# OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 93-101 - January 10, 2001

Trustees: A. Frank Dunham, Michael H. Holland, Marty D. Hudson, and Elliot A. Segal.

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

## Background Facts

The Complainant is an active employee of the Respondent, a signatory employer. The Complainant's son incurred two medical bills on December 21, 1996. The Respondent's insurance carrier reviewed and denied the claims on January 13, 1997, January 31, 1997, and May 30, 1997, indicating that the Complainant had coverage through another insurance plan.

The Respondent had on file a coordination of benefits form dated October 29, 1995, completed by the Complainant that indicated that the Complainant's spouse had coverage through her employer. According to the Respondent, based on Article III. A. (10) (f) 2. of the Employer Benefit Plan, primary coverage for the Complainant's son would fall under his spouse's health plan.

On July 22, 1997, the medical bills were turned over to an attorney for collection. When the Respondent learned on July 23, 1997, that the Complainant's spouse no longer had coverage as an employee--her coverage ended in April 1996--payment for both medical claims was issued. On July 30, 1997, one of the claims was paid directly to the provider, while the Respondent sent payment for the second claim ($17.00) directly to the Complainant.

The Complainant failed to turn the $17.00 over to the provider and on December 19, 1997, judgment was entered against the Complainant for $620.40 which included the amount of the original claim, plus legal fees and court costs.

## Dispute

Is the Respondent required to provide coverage for the legal fees and court costs incurred in connection with a providers attempt to collect charges for medical claims incurred on December 21, 1996?

## Positions of the Parties

Position of the Complainant: The Respondent is required to provide coverage for the legal fees and court costs because the Respondent incorrectly denied coverage for the medical bills which caused the bills to be turned over for collection.

Position of the Respondent: The Respondent is not required to provide coverage for the legal fees and court costs because the Complainant failed to notify the Respondent of a change in his benefits coverage. The Respondent has no liability for any court costs or attorney's fees because the claims were paid in a timely manner.

## Pertinent Provisions

Article III. A. (10) (f) 1. and 2. provide in pertinent part:

ARTICLE III BENEFITS

A. Health Benefits

(10) General Provisions

(f) Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

1. Benefits will be reduced by benefits provided under any other group plan, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

(i) does not include a coordination of benefits or non-duplication provision, or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

2. In determining whether this Plan or another group plan is primary, the following criteria will be applied:

(i) The Plan covering the patient other than as a dependent will be the primary plan.

(ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

Article III. A. (11) (a) 18. of the Employer Benefit Plan provides:

(11) General Exclusions

(a) In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:

18. Finance charges in connection with a medical bill.

Discussion

Article III. A. (10) (f) of the Employer Benefit Plan provides for non-duplication of benefits by the Employer Benefit Plan and another group plan in situations where a beneficiary is covered by both plans. Article III A. (10) (f) 2. also states the criteria to be applied in determining whether the Employer Benefit Plan or another group plan is primary.

The Complainant completed a coordination of benefits form for the Respondent on October 29, 1995, which indicated that the Complainant's spouse had coverage under a group plan through her employer. Also listed as covered by the Complainant's spouse's employer's plan were the Complainant and three dependent children. The medical bills in question were incurred by one of the complainant's dependent children who was covered by both the Employer Benefit Plan and the spouse's employer's plan.

Article III. A.(10)(f) 2. (ii) states the criteria to be applied when the Employer Benefit Plan and another group plan cover the same dependent. It provides that the plan of the parent whose birthday occurs earlier in the calendar year will be the primary plan. According to the Respondent, the Complainant's spouse's birthday is in May and the Complainant's birthday is in September. Based on this information, the Respondent correctly determined that the spouse's employer's plan was the primary plan for the Complainant's dependent children.

The Complainant's spouse's coverage under her employer's plan ended in April 1996. The claim in dispute occurred in December 1996 when the insurance carrier denied the claim indicating that another insurance plan was responsible for coverage. The Complainant states that the Respondent should be required to provide coverage for the charges arising from the court action by a provider to obtain payment because the Respondent incorrectly denied the claim.

In previous RODs, the Trustees have held that the Employee is required to keep the Employer informed concerning health claims matters in a timely manner. Here the record reflects that the Complainant's health claims were denied on three occasions, January 13, January 31, and May 30, 1997, yet the Complainant did not inform the Respondent of these denials until July 23, 1997, after the provider submitted the medical claims to an attorney for collection. Additionally, even after receiving payment from the Respondent for one of the medical claims, the Complainant failed to pay the provider. Moreover, while there is a discrepancy in the record as to when the Respondent's insurance carrier was notified that the Complainant's spouse's coverage had terminated in April 1996, this information is not material under the terms of the Employer Benefit Plan. Article III. A. (11) (a) 18. excludes finance charges in connection with a medical bill. The Trustees have found that finance charges, as excluded under Article III. A.(11)(a) 18. can include late charges, legal fees and court costs (See ROD 88-666). Consequently, the Respondent is not required to provide coverage for costs incurred in connection with a provider's attempt to collect charges incurred on December 21, 1996.

## Opinion of the Trustees

The Respondent is not required to provide coverage for the legal fees and court costs incurred in connection with the providers attempt to collect charges incurred on December 21, 1996.