

**SOUTH DAKOTA DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT**

**NANCY WILLOUGHBY,
Petitioner,**

HF No. 14 G, 2006/07

v.

DECISION

**GEDDES SCHOOL DISTRICT,
Respondent.**

This matter comes before the Department of Labor based on Petitioner Nancy Willoughby's Petition for Hearing on Grievance filed pursuant to SDCL 3-18-15.2. Petitioner appeared on her own behalf. Rodney Freeman, Jr. represented Respondent Geddes School District. The Department of Labor conducted a hearing on February 26, 2008, in Lake Andes, South Dakota. Upon consideration of the live testimony given at hearing and the evidence presented at hearing, Petitioner's request for relief is hereby denied.

Issues:

1. Whether Petitioner timely filed her Petition for Hearing on Grievance.
2. Whether Respondent violated, misinterpreted, or inequitably applied its policies and procedures when it refused to pay claims for medical services provided when the South Dakota School District Benefits Fund Healthcare Plan was in force.
3. Whether Respondent violated, misinterpreted, or inequitably applied its policies and procedures by not answering Petitioner's questions during and after the meeting of April 9, 2007.

Facts:

Based upon the record and the live testimony at hearing, the following facts are found by a preponderance of the evidence:

1. Petitioner and Respondent are parties to a collective bargaining agreement called the Geddes Negotiated Agreement (the Agreement).
2. The Agreement was effective for the period from July 1, 2005 through June 30, 2006.
3. Petitioner worked as a first and second grade teacher for the Geddes School District during the 2005/2006 school year.
4. During the 2005/2006 school year, Petitioner paid premiums into Respondent's self-funded healthcare benefits plan.
5. The healthcare benefit plan was known as the South Dakota School District Benefits Fund Healthcare Plan (the Plan).
6. The Plan was administrated by the South Dakota School District Benefits Fund.
7. First American Administrators out of Rapid City, South Dakota, acted as the Plan's claims administrator.
8. The Agreement provides under the Insurance section of the Agreement:

The board shall have the exclusive right to choose the insurance carrier and program. The teachers association shall review the insurance program and coverage on an annual basis and give its recommendations, in writing, to the board for the board's considerations.

1. Health - - the district will pay up to \$300 per month toward the school's group single coverage insurance for each teacher with a 50% teaching contract or greater. The teacher shall have the option of choosing a higher deductible (if the plan provides such an option) and receiving 85% of the difference between the amount offered toward a single premium and the lower premium.
9. During the 2005/2006 school year, Respondent's Board of Education realized that consolidation with either the Platte School District or the Armour School District was inevitable.
10. The Board of Education determined that a switch to the same healthcare plan as either the Platte or the Armour School Districts was a prudent step to take in the consolidation process.
11. Respondent, through its business manager, informed the Geddes Education Association, of which Petitioner was a member, that it was looking to switch healthcare plans.
12. Respondent asked for input from the Geddes Education Association regarding the switch in healthcare plans.
13. Respondent made the decision to switch healthcare plans from the Plan to the Sioux Valley Health Plan (SVHP).
14. The Geddes Education Association approved the switch in healthcare plans.
15. Respondent held multiple educational sessions with employees affected by the change in healthcare plans.
16. The Plan ended on June 30, 2006.
17. SVHP began as a secondary payer on June 1, 2006.
18. Respondent informed employees, including Petitioner, that all claims had to be submitted in writing to the Plan by June 30, 2006.
19. Petitioner received written instructions to submit all claims to the Plan by June 30, 2006.
20. Petitioner received written and verbal notice that claims not submitted by June 30, 2006, would be denied.
21. Under the SVHP, Petitioner selected a \$1500.00 deductible and did not elect to have her husband insured on the new healthcare plan.
22. Respondent informed employees, including Petitioner, that the Plan would end on June 30, 2006.
23. Petitioner's husband was insured through the Plan. He incurred expenses through the Veterans Administration (the V.A.) during the plan year.
24. Respondent, through Stephanie Hubers, called all employees on June 15, 2006, and again warned each employee that all claims had to be submitted by June 30, 2006. Respondent also asked each employee about any medical expenses that had been incurred in the preceding six months.

25. In response to Stephanie Hubers's questions, Petitioner responded that all claims had been submitted and gave Hubers a list of all medical providers whom she had seen in the preceding six months. Petitioner did not mention her husband's treatments with the V.A.
26. Petitioner incurred medical expenses on June 30, 2006.
27. Petitioner did not submit her claim to the Plan by June 30, 2006. The claim was submitted after June 30, 2006.
28. The Plan's administrator denied Petitioner's claim because she had not filed it by the June 30, 2006, deadline.
29. SVHP accepted Petitioner's claim and applied the \$1,092.75 to her \$1,500.00 deductible.
30. Petitioner submitted her claim to a private policy of insurance she had purchased from Blue Cross/Blue Shield.
31. Petitioner's Blue Cross/Blue Shield paid for all expenses except \$279.67 and a \$20.00 co-pay for two office visits.
32. Petitioner did not submit her husband's medical expenses from the V.A. to the Plan until sometime in the fall of 2006.
33. Petitioner's V.A. claims were denied by the Plan.
34. Upon reconsideration, Petitioner's V.A. claims were ultimately accepted, in part, by the Plan Administrator, Malcolm McKillop, on August 29, 2007.
35. Petitioner seeks reimbursement for \$2,126.40 to the V.A. and \$1,092.75, with Blue Cross/Blue Shield receiving \$793.08 of that amount.
36. Petitioner filed a Petition for Hearing on Grievance. Her Statement of Grievance provides:

After having paid premiums for health insurance the Geddes School Board refuses to pay claim for medical services provided while policy was in force. We met with the School Board April 9, 2007. They refused to answer any of our questions by telling us they had to talk to their lawyer. We have not had a response as of this date. My husband and I are requesting a hearing with the SD Department of Labor.

37. Respondent filed its Answer denying the Petition, alleging that the Petition "fails to set forth any rule, regulation, policy, ordinance, contract or agreement that has been violated."
38. Respondent also moved to dismiss the Petition, arguing that the Petition was not timely filed. Respondent renewed its Motion to Dismiss at time of hearing.
39. Other facts will be developed as necessary.

Issue One

Whether Petitioner timely filed her Petition for Hearing on Grievance.

SDCL 3-18-1.1 defines a grievance:

The term "grievance" as used in this chapter means a complaint by a public employee or group of public employees based upon an alleged violation, misinterpretation, or inequitable application of any existing agreements,

contracts, ordinances, policies or rules of the government of the state of South Dakota or the government of any one or more of the political subdivisions thereof, or of the public schools, or any authority, commission, or board, or any other branch of the public service, as they apply to the conditions of employment. Negotiations for, or a disagreement over, a nonexisting agreement, contract, ordinance, policy or rule is not a "grievance" and is not subject to this section.

The Department's role in resolving a grievance is defined by SDCL 3-18-15.2. SDCL 3-18-15.2 reads, in part:

If, after following the grievance procedure enacted by the governing body, the grievance remains unresolved . . . it may be appealed to the department of labor . . . The department of labor shall conduct an investigation and hearing and shall issue an order covering the points raised, which order is binding on the employees and the governmental agency.

The burden of proof is on Petitioner. Rininger v. Bennett County Sch. Dist., 468 N.W.2d 423 (S.D. 1991).

Respondent's grievance procedure provides in relevant part:

1. The definition of Grievance shall be that as identified in SDCL 3-18-1.1. A complaint by a public employee or group of public employees based on an alleged violation, misinterpretation, or inequitable application of any existing agreements, contracts, ordinances, policies, rules or regulations, as they apply to the conditions of employment. Negotiations for, or a disagreement over, a non-existing agreement, contract, ordinance, policy, rule or regulation is not a "grievance" and is not subject to this section.
2. The teacher will present his/her grievance to the Principal/Elementary Administrator in writing within fifteen (15) calendar days from the time the teacher knew or should have known of the circumstances causing rise for said grievance.
3. If the grievance is not resolved at Level I within five (5) calendar days after the Principal/Elementary Administrator has received the grievance, the teacher may present the grievance, in writing, to the Superintendent/CEO at Level II, the same to be done with fourteen (14) calendar days from the time the teacher filed the grievance with the Principal/Elementary Administrator.
4. If the grievance is not resolved within fourteen (14) days at Level III, the teacher may present the grievance in writing to the Board of Education. The Board of Education will hear the matter giving rise to said grievance at the next regularly scheduled Board meeting. The Superintendent/CEO and teacher shall be present at the executive session held relative to said grievance, and shall have the right to be represented at said hearing. The Board shall issue its decision, in writing, within fourteen (14) calendar days of the meeting.
5. The time limits above may be extended by mutual agreement, in writing, by the aforementioned parties.

6. The teacher may appeal (Level IV) the decision of the Board to South Dakota Department of Labor should the teacher feel aggrieved by the decision of the Board.

Petitioner did not file a Grievance Form or a Level I Grievance with her Principal/Elementary Administrator. Petitioner was advised by letter dated March 15, 2007, that her healthcare claims would be denied. Petitioner did not file the proper paperwork with 15 days of the March 15, 2007, letter. The terms in the Agreement are mandatory and must be followed. Petitioner's grievance was not timely filed and must be denied.

Issue Two

Whether Respondent violated, misinterpreted, or inequitably applied its policies and procedures when it refused to pay claims for medical services provided when the South Dakota School District Benefits Fund Healthcare Plan was in force.

The Department lacks jurisdiction over this issue. The Plan's Summary Plan Description provides the following regarding a disputed claim under the Plan:

S10.03 APPEALING A CLAIM

If your claim is denied in whole or in part, you will receive written notification delivered in the same fashion as reimbursement for a claim. An Explanation of Benefits will be provided by the Claims Administrator showing the calculation of the total amount payable, charges not payable, and the reason. If additional information is needed for payment of a claim, the Claims Administrator will request same. You may request a review by filing a written application with the Claim Administrator for delivery to the Plan Administrator. On receipt of written request for review of a claim, the Claims Administrator will review the claim and furnish copies of all documents and all reasons and facts relating to the decision to the Plan Administrator. You or your authorized representative may examine pertinent documents (except as information may be contained therein which the "physician" does not wish made known to the claimant) which the Claims Administrator has and you may submit your opinion of what are the issues and your comments in writing to the Claims Administrator, which will be forwarded to the Plan Administrator. Requests for review must be filed within 120 days after denial is received; however, we suggest it be filed promptly whenever possible. Decision by the Plan Administrator will be final and will be made within 60 days unless special circumstance require extension. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provisions upon which the decision is based. All statements and documentation provided to the Plan Administrator will be confidential.

S10.04 ADMINISTRATION AND PLAN ADMINISTRATOR AUTHORITY

The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Claimant's Administrator experienced in claims processing.

The Plan is a legal entity. Legal notices may be filed with and legal process served upon the Claims Administrator and Plan Administrator.

The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of this Plan and Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of the Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.

Petitioner has not shown that she followed this process for appealing the denial of her claims or that Respondent or its agents failed to follow this procedure. The Plan requires that a denial of a medical claim be appealed to the Plan Administrator. On August 29, 2007, Respondent's Plan Administrator reconsidered the denial of the V.A. claims and ordered partial reimbursement the claims. Based upon the record before the Department, the appeal process for a disputed claim under the Plan was followed. The Department of Labor lacks jurisdiction over a dispute regarding whether the Plan Administrator acted arbitrarily or capriciously in denying a medical claim. The Department's jurisdiction is limited to a "violation, misinterpretation, or inequitable application" of regulations by Respondent. The Plan is a legal entity and is governed by laws outside of those contemplated by SDCL 3-18-1.1.

Issue Three

Whether Respondent violated, misinterpreted, or inequitably applied its policies and procedures by not answering Petitioner's questions during and after the meeting of April 9, 2007.

The meeting of April 9, 2007, was a regular board meeting where Petitioner was allowed to present her concerns regarding her medical claims. The Plan gives the Plan Administrator the power to terminate and amend the Plan at any time, under any circumstances, subject to the Negotiated Agreement Language. The Plan provides:

S10.06 PLAN TERMINATION

The Plan Administrator may terminate the Plan at any time. Upon termination, the rights of participant and dependents to benefits are

limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to participants.

S10.08 AMENDMENT OF PLAN DOCUMENT

The Plan Administrator or its designee may modify or amend the Plan from time to time at its sole discretion and such amendments or modifications which affect covered participants will be communicated to the participants.

S10.22 PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any participant or to be a consideration for, or an inducement or condition of, the employment of any participant. Nothing in the Plan shall be deemed to give any participant the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Sponsor with the bargaining representative of any participants.

Petitioner was given timely notice of all changes. The Board listened to her questions regarding the healthcare coverage at the April 9, 2007, meeting and was not obligated to provide an answer. Respondent did not violate, misinterpret, or inequitably apply its policies and procedures by not answering Petitioner's questions. Based upon the foregoing, Petitioner's request for relief is denied and must be dismissed in its entirety.

Respondent shall submit proposed Findings of Fact and Conclusions of Law, and an Order consistent with this Decision within ten (10) days from the date of receipt of this Decision. Petitioner shall have ten (10) days from the date of receipt of Respondent's proposed Findings of Fact and Conclusions to submit objections thereto or to submit proposed Findings and Conclusions. The parties may stipulate to a waiver of Findings of Fact and Conclusions of Law and if they do so, Respondent shall submit such Stipulation along with an Order in accordance with this Decision.

Dated this 25th day of April, 2008.

SOUTH DAKOTA DEPARTMENT OF LABOR

Heather E. Covey
Administrative Law Judge