Award No. 777
OPINION AND AWARD
In the Matter of Arbitration Between
INLAND STEEL COMPANY
and
UNITED STEELWORKERS OF AMERICA
LOCAL UNION 1010
Grievance No. PIB-R6-98
Appeal No. 1388
Arbitrator: Herbert Fishgold
September 2, 1987
Appearances:
For the Company
R.V. Cayia, Arbitration Coordinator, Union Relations
M.M. Roglich, Senior Representative, Union Relations
R. Vela, Section Manager, Advocacy, Arbitration and Administration, Union Relations
F. Sarlea, Section Manager, Equitable Insurance Society
Donald E. Johnson, Supervisor, Insurance Services, Personnel
For the Union
W. Trella, Staff Representative
G. Galvan, Chairman, Grievance Committee
R. Luckel, Grievant
M. Luckel, Son of Grievant
Statement of the Grievance: "The aggrieved, Raymond Luckel, Payroll No. 402, was denied payment of hospital charges under extended major medical charges by program of Insurance Benefits."
Relief sought: That the Company pay all appropriate charges due under the agreement."
Contract provisions cited: The Union cites the Company with alleged violations of paragraphs 5.5 and 5.10 of the program of Insurance Benefits pursuant to the agreement between the parties."
Statement of the Award: The grievance is denied.
CHRONOLOGY
Grievance No. PIB-R6-98
Grievance filed: February 20, 1985
Step 3 hearing: March 4, 1985
Step 3 minutes: June 10, 1985
Step 4 appeal: June 17, 1985
Step 4 hearing(s): September 19, 1986 and July 2, 1987
Step 4 minutes: July 21, 1987
Appeal to Arbitration: July 22, 1987
Arbitration hearing: July 29, 1987
Award issued: September 2, 1987
By way of background, the grievant, Raymond Luckel, submitted claims which sought the payment of major medical benefits for charges associated with the treatment of his son, M. Luckel, for the period between September 15, 1984 and September 19, 1984.
M. Luckel, then 23 years of age, was treated for a disability diagnosed by his personal physician as "chronic internal derangement with perforation of articular disk-posterior ligament and degenerative joint disease left temporomandibular joint" with a surgical procedure identified as a "menisectomy with silastic implant left temporomandibular joint." The medical charges associated with that procedure were as follows: September 15, 1984 - x-ray($18.00); September 18, 1984 - laboratory work ($50.00); September 18, 1984 - anesthesiologist (264.00); September 18, 1984 surgery ($750.00); and September, 17 through 19, 1984 - hospital charge ($1,894.90), for a total of $2,976.90.
The issue in dispute in this case is whether the Equitable Insurance Society's denial of the claims seeking major medical coverage for the above listed charges was in violation of paragraphs 5.5, 5.9 and 5.10 of the Program of Insurance Benefits (P.I.B.) Agreement, effective January 1, 1981.
The subject benefit denials were based on an interpretation of the provisions in paragraph 5.10, entitled "Continuation of Benefits After Termination of Coverage" in the Major Medical Benefits section of the P.I.B. Agreement. That paragraph, with the language pertinent to the denial underscored, reads as follows:

Continuation of Benefits After Termination of Coverage
If you or one of your dependents is totally disabled when coverage for major medical benefits terminates for any reason and you are not eligible for the hospital and medical coverage for pensioners and surviving spouses pursuant to paragraphs 9.29 - 9.31, benefits are payable solely with repect to Covered Medical Expenses incurred for the illness or injury which caused the total disability. Such benefits will be payable during the uninterrupted continuance of such total disability, as if coverage for major medical benefits had not terminated, but not beyond one year from the date such coverage terminates. In determining the amounts payable pursuant to this paragraph, benefits payable for such expenses under Sections 3 or 4 and under Medicare, if applicable, shall be deemed to have been paid, even though coverage under Section 3 and 4 was not in effect.
That paragraph 5.10 is the applicable provision to this case is undisputed by the parties to this grievance. The patient, M. Luckel, was considered terminated from coverage under the P.I.B. Agreement because he was not then enrolled in any educational institution at the time when the subject medical charges were incurred. The fact that he could not claim student dependent status under the P.I.B. Agreement resulted in his being terminated from insurance coverage, except as otherwise otherwise by paragraph 5.10. The coverage available to him under those specific provisions is restricted to providing major medical benefits only for charges related to a totally disabling condition that existed at the time insurance benefits were terminated. This restricted coverage is further limited to a maximum of one year's time after insurance termination.
There is no disagreement that M. Luckel was eligible under paragraph 5.10 to make claim for the subject medical charges. What is in dispute involved the interpretation of the language to determine the amounts payable pursuant to this paragraph under the restricted circumstances presented in this case.
The Union argues that the Company's denial of the claims in question is the result of a misinterpretation of paragraph 5.10 as it relates to major medical benefits. According to the Union's reading of 5.10, since M. Luckel did not qualify for coverage provided in Sections 3 and 4 of the base plan, and since all of the claimed medical expenses are covered by paragraph 5.5, grievant is entitled to be reimbursed for major medical benefits equal to those found in the base plan. In sum, the Union contends that the Major Medical Benefits plan can independently provide coverage equal to the base plan if the latter is rendered inapplicable.
The Company, on its part, contends that the clear meaning of paragraph 5.10 specificallly provides that benefits payable under its provisions have to exclude those benefits covered under Sections 3 and 4 of the Program. Since the charges submitted by the grievant were medical items that undisputedly are provided coverage under Sections 3 and 4 of the Program, based on the proviso contained in P.I.B. 5.10, they were properly excluded from payment consideration, resulting in the denial of the submitted claims. In sum, the Company contends that the major medical plan supplements the coverage provided in Section 3 and 4 of the Program with benefits that are in addition to those contained in the base plan, and has no Program authority to provide benefits equal to those covered under Sections 3 and 4 of the P.I.B. Agreement.
Turning to the merits of the respective arguments, probably no function of the arbitrator is more important than that of interpreting the collective bargaining agreement. In that regard, there is no need for interpretation unless the agreement is ambiguous. As stated in Elkouri & Elkouri, How Arbitration Works, BNA, 4th Ed., 1985, p. 342:
"An agreement is not ambiguous if the arbitrator can determine its meaning without any guide other than a knowledge of the simple facts on which, from the nature of language in general, its meaning depends. But an agreement is ambiguous if plausible contentions may be made for conflicting interpretations thereof. Moreover, it is recognized that whether a document is or is not ambiguous is a matter of impression rather than of definition; provision may be as clear and definite as language can make it, yet the result of the whole be doubtful from lack of harmony in its various parts." [citations omitted]
These principles have long been recognized in Inland Arbitration Awards, e.g., Award 224, 227 and 249.
Applying these principles to the instant grievance, the Arbitrator finds that the disputed language in paragraph 5.10, when read in conjunction with Sections 3 and 4, as well as the other relevant provisions in Section 5, does not provide any basis to support the grievant's claim for reimbursement herein. This conclusion is obvious when the language in paragraph 5.0 "Purpose" and paragraph 5.1 "Benefit and Provisions - Deductibles" is considered:
5.0 Purpose
Although the benefits described in Sections 3 and 4 provide substantial protection against many medical expenses incurred by you and your dependents, there are cases in which you or your dependents can incur

medical expenses not covered under those provisions. Therefore, these major medical provisions have been included in the Program to protect you against a major portion of certain expenses not covered by the benefits described in Sections 3 and 4. These provisions operate as described in the following paragraphs. [Emphasis added]
5.1 Benefit Provisions - Deductibles
If as a result of illness or injury, you or one of your dependents incurs Covered Medical Expenses, as described below and while insured for major medical benefits, you will be paid a benefit equal to 80% (except as otherwise provided in paragraph 5.5 (1) of the amount by which such expenses for all illneses or injuries during any one calender year (January 1-December 3) exceed the sum of:
(a) Any benefits payable for Covered Medical Expenses under Sections 3 or 4, and
(b) A deductible amount of $75 of Covered Medical Expenses for which no benefits are payable under the Program for you or one of your dependents or a deductible amount of $150 of Covered Medical Expenes for which no benefits are payable under the Program for you and all of your dependents. [Empahasis added]
These paragraphs clearly indicate that the major medical provisions are to protect against a portion of certain expenses not covered by the benefits described in Sections 3and 4, and that payment will be based, in part, upon a percentage by which such expenses exceed any benefits payable for Covered Medical Expenses under Sections 3 or 4.
It is true that the benefit items listed under "Covered Medical Expenses" in paragraph 5.5, in particular 5.5 (a) Services of licensed physicians; (c) Room and board in a hospital; (e) Anesthetics; and (f) Diagnostic x-ray, track the types of expenses incurred by M. Luckel herein. However, contrary to the Union's reliance thereon, it is evident from reading paragraphs 5.0 and 5.1 above, that these benefit items are to provide coverage to the extent not otherwise already provided in Sections 3 and 4 of the Program.
For example, they would apply in those instances where the maximum duration of benefits or dollar amounts allowed for such services in the base plan were exceeded, or where a covered service was performed in an office rather than a hospital, or by someone other than a physician. It is undisputed that none of those factors was involved in the medical expenses incurred and claimed herein.
Finally, it is also clear from reading other applicalbe provisions in the Program that M. Luckel only qualifies for such benefits as are provided by paragraph 5.10. Pursuant to paragraph 8.1 "Definition of Dependents", M. Luckel, then 23, would only be considered a dependent for purposes of coverage under the base plan and major medical if he remained enrolled as a full-time student in a recognized course of study or training. As noted earlier, he was no longer enrolled as a full-time student when the medical expenses in question were incurred.
Furthermore, in order for M. Luckel to be considered to be covered as a disabled dependent pursuant to paragraph 9.38, and therefore entitled to base plan and major medical coverage, an application for such coverage would have to have been made prior to his turning 19. As noted, M. Luckel was 23 at the time the medical expenses in question were incurred.
Thus, it is only pursuant to the limited circumstances provided in paragraph 5.10 that M. Luckel would be entitled to any benefits payments. Based upon the clear language regarding determination of amounts payable pursuant to that paragraph, the Arbitrator must conclude that the base plan must be put into the payment calculation before a final determination on payable benefits is made. The provision specifically notes that coverage under Sections 3 and 4 is not in effect, due to dependent termination from the Program, but nonetheless requires that such covered benefits be considered paid for purposes of determining any amount payable. Inasmuch as all of the expenses claimed herein were within the maximum and types of services covered by Sections 3 and 4. they must be considered as having been paid for purposes of paragraph 5.10, and accordingly, the Company did not violate the Program by denial of benefits to M. Luckel.
In addition to the clear language and intent evidenced by the provisions of the Program itself, the Arbitrator also notes that the unrefuted testimony from Company witnesses further indicated that the interpretation that major medical benefits provide coverage in addition to that already present in the base plan is one that has been consistently applied since the major medical plan was added to the Program in 1970. The testimony further indicated that the same major medical plan is in effect for the basic steel industry, and that the same interpretation has been given to the language in question at Bethlehem, USX and LTV.
Accordingly, the Arbitrator finds that the denial of benefits was based upon a proper application of the specific language in paragraph 5.10 of the P.I.B. Agreement.
AWARD

The grievance is denied.
/s/ Herbert Fishgold
Herbert Fishgold
Arbitrator
Washington, D.C.
September 2, 1987