STATE EMPLOYMENT
RELATIONS BOARD

2005 SEP -9 P 12: 18

**IN THE MATTER OF CONCILIATION
BETWEEN**

CITY OF INDEPENDENCE	)	
	)	**CASE NO. 04-MED-09-0984**
	)	
AND	)	
	)	
	)	**<u>OPINION AND AWARD</u>**
INDEPENDENCE FIRE FIGHTERS	)	
ASSOCIATION, IAFF LOCAL 2375	)	

JAMES M. MANCINI, ARBITRATOR

APPEARANCES:

FOR THE UNION

**Susannah Muskovitz, Esq.
Ryan J. Lemmerbrock, Esq.**

FOR THE CITY

Jack L. Petronelli, Esq.

SUBMISSION

This matter concerns conciliation proceedings between the City of Independence (hereinafter referred to as the Employer or City) and the Independence Fire Fighters Association, IAFF Local 2375, AFL-CIO (hereinafter referred to as the Firefighters or Union). The State Employment Relations Board (SERB) duly appointed the undersigned as conciliator in this matter. Conciliation proceedings were held on August 8, 2005.

This conciliation proceeding was conducted pursuant to the Ohio Collective Bargaining Law as well as the rules and regulations of SERB. During the conciliation proceeding, this conciliator attempted mediation of the issues at impasse. Pursuant to those mediation efforts, the parties agreed that this conciliator could issue his Opinion and Award on the issues presented to him based upon the arguments and evidence submitted. The parties further agreed that this conciliator could issue his awards in summary fashion with an abbreviated explanation.

The applicable bargaining unit involved herein consists of all full-time firefighters. There are approximately eighteen firefighters in the bargaining unit.

This conciliator in rendering the following awards of the issues at impasse has taken into consideration the criteria set forth in Ohio Revised Code Section 4117-14(G)(6)(7). This conciliator therefore after carefully reviewing all of the arguments presented by the parties hereby submits his Opinion and Award with respect to each of the outstanding issues submitted.

1. HOURS OF WORK

The Union proposes a 48 hour workweek effective with the first full work cycle of 2006. The City proposes to retain the current work schedule of 50.4 hours per week.

ANALYSIS – This conciliator adopts as his award herein with reference to the Hours of Work issue the Employer's final offer. That is, the current 50.4 hour workweek for firefighters shall be retained with no change.

The evidence indicates that the current work schedule of 50.4 hours per week is comparable to the workweeks of firefighters in neighboring jurisdictions. Workweek comparables for 2004 indicate that Independence ranked sixteenth among the twenty-five cities used in the comparison. Moreover any further reduction in the current workweek would have additional cost implications for the City.

AWARD

This conciliator hereby awards the City's position with respect to Hours of Work.

ARTICLE XVI, HOURS OF WORK

Section 16.01 – Current language, no change.

Section 16.02 – Current language, no change.

2. HOSPITALIZATION INSURANCE

The Employer proposes to change Article XXIX to reflect the current healthcare plan that went into effect on January 1, 2005. Further, the City proposes that effective April 1, 2006 the article be modified to reflect that a different healthcare plan is to be implemented. Finally, the Employer proposes that there be a change to Section 29.02 effective on April 1, 2006 whereby the employees would become responsible for contributing 10% towards healthcare premiums.

The Union agrees to the changes in Section 29.01 proposed by the City to reflect that the current plan became effective on January 1, 2005. Moreover, the Union can agree to change Section 29.01to reflect that effective April 1, 2006 there is to be a different healthcare plan. However, the Union opposes the City's proposal to have employees contribute 10% towards healthcare premiums.

ANALYSIS – This conciliator hereby awards the Union's position with respect to the Hospitalization Insurance issue. Section 29.01 is to be modified to reflect that the current healthcare plan which is set forth in Appendix A became effective on January 1, 2005. The provision shall also be modified to indicate that effective on April 1, 2006 all employees are to have coverage as summarized in Appendix B. Additional language would be provided whereby if any employee desired coverage in Appendix A, the employee would pay the difference in cost through automatic payroll deduction. In addition, the prescription drug card provision is to be modified to provide for an $8 deductible for generic drugs and a $15 deductible for name brand drugs.

This conciliator would also finds that the City shall continue to pay for the entire cost for family or single coverages. This would follow the pattern established whereby the City has agreed to continue to pay the entire premium for hospitalization insurance for all other employees. There is no basis to support the City's proposal that firefighters be singled out as being the only employee group to have to contribute towards healthcare premiums and for that reason, the fact-finder's recommendation on this issue cannot be adopted.

Finally, this conciliator would adopt the joint medical/hospitalization insurance committee language which the parties agreed should be included in the firefighters' contract.

AWARD

This conciliator hereby awards the Union's position with respect to the Hospitalization Insurance issue as more fully set forth below:

ARTICLE XXIX, HOSPITALIZATION INSURANCE

The Employer will provide on behalf of each full-time employee and his family if such employee is married, the drug, dental and vision coverage as follows:

(A) Effective January 1, 2005, all employees shall have the coverage summarized and contained in Appendix A (Current Plan), through March 31, 2006.

(B) Effective April 1, 2006, all employees shall have the coverage summarized and contained in Appendix B.

(C) Effective April 1, 2006, if any employees desire the coverage summarized and contained in Appendix A, the employee will pay the difference in cost through automatic payroll deduction. The Employer will make the cost and option available to the employee before March 31, 2006.

(D) The prescription drug card provision shall be modified to provide for an eight ($8.00) dollar deductible for generic drugs and a fifteen ($15.00) dollar deductible for name brand drugs.

29.02. Modify as follows:

The Employer will pay for family coverage or for single coverage, whichever is applicable for Appendix A coverage through March 31, 2006 and for Appendix B coverage from April 1, 2006 though December 31, 2007.

29.02 Modify as follows:

The parties agree that in their continued efforts to reduce hospitalization medical costs the Employer-wide Joint Medical/ Hospitalization Insurance Committee will be maintained and convened as necessary to review alternative insurance coverages and plans and make recommendations to the Employer. It is understood that such recommendations do not obligate either party contractually. If the Committee obtains a plan more favorable to employees than the plans to be in effect on January 1, 2005 or April 1, 2006, at a cost acceptable to the Employer, such plan, at the Employer's discretion, may be substituted for the then Current Plan.

UnitedHealthcare Choice Plus *Plan 001(Mod-FTE)*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care.*

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all the rules very carefully and compare them with the rules of any other plan that covers you and your family.
Benefits are underwritten by United HealthCare Insurance Company.

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Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** No Annual Deductible. **Out-of-Pocket Maximum:** $500 per Covered Person per calendar year, not to exceed $1,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 per Covered Person.	**Annual Deductible:** $100 per Covered Person per calendar year, not to exceed $200 for all Covered Persons in a family **Out-of-Pocket Maximum:** $900 per Covered Person per calendar year, not to exceed $1,800 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 per Covered Person.
1. Ambulance Services - Emergency only	Ground Transportation: No Copayment Air Transportation: 0% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*No Copayment *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $50,000 per calendar year.	No Copayment	*20% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$50 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one each calendar year from a Network Provider.	$10 per visit	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	No Copayment	*20% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	No Copayment	*0% of Eligible Expenses
8. Hospital - Inpatient Stay	No Copayment	*20% of Eligible Expenses
9. Injections Received in a Physician's Office	$10 per visit	20% of Eligible Expenses
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	No Copayment	20% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	No Copayment	20% of Eligible Expenses
Outpatient Therapeutic Treatments	No Copayment	20% of Eligible Expenses
12. Physician's Office Services Network and Non-Network Benefits for Child Health Supervision Services are limited to $500 from birth to age 1, thereafter; $150 per calendar year from ages 1 to 9.	$10 per visit No Copayment applies when a Physician charge is not assessed.	20% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	No Copayment	20% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $50,000 per calendar year.	No Copayment	20% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 60 visits of physical therapy; 60 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	$10 per visit	20% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	No Copayment	*20% of Eligible Expenses
18. Transplantation Services	*No Copayment	*20% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	$35 per visit	10% of Eligible Expenses
Additional Benefits		
Cytologic Screening and Screening Mammography Benefits for Screening Mammography performed in Ohio are limited to $85 per test.	Same as 11, 12, and 13	Same as 11, 12, and 13
Mental Health Services For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 50 visits per calendar year for outpatient Mental Health Services, and to 30 days per calendar year for inpatient Mental Health Services.	For outpatient Mental Health Services: $10 per individual visit; $5 per group visit For inpatient Mental Health Services: No Copayment	20% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 12 visits per calendar year.	$10 per visit	20% of Eligible Expenses
Substance Abuse Services - Outpatient, Inpatient, and Intermediate For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 50 visits per calendar year for outpatient Substance Abuse Services, and 30 days per calendar year for inpatient Substance Abuse Services.	For outpatient Substance Abuse Services: $10 per individual visit; $5 per group visit For inpatient and intermediate Substance Abuse Services: No Copayment	20% of Eligible Expenses

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. Refer to Section 6 of the COC (External Independent Review for Terminal Conditions) for exceptions to this exclusion.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces) are excluded. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. Residential treatment services.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would

have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you and health services while on active military duty. This exclusion does not apply if you have continued coverage during a call to military duty as described in Section 8 of the COC under the heading Continuation of Coverage During Military Service.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion. Emergency ambulance transportation is a Covered Health Service as described in Section 1 of the COC.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends. This exclusion does not apply when coverage is extended as described in Section of 8 of the COC under the heading of Extended Coverage if You are an Inpatient.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer or as necessary to safeguard a Covered Person's health due to an non-dental physiological impairment. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

UnitedHealthcare Choice Plus *Plan 001(M2-FTE)*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care.*

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all the rules very carefully and compare them with the rules of any other plan that covers you and your family.
Benefits are underwritten by United HealthCare Insurance Company.

OHXGMXXX02

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $150 per Covered Person per calendar year, not to exceed $300 for all Covered Persons in a family **Out-of-Pocket Maximum:** $600 per Covered Person per calendar year, not to exceed $1,200 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 per Covered Person.	**Annual Deductible:** $300 per Covered Person per calendar year, not to exceed $600 for all Covered Persons in a family **Out-of-Pocket Maximum:** $1200 per Covered Person per calendar year, not to exceed $2.400 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 per Covered Person.
1. Ambulance Services - Emergency only	Ground Transportation: 10% of Eligible Expenses Air Transportation: 10% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*10% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $50,000 per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$50 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one each calendar year from a Network Provider.	$10 per visit	30% of Eligible Expenses Eye Examinations for refractive errors are not covered.

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	10% of Eligible Expenses	*30% of Eligible Expenses
8. Hospital - Inpatient Stay	10% of Eligible Expenses	*30% of Eligible Expenses
9. Injections Received in a Physician's Office	$10 per visit	30% of Eligible Expenses
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	30% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Therapeutic Treatments	10% of Eligible Expenses	30% of Eligible Expenses
12. Physician's Office Services Network and Non-Network Benefits for Child Health Supervision Services are limited to $500 from birth to age 1, thereafter; $150 per calendar year from ages 1 to 9.	$10 per visit No Copayment applies when a Physician charge is not assessed.	30% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	30% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $50,000 per calendar year.	10% of Eligible Expenses	30% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 60 visits of physical therapy; 60 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	$10 per visit	30% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	10% of Eligible Expenses	*30% of Eligible Expenses
18. Transplantation Services	*10% of Eligible Expenses	*30% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	$35 per visit	30% of Eligible Expenses
Additional Benefits		
Cytologic Screening and Screening Mammography Benefits for Screening Mammography performed in Ohio are limited to $85 per test.	Same as 11, 12, and 13	Same as 11, 12, and 13
Mental Health Services For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 50 visits per calendar year for outpatient Mental Health Services, and to 30 days per calendar year for inpatient Mental Health Services.	For outpatient Mental Health Services: $10 per individual visit; $5 per group visit For inpatient Mental Health Services: 10% of Eligible Expenses	30% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 12 visits per calendar year.	$10 per visit	30% of Eligible Expenses
Substance Abuse Services - Outpatient, Inpatient, and Intermediate For Network Benefits, you must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 50 visits per calendar year for outpatient Substance Abuse Services, and 30 days per calendar year for inpatient Substance Abuse Services.	For outpatient Substance Abuse Services: $10 per individual visit; $5 per group visit For inpatient and intermediate Substance Abuse Services: 10% of Eligible Expenses	30% of Eligible Expenses

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the COC for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. Refer to Section 6 of the COC (External Independent Review for Terminal Conditions) for exceptions to this exclusion.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces) are excluded. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of Mental Illnesses which will not substantially improve beyond the current level of functioning, or for conditions not subject to favorable modification or management according to generally accepted standards of psychiatric care, as determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. Residential treatment services.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would

have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you and health services while on active military duty. This exclusion does not apply if you have continued coverage during a call to military duty as described in Section 8 of the COC under the heading Continuation of Coverage During Military Service.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion. Emergency ambulance transportation is a Covered Health Service as described in Section 1 of the COC.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise ıerapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends. This exclusion does not apply when coverage is extended as described in Section of 8 of the COC under the heading of Extended Coverage if You are an Inpatient.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer or as necessary to safeguard a Covered Person's health due to an non-dental physiological impairment. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

3. COMPENSATION SCHEDULE

The Employer proposes wage increases of 3% effective January 1, 2005 with 3.25% increases in compensation in each of the final two years of the Agreement. The Union proposes wage increases for firefighters of 3.5% effective January 1, 2005, 3.75% on January 1, 2006, and 3.75% on January 1, 2007.

ANALYSIS – This conciliator adopts as his award with respect to the wage issue the City's final proposal. That is, there is to be a wage increase for firefighters of 3% retroactive to January 1, 2005, 3.25% increase on January 1, 2006, and another 3.25% increase effective on January 1, 2007. Such wage increases would be the same as those which have been provided to the police and dispatchers' bargaining units. Wage comparables for firefighters in the area provides further support for the wage award rendered in this case.

A W A R D

This conciliator hereby awards the Employer's proposal with respect to wage increases for the bargaining unit.

ARTICLE XXXIV, COMPENSATION SCHEDULE

January 1, 2005 – 3.0% across the board increase (retroactive)

January 1, 2006 – 3.25% across the board increase

January 1, 2007 – 3.25% across the board increase

4. PARAMEDIC COMPENSATION

The Union proposes that retroactive to January 1, 2005, every Firefighter/ Paramedic shall be paid an additional $500. Effective January 1, 2006, the paramedic pay shall be increased to $1,000 per year.

The Employer is opposed to any provision providing for any type of compensation for paramedic pay. The City proposes to retain the current schedule which it notes contains two pay schedules with one for employees with paramedic certification and another for employees without paramedic certification.

ANALYSIS – This conciliator hereby awards the Union's position with respect to paramedic compensation. That is, effective in January 1, 2005 every Firefighter/ Paramedic qualified as a paramedic is to be paid an additional $500. Effective January 1, 2006, the paramedic pay shall be increased to $1,000 per year to be paid as part of the firefighter's regular pay. It should be noted that all firefighters employed by the City of Independence are certified paramedics.

Comparable evidence establishes that paramedic pay is provided to other firefighters in area jurisdictions. For example, paramedic pay is currently provided to firefighters in Brooklyn, Solon, and Valley View. Moreover with the additional paramedic pay provided herein, the Independence Fire Fighters will be able to retain their relative ranking in the area with respect to total compensation received. With the City's final wage proposal and paramedic pay proposal which is being adopted herein, the firefighters in Independence will continue to be ranked nineteenth among the jurisdictions

in the area with respect to their total compensation. The evidence submitted clearly does not support the fact-finder's recommendation on this issue.

AWARD

This conciliator hereby adopts the Union's proposal with respect to paramedic pay.

PARAMEDIC COMPENSATION

(New) 34.02. The following language is to be added:

Retroactive to January 1, 2005, every Firefighter/Paramedic qualified as a paramedic shall be paid an additional $500 to be paid consistent with the employee's work schedule as part of the regular pay. Effective January 1, 2006, every Firefighter/Paramedic qualified as a paramedic shall be paid an additional $1,000 per year, to be paid consistent with the employee's work schedule as part of the regular pay. As used in this section, qualified paramedic shall mean Firefighter/Paramedic who has successfully completed a Paramedic course, certified by the State of of Ohio, and who maintains a current paramedic certification under all laws of the State of Ohio, that govern said certifications, including any continuing education requirements. If a Firefighter/Paramedic performs duties as a "qualified paramedic" for only part of the year, or remains with the City of Independence Fire Department for only part of the year, the $1,000 shall be paid pro-rata and consistent with the employee's work schedule. There shall be no lump sum payment of paramedic pay.

5. TENTATIVE AGREEMENTS

The parties entered into a number of tentative agreements which this conciliator hereby incorporates into his report. Those tentative agreements are attached hereto.

IAFF Local 2375 and City of Independence
SERB Case No.: 04-MED-09-0984
Tentative Agreements
August 1, 2005

ARTICLE XXIII, SICK LEAVE

23.01. Add to end of section: "Sick leave of more than five (5) separate occurrences in any calendar year is cause for a review."

ARTICLE XXIII, SICK LEAVE

23.07. Delete: "...residing at the home of the employee..."

ARTICLE XXIV, DISABILITY LEAVE

24.04. Change first sentence as follows: "The Chief may assign transitional work to firefighters, at his discretion, who are injured on-duty or incurred an illness, assuming work is available." Remainder of section to remain unchanged.

ARTICLE XXV, LEAVE OF ABSENCE

25.01. Add to end of section: "An employee who is granted an unpaid leave of absence shall not accrue any benefits during his absence, including seniority."

ARTICLE XXXIII, OIC PAY

33.01. Increase OIC pay from $1.50 per hour to $1.75 per hour, effective upon ratification.

ARTICLE XL, DURATION OF AGREEMENT

40.01. Change "December 31, 2004" to "December 31, 2007."

ARTICLE ___, PERFECT ATTENDANCE

Section 1. Effective January 1, 2005, sick leave incentive shall be paid in accordance with these guidelines. If an employee does not utilize any of his sick leave within a four-month period, i.e. January 1st through April 30th, May 1st through August 31st, September 1st through December 31st, he/she shall be paid a bonus of three hundred dollars ($300.00) at the end of that four-month pay period. If an employee does not utilize any sick time for the entire year, along with the four-month bonuses of three hundred dollars ($300.00), he/she shall be given an additional three hundred dollar ($300.00) bonus at the end of each year of this Agreement.

Section 2. For purposes of this Article, the mandatory use of sick leave under the Disability Article shall not be deemed sick leave absence.

ARTICLE ___, ALCOHOL & CONTROLLED SUBSTANCES POLICY

See attached.

3/23/05

City of Independence

Alcohol & Controlled Substances Policy

I. PURPOSE

It is the policy of the City of Independence that its employees be free of substance and alcohol abuse.. Consequently, the use of controlled substances by employees is prohibited. Further, employees who use alcohol while on duty shall be deemed to have engaged in prohibited conduct. The City will take the necessary steps, including controlled substance and alcohol testing to meet our overall goal, prevention, detection, deterrence and rehabilitation rather than termination.

II. APPLICABILITY

This policy applies to all employees of the City.

III. TESTING REQUIRED

The cost of the testing shall be borne by City of Independence.

Pre-employment

Reasonable suspicion – employee violated the alcohol or controlled substance prohibitions, based on specific, direct, articulable, observations concerning the appearance, behavior, speech or body odors of the employee Erratic/abnormal behavior, deteriorating work performance.

Post-accident – an unplanned, event that occurs on City business, during working hours, or involves City supplied motor vehicles that are used in conducting City business or is within the scope of employment and which results in any of the following:

a. a fatality of anyone involved in the accident
b. bodily injury to employee or another person that requires off-site medical attention
c. vehicular damage in apparent excess of $~~750.~~ 1500
d. Non-vehicular damage in apparent excess of $5~~00.~~ 1,000

When such an accident results in one of the situations above, any employee involved in such accident will be tested for controlled substance or alcohol use or both.

IV. CONTROLLED SUBSTANCE DEFINITIONS

The term **"controlled substance"** include cannabis as well as other controlled substances including but not limited to **(amphetamines, cocaine, marijuana, opiates and PCP)** as defined in the Ohio Revised Code. The term "drug usage" includes the use of cannabis or any controlled substance which has not been legally prescribed and/or dispensed, or the abusive use of a legally prescribed drug. The term "**drug test**" means a urinalysis test consisting of an initial screening (EMIT) test and a confirmation test employing the gas chromatography/mass spectrometry (GC/MS). ~~utilizing urine samples collected according to procedures and chain of custody established by this policy.~~

Alcohol concentrations exceeding .04 will be considered a verified positive result. In the event of an accident where an employee has a "whole blood" alcohol drawn at a medical treatment facility, a result equal to or greater than .04 shall be considered to be a verified positive result. The City also expressly reserves the right to add or delete substances on the list above, ~~especially~~ if mandated by changes in existing Federal or State regulations or legislation.

V. USE OF ALCOHOL AND/OR DRUGS

Employees while on duty shall not be under the influence of alcohol or drugs, nor have their ability to safely, efficiently and effectively perform the duties of their position impaired as a result of the use of alcohol or drugs. No employee shall use, possess, sell, deliver or purchase an illegal drug during working hours (including duty-free rest and lunch periods).

VI. EDUCATION OF EMPLOYEES REGARDING DRUG TESTING

Every current employee will be required to attend a session in which this program is discussed. The written policy will be shared, and everyone will be expected to sign for receipt. A qualified person will explain why and how substance use is a workplace problem, the effects, signs/symptoms of use, effects of commonly used drugs in the workplace and how to get help. There will be a minimum of two hour of educational awareness annually for all employees. New employees will hear about the program during orientation and will receive substance education as soon as possible.

~~Supervisor Training~~ Supervisors will be trained to recognize substance problems that may endanger the employee and others as well as violate this Policy. This training is in addition to annual employee education. Supervisors will be trained about testing responsibilities, how to recognize behaviors that demonstrate alcohol/drug problem and how to make referrals for help.

VII. PROCEDURES

The City will use a third-party vendor to provide sampling and testing of employees. The testing program consists of an initial screening test. If the initial results are positive, then a second test is used. Cut-off levels for each drug and for alcohol are established based on federal guidelines. Any individual subject to testing under this Policy shall be permitted to provide urine specimens in private, but subject to strict scrutiny by collection personnel so as to avoid any alteration or substitution of the specimen to be provided. There are many other protections for employees that are built in. The certified lab will report the results to a Medical Review Officer (MRO) designated by the employer. Before reporting a positive test result to the employer, the MRO will attempt to contact the employee to discuss the test result. If the MRO is unable to contact the employee directly, the MRO will contact the Human Resource Manager or Employer Management Official designated in advance by the employer, who shall in turn contact the employee and direct the employee to contact the MRO immediately or, if after the MRO's business hours and the MRO is unavailable, at the start of the MRO's next business day. In the MRO's sole discretion, a determination will be made as to whether a result is positive or negative. Cut-off levels are used to determine when an employee has enough of a certain drug or alcohol in his/her system so that it should be considered a positive test.

1. Discipline resulting from controlled substance abuse/alcohol abuse will be handled on an individual basis and the Union will be informed of the City's action immediately~~, provided the employee has authorized disclosure to the Union.~~

   Upon the findings of positive for a controlled substance by the tests, the Employer shall conduct an internal investigation to determine if facts exist to support the conclusion that the employee knowingly used an illegal controlled substance. Upon the conclusion of such investigation, an employee who has tested positive for the presence of controlled substance/alcohol abuse pursuant to this Section shall ~~be referred to~~ an employee assistance program or detoxification program at the employee's expense (if such exceeds Employer health care coverage), as

determined by appropriate medical personnel unless, the employee has previously tested positive within three (3) years for the use of controlled substance/alcohol, refused to participate in an EAP or counseling, or some other unusual and/or exceptional facts exist so as to bypass the EAP, in which case the Employer shall have the right to disciplinary action, including termination. An employee who participates in a rehabilitation or detoxification program shall be allowed to use accrued paid leave for the period of the detoxification program. If no such leave credits are available, such employee shall be placed on a family and medical leave of absence without pay for the period of the rehabilitation or detoxification program. Upon completion of such program and a retest that demonstrates the employee is no longer using a controlled substance, the employee shall be returned to his position. Such employee may be subject to periodic retesting at the sole discretion of the Employer upon his return to his position for a period of one (1) year. "Periodic" shall mean not more than twelve (12) times per year except that substance abuse tests may be performed at any time upon "reasonable suspicion" of drug use. Any employee in the above mentioned rehabilitation or detoxification programs will not lose any seniority or benefits should it be necessary that he be required to take a family and medical leave of absence without pay for a period not to exceed (90) days.

2. If the employee refuses to undergo and complete rehabilitation or detoxification, of if he test positive at any time within one (1) years after his return to work upon completion of the program for rehabilitation, such employee may be subject to disciplinary action, up to and including termination. Except as otherwise provided herein, costs of all drug screening tests and confirmatory tests shall be borne by the Employer.

3. No controlled substance abuse/alcohol testing shall be conducted without the authorization of the Mayor. Refusal to submit to toxicology testing after being ordered to do so may result in disciplinary action, including termination. Records of controlled substance abuse and alcohol testing shall be kept in the office of Human Resources and shall be kept confidential except as provided by the Ohio Public Records laws, however, test results and records may be used in future disciplinary actions as set forth in the Article.

4. Records of disciplinary action or rehabilitation resulting from positive test results may be used in subsequent disciplinary actions for a period of ~~three (3) years~~ TWO (2) years.

VIII. Employee Assistance

The City believes in offering assistance to employees with a controlled substance/alcohol abuse problem. We are supportive of employees taking action on their own behalf to address a controlled substance/alcohol abuse problem. The City believes in offering a second chance to employees who are willing to do something about their problem. ~~To help those who come forward voluntarily and those who test positive in violation of this Policy, we've established a relationship with an employee assistance provider.~~ It is important for the employee to come to an understanding regarding the extent of the problem in order to correct the problem and avoid future violation of this policy. If employee is willing to actively engage in resolving the substance/alcohol abuse problem, the City will refer the employee to the provider for an assessment and possible outpatient counseling with a substance professional. THE EMPLOYEE ASSISTANCE INFORMATION WILL ALSO BE PROVIDED TO THE UNION IN ORDER TO ASSIST MEMBERS IN SEEKING EMPLOYEE ASSISTANCE WITHOUT THE INTERVENTION OF THE CITY

IX. POSITIVE TEST RESULTS

Employees who are found to have a confirmed positive drug or alcohol test will be immediately take off safety-sensitive duties.

CONCLUSION

In conclusion, this conciliator hereby submits his awards on the outstanding issues presented.

SEPTEMBER 7, 2005

JAMES M. MANCINI, CONCILIATOR