

GR. No.: 18PW-0010

ArcelorMittal Case 91

GRIEVANT

Linda Spencer

ISSUE

Denial of Sick and Accident Benefits

HEARING

March 21, 2019
Chesterton, IN

APPEARANCES

For the Employer
Joshua Pelletier
Sr. Representative, Labor Relations

For the Union
Jim Flores
United Steelworkers
Staff Representative, District 7

ADMINISTRATIVE

The undersigned Arbitrator, Ronald F. Talarico, Esq., was mutually selected by the parties to hear and determine the issues herein. An evidentiary hearing was held on March 21, 2019 in Chesterton, Indiana at which time the parties were afforded a full and complete opportunity to introduce any evidence they deemed appropriate in support of their respective positions and in rebuttal to the position of the other, to examine and cross examine witnesses and to make such arguments that they so desired. The record was closed at the conclusion of the hearing. No jurisdictional issues were raised.

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.

Medical, mental health and alcohol and substance abuse services, dental, and vision benefits for you and your eligible family members are provided from the Steelworkers Health and Welfare Fund (the "Fund"). Please refer to the separate SPD provided by the Fund for a description of the terms and conditions of these benefits.

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 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. . . .

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 a 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 standards 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

. . .

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. This review provision will allow you to request from the Plan a review of any Claim for benefits. Such request must include the employee/retiree name and social security number, and name of the patient. The request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim. Submit written comments, documents, records, and other information relating to the Claim. This appeal provision will also allow you to request, free of charge, reasonable access to documents, records, and other information relevant to your Claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice of statement was relied upon in making the benefit determination.

. . .

The Plan Administrator will make the appeal determination. The appeal determination will not defer to the initial Claim determination or the determination on review and will take into account all comments,

documents, records and other information submitted by you without regard to whether such information was previously submitted or relied upon in the initial determination or the request for review. In upholding any denied request for review that is appealed, which denial is based in whole or in part on a medical judgment, an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied request for review that is the subject of the appeal nor the subordinate of any such individual shall be consulted.

Under normal circumstances, the Plan Administrator will render a decision on your appeal within 30 days after receipt of your appeal. However, if your request for appeal is for a Claim involving Urgent Care, the Plan Administrator will render a decision on your request for appeal within 72 hours after receipt of your appeal.

. . .

SECTION 8.
OTHER INFORMATION

Official Plan Documents

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"). It is provided for informational purposes only and is not a contract of employment between the Company and you. 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.

8.1 . . .

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.

* * * * *

INSURANCE AGREEMENT

Agreement
Between
ArcelorMittal USA LLC
and the
United Steelworkers

Effective September 1, 2015

. . .

7. Administration of the Program

(a) The Program (and the Prior Programs) shall be administered by the Company or through arrangements provided by it. Except as may otherwise be provided in the Agreement, the Company will arrange to have benefits (Medical, Prescription Drug, Dental, Vision, Life Insurance, and Sickness and Accident benefits) provided through contracts with carriers and/or administrators mutually agreed to by the Company and the Union. Any contracts entered into by the Company with respect to the benefits of the Program (and the Prior Programs) shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklets. Any elective change in carriers/vendors by the Company or the USW Health and Welfare Fund will be discussed in advance by both parties.

BACKGROUND

The Employer is ArcelorMittal USA with Plant facilities located in Burns Harbor, Indiana. The Union, United Steelworkers, Local 6787, is the exclusive collective bargaining representative for all production and maintenance employees at the Plant. The Employer and Union have been parties to a series of collective bargaining agreements throughout the years the most recent of which is effective September 1, 2015. The Grievant is Linda Spencer who at all times pertinent to the within matter held the position of Grinder Helper in the #2 Roll Shop with 42 years of service.

On or about May 23, 2018 a request was made by Grievant to the Reed Group, the Company's third party claims administrator, for Sickness and Accident benefits beginning May 28, 2018 and ending June 26, 2018. On June 6, 2018 Dr. Vineet Shah completed an Attending Physician Statement for Grievant indicating she received left knee arthroscopy with a partial medial meniscectomy procedure on May 29, 2018 and was discharged that same day. Dr. Shah further indicated that her next scheduled visit was on June 20, 2018 and that Grievant's course of treatment would be physical therapy three times per week for four weeks. The Attending Physician Statement also indicated the specific medications that were prescribed. On June 8, 2018, the Reed Group approved Grievant's claim for Sickness and Accident benefits for the period May 28, 2018 through June 26, 2018.

On June 20, 2018, Grievant kept her scheduled follow-up appointment. Dr. Shah's office notes for that visit detailed his subjective findings, objective findings, impression of the patient and plan for the patient. Those notes indicated, inter alia, that "the patient is doing well, and the pain is well tolerated. . . . Patient has a good range of motion of the knee."

On or about June 21, 2018, the Reed Group received a request from Grievant to extend her Sickness and Accident benefits from June 27, 2018 through July 8, 2018. A letter from the Reed Group was sent to Dr. Shah on June 21, 2018, requesting that he complete a second Attending Physician Statement.

On June 26, 2018, a second Attending Physician Statement was submitted by Dr. Shah for the requested claim extension indicating a return to work date of July 9, 2018. The form asked, "Has the patient been or will the patient be totally unable to work?" and contained two boxes to be checked, "yes" or "no", but Dr. Shah did not check either box. The question then indicated, "If yes" and was followed by blank spaces to reflect the dates of the "total disability". In those blanks Dr. Shah wrote, "From: 05-29-18 Through: 07-08-18". Dr. Shah further indicated that Grievant was to "continue in the physical therapy program for strengthening LLE in order to safely return to work on 07-09-18".

On June 28, 2018, the physical therapy program at Methodist Hospitals discharged Grievant from physical therapy. Grievant had received a total of 11 sessions. The Therapist stated that she was pleased with Grievant's progress and that Grievant denies any pain at this time. Objective findings indicate a score of "64/80 = 20% impairment with good motion, stability and strength in her knee."

On July 16, 2018, the Reed Group denied the benefits extension request for June 27, 2018 through July 8, 2018. On or about July 20, 2018, the Grievant appealed the July 16, 2018 denial of her Sickness & Accident extension request. On August 6, 2018, the Reed Group sent the documents submitted by Dr. Shah regarding the requested extension to an independent physician, Dr. Daniel Benson, M.D., Board Certified Orthopedic Surgeon, for his review. Dr. Benson subsequently indicated, "The documents do not outline any functional impairment; she had a

solid post-operative recovery and had been discharged from therapy after 11 structured sessions having obtained a good outcome." Dr. Benson additionally explained that the provider's note from June 20, 2018 only noted a solid recovery that was not detailed and he (Dr. Shah) recommended a later return to work date but provided no explanation for the return to work date chosen.

Dr. Benson also specified that the medical information failed to support impairment based on the addendum notes which provide no clinical details or documentation of any functional impairment that might have benefited through this extension for the entire timeframe. Dr. Benson, also noted that, "The individual was capable of working in a full unrestricted capacity June 27, 2018 to July 8, 2018.

On August 28, 2018, Dr. Shah faxed a supplemental doctor's note to the Reed Group. On September 17, 2018, the Reed Group responded and denied the Grievant's appeal request which included a summary of the review conducted by Dr. Benson for claim dates June 27, 2018 through July 8, 2018. The stated reason for denial indicated:

> **"Your claim was denied effective June 29, 2018 as Objective Medical Documentation was not received from you or any authorized healthcare provider containing sufficient information to certify you were totally disabled and unable to perform the duties of your job."**

On September 19, 2018, the Union filed the following Step 3 grievance.

> **"The Company has violated the Agreement between the parties as provided for in the Program of Insurance Benefits (PIB) for active employees by having Reed Group have the employee file an appeal through Reed Group for denying Sickness & Accident (S&A) benefits. Per the PIB, the Reed Group appeal is not the "Agreed to" appeal and has improperly denied her benefits."**

ISSUE

Whether the Employer violated the collective bargaining agreement when it allowed the Reed Group to decide Grievant's appeal of its denial of her request for an extension of her Sick & Accident benefits claim?

If so, what should be the appropriate remedy?

POSITION OF THE UNION

I have to start out by referring to the opening the Company used. When they started their opening statement today the Company indicated and the Union had to carry the three (3) elements. In their opening statement the Company stated that the Union must therefore demonstrate how each of the elements, not just one or two, but each and every element under Section 4.0 regarding sickness and accident eligibility were met which therefore meant Ms. Spencer is eligible for sickness and accident benefits.

Let me go further to state as per Section 4.0 of the Program of Insurance Benefits the clear and explicit requirements that establish the right of an employee to receive benefits. One is total disability. Ms. Stankich's testimony was cross-examined and she was asked for the definition of the common meaning of total disability. She didn't have an answer for that. However. Union Exhibit "2" total disability is defined by Dr. Shah who is one of the very limited group of physicians that can authorize therapy and he indicated that her total disability is based upon the surgery to the left knee. Dr. Shah also stated that his objective clinical findings approximated that she would be off work until June 26, 2018.

You heard testimony from the Grievant that she was not fully healed by June 26, 2018. It was Dr. Shah and only Dr. Shah who is the authorized provider and agreed to by the parties that

has that ability and authority to authorize therapy. So that is total disability. In Union Exhibit "3" Dr. Shah, once again, made the determination that she was not completely healed. She was still disabled, in his opinion, and that she needed to continue with the physical therapy program that he had prescribed and that she would be able to return to work safely on July 9, 2018. That also satisfies what the Company asked for as far as an injury, an accident or an illness, but also satisfies the number 2 condition as to be prevented from performing the duties of her job. That satisfies that requirement as is set forth in No. 2.

Once again, the Company relies in their case very heavily upon documentation of a physical therapist who, frankly, is not an individual listed in the limited scope in 4.0 as an "authorized provider". The physical therapist could not sign an Authorized Provider Form and, therefore, she cannot be relied upon as to the condition of an employee. They simply are not who the parties agreed to that would have that authority. The Company also relied heavily upon a peer review by Dr. Benson. It is clear in testimony and on cross-examination that Dr. Benson did not perform the surgery, nor did Dr. Benson physically examine the Grievant and, therefore, his opinion is just that. It does not carry much weight. The weight that should be credited here is that of Dr. Shah.

You also heard testimony from Ms. Stankich that she was the Plan Administrator and not the Reed Group as they would like you to believe. Ms. Stankich testified that she did not make the appeal determination.

I would like to introduce in closing Arbitration Decision No. 88 of these parties. With Arbitrator Barnoff, on page 20, last paragraph, addressed this issue about the Reed Group. It is clear that the parties did not intend for the appeal process in Section 7 to be delegated to the Third Party Administrator since the PIB states that written Appeals are to be made to the Plan

Administrator, who is identified as the Company's Manager of Employee Benefits. This Section also states that the Plan Administrator will make the Appeal determination. It is clear from the testimony of Ms. Stankich that she is that person and it is also clear in the evidence presented by the Company and the Union that she did not make that determination. It was made by the Reed Group.

Mr. Arbitrator the Union has put forth their argument for Section 4.0 (Eligibility) and we believe that we established Ms. Spencer's short-term disability was, in fact, from May 29, 2018 and should have been carried through to July 8, 2018. In closing we ask that you grant this grievance based on the evidence presented on 4.0 and order the Company to make whole the Grievant.

POSITION OF THE EMPLOYER

Mr. Arbitrator, when we began today's hearing, I listed the clear and unambiguous language from Section 4.0, the Eligibility section, in which an authorized provider must certify thereto:

1. Total disability
2. As a result of injury, illness, or accident
3. As to be prevented from performing the duties of their employment.

As the Union even testified too, these eligibility requirements under Section 4.0, remain the same regardless of the employee's years of service, age or the number of days the employee requested Sickness and Accident leave.

As the Union witnesses testified to, the Plan "shall be administered" by the Company or arrangements provided by it. In addition, the Union also testified, today, that under Section 8.0, it is the Plan Administrator, Ms. Stankich, who is responsible to make and enforce any necessary rules for the Plan and to interpret the Plan provisions. What is noted during this testimony is the

language is clear in saying it is not the Union benefit coordinators or the Employee's physician that holds this agreed to responsibility. Further, under the Parties' Sickness and Accident Appeal Process found in Section 7.3, as it was testified too, it is clear, that only the Plan Administrator, Ms. Stankich, is identified as making the appeal determination. Nothing prohibits the Company from requesting substantiation for any period in which the Employee claims total disability in order to investigate the requirements behind the Sickness and Accident Claim.

In this case, there is no dispute that Dr. Shah would be considered an authorized provider per the language of the agreement. Rather, the dispute is that the objective findings of Dr. Shah did not certify that Ms. Spencer was totally disabled, as a result from an injury, illness or accident which prevented her from performing her job duties from June 27 through July 8, 2018.

In this case, we know that Ms. Spencer had outpatient surgery on May 29, 2018 and was released from the hospital on the same day. For the surgery, Dr. Shah filled out the June 6, 2018 Attending Provider Statement, and that is where I want to start to point out the key facts you heard throughout this case.

The Company recognizes having conversation surrounding someone not being paid benefits is never a favorable discussion to be involved in, which is why the Company takes administration of our insurance program very seriously. The conversation in this case though is not difficult, in fact, it is easy conversation to have. It is easy because this case is not a case about Linda Spencer. This case is about administering an insurance program. With that said, the Company has a responsibility to administer the Sickness and Accident plan in accordance with the Parties agreement for all eligibility requests.

The Company is tasked with more than 10,000 Employees who are able to make a request for Sickness and Accident benefits and must adhere to the explicit language under

Section 4.0 so that all Employees receive uniform treatment in their determination of Sickness and Accident eligibility. This is done to ensure that eligibility for Sickness and Accident payment does not run afoul. This ensures the Company does not act on judgment alone as well.

Mr. Arbitrator, this is not a scenario where the Company has acted unreasonably or acted cold-heartedly and shouldn't be painted as such. Like all cases, we want you to know that the Company gave Ms. Spencer's claim the utmost diligence when determining to deny her request for Sickness and Accident from June 27 through July 8, 2018. As proof of that, Dr. Shah's documents were sent to an Independent Physician, Dr. Daniel Benson. Dr. Benson is a Board Certified Physician with specific expertise in Orthopedic Surgery. His review and position of the documents are found in evidence.

Lastly, Mr. Arbitrator, I must leave you with the instructions and decisions previously given to the Parties. In Decision No. 2929, the arbitrator reminds the parties that where there are disputes between the parties interpretations of the language specifically like this case, and similar to that of Decision 2929, where the provision is being used for the purpose of day-to-day applications, such problems, become easier to resolve when it is realized that it is always the language of the agreement between the parties which governs and not the instructions drafted by either side.

I also submit to you Arbitration Case No. USS-44-142. In the arbitration, the Employee protested not being paid Sickness and Accident benefits from October 18 through December 14 of 2003. In his decision, the Arbitrator noted, the Grievants physician supplied two written "excuse slips" for her. One stated she can be released to work on October 22, 2003 and the other listed a return to work on December 12, 2003. As noted by the Arbitrator, neither release said anything about the Grievant suffering from "total disability". As noted in his decision, a licensed

physician must certify that an employee is totally disabled. Much like our case today, the doctor supplies two different return to work dates, the first one was June 27, 2018 and the second date was July 9, 2018, but the doctor provides no documentation which certifies towards total disability.

Lastly, I give you Arbitration Decision No. 3670. This arbitration comes from this very same plant, Burns Harbor, between Bethlehem Steel and Local 6787. This award specifically noted that the Program of Insurance Benefits makes clear that an employee is eligible for Sickness and Accident benefits only for periods during which the employee is totally disabled, this same language remains unchanged in our Program of Insurance benefits booklet today.

Mr. Arbitrator, it is clear according to the language under Section 4.0 of the Program on Insurance Benefits that Ms. Spencer is not eligible for Sickness and Accident benefits from June 27, 2018 through July 8, 2018. The Union in this case has not met its burden of proof in showing that the Company improperly administer the plan by denying benefits.

While a physician may not release you to work, an excusal from work has a separate set of requirements than the requirements needed to satisfy the eligibility language for Sickness and Accident payment.

Therefore, the Company respectfully requests that this grievance be denied.

FINDINGS AND DISCUSSION

The essential underlying facts in the within grievance are not in dispute and the issue is a straight-forward matter of contract interpretation. The rule primarily to be observed in the construction of written agreements is that the interpreter must, if possible, ascertain and give effect to the mutual intent of the parties. The collective bargaining agreement should be

construed, not narrowly and technically, but broadly so as to accomplish its evident aims. In determining the intent of the parties, inquiry is made as to what the language meant to the parties when the agreement was written. It is this meaning that governs, not the meaning that can possibly be read into the language.

This case involves the operation of the Company's Sickness and Accident benefits program. In order to claim Sickness and Accident 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 ("PIB"), which has been negotiated between the Union and the Company pursuant to their Insurance Agreement effective September 1, 2015.

The PIB is the official document provided to employees describing the benefits that have been established under the Insurance Agreement. The Company's Sickness and Accident program is self-funded, and the Plan Administrator is specifically identified therein as the Company's Manager of Employee Benefits, which at all times pertinent to the within matter was Maxine Stankich. A third-party administrator, the Reed Group, evaluates claimants' medical documentation, and performs other claims administration functions on behalf of the Company.

As indicated within, the Grievant applied for Sickness and Accident benefits through the Reed Group on May 23, 2018 and which was subsequently approved for the period May 28, 2018 through June 26, 2018. That approval was based upon an Attending Provider Statement submitted by Dr. Vineet Shah on June 6, 2018. That statement contains, inter alia, the following pertinent information to the issue of whether Grievant was eligible for Sickness and Accident benefits:

1. Is the absence from work medically necessary? **YES.**

2. Has the patient been and will the patient be totally unable to work? **YES.**

3. If yes, indicate the duration of the period of time that Grievant was totally unable to work. Dr. Shah indicated "From 5-29-18 Through **approximately** 6-26-18."

4. Estimated return-to-work date: **Approximately** 6-27-18.

The form completed by Dr. Shah went on to describe his primary and secondary diagnosis, the treatment plan of physical therapy, the medications the Grievant was to take and when her next scheduled visit would be. Based upon this information, on June 8, 2018 the Reed Group approved the Grievant's claim for Sickness and Accident benefits starting May 28, 2018 and ending June 26, 2018.

On or about June 21, 2018 the Reed Group received a request from Grievant to **extend** her Sickness & Accident benefits from June 27, 2018 and July 8, 2018, a period of some 11 days. By letter dated June 21, 2018, the Reed Group forwarded a second Attending Physician's Statement to Dr. Shah to be completed. Dr. Shah completed that form on June 26, 2018 which provided, inter alia, the following information regarding the Grievant's condition:

1. Is Grievant's absence from work medically necessary? **YES.**

2. Has the patient been or will the patient be totally unable to work? For reasons not established in the record, but which I believe was merely an oversight, Dr. Shah did not check either the "yes" or "no" boxes provided. Significantly, however, the form goes on to indicate next to those two boxes, "If yes", then the physician was to fill-in the actual dates of the inability to work. In those blank spaces adjacent to the "yes" or "no" boxes Dr. Shah wrote in "From: 6-29-18 Through: 7-8-18". The only reasonable conclusion than can be deduced from this question is that Dr. Shah was indicating "**yes**", the Grievant was in

fact totally unable to work during the period 6-29-18 through 7-8-18 the requested extension period.

3. What are the objective clinical findings/functional limitations that currently prevent the patient from working in any capacity? Dr. Shah indicated "continue PT program for strengthening LLE in order to safety RTW on 07-09-18."

4. Dr. Shah indicated that the Grievant would have a full-time full duty no restrictions or limitations return-to-work date of July 9, 2018. Dr. Shah then gave the primary and secondary diagnosis and identified the treatment plan as "continue post-operative physical therapy program. As for the Grievant's next scheduled visit, Dr. Shah indicated "PRN" which means as needed.

It must be remembered that in the initial Attending Provider Statement submitted by Dr. Shah on June 6, 2018 he indicated that the period of time he believed the Grievant would be totally unable to work was only an **approximation**. And, again, he specifically indicated that her expected return-to-work date on June 27, 2018 was only an **approximation**. This is not unusual considering the unpredictability of any patients' recovery period from almost any surgical procedure.

The Reed Group **denied** the claim extension request on July 16, 2018. On July 20, 2018 the Grievant appealed that denial. In response, on August 6, 2018 the Reed Group sent a Peer File Review to an independent physician. Dr. Shah also faxed a Supplemental Report to the Reed Group on August 28, 2018 indicating, in part, as follows:

> **"She was last seen in clinic on 6-20-18 at which time she was advised to ice the knee and slowly progress activities over the**

next few weeks, continue with HEP in preparation of returning to work as discussed for 7-9-2018."

On September 17, 2018 the Reed Group denied the Grievant's appeal and advised her, in part, as follows:

"Dear Linda Spencer:

This letter response to your request for a review of the adverse benefit determination that was made on 7/16/2018 with respect to benefits requested under the ArcellorMittal Disability Plan . . . we have determined that the benefits being requested are not covered by the Plan and accordingly the decision following review is that your request for Plan benefits must be denied.

REASON FOR DENIAL

Your claim was denied effective June 29, 2018 as objective medical documentation was not received from you or any authorized healthcare provider containing sufficient information to certify you were totally disabled and unable to perform the duties of your job. . . Please carefully review the above information. If you decide to appeal this denial by requesting a review as described above, your appeal should be sent within the prescribed time period to:

Reed Group
P.O. Box 6248
Broomfield, CO 80021
Attention: Second Level Appeals Department."

The evidence is clear that the second Attending Provider Statement submitted by Dr. Shah on June 26, 2018 was not simply an "excuse slip" or just a release to return to work note. On the contrary, Dr. Shah indicated that the Grievant was totally unable to work during the period May 29, 2018 through July 8, 2018. Moreover, he directed that she would continue her physical therapy program for strengthening LLE in order to safely return to work on July 9, 2018. It must also be remembered that in the initial Attending Provider Statement submitted by

Dr. Shah on June 6, 2018 Dr. Shah was unsure about when the Grievant would be able to return to work and twice indicated that the projected date of June 27, 2018 was only an **approximation**.

Let us turn now to the core issue presented in this grievance of whether the Reed Group had the authority to first entertain and then deny the Grievant's appeal of its decision not to grant an extension of her originally approved Sickness and Accident benefits claim.

Section 7 (Claim Procedures) of the PIB provides in Sub-Section 3 Appeal Process as follows:

> "If you want to appeal (in whole or in part) the decision on your request for review, you, or your authorized representative, must file a written appeal with the **Plan Administrator** (emphasis added) within 180 days . . . .
>
> . . .
>
> The Plan Administrator will make the appeal determination. The appeal determination will not defer to the initial claim determination or the determination on review and will take into account all comments, documents, records or other information submitted by you with regard to whether such information was previously submitted or relied upon in the initial determination or the request for review."

Section 8 of the PIB clearly and unequivocally identifies the Plan Administrator as the ArcellorMittal Manager, Employee Benefits which in this matter is Maxine Stankich. Ms. Stankich unequivocally testified at hearing that she did not make the appeal determination. While the PIB indicates that the day-to-day operations of the Plan are handled by the claims administrator, which is the Reed Group, there is no indication whatsoever that the Reed Group has any role in adjudicating any request for review of this benefit denial.

The evidence is indisputable that the Reed Group handled Grievant's request for review of the denial of her requested extension of Sickness and Accident benefits. Moreover, as

indicated in its September 17, 2018 letter to Grievant, the Reed Group gave explicit reasons for its denial of her claim. It is important to note that I am not questioning the competency or the good faith of the Reed Group in deciding the Grievant's appeal. To the contrary, it went to great lengths and even retained the services of an independent medical examiner to review the records in the case and advise them accordingly. Unfortunately, the issue boils down to the fact that the agreement between the parties did not confer any such authority on the Reed Group. In fact, the Reed Group even advised Grievant of further appeal rights from its denial decision, but again she was improperly advised that any further appeal must also be directed to the Reed Group.

Based upon all of the above, the within grievance can be sustained on two basis. First, the Reed Group had no authority whatsoever to adjudicate the Grievant's request for review of its decision to deny her claim for benefits for the period June 27, 2018 through July 8, 2018. Secondly, even assuming, arguendo, that the Reed Group did have such authority, the Grievant satisfied all of the elements set forth in Section 4 of the PIB to establish her eligibility to receive Sickness and Accident benefits through July 8, 2018.

AWARD

The grievance is sustained. The Grievant shall be made whole in all respects.

Jurisdiction shall be retained in order to ensure compliance with this Award.

Date: 4-29-19
Pittsburgh, PA

Ronald F. Talarico, Esq.
Arbitrator