OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 88-623 - June 25, 1993

Board of Trustees: Michael H. Holland, Chairman; Thomas F. Connors, Trustee; Marty D. Hudson, Trustee; Robert T. Wallace, Trustee.

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of health benefits coverage for an Employee under the terms of the Employer Benefit Plan.

Background Facts

The Employee states that the Employer changed insurance carriers effective May 1, 1992, and that the new carrier is not providing health benefits in accordance with the provisions of the National Bituminous Coal Wage Agreement of 1988. To support his position, the Employee has submitted a copy of the new plan that was distributed by the Employer and an "Identification Card Supplement" which outlines the particular deductibles and co-payments applicable under the new plan.

The Employer has not responded to repeated requests for information to support its position in this dispute.

The Employer's new plan is called the Competitive Allowance Plan (CAP). Review by the Funds' staff reveals that the Plan differs from the Employer Benefit Plan in many particulars. Some of the major differences include: 1) If an Employee chooses to utilize a provider that is considered a "participating provider" by the carrier, the Employee would be responsible only for the appropriate deductible. Participating providers have agreed to accept the insurance carrier's allowance as payment in full for covered services. The Employee would be responsible for any deductible, co-insurance or shared payment, any amounts in excess of specific benefit limitations of the Employee's program and charges for non-covered services. In this case, the deductible as specified on the Identification Card Supplement sheet would be $100 per calendar year for an individual, and $200 per calendar year for a family. 2) If an Employee chooses not to utilize a participating provider, then the Employee's charges would be reimbursable at 80 percent after the satisfaction of the aforementioned deductible. The Plan would actually pay 80 percent of the amount allowable for participating providers under the plan, not necessarily 80 percent of the

billed amount. The Employee would be responsible for any excess charges, non-covered charges, etc. 3) The Plan contains a $5.00 deductible for insulin and generic drugs, and a $10.00 deductible for brand-name drugs or any compound order. 4) The Mental and Nervous Benefits are paid as follows: The first $100 of allowable expenses in the benefit period are payable at 100 percent; the next $100 of allowable expenses in a benefit period are payable at 80 percent; and the next $1,640 of allowable expenses in a benefit period are payable at 50 percent. The Lifetime Maximum per subscriber is $7,500. A Benefit Period is defined as the 12 month period beginning yearly on the subscriber's effective date of coverage.

The new plan contains no mention of vision care expense reimbursement.

Furthermore, the Employee contends that prior to the effective date of the new plan (May 1, 1992) some Employees had incurred deductibles under the old carrier. The company informed the Employees that it would re-pay the Employees any difference between the deductibles taken under the previous plan and the new Plan. There is no evidence that this was done. Additionally, the new insurance carrier is subtracting the entire year's deductible prior to paying any benefits under the plan rather than taking the co-payments on a per-visit basis as specified under Article III.A.(8)(a) of the Employer Benefit Plan.

Dispute

Is the Employer's implementation of its health coverage plan in violation of the 1988 Wage Agreement?

Positions of the Parties

Position of the Employee: The Employer has implemented a plan for health benefits coverage that is not in accordance with the 1988 Wage Agreement.

Position of the Employer: The Employer has not responded to repeated requests for information to support its position in this dispute.

Pertinent Provisions

Article XX Section (c)(3)(i) of the National Bituminous Coal Wage Agreements of 1984 and 1988 provides in pertinent part:

(3)(i) Each signatory Employer shall establish and maintain an Employee benefit plan to provide, implemented through an insurance carrier(s), health and other non-pension benefits for its Employees covered by this Agreement as well as pensioners, under the 1974 Pension Plan and Trust, whose last signatory classified employment was with such Employer. The benefits provided by the Employer to its eligible Participants pursuant to such plans shall be guaranteed during the term of this Agreement by that Employer at levels set forth in such plans.....

Article XX (10) of the 1988 Wage Agreement provides in pertinent part:

(10) Health Care

Explanatory Note on Provider Provided Health Plans

Active miners and their surviving spouses and dependents, and pensioners, their dependents, and surviving spouses receiving pensions from the 1974 Pension Plan, will receive health care provided by their Employer through insurance carriers. A health service card identifying the Participant's eligibility for benefits under the health plan shall be provided by the Employer.

* * *

Claim forms will be available at most hospitals, clinics, and physicians offices. Generally, nothing more is required than signing the forms authorizing the hospital, clinic, or physician to bill the insurance carrier for the services rendered. The insurance carrier will keep individual records for each Participant and dependent and will notify the Participant of the co-payments credited to his account. The hospital, clinic, or physician will bill the Participant for the co-payment amount until the maximum is reached. In some instances, when the Employee pays for services or drugs, the bills should be obtained and submitted with the claim form according to the instructions on the form. If the annual co-payment maximum is reached, the carrier will remit to the Participant the full payment for covered benefits.

Article I (1), (2) and (4) of the 1988 Employer Plan provide:

(1) "Employer" means (Insert Employer's Name) .

(2) "Wage Agreement" means the National Bituminous Coal Wage Agreement of 1988, as amended from time to time and any successor agreement.

(4) "Employee" shall mean a person working in a classified job for the Employer, eligible to receive benefits hereunder.

Article II.A. (1) and (4) of the Employer Benefit Plan provide:

The persons eligible to receive the health benefits pursuant to Article III are as follows:

A. Active Employees

Benefits under Article III shall be provided to any Employee who:

(1) is actively at work[1] for the Employer on the effective date of the Wage Agreement; or

(4) A new Employee will be eligible for health benefits from the first day worked with the Employer.

Article III.A. (8) of the Employer Benefit Plan states in pertinent part:

(8) Co-Payments

Certain benefits provided in this Plan shall be subject to the co-payments set forth below and such co-payments will be the responsibility of the Beneficiary....

Co-payments for covered Health Benefits are established as follows:

Benefit	Co-Payments
(a) Physician services as an out-patient as set forth in Section A.(2) and physician visits in connection with the benefits set forth in Section A.(3), paragraph (c) but only for pre- and post-natal visits if the physician charges separately for such visits in addition to the charge for delivery, and paragraphs (g) through (m), paragraph (n) except inpatient surgery, paragraph (o) and Section A.(7) paragraph (f).	Working Group -- $7.50 per visit up to a maximum of $150 per 12-month period[2] per family. Non-working Group -- $5 per visit up to maximum of $100 per 12-month period[2] per family.
(b) Prescription drugs and insulin, as set forth in Section A.(4) and take-home drugs following hospital confinement as set forth in Section A.(1)(a). each 30 days (or fraction	$5 per prescription or refill up to $50 maximum per 12-month period[2] per family. Note: For purposes of this co-payment provision, a prescription or refill shall be deemed to be thereof) supply.

[1] Actively at work includes an Employee of the Employer who was actively at work on January 31, 1988, and who returns to active work with the Employer two weeks after the effective date of the Wage Agreement.

[2] The 12-month periods shall begin on the following dates: March 27, 1988; March 27, 1989; March 27, 1990; March 27, 1991 and March 27, 1992.

Article III A. (9) (a) of the Employer Benefit Plan provides in pertinent part:

(9) Vision Care Program

(a) Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	$20	Once every 24 months
Per Lens (Maximum = 2)		Once every 24 months
- Single Vision	10	
- Bifocal	15	
- Trifocal	20	
- Lenticular	25	
- Contact	15	
Frames	14	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

Article III.A. (10)(g)(3) of the Employer Benefit Plan states:

3. The Employer and the UMWA agree that the excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Plan Administrator or his agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. Whether the Plan Administrator or his agent negotiates a resolution of a matter or defends a legal action on a Beneficiary's behalf, the Beneficiary shall not be responsible for any legal fees, settlements, judgements or other expenses in connection with the case, but may be liable for any services of the provider which are not provided for under the Plan. The Plan Administrator or his agent shall have sole control over the

conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

Discussion

Article III.A. (8) of the Employer Benefit Plan provides that certain benefits provided under the Plan shall be subject to co-payments of $5.00 or $7.50 and that such co-payments shall be the responsibility of the Beneficiary. Pursuant to the Wage Agreement claims filing procedure, the beneficiary is expected to authorize the provider to bill the insurance carrier for the services rendered, the beneficiary pays only the co-payment charge as set forth in Article III.A.(8), until the specified yearly amount is reached. The procedure for claim handling and the method of payment established by the Employer in this case are inconsistent with the claim procedure contemplated under the terms of the Wage Agreement and the Employer Benefit Plan.

The Employer's newly established CAP Plan contains a provision that requires the Employees to pay a $5.00 deductible for generic drugs and insulin, and a $10.00 deductible for brand-name drugs or compound orders. This is in contradiction to the Employer Benefit Plan which requires only a $5.00 deductible per prescription or refill (up to a 30 day supply). Also, the CAP Plan does not provide for vision care reimbursement. Article III A (a)(9) of the Employer Benefit Plan establishes coverage for vision care according to a pre-determined schedule of benefits. In addition, the CAP Plan differs from the Employer Benefit Plan in its provisions for Mental & Nervous benefits. The CAP Plan pays the first $100 of allowable expenses at 100 percent, the next $100 of allowable expenses are payable at 80 percent, and the next $1,640 of allowable expenses are payable at 50 percent. The lifetime maximum per subscriber is $7,500. The Employer Benefit Plan allows for 30 days of in-hospital benefits (and in some cases 60 days) in any two year period. Outpatient benefits are payable at 100 percent minus the appropriate deductible (either $7.50 or $5.00). Once the deductible maximum is reached, the charges are payable at 100 percent with no maximums on frequency, time, or dollar amounts.

Article XX Section (c)(3)(i) of the 1988 Wage Agreement requires each signatory Employer to establish and maintain an Employer Benefit Plan, implemented through an insurance carrier(s), to provide health and other non-pension benefits for its Employees. The Wage Agreement further stipulates that benefit provided by the Employer pursuant to such Plan shall be guaranteed during the term of the Agreement at levels set forth in such Plan. Thus, levels of benefits to be provided to Employees, Pensioners and their dependents and survivors which are established through collective bargaining may not be unilaterally changed. Given the clear language of Article XX, an Employer cannot arbitrarily change Plan benefits. In this case, the Employer's Plan does not provide its Employees and dependents coverage at the level specified by Article XX of the Wage Agreement, thus the Trustees conclude that the Employer's Plan is a non-conforming health plan and is inconsistent with the express provisions of the Wage Agreement and the Employer Benefit Plan.

Opinion of the Trustees

The Employer's implementation of a non-conforming health benefit plan is inconsistent with the express provisions of the 1988 Wage Agreement. The Employer is required to provide health

benefits coverage, as well as vision coverage, for the Employees and their eligible dependents at the level specified in the Employer Benefit Plan. Furthermore, the Employer is required to reimburse the Employees any excess deductible taken in excess of the appropriate deductible amount as specified under Article III.A.(8).