OPINION OF TRUSTEES

In Re

Complainant: Employee
Respondent: Employer
ROD Case No: 93-105 – July 18, 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 a miner eligible to receive health benefits coverage from the Respondent. The Complainant states that his medical claims for services covered under the Employer Benefit Plan have not been paid in full because the Respondent's insurance carrier has determined that the charges are excessive. According to the Complainant's spouse, she has contacted the providers to request that they accept the insurance payment as payment in full. She states that some providers will accept the insurance payment, while others will not. As a result, the Complainant has paid the remaining balance on some of the bills. Some providers who have not received payment in full have turned the Complainant's bills over for collection.

In August 1997, the Complainant states that he submitted a request in writing asking that the Respondent hold him harmless against the excessive charges. The Complainant states that the Respondent has refused to hold him harmless against the providers' attempts to collect the charges in dispute. According the hold harmless provision of the Employer Benefit Plan (Article III A. (10) (h) 2.), if a charge for a covered service is determined to be excessive, the Plan Administrator shall attempt to resolve the matter or defend the Employee against a provider who seeks to collect such a charge.

Under the Employer Benefit Plan, a beneficiary is required to meet an annual deductible before the hold harmless provision can be implemented. Article III A. (8) of the Plan states that "[t]he first $1,000 of all covered medical expenses incurred by any covered family member will be counted toward satisfying the deductible." Under the Employer Benefit Plan, covered medical expenses include physician visits, inpatient and outpatient hospital benefits and other non-pharmacy services. According to a representative for the Respondent's insurance carrier, only two covered services were applied to the Complainant's annual deductible--x-rays and lab diagnostic testing. The representative states that the Complainant did not meet his annual 1997 deductible until February 24, 1999.

Dispute

Is the Respondent required to hold the Complainant harmless for payment of charges which exceed the reasonable and customary charge?

Positions of the Parties

Position of the Complainant: The Respondent is required to hold the Complainant harmless from providers' attempts to collect charges that exceed the reasonable and customary charge. The Respondent is required to defend the Complainant if a provider sues to collect such charges.

Position of the Respondent: The Respondent has not replied to repeated correspondence from Funds' staff requesting its position in this dispute.

Pertinent Provisions

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

ARTICLE III

A. Health Benefits

(8) Co-Payments and Deductibles

> Effective January 1, 1994, the benefits provided in this Plan shall be subject to the co-payments and deductibles set forth below and such co-payments and deductibles shall be the responsibility of the Beneficiary. The Plan Administrator shall implement such procedures as deemed appropriate to achieve the intent of these co-payments and deductibles. Beneficiaries and providers shall provide such information as the Plan Administrator may require to effectively administer these co-payments and deductibles, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment and/or deductible from a participant or Beneficiary shall be repaid to the Plan Administrator by such provider.
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> Co-payments for covered Health Benefits are established below. Co-payments for services or supplies subject to a deductible only apply after the deductible has been met in full for the year.

Participating Provider Lists (PPLs) implemented by the Employer pursuant to Article IV may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for hospitals and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection (10) (h) (2)(Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of Article IV.C, the Beneficiary will be responsible for the deductible and co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection (10) (h) (2)(Hold Harmless) will apply.

If an employee is covered under an employer Plan (established pursuant to the NBCWA of 1993) by more than one signatory employer during a calendar year, the total deductibles and co-payments made and documented by the employee during such calendar year shall be counted toward the deductible and out-of-pocket maximum in the same manner as if they had been made under a single plan. Notwithstanding any other provision of this Plan, the amount of the deductible in such a case shall be the same as the deductible that applied to the employee under the first employer Plan that covered him during the calendar year. No employee covered under an employer Plan by more than one signatory employer during a calendar year shall be entitled to more than one Health Care Bonus pursuant to Article XX (General Description) (10) c of the 1993 NBCWA for such year, and the preceding two sentences shall not apply in the case of any employee that receives a Health Care Bonus from more than one signatory employer for the calendar year.

Physician Office Visits:

In PPL: $10.00 per office visit (up to an annual maximum of $200 per family)

Non-PPL: $15.00 per office visit

Hospital and Related Charges:

In PPL: No Co-payment

Non-PPL: Balance of charges after Plan pays 90% of the PPL rate for covered services from a non-PPL source.

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Deductibles for covered Health Benefits refer to the first portion of covered benefits that must be paid by a Beneficiary during a calendar year before any amounts will be paid by the Plan. The first $1,000 of all covered medical expenses incurred by any covered family member will be counted toward satisfying the deductible. Vision care and prescription drug expenses are not subject to the deductible. Any deductible applicable to a covered benefit must be met before co-pays apply. In no event will the deductible applicable to a family for a calendar year exceed the gross amount of the Health Care Bonus paid for that year to that family either from the Employer or from the UMWA 1974 Pension Plan pursuant to Article XX (General Description) (10) c of the 1993 NBCWA. Deductibles are established as follows:

Benefit	Deductible
Physician, hospital or other non-pharmacy services	$1,000 per family

The following payment will be required as an additional deductible, and will apply regardless of whether the original deductible has been met for the year:

Any specified service obtained without required precertification	$300.00, not applied to the annual out-of-pocket maximum

The following special rules apply to the annual deductible:

(i) The deductible for a laid-off employee or for a surviving spouse for a calendar year shall be the pro-rata portion of $1,000 that reflects the number of calendar quarters during which he or she is entitled to Employer-provided health care under the plan during such year.

(ii) The deductible for a pensioner or a surviving spouse for the calendar year in which he or she will attain age 65 shall be the pro-rata portion of $1,000 that reflects the number of calendar quarters during such year prior to the month in which he or she attains age 65. The deductible shall not be applicable to such pensioner or surviving spouse in succeeding calendar years.

(iii)The deductible for a disabled employee, or a disabled pensioner under age 65, will cease to be in effect beginning with the first calendar year following his or her eligibility for Medicare benefits.

(iv)A newly-hired employee or an employee recalled from layoff who

commences coverage after January 1 of any year shall be subject to a deductible that reflects the number of calendar quarters remaining in the year.

Annual Out-of-Pocket Maximum:

The requirement that co-payments be paid (other than the additional deductible for services obtained without required precertification and all co-payments relating to prescription drugs) will be suspended for the remainder of any calendar year during which the following out-of-pocket maximum amounts have been paid:

Benefit	Annual Out-of-Pocket Maximum
For services obtained from a PPL providers	$1,200.00 per family, including the $1,000 deductible and $200 in per physician office visit co-pays
For services obtained from a non-PPL provider	$2,500.00 per family, including the $1,000 deductible and $1,500 in physician office visit co-pays and balance billing after Plan pays 90% of PPL rate for covered service.

When the non-PPL out-of-pocket maximum has been reached, the Plan will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

Article III A. (10)(h)2. of the Employer Benefit Plan states:

ARTICLE III BENEFITS

A. Health Benefits

(10) General Provisions

(h) Explanation of Benefits (EOB), and Hold Harmless

1. Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been

determined by the Plan Administrator to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention:Benefits Department).

2. The Employer and the UMWA agree that 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, judgments or other expenses in connection with the case, but may be liable for any services of the provider which are not provided 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. The "hold harmless" protections available under this subparagraph do not apply until the deductible is met in full for the year, and shall not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of–pocket maximum is reached.

Article IV A. (2) of the Employer Benefit Plan provides:

ARTICLE IV MANAGED CARE, COST CONTAINMENT

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(2). In addition, the Employer may implement certain other managed care and cost containment rules, which may apply to benefits provided both by PPL providers and by non-PPL sources but which (except for the deductibles and co-payments specifically provided for in the Plan) will not result in a reduction of benefits or additional costs for covered services provided under the Plan.

Discussion

In accordance with Article III A. (10)(h) 2. of the Employer Benefit Plan, the Plan Administrator may determine whether or not a charge for a covered medical service exceeds the reasonable and customary charge for that service in the area where the service is provided. If the charge for a covered service is not excessive, the Employer is responsible for payment of the charge under the terms of the Employer Benefit Plan. If a charge for a covered service is determined to be excessive, the Plan Administrator shall attempt to resolve the matter or defend the Employee against a provider who seeks to collect such a charge. Whether the Employer negotiates a resolution or defends a legal action, the Employee would not be responsible for any legal fees, settlements, judgments or other expenses in connection with the case, but may be liable for any services of the provider which are not provided under the Plan. Article III A. (10) (h) 2. is known as the Plan's hold harmless provision.

Article III A. (10) (h) 2. of the Plan further states that the hold harmless protections available under this subparagraph do not apply until the deductible is met in full for the year and shall not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of–pocket maximum is reached.

Under Article III A. (8) the deductible amount established under the 1993 Benefit Plan is $1,000 per family for physician, hospital or other non-pharmacy services obtained from a Participating Provider List (PPL) provider. The non-PPL annual out-of-pocket maximum is $2,500. Therefore, a beneficiary seeking hold harmless protection under Article III A. (10) (h) 2. against a PPL provider, must first meet the $1,000 deductible. A beneficiary who is seeking hold harmless protection from a non-PPL source must first meet the $2,500 annual out-of-pocket maximum.

According to the insurance carrier, the Respondent in this case has not implemented a PPL. The Trustees in ROD 93-035 determined that "[i]f an employer does not establish a PPL, it should implement procedures that allow beneficiaries of its benefit plan to pay the in-PPL co-payments and deductibles. Otherwise, the beneficiaries of a benefit plan that does not have a PPL program will be subject to additional costs through higher copayments and deductibles." Thus, because the Respondent has not implemented a PPL, the deductible applicable to the Complainant in this case is the in-PPL annual deductible of $1,000 per family.

Article III A. (8) states that " [d]eductibles for covered Health Benefits refer to the first portions of covered benefits that must be paid by a Beneficiary during a calendar year before any amounts will be paid by the Plan. The first $1,000 of all covered medical expenses incurred by any covered family member will be counted toward satisfying the deductible." Under the Plan, covered expenses include inpatient and outpatient hospital benefits and physician visits. However, according to the Respondent's insurance carrier, the only covered medical expenses applied to the Complainant's deductible were for x-ray and lab diagnostic testing. Consequently,

the Respondent did not apply all of the Complainant's covered medical expenses towards the deductible as required by the Plan. Also, because the deductible is applied to a calendar year, a deductible for 1997 must be met in 1997. Therefore, the date, February 24, 1999, that the Respondent's insurance carrier states that the Complainant met his 1997 deductible is not accurate.

The Complainant in this case has requested that the Respondent initiate hold harmless procedures against providers who have requested payment for the balance of a charge that the Respondent has determined to be excessive. The Plan requires that the Complainant meet a $1,000 annual deductible before the hold harmless provision is implemented. As indicated above, the Respondent's administration of the deductible is inconsistent with the Employer Benefit Plan. Therefore, the Respondent is required to follow the provisions of Article III A. (8) of the Employer Benefit Plan which requires that $1,000 of all covered medical expenses incurred by any family member first be counted towards satisfaction of the annual deductible.

Once the Complainant has met the deductible, the Respondent is required to follow the hold harmless provision of Article III A. (10)(h) 2. of the Employer Benefit Plan whenever a provider's charge is determined to be excessive.

Opinion of the Trustees

The Respondent's administration of the deductible is inconsistent with the Employer Benefit Plan. The Respondent is required to follow the provisions of Article III A. (8) of the Employer Benefit Plan which requires that $1,000 of all covered medical expenses incurred by any family member first be counted toward satisfaction of the annual deductible. Once the Complainant has met the deductible, the Respondent is required to follow the hold harmless provision of Article III A. (10) (h) 2. of the Employer Benefit Plan when a charge has been determined to be excessive during a calendar year.