OPINION OF TRUSTEES

In Re

Complainant: Pensioner
Respondent: Employer
ROD Case No: CA-074 - January 30, 2008

Trustees: A. Frank Dunham, Michael H. Holland, Elliot A. Segal, and Carlo Tarley.

The Trustees have reviewed the facts and circumstances of this dispute concerning the provision of benefits under the terms of the Coal Industry Retiree Benefit Act of 1992 (Coal Act) Employer Benefit Plan maintained pursuant to section 9711 of the Internal Revenue Code.

Background Facts

The Complainant ceased working in a classified job for the Respondent on May 12, 1993, to have surgery on his left foot, which he injured in a mining accident in August 1991. According to the Respondent, the Complainant was eligible for 52 weeks of Sickness and Accident benefits but “did not have the required hours worked to entitle him to the balance of the month plus 12.” Therefore, the Respondent determined that the Complainant was eligible for continuation of health coverage through May 13, 1994.

On June 10, 1993, the Respondent was struck by the United Mine Workers of America ("UMWA") and the Complainant’s health coverage was terminated. The strike ended on December 15, 1993. Complainant had continued health coverage through COBRA, paying the last COBRA premium in the amount of $256.02 for the period from December 14, 1993, to January 13, 1994. The Respondent reinstated the Complainant’s health coverage effective December 16, 1993, and provided health coverage through May 13, 1994. Subsequently, the Complainant elected COBRA coverage. The Complainant paid COBRA premiums for the period of May 14, 1994, through November 13, 1994.

The Complainant was notified by letter dated October 29, 1999, that he was awarded a 1974 Pension Plan Disability pension, retroactive to January 1, 1994. Subsequently, the Respondent reinstated the Complainant’s health coverage with the same effective date.

The Complainant requested reimbursement for medical expenses incurred by his family at a local hospital. According to the Complainant’s spouse, from June 15, 1998 to September 19, 2003, her health coverage (Unicare/Healthlink) through her employer was primary for both her and the Complainant. Unicare continued to be the Complainant’s spouse’s primary coverage until the end of November 2005, when her coverage was terminated.

The Complainant submitted printouts of his account from the hospital's accounting office as documentation for reimbursement of covered medical expenses. The printouts provide the patient's name, date of birth, admittance and discharge dates, insurance billing and payment information, Current Procedural Terminology ("CPT") code, a five-digit identifier which provides a description of the medical procedures or services provided to the patient, and the diagnostic code, which is developed by the World Health Organization for the purpose of classifying causes of death and disease and is used by physicians to report a patient's diagnosis to a health insurance carrier. The diagnostic code is commonly referred to as ICD9. For some of the charges listed on the hospital printout, the Complainant also provided copies of Explanation of Benefit (EOB) statements along with cancelled checks.

According to Funds' records, the Complainant was eligible for Medicare Parts A & B on June 1, 1999. His Medicare Part B enrollment date was October 1, 2001.

Following a review of the information submitted, the Respondent reimbursed the Complainant $404.09 for claims dated November 5, 1998, November 16, 1998, and December 20, 1998, because the Complainant provided EOB statements for these claims.

The Respondent states that the printouts and documentation submitted by the Complainant is insufficient to review the claims (other than those mentioned above) for which the Complainant is requesting reimbursement. The Respondent has asked the Complainant to submit a standard insurance claim form known as "UB-92" for each claim for which he is seeking reimbursement. According to the Complainant, the hospital will reproduce copies of the "UB-92" claim forms for a fee. The Respondent states that it is not responsible for the cost of reproducing copies of the Complainant's UB-92 claim forms.

The Respondent also states that because the Complainant's spouse had other insurance coverage, the Complainant should submit copies of the EOB statements and UB-92 claim forms from his spouse's insurance carrier so that the Respondent may appropriately coordinate benefits.

Dispute

Is the information submitted by the Complainant sufficient for the Respondent to reimburse the Complainant for the medical expenses? If the information submitted by the Complainant is not sufficient, then is the Respondent required to pay for the costs of reproducing the UB-92 claim forms?

Is the Respondent required to reimburse the Complainant for the balance of the premium paid for the COBRA coverage from January 1 to January 13, 1994?

Is the Respondent required to provide coverage and to reimburse the Complainant for medical expenses during the period when the Complainant was eligible for, but not enrolled in, Medicare Part B?

Positions of the Parties

Position of the Complainant: The Complainant submitted sufficient information to the Respondent for the requested reimbursement. If UB-92 claim forms are required to review for reimbursement, the Respondent should cover the cost of the UB-92 claim forms. The Respondent should reimburse the Complainant for all COBRA premiums paid during this period. The Respondent should reimburse the Complainant for medical expenses incurred by his family at a local hospital.

Position of the Respondent: The information submitted by the Complainant lacks “clear ICD9 codes, diagnosis codes and hospital revenue codes,” and the Respondent will not consider it. The Respondent cited ROD 81-573 to support this position indicating that “the Trustees ruled [in ROD 81-573] that the respondent is responsible for payment of medical charges . . . upon proper submission of itemized claims information.” In order for the Respondent to “appropriately coordinate benefits,” the Complainant must provide EOB statements and UB-92 claim forms for the claims paid by the Complainant’s spouse’s employer’s insurance carrier. The Respondent also states that “requiring claims to be submitted on appropriate forms falls within reasonable procedures.”

The Complainant is responsible for the cost of reproducing copies of the UB-92 claim forms because the Complainant should have received the form from the provider or should have requested the form at the time of service. The Respondent states that ROD 88-440 supports its position in this case.

The Complainant became Medicare eligible on June 1, 1999, but did not enroll in Medicare Part B until October 1, 2001. Respondent asserts that claims between these dates are not eligible for consideration because the Complainant would not have been an eligible Beneficiary. The Respondent states that ROD 81-260 supports its position in this case.

Pertinent Provisions

Article I (1), (2) and (4) of the Coal Act Employer Benefit Plan provides:

Article I Definitions

The following terms shall have the meanings herein set forth:

(1) "Employer" means (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) "Pensioner" shall mean any person who is receiving a pension, other than (i) a deferred vested pension based on less than 20 years of credited service, or (ii) a pension based in whole or in part on years of service credited under the terms of Article II G of the 1974 Pension Plan, or any corresponding paragraph of any successor thereto, under the 1974 Pension Plan (or any successor thereto), whose last classified signatory employment was with the Employer, subject to the provisions of Article II of this Plan. Notwithstanding the foregoing, "Pensioner" shall not mean any person who had not met all age and service requirements for receiving benefits as of February 1, 1993, and shall not mean any person who retires from the coal industry after September 30, 1994.

Article II of the Coal Act Employer Benefit Plan provides in pertinent part:

Article II Eligibility

The persons eligible to receive the health benefits pursuant to Article III are those individuals who are entitled to receive such benefits under section 9711 of the Internal Revenue Code, subject to the eligibility provisions of the Employer Plan in effect on February 1, 1993 [the Employer Benefit Plan maintained pursuant to the National Bituminous Coal Wage Agreement of 1988 (1988 Employer Benefit Plan), and to all other provisions of this Plan. . . .

As noted in Article II of the Coal Act Employer Benefit Plan, individuals eligible to receive health benefits under section 9711 of the Internal Revenue Code (the Coal Act) are subject to the eligibility provisions of the Employer Benefit Plan in effect on February 1, 1993. The Plan in effect on February 1, 1993, was the 1988 Employer Benefit Plan.

Article III. A. (10) (d) of the Coal Act Employer Benefit Plan provides:

(d) Medicare

1. For Pensioners, and surviving spouses, the benefits provided under the Plan will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive benefits provided under the Plan only to the extent such benefits are not provided under Medicare.

2. For Employees age 65 or older the benefits provided under the Plan will be paid to a Beneficiary unless the company is furnished written notice of electing coverage under Medicare rather than coverage under the Plan. Alternatively, the participant may elect to enroll for Medicare as secondary payer.

The Plan Administrator shall give written notification of the obligation to enroll with respect to 1. above and of the options to enroll with respect to 2. above. For active

> Employees, such notice shall be given prior to their 65th birthdays, but subsequent to their 64th birthdays. Said notice shall explain the limited annual enrollment period and the effect of failing to enroll if retirement should occur prior to the next enrollment period. Failure to provide such notification shall not remove any obligation to enroll.

Article III. A. (11) (a) 3. of the Coal Act Employer Benefit Plan states:

> (11) General Exclusions
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> (a) In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:
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> 3. Services furnished by any governmental agency, including benefits provided under Medicaid, Federal Medicare and Federal and State Black Lung Legislation for which a beneficiary is eligible or upon proper application would be eligible.

Discussion

The Complainant was awarded a disability pension effective January 1, 1994, and is receiving health coverage from the Respondent. His eligibility for health coverage is not in dispute. In dispute is whether sufficient information has been submitted regarding medical bills submitted to the Respondent during the time coverage was in effect. To support his request, the Complainant submitted printouts of the Complainant's account from the hospital's accounting office, EOB statements for some of the claims listed on the printouts, and copies of checks. The Respondent states that the information submitted by the Complainant is insufficient to provide reimbursement because it lacks "clear ICD9 codes, diagnosis codes and hospital revenue codes." The Respondent cited ROD 81-573 to support its position. The issue in ROD 81-573 was the payment of covered services during an employee's period of active employment. The Trustees found that the Respondent was responsible for payment of medical charges "upon proper submission of itemized claims information." However, the Trustees did not specifically address what constituted "itemized claims information."

The Respondent states that "requiring claims to be submitted on appropriate forms falls within reasonable procedures" and refers to ROD 88-440 to support this position. In ROD 88-440, the employer changed its claims procedures, and an employee failed to follow the new procedures. As a result, the employee's medical bill was sent to collections. The Trustees determined that because the change in the claims procedure was reasonable and clearly communicated to Employees, the Employer was not liable for the charges incurred as a result of the unpaid bill. What exactly is required in a claims form was not addressed in ROD 88-440.

In order to review the Complainant's claims for reimbursement, the Respondent has required that the Complainant submit copies of the UB-92 claim forms that are sent from the provider to the insurance carrier for payment. Information generally required to pay a claim include the following: diagnosis and CPT code; place of service; date of service; patient's name; provider's name; and the charge for the service. Although a UB-92 claim form provides the information necessary to process a medical claim, the same information may be provided through other means.

The hospital account information submitted by the Complainant provides the following information: place and date of service; name of the patient and provider; CPT codes; charge for the service; and diagnostic codes. The information submitted by the Complainant would be considered sufficient to review for reimbursement by the health plans administered by the Funds. As a result, the Trustees do not need to address the issue of whether the Respondent is required to pay for the costs of reproducing the UB-92 claim forms.

On December 16, 1993, the Respondent signed the Wage Agreement of 1993 and reinstated the Complainant's benefits coverage. The last COBRA premium paid by the Complainant during the strike period was $256.02 for the period from December 14, 1993, to January 13, 1994. The Respondent reimbursed the Complainant $140.38 for the COBRA premium paid for the period of December 15, 1993, to December 31, 1993. The Trustees have previously determined that when an Employee has paid the Employer for the cost of insurance premiums to maintain coverage during a period when the Employer is obligated to provide coverage, the Employer is required to reimburse the Employee for the cost of the insurance premiums. See RODs 88-327 and 88-450. Therefore, the Respondent is also required to reimburse the Complainant $115.64 for the balance of the premium paid for the COBRA coverage from January 1 to January 13, 1994.

According to Funds records, the Complainant's effective date under Medicare Part A was June 1, 1999. His Medicare Part B effective date was October 1, 2001. Article III. A. (10)(d) of the Coal Act Employer Benefit Plan states that the benefits provided under the Plan will not be paid to a Beneficiary unless such Beneficiary is enrolled in each part of Medicare for which he is eligible. Article III. A. (11) (a) 3 j. of the Coal Act Employer Benefit Plan excludes from coverage benefits provided under Medicare for which a Beneficiary is eligible or upon proper application would be eligible. The Respondent is not required to provide health benefits for the Complainant from June 1, 1999 to September 30, 2001, under the Employer Benefit Plan, because during that period the Complainant was eligible for, but not enrolled in, Medicare Part B. ROD 81-260 supports this conclusion. Consequently, the Respondent is not required to reimburse the Complainant for medical expenses during the same period.

Opinion of the Trustees

The information submitted to the Respondent is sufficient to review for reimbursement of medical expenses incurred by the Complainant and his dependents, subject to the Coordination of Benefits provisions in Article III. A. (10)(f) 1. and 2. of the Coal Act Employer Benefit Plan.

The Respondent is required to reimburse the Complainant $115.64 for the balance of the premium paid for the COBRA coverage from January 1 to January 13, 1994.

The Respondent is not required to provide coverage or to reimburse the Complainant for medical expenses during the period the Complainant was eligible for, but not enrolled in, Medicare Part B.