In the Matter of the Arbitration Between

UNITED STEELWORKERS OF AMERICA

and

INLAND STEEL COMPANY
Indiana Harbor Works

O P I N I O N

Grievance Filed	December 3, 1975
Meeting with Local Union Representative	December 12, 1975
Minutes of Meeting with Local Union Representative	April 14, 1976
Meeting with International Union Representative	June 23, 1976
Minutes of Meeting with International Union Representative	August 24, 1976
Arbitration Appeal	November 22, 1976
Arbitration Hearing	December 9, 1977
Award Issued	January 6, 1973

When the Union and the Company determined that they could not resolve the grievance of Ermer Johnson they submitted it to Patrick J. Fisher as sole Impartial Arbitrator. Pursuant to notice a hearing was held at the Holiday Inn of Chicago South, Harvey, Illinois, on December 9, 1977. At this hearing the parties were given the opportunity to present oral and written evidence, to examine witnesses and to make arguments. Both the Union and the Company waived their right to submit post-hearing briefs.

The Company denied sickness and accident benefits to Ermer Johnson and she filed a grievance on December 3, 1975, which reads as follows:

> The grievant, Ermer Jean Johnson, #21146, was denied Accident and Sickness benefits from October 15, 1975 through November 13, 1975, in violation of the P.I.B. Agreement.
>
> RELIEF SOUGHT: The grievant be paid all monies due her.

The Union contends that Ms. Johnson was totally disabled after October 14, 1975, and that the Company improperly denied sickness and accident benefits beyond that date. It maintains that the failure to provide benefits through November 13, 1975, constituted a violation of the Program of Insurance Benefits which the parties had negotiated. The Union claims that the grievant did not intentionally deprive the Company's insurance carrier of its right of medical examination. It asserts that when Ms. Ermer received a letter in October relating to a second examination she was confused and thought that the letter merely covered the first examination she already had. The Union argues that there can be no doubt about the fact of her disability because the Company made that determination by denying her claim for Supplemental Employment Benefits.

The Company contends that the denial of sickness and accident benefits was proper because of the grievant's failure to comply with the requirement in the Program of Insurance Benefits and the Certificate of Insurance that she undergo physical examinations. It points out that Ms. Johnson did not respond to the insurance carrier's request for an examination dated October 15. The Company maintains that her failure to make inquires in respect to that request denied the insurance carrier an opportunity to determine whether she was still disabled. The Company cites paragraphs 2.0 and 2.9 of the Program of Insurance Benefits which provide:

> 2.0 If you become totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment and a licensed physician certifies thereto, you will be eligible to receive weekly sickness and accident benefits. Benefits will not be payable for any period during which you are not under the care of a licensed physician. In order for you to be eligible for benefits the Company must receive written notice of your claim within 21 days after you disability commences, but this requirement will be waived upon showing of good and sufficient reason

that you were unable to furnish such notice or have it furnished by someone else on your behalf as described in paragraph 2.8.

2.9 The payment of sickness and accident benefits is an obligation of the Company, but the Agreement with the Union permits the Company to provide the payment in accordance with a policy with an insurance company. The Company performs important administrative functions in connection with the handling of claims, including the issuance of benefit checks. In the typical case, such handling is routine and a claim is paid within two weeks after it is received by the Company. The Company is authorized to make benefit payments on claims without prior approval of the insurance company when Company personnel engaged in claims work determine the claim meets the standards established by the insurance company for Company approval. If you have a claim which does not meet these standards it is referred to the insurance company for decision and you are notified of such action within two weeks after the claim is received by the Company. In reaching its decision, the insurance company may take reasonable steps to investigate the medical and other factual aspects of the claim.

It also refers to the Certificate of Group Insurance which states:

. . . .

EXAMINATIONS. The Equitable shall have the right and opportunity through its medical representative to examine any person when and so often as it may reasonably require during the pendency of claim under the policy.

. . . .

On September 3, 1975, Ermer Jean Johnson reported to the Medical Department at the Indiana Harbor Works complaining of low back pain. She was released from work, and on the following day she was examined by her personal physician, Dr. Roger Gordon. He diagnosed her condition as lumbosacral sprain. The grievant then filed a claim for sickness and accident benefits. In the attached physician's statement Dr. Gordon described her disability as "lumbar sacral strain." Ms. Johnson was also examined by a physician appointed by the Company's insurance carrier, The Equitable Life Assurance Society. Thereupon benefits in the

amount of $118.00 per week were authorized and paid. However, Equitable advised the Company to review her status by October 13, 1975 "to establish a new guideline." By October 13 Ms. Johnson had not returned to work and was still drawing sickness and accident benefits. Because of that a second physical examination by an Equitable-appointed doctor was deemed necessary. Thereupon, on October 15, 1975, the Company wrote to Ms. Johnson and notified her that her claim had been referred to Equitable for "evaluation, investigation and/or medical examination." On the same day Equitable wrote the following letter to Ms. Johnson:

> Your Sickness and Accident coverage provides that The Equitable Life Assurance Society of the United States shall have the right and the opportunity to have any employee submit to a medical examination during the pendency of the claim under the policy.
>
> If you are still off work and are making claim for Sickness and Accident benefits in connection with your present absence, you are hereby requested to telephone the office of our examiner indicated below to make arrangements for a physical examination.
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> | | | |
> |---|---|---|
> | Dr. N. A. Martirez | 4710 Indianapolis East Chicago, Indiana | Phone Number 397-0223 |
>
> THE EXAMINERS OFFICE MUST BE CONTACTED IMMEDIATELY, BUT IN ANY EVENT, NO LATER THAN SEVEN DAYS AFTER THE DATE OF THIS LETTER.
>
> Failure to comply with this request will result in the loss of any Sickness and Accident benefits you may claim under the Group Insurance Policy. If you cannot comply with the request, you should notify this office immediately and the reason thereof.
>
> If you have returned to work, do not contact the examiners office, but write the date you were able to return to work at the bottom of this letter and return the letter to the Equitable address indicated above.

Ms. Johnson made no response to the foregoing letter and her sickness and accident benefits were discontinued.

This is not a SUB case. Supplemental unemployment benefits are separate and distinct from sickness and accident benefits. The entitlement to each is governed by a separate document. An employee can be denied SUB benefits for failure to register with the State Employment Security Division. Therefore, it cannot be found that the denial of an employee's SUB claim establishes that he is disabled. Certainly the Program of Insurance Benefits doesn't provide that such an employee is automatically entitled to sickness and accident benefits.

Ms. Johnson was familiar with the procedures for filing claims for sickness and accident benefits because of her experience in filing five previous claims which resulted in seventy-three weeks of compensated time off. Perhaps that accounts for the fact that neither she nor the Union have challenged the right of Equitable Assurance Society to insist upon a physical examination. Nor does the grievant make any claim that she was unable to contact Dr. Martirez. The Union asserts that she was confused because she also received a layoff notice within the period when she was to report to the doctor. However, if that were the case, all Ms. Johnson had to do was to make a telephone call to the insurance company or to Inland Steel. She had received letters from both of them and each of those letters was written in language which was easy to understand. The letter from Equitable advised her to notify them if she couldn't comply with the request. It also stated that failure to comply "will result in the loss of any Sickness and Accident benefits you may claim."

It is difficult to understand how the grievant could have associated the request for a physical examination with an earlier request because more than four weeks had elapsed since her previous examination. The insurance carrier had no way of knowing how long her disability would last. There were additional reasons for an examination by a physician appointed by Equitable. At the

time when Dr. Martirez examined the grievant on September 12, 1975, he made the following comment on his report:

> This patient is hard to evaluate as she has had similiar episode of Lumbar sacral problem I regret that I can not determine, if she is really disabled or not. Patient claims her physician may consider her release by Oct.

Ms. Johnson had changed doctors and the new doctor had given a different diagnosis than that by Dr. Gordon. He had made a determination that her problem was caused by a strain. However, Dr. Broomes' diagnosis identified her condition as one which results from an inflammation or an infection of a muscle.

Under the Program of Insurance Benefits, as well as the Certificate of Insurance, Equitable had a right to require the grievant to submit to a physical examination. The language in those documents is clear and unambiguous. However, Ms. Johnson didn't respond to the letter from the insurance carrier. Because of her failure to have a physical examination by Dr. Martirez Equitable was deprived of the opportunity to determine whether she was still totally disabled. That failure to cooperate makes it necessary to hold that the grievance is without merit.

A W A R D

Ermer Jean Johnson was properly denied sickness and accident benefits. The grievance is denied.

Patrick J. Fisher, Impartial Arbitrator

January 6, 1978.