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STATE EMPLOYMENT
RELATIONS BOARD
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STATE OF OHIO
STATE EMPLOYMENT RELATIONS BOARD
STATUTORY FACT FINDING PROCEEDING

In the Matter of the Fact Finding between:

**UNIVERSITY OF TOLEDO CHAPTER,
AMERICAN ASSOCIATION OF UNIVERSITY
PROFESSORS, and**

SERB Case Nos.

01-MED-10-0983

**COMMUNICATION WORKERS OF AMERICA,
Local 4530, and**

01-MED-08-0704

**UNIVERSITY OF TOLEDO POLICE
PATROLMEN'S ASSOCIATION,
Local No. 70**

01-MED-12-1107

Employee Organizations

- and -

THE UNIVERSITY OF TOLEDO,

Employer

FACT FINDER'S REPORT AND RECOMMENDATION

Hearings convened on the 20th and 28th days of February and March 18, 2002,
at The University of Toledo Student Union in the County of Lucas and State of Ohio.

DATE OF REPORT: APRIL 1, 2002

APPEARANCES:

Representative for the UT-AAUP
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Representative for the Employer
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PART ONE: INTRODUCTION

I. BACKGROUND

This case grows out of a dispute between The University of Toledo ("The University"), The University of Toledo Chapter of the American Association of University Professors ("UT-AAUP"), The Communication Workers of America Local 4530 ("CWA"), and The University of Toledo Police Patrolman's Association ("UTPPA") involving negotiation of health care re-openers covering two units (Tenure/Tenure Track and Adjunct/Visiting Professors) represented by UT-AAUP and separate bargaining units represented by CWA and UTPPA.

The parties held negotiation sessions since the summer of 2001 on health care issues through the University's Joint Benefits Committee. By agreement filed on February 8, 2002, with the State Employment Relations Board, the parties consented to multi-unit bargaining and mutually selected Stanley T. Dobry to serve as fact finder. Although the parties agreed to submit the matter to a single fact finder each party has retained its respective right to accept or reject the fact finder's report within the time limits of O.R.C. 4117.14. The parties agreed to extend the statutory time lines with the understanding the fact finder's report would be issued on April 1, 2002. The parties position statements were filed in accordance with the Fact Finder's directions and Ohio Admin. Code 4117-9-05.

II. MEDIATION AND TENTATIVE AGREEMENTS

The first two days of the hearings were essentially a mediation. The parties identified several components of the health care benefits plan they agreed upon. The mediation resulted in both parties changing their originally-presented Position Statement proposals, and some tentative agreements were made. The parties were unable to resolve all the differences between them. However, the mediation had the ancillary beneficial effect of familiarizing the fact finder with the history of the benefits plan and the current issues and parties' interests.

The tentative agreements are incorporated herein by reference as though set forth in full, and are a part of the formal recommendations of the fact finder. While these few agreements were reached voluntarily and will effect changes and savings, it is unfortunate the parties were unable to finish the job.

III. THE HEARING, PROCEDURE AND PARTICIPANTS

The three day hearing was conducted with a degree of informality. To a large extent, it is a case that is filled out by piles of documents. The rules of evidence were *not* followed. The parties were given a full opportunity to elucidate their convictions. The procedure was a formalized extension of the mediation and collective bargaining that preceded it. We tailored the process to fit the special needs of the dispute.¹ It was designed to give the fact finder a comprehensive understanding of the issues, and the competing facts, arguments and priorities attached to the positions.

In addition to the advocates listed above, in attendance were:

For the Employer:

Deithra Glaze, Director of Benefits
Laura Newman, Director of Labor and Employee Relations
Al Comley, Senior Director of Business Services
Joe Klep, Labor Relations Specialist
Pamela Courtney, Human Resources Secretary
Craig Burns and David Manning, Burns Consulting Associates Inc.
Greg Arndt, CPA, William Vaughn Company
Adele M. Jasion, CPA, Gilmore, Jasion & Mahler, Ltd.

For the Unions:

Dr. James King, Benefits Comprehensive, Health Care Consultant
Michael Ledford, CWA President
Lynn Gowing, CWA Vice President
Wayde Bockert, CWA Chief Steward
Sherry Lewallen, CWA Steward
Rick Seward, CWA Bargaining Committee Member
Mike Kozmatak, CWA Bargaining Committee Member
Dr. Harvey Wolff, UT-AAUP President
Dr. Cathy Thompson-Casado, UT-AAUP Bargaining Committee Member
Maureen Conroy, UT-AAUP Joint Benefits Committee Representative

Dr. Patricia Groves testified under oath for the Unions regarding the issue of domestic partner benefits, in supplement to the documentary evidence presented by the unions on that issue.

Throughout the proceeding, Dr. James King worked with the Unions, and Craig Burns worked with the Employer as experts for the fact finder. They offered technical guidance and insight into the arcane workings of the health care insurance process. Their valuable critique has been taken into account in this recommendation.

As a personal note, I appreciate each parties' strenuous efforts in preparing and presenting their case. Obviously this was labor intensive and time consuming. Each has strongly held positions. I write this opinion and recommendation in the hope that the effort will not be in vain, and they can avoid the losses, consequences, and risks of an ongoing labor dispute or strike.

IV. FACT-FINDERS AUTHORITY AND STATUTORY CRITERIA

The following findings and recommendations are offered for the parties' consideration. They were arrived at pursuant to their mutual interests and concerns, in light of the entire record.

The applicable statute, Ohio Revised Code Section 4117.14(C), and the SERB regulation, Ohio Administrative Code Section 4117-9-05, govern this proceeding. They require that the fact-finder in making his recommendations consider:

¹That's why they call it "Alternate Dispute Resolution."

1. Past collectively bargained agreements, if any, between the parties;
2. Comparison of the unresolved issues relative to the employees in the bargaining unit with those issues related to other public and private employees doing comparable work, giving consideration to factors peculiar to the area and classification involved;
3. The interest and welfare of the public, the ability of the public employer to finance and administer the issues proposed, and the effect of the adjustments on the normal standard of the public service;
4. The lawful authority of the public employer;
5. Any stipulations of the parties;
6. Such other factors, not confined to those listed above, which are normally or traditionally taken into consideration in the determination of the issues submitted to mutually agreed upon dispute settlement procedures in the public service or in private employment.

V. OVERVIEW OF THE UNIVERSITY OF TOLEDO

The University of Toledo is the fourth largest of Ohio's thirteen State Universities. It was established in 1872 and became a member of the State University system in 1967. The University offers more than 140 programs of study in eight colleges: Arts & Sciences, Business, Education, Engineering, Health and Human Services, Law, Pharmacy, and University College. The University holds a "Doctoral/Research Extensive" classification from the Carnegie Foundation.

The fall enrollment for the 2001-2002 (fiscal year 2002) was 20,313 students. The annual fees for full time students are \$5,103 for Ohio residents and \$12,461 for non-residents. Graduate fees are \$7,266 for Ohio residents and \$14,624 for non-residents. These fees were raised by 9% over the 2000-2001 fees by the University's Board of Trustees in June, 2001. The University operates on a semester calendar.

The General Fund Budget for the 2001-2002 (fiscal year 2002) academic year (July 1, 2001 through June 30, 2002) is \$205,000,000. The Auxiliary Fund Expenditure Budget for the 2001-2002 academic year is \$43,000,000.

VI. RELATIONSHIP AND INTERNAL COMPARABLES

The University has approximately 1,999 employees. A significant number are represented in four bargaining units.

<u>Bargaining Units</u>	<u>Number of Employees</u>
UT-AAUP Tenure/Tenure-Track	591
UT-AAUP Adjunct/Visiting Professor	27
CWA	622
UTPPA	<u>25</u>
<i>Total</i>	1,265

The remaining University employees are not represented for purposes of collective bargaining and consist of 650 professional staff, 24 classified exempt, and 60 twelve-month faculty.

There are currently approximately 1,862 employees plus their dependents that are covered by the University's health care benefit plan. The same benefit plan is provided to all employees regardless of whether they are in a bargaining unit or not. Likewise all employees pay the same monthly premium contribution of \$15.44 for single coverage, \$30.90 for two-party coverage, and \$46.34 for family coverage. Premiums are treated on a pre-tax basis pursuant to an IRS § 125 plan for all employees.

Thus, while a little over 60% of the University's employees are covered by a collective bargaining agreement, the nature of the health plan coverage has University wide implications. As such, internal comparability and symmetry are an important

consideration for the fact finder.

VII. EXTERNAL COMPARABLES

The parties provided comparable data via the State Employment Relations Board 1999 and 2000 Reports on the Cost of Health Insurance in Ohio's Public Sector. The employer also submitted a detailed report based upon a poll of other Ohio four year Universities (whether unionized or not). That data contained a detailed break down of the types of coverage provided by those employers, the networks through which care was provided, and monthly premium contributions paid by employees participating in the health program.

The data presented reflects the impact that health care has in the market place and upon employers making every effort to provide benefits to its employees.

The ranges of coverage and networks provided are diverse, depending upon geographic location. The employee contribution to premiums vary as well with a few employers continuing to provide 100% employee paid plans, and a significant number of employers who require employee contributions. Monthly premium contribution levels for employees vary depending upon the plan the employee elects and in some instances based upon the employee's income level or both.

While the parties did not follow this fact finder's preference of agreeing upon proposed comparables, nevertheless, the comparable data submitted helped.

VIII. DISPUTED ISSUES

The general issue submitted to fact finding was the contract reopener of the parties' health care benefit plan. Within that general topic the parties were in agreement that the University's dental and vision benefits would remain the same, that dependent pregnancy and kinesiotherapy (through the University's program) would be clarified as covered benefits and that the new pharmacy benefits manager would be Caremark through the Inter University Council Program.

The parties differed on the level of benefits to be offered, the networks through which the benefits would be offered, the monthly premiums the employees would pay for such coverage, the amount of prescription drug co-payments and whether a drug formulary should be utilized, among other issues.

PART TWO: DISPUTED ISSUES AND POSITIONS OF THE PARTIES

THE UNIVERSITY'S POSITION

Calendar Year 2002 Cost Projection.

In the absence of any changes in the current medical or prescription drug plan offered to UT employees, UT's costs are projected to increase by \$1,669,281, or 16.8% over 2001 Plan Year costs, based upon assumed inflation rates of 12.0% and 20.0% for medical and prescription drug claim costs, respectively. See Exhibit 140 and 155.

These levels of projected cost increases are supported by UT's 2001 Plan (Calendar) Year projections utilizing 12/0% and 20.0 % claim cost inflation projection which resulted in a variance of less than 0.5% from actual 2001 Plan Year Costs. See Exhibit 141.

Based upon the assumed inflation rates for Fiscal Year 2002, for medical and prescription drug claims exhibited above, actual expenses are approximately \$28,032 under the fiscal year projected expenses as of January 31, 2002. The end of year projection for fiscal year 2002, currently illustrate a projected shortfall of \$9,781. See Exhibit 124.

2001 RFP Process

Given the significant increases experienced by the UT community in health care costs since 1998, and corresponding with the expiration of the underlying collective bargaining agreement provisions related to health care benefits, UT and representatives of the Unions jointly agreed upon the selection of a health care consultant to prepare a Request For Proposal document and evaluate proposals received by UT pursuant to the RFP process.

Because of concerns expressed by the labor unions regarding the lack of information that had been shared with the UT Joint Benefits Committee, UT, in addition to retaining the services of a health care consultant, retained two independent CPA firms to audit and validate substantive provisions of finalist vendor proposals and to work with the consultant in the scoring of the RFP responses. See Exhibits 142 and 143.

Based on the responses to the RFP process, UT prepared specific proposals for changes in health care benefits commencing with the 2002 Plan Year.

Recommended 2002 Plan Year Changes

Given the escalation in costs experienced by UT over the life of the prior bargaining agreement, UT has proposed to offer employees choices among a PPO plan, a POS plan, and an EPO utilizing one of three health care provider networks, CHN, Paramount, or MMO.² Benefits are generally the same among all plan options and include improvements to the current PPO plan as well as increases in Prescription Drug co-pays under the Prescription Drug Plan. See Exhibits 111, 113 and 114.

Employees, in choosing their plan of benefits, must select from the current CHN network, which includes substantially all Toledo area hospitals, or from Paramount or MMO,² which do not include all Toledo area hospitals. See Exhibit 144.

Under the proposed UT plan of benefits, employees who elect any of the PPO or POS options and who choose to use an out-of-network hospital or other health care provider, are exposed, at the most, **a maximum additional out-of-pocket cost of \$500 annually per person.**³

Prescription drug benefits would be changed from the current \$2 generic, 80%/20% brand to a \$10 maximum to a \$4 generic, \$8 brand formulary, and \$16 brand non-formulary co-pay plan, with incremental changes made in years two and three of the

²Hospital and physician provider booklets for each network are set forth in Exhibits 113, 152, 153, and 154.

³ The \$500 is the maximum additional out-of-pocket costs to which an employee or other covered person is subject by going out of

contracts to \$5-\$10-\$20, then \$6-\$12-\$24, as reflected in Exhibits 111 and 113.

Given a 20.56% increase in prescription drug costs absorbed by UT in 2001 and the projected 20.0% increase in prescription drug costs for 2002, the gradual phase-in of increased co-pays under the prescription drug plan reasonably shares the increased cost of prescription drug benefits between the University and its employees. For example, the increase in co-pays to the proposed \$4 generic/\$8 brand formulary/\$ 16 brand non-formulary level reduces the level of increase in 2002 projected prescription drug costs for UT from 20.0% to 17.84%. See Exhibit 145.

While the selection of CHN offers UT employees in-network benefits at substantially any Toledo area hospital, the broad based nature of the CHN network comes with a significant cost in the form of higher payments to hospitals and physicians, and correspondingly higher costs for UT and its employees, compared to Paramount and MMO.

Furthermore, in comparing UT to a peer group of universities for whom data was available, UT's proposed plan of offering employee choice among competing networks with varying degrees of network coverage is both prudent and reasonable and common within the peer group. See Exhibits 144, 150, and 151.

UT's proposed benefit plan options represent a reduction in annual costs of approximately \$650,000 based upon the plan options shown in Exhibit 114. This would result in a reduction in UT's projected 2002 cost increase for medical and prescription drug benefits from \$1,669,281 to \$1,019,281, and would correspondingly reduce the rate of increase for 2002 from 16.8% to 10.27%. See Exhibit 146.

Over the three year term of the collective bargaining agreements between UT and the Unions, this would represent a total reduction in UT's future costs for medical and prescription drug benefits of \$1,950,000. Given the delayed effective date of any plan changes in 2002, not all of these cost reductions should be expected to be realized during this contract cycle.

Given the budget reductions being faced by the University and the potential for increased tuition costs to its students and parents, the University's proposal is a fiscally prudent step to take in light of the University's fiduciary responsibility to its students, parents, employees, and the tax payers of Ohio. If costs can be avoided by taking a balanced approach, it is more fiscally responsible to avoid these costs than to continue to incur costs which could result in the cutting of programs, services, or employees which would otherwise have to be reduced to balance the budget.

Under UT's proposal, total employee monthly premium contributions would increase by 3.0% from current levels for employees selecting either the POS plan with Paramount or the PPO plan with MMO (e.g. from \$15.44 to \$15.90 per employee per month). See Exhibits 107, 108, 109, 110, and 148. Employee premium contributions for the EPO plan with either Paramount or MMO would be reduced in total from current levels and contributions for the PPO benefit with CHN would be increased in total. See Exhibit 147 and 148.

The University's proposal further adjusts premium contributions by introducing a differential contribution rate based upon employee earnings. Employees earning less than \$30,000 annually would pay a reduced contribution from the baseline contribution rate, and employees earning greater than \$100,000 would pay an increased contribution from the baseline contribution rate. See Exhibit 148.

Economic Impact of Proposed Changes on Bargaining Unit Members

The improved Benefit Plan design proposed by the University is the same for all networks, with the exception of the Paramount option, which requires a gatekeeper (primary care physician) to direct referrals.⁴ See Exhibit 113. The

network. See Exhibit 113 at page 1.

⁴See Exhibit 113. The In-Network Plan design for the EPO options under the MMO and Paramount networks is the same in-network plan design as the CHN and MMO, PPO in-network and the Paramount POS in-network. See Exhibit 113. The EPO options do not have an out of network benefit. The out-of-network benefits for the CHN and MMO PPPO and the Paramount POS networks are the same with the maximum additional cost under any of the options to an employee or other covered person who utilizes an out-of-

gatekeeper is required by the Paramount proposal as Paramount has offered the University the opportunity to access its HMO level of discounts, which requires a gatekeeper, but through a POS format.

Because of better pricing available through the MMO and Paramount networks, the University's proposal differentiates the monthly premium charges to employees based upon the network the employee elects.⁵

Since calendar year 2000 to the present, employees have paid \$15.45 for single, \$30.90 for two-party and \$46.35 for family coverage each month. In calendar year 1999, employees paid \$15.00 for single, \$30.00 for two-party, and \$45.00 for family. See Exhibits 101 at 33, 102 at 15, 103 at 32, and 104 at 34. Under the University's proposal, employees earning between \$30,000 and \$100,000 dollars annually, opting to stay with the CHN network, would pay monthly premiums of \$24.81 for single (an increase of \$9.36 per month), \$49.64 for two-party (an increase of \$18.74 per month), or \$74.45 for family (an increase of \$28.10 per month). For a twelve month employee this amounts to an increased deduction of \$4.68 for single, \$9.37 for two-party, and \$14.05 for family per pay.⁶ The annualized increase in monthly premiums would be an additional \$112.32 for single, \$224.88 for two-party, and \$337.20 for family.⁷

Because of delays due to negotiations, these increased monthly premiums will not be charged until re-enrollment is completed following fact finding. Such reenrollment will take anywhere from 90 to 120 days. This means the earliest the new premium rates will go into effect is July 1, 2002.

By comparison during fiscal year 2002, (July 1, 2001 through June 30, 2002) University bargaining unit employee compensation will increase without any increase in the monthly premium contribution. See Exhibits 101 at page 30-33, 103 at page 31-32, and 104 at page 34 and 38.

The CWA received a 3% increase effective July 1, 2001; UTPPA received a 3% increase effective October 1, 2001; AAUP Adjunct employees received significant increases in minimum salary plus 3% increases retroactive for fiscal year 2002 (July 1, 2001 through June 30, 2002) and the University proposed (in fact finding) a 3% across-the-board increase for AAUP Tenure Track employees retroactive for fiscal year 2002. *Id.*

The CWA, UTPPA, and AAUP Adjunct bargaining units are scheduled to receive a 3% increase in fiscal year 2003 (July 1, 2002 through June 30, 2003) and the University has also proposed a 3% across-the-board increase for AAUP Tenure Track

network hospital or provider limited to an additional \$500 annually per person.

⁵The University has also adopted a wage/salary tiered premium contribution approach as proposed by the Unions based upon income levels of <\$30,000, \$30,000-\$ 100,000 and > \$100,000. See Exhibits 107, 108, 109, 110, and 148.

⁶Twelve month employees at the University are compensated over 26 pay periods, with medical premiums deducted from the first two pay periods in a month. Nine month employees are compensated over 18 or 19 pays with medical insurance deducted from each pay.

⁷All monthly premiums are charged to employees on a pre-tax basis under the University's IRS Section 125 Plan. See Exhibits 101 at page 34, 102 at page 15, 103 at page 33, and 104 at page 35. Monthly premiums to be charged to all employees would increase by 3% on January 1, 2003, and 3% on January 1, 2004, regardless of the network the employee chooses. Compare this to the inflation trends for medical and prescription drug costs which are averaging in the range of 19-20% for medical and 20-25% for prescriptions annually. See Exhibit 155. Comparing the proposed monthly premium increases, the University continues to absorb the vast majority of cost increases and is not unreasonably increasing employee premium participation. See Exhibits 140, 148, 160, and 162.

employees for fiscal year 2003. The CWA and UTPPA are scheduled for 3% increases for fiscal year 2004 (July 1, 2003 through June 30, 2004) while both AAUP contracts expire in 2003. *Id.* With the cost of living for the past twelve months running at approximately 1% (see Exhibit 160), University employees will have received wage increases for fiscal year 2002 without any health care premium increases. Employees will also receive an additional wage increase for fiscal year 2003 at or near the time any proposed medical premium increases take effect. The modest increases proposed are not unreasonable, given that the consumer price index has only increased slightly, medical inflation is running at high rates, and the monthly premiums have not increased in three years.

It is important to note that while proposing that an employee pay reasonable additional premium contributions if he/she elects to stay with the CHN, the University's proposals reduce the employee's monthly premium contributions, if an employee elects either the Medical Mutual or Paramount networks. Future monthly premium contributions grow at only a 3% increase each year. See Exhibit 148.

The Unions have claimed that the Medical Mutual and Paramount options restrict employee's access to all area hospitals. Exhibit 144 at page 3 demonstrates that most other Ohio Universities offer networks which do not provide 100% access to all hospitals. This makes economic sense in that networks will offer their best pricing to those employee plans which will direct business into their network. Under the University's proposal, an employee who is comfortable staying within a particular network can elect the EPO option. An employee who wants the protection of an out-of-network benefit (at a maximum expense of \$500 per covered person annually) can elect the CHN or MMO PPO options or the Paramount POS option.

It should also be noted, under the University's proposal, that employees who live in Michigan or outside the Toledo area can elect the Medical Mutual option and reduce their monthly premium costs because: 1) the Michigan network for CHN and MMO is the same (PPOM), and 2) because for such out-of-town employees claims are treated on an in-network basis. See Exhibit 159.

The University's proposal allows employees access to the same improved level of benefits under alternate network options which can lower an employee's monthly premium contribution from current levels and lowers an employee's exposure to out-of-pocket charges as a result of more competitive pricing. The University's proposal allows employees a range of options at monthly premium contributions which are reasonably reflective of the pricing offered by the networks to the University. The University's proposal allows employees to retain the CHN network at modest premium increases if they wish but also gives employees the option to reduce monthly premiums without sacrificing quality.

The Unions argue that the current plan is not broken and does not need to be fixed.⁸ The University has presented clear data to show that the costs of the health care plan have risen for the University and employees alike. While the Unions claim that the plan is performing adequately and argue the University's costs are lower than other Universities, *ergo* no changes should be made, the simple truth is the inquiry cannot end there. Given the budget constraints; the increased expense the University faces and increased tuition itsr students and parents face, the health care plan must be reviewed to determine if the benefits can be provided in a more cost efficient way.

In summary, the University's proposal reasonably balances the difficult problem of the escalating cost of health care with employee choice of programs and varying network access to hospitals and to health care providers. Under the UT proposal, employees may choose from the plan that best fits their needs and objectives, ranging from a PPO plan utilizing the CHN broad panel health care provider network, to PPO/POS and EPO plans utilizing the Paramount and MMO networks. The proposal continues to provide a quality health care program to employees in a fiscally prudent manner consistent with the University's fiduciary obligations to students, parents, employees, and the taxpayers of Ohio.

⁸The Unions have also proposed that domestic partner benefits be extended at the University. The University is not willing to extend domestic partner benefits until the matter is addressed by the legislature. See Substitute HB 234, Exhibit 149.

THE UNIONS' POSITION

The Unions' position can best be summarized by noting that the current Plan is functioning very well and consistent with its intended design, and that the Plan should be left largely intact as it was planned and approved to protect long-term health care issues which both the Employer and Unions face. The Union disputes the Employer's contention that the Plan does not operate in a cost effective manner and, therefore, must be moved to a more cost effective configuration. The Unions set forth the following elements as relevant in providing a complete and accurate evaluation of the present plan.

Several considerations, all of which have important implications to financial functioning of the plan, were considered in construction and implementation of the Plan. Among the more important issues that went into construction of the Plan design and that remain critical considerations that favor leaving the current Plan largely unchanged are:

1) Dispersion of the UT staff population.

The existing delivery system associated with the Rocket Plan was designed to provide UT plan participants with the highest level of coverage and deepest possible discounts. The Employer and labor recognized that the UT staff population live and receive health coverage outside the Lucas County, Ohio area. Surveys at the time the Plan was being constructed revealed that the majority of staff lived in a ten-county area comprising Northwest Ohio and Southern Michigan. However, it was also discovered that a considerable number of staff lived in other states including Indiana, Pennsylvania and New York. Still other members, primarily faculty, were covered while on temporary assignments associated with research programs, sabbaticals, and other assignments of a temporary nature.

The majority of other proposed programs placed significant restrictions on these staff. The HMO's required care to be given through panel members (largely restricted to the Northwest Ohio area) or pay 100% of the care (emergency care was considered an exception). For elective procedures, these plan participants were required to return to Northwest Ohio in order to receive coverage.

Preferred provider options were similarly severely restricted and involved conformance to strict "managed care requirements." These requirements included use of primary care physicians who alone determine whether procedures are medically necessary, whether they could perform them in their personal offices, and compliance with referral procedures including to whom and whether a referral was appropriate. Un-referred care amounted to denied care or care with significant and severe penalties to be endured by the patient whether or not the care was medically necessary.

In order to meet the needs of a geographic dispersed population and to avoid the negative penalties associated with managed care, the Plan was constructed to include multiple panels. Specifically, the geographically concentrated populations of Northwestern Ohio and Southern Michigan could receive "in-panel care" through providers associated with either the Cooperative Health Network (CHN) or Preferred Physicians of Michigan (PPOM). In order to address the nationally dispersed population of UT Plan participants, the Plan also included all providers participating in Multi-Plan. Reception of service through providers associated with any of these three systems was considered to be service received as "in-panel" or "in network" and the participant incurred no penalty.

The importance of the Plan's use of the three systems was to recognize the geographic dispersion of the population, to provide a comprehensive and equitable coverage for all Plan participants, and to realize some level of discount.

2) Importance of avoiding the negative aspects of "managed care."

The national literature regarding health care delivery systems is replete with examples of the abuses of "managed care." A great deal of what purports to be managed care is nothing more than "managing the money associated with care." The position of the Unions, and of the Committee which developed the Plan, is that physicians and not functionaries (nurses and employee physicians of the HMO, Insurance carrier, or alternate delivery system) should be making medical decisions on behalf of plan participants. Whether or not a referral is made should not be a financial decision controlled by these carriers, but by medical professionals whose primary interest is delivery of the highest quality service to plan participants.

The Committee recognized that medical necessity reviews would be required in some instances and included a medical review program. This review program was designed to operate independently of the employer and the delivery system. It also included an appeals process that could be accessed by patients and their physicians.

3) Willingness of staff to participate in plan elements that were important to achievement of required discounting.

- a. **Restriction of Providers.** Labor and the Employer recognize that deeper discounts are associated with restriction of providers. The Cooperative Health Network (CHN) provided the broadest level of providers (both inpatient and physicians) while still offering significant discounts. Discounts associated with this component of plan performance consistently produced between 40% and 42% discounts for its participants. Discounts associated with PPOM and Multi-Plan have been provided to the employer. Obviously, these discounts are not as deeply discounted as those associated with the CHN though are significant.

It must be noted that the discount amount also contains for the year 2000 a very limited discount, if any, for approximately \$1,200,000 in charges incurred outside the three panels considered as "in-panel." These incurred charges have only limited "fast pay" discounts and have the impact of limiting the overall size of the discounts. It must be remembered that these charges reflect the geographic and professional dispersion of the staff.

- b. **Increased Out of Pocket Payments.** In 1998 the total payments made through payroll deductions from employees amounted to \$755,091 or approximately \$30.24 PEPM in out of pocket expenses. (See Exhibit G1). Also see Exhibit G2 for a discussion as to how the Employer has failed to recognize the other financial contributions made by employees, associated with the pre-1999 Rocket Plan.)

In order to see that the plan was fully funded (funded to the level of expected costs), the employees agreed in 1999 to a 100% increase in the out of pocket cost associated with physician visits, ER visits, Urgent Care Center visits. They also agreed to significant deductibles and co-payments. The significance of these employee contributions are shown in Exhibit G3 which provides a projection of expected additional contributions based on plan design and industry standards. These expectations amounted to increasing staff out of pocket amounts by \$885,927.50 in addition to the \$815,220 generated through payroll deductions for an expected total of \$1,701,147.50 or a total increase to the staff of \$946,056.74. These numbers are based on holding the enrollments constant to those in place at the time (1998).

- c. **Maintenance of Payroll Deductions.** The Plan requires maintenance of some level of payroll deduction. Accordingly, a payroll deduction of approximately \$15 for a single plan, \$30 for a 2 party plan, and \$45 for a family plan has been maintained. See Exhibit FP1 for a full disclosure of the monies contributed toward the plan generated over the past three years through such deductions.
- d. **Out of Panel Penalties.** It was also recognized that there would be situations where care would be delivered outside the three provider systems. In order to discourage seeking care through non-panel providers a penalty consisting of a 20% differential from in-panel use was implemented.
- e. **Medical necessity review.** The Plan incorporates the use of an independent medical review function in order to review questionable procedures and care. The requirement for the review function of greatest importance outside of quality of procedures, was the independence of the review form the delivery system and providers. This was achieved.

4) Importance of pooling risk in a single plan.

Under the previous plans the potential for concentrations of risk in one provider delivery system versus another was a real possibility. With the creation of a single unified plan all the risk was put in a single pool, which provided a better technique for determining what risk the total Plan faces and for acquiring a meaningful reinsurance or stop-loss program. All risk was aggregated within a single benefit plan with identical participation factors and providers. Medical necessity, referral practices, eligibility factors, coordination of benefit procedures, and a wide variety of such factors became the same for all participants. As such, the reinsurance industry was better able to provide better attachment points and lower rates for the Plan.

- 5) **Importance of achieving independence from provider owned and operated systems and plans.**
- 6) **Importance of limiting “medical inflation” over multiple year contracts.**
- 7) **Importance of “case pricing.”**

The Unions note that one of the most significant factors facing the medical care delivery system in Northwest Ohio is the fragmentation into two distinct and separate systems (ProMedica (which offers the Paramount Program) and Mercy (program offered through the Medical Mutual Program)). These systems have spared no expense in competing against each other. The CHN systems used to this point by the Plan bridges both systems and has achieved significant discounting from both.

Both ProMedica and Medical Mutual have incurred great expenses in new construction and the purchase and acquisition of physician practices in Northwest Ohio. Upon completion of the proposed Toledo Hospital renovation project, the total dollars expended will have exceeded one billion dollars. This billion dollars, most likely amortized over a 20 year period, can only be recovered through passing it along to utilizers of the health system. These cost increases will be in addition to normal medical inflation and medical innovation. As such, there will be tremendous pressure to increase charges for care.

The provider systems owned by these two systems will provide the easiest mechanism through which to accomplish this. Preferred Provider Organizations, like the CHN, with negotiated long term contracts and built in inflation mechanisms, will provide better long range hedges against such cost shifting. For example, the CHN inpatient facility contracts are tied to the Urban Index of the CPI or 5% whichever is less. Physician contracts all work off of the Federal Government’s Resource Based Relative Value Scale used in Medicare. CHN contracts are tied to this federal system and, as a result, have a built in hedge against localized inflation.

The Unions maintain that UT is in a much better position to control its medical cost over the long range through its association with independent PPOs than to enter into short term contracts with provider systems that have both a vested interest and significant pressure to cover their additional costs as well as to make a profit.

- 8) **Importance of freedom of choice of physicians and input into the referral process.**

The employees assert that there is no more important decision in health care than the selection of one’s personal physician(s). Under the CHN, there is some restriction of physicians. However, the CHN provides access to over 85% of all physicians practicing in the area of highest concentration of University employees and dependents. Additionally, the Plan parameters do not require an individual to utilize a specialist physician selected by someone else. Rather, there is freedom of choice to select both primary and secondary care physicians.

In surveys of University personnel, this issue ranked as among the most significant (See exhibit G4: Staff Survey). Feedback from present membership reveals that choice is still one of the most significant considerations for staff.

- 9) **Importance of avoiding perverse medical delivery associated with plans where primary care physicians are required to obtain prior authorizations for referrals to specialists and are permitted to refer to in-panel specialists.**

The referral system under the present Plan permits the individual to select the deliverer of care. This approach stands in stark contrast to the models employed in Exclusive Provider Organizations with managed care elements that require evaluation of referrals. A regression to such a managed care approach represents a significant loss of quality.

The Unions presented detailed evidence concerning the ability of the University to pay based upon the overall financial health of the institute as determined by an independent analysis of the Employer’s audited financial statements (the “Rudy Report”), which contrast somewhat with the budget projections on which the Employer bases its allegations of budgetary constraints. The Unions also presented, through models prepared by Dr. Jim King, a costing of the current Plan versus the proposals which the Employer has put forth, and also comparing the Plan performance against the projections and predictions put forth by the Employer.

The Unions question whether the Employer has ever “fully funded” the health insurance program, meaning it does not appear that the Employer ever set aside for the plan the “10.9% of the total salary base” for employees that the Employer claims it must budget for health insurance costs. If that amount were budgeted separately by the Employer, the Plan would have a rainy day fund to cover catastrophic years, as the amount budgeted in each of the past two years would have been in excess of \$14 million, while total costs, including prescription drugs, remained below \$10 million each year. The Employer counters that all claims were paid, so the

plan is "fully funded."

Nevertheless, the Unions make a valid point. The Employer is "saving" money that it claims to budget for health care, and those savings are not positively affecting the employees' wages or financial participation in the Plan.

The employees' wages, at least the faculty wages, are not keeping up with cost of living increases, and there is a limited ability, therefore, for the employees to assume even more cost associated with their health care benefits. The Employer's own statistics show that under the Employer's proposal, if employees want to stay with the Plan providers they have enjoyed and paid to have access to since 1999, employees will receive a net increase that is less than the cost of living increase for 2002.

The Unions maintain they are prepared to continue to pay a fair share of medical insurance costs, but that the Employer has not demonstrated its commitment to budget appropriate funding to the Plan. A "designated fund" for the Plan was never established. The Unions fear that splitting participation among the plans put forth by the Employer will have a negative effect on the Plan's ability in the long-term to negotiate the best rates for medical costs and stop loss insurance, and that the rates which the Paramount and MMO plans are offering at this time are so artificially low that the two networks will impose inordinate increases on the Plan at their first available opportunity, possibly before the expiration of 2004. The Unions propose the current Plan be continued with modest (three percent annually) increases in the monthly premiums paid by employees over the next two years.

PART THREE: FINDINGS AND RECOMMENDATIONS

The Fact Finder recognizes that health care is a fundamental and divisive issue. It has an overriding effect on the employees' sense of well being and personal and family security. It has become the most costly single benefit. It is an important consideration for potential employees.

The parties in this case spent considerable time in their negotiations debating the wisdom and effects of the health care decisions made in the past. The Fact Finder recognizes the parties' emotional attachment to the past and the costs incurred by both the University and its employees.

The Fact Finder evaluated each party's proposal as part of the larger agreements to which they are mutually bound, *i.e.*, that the ability of either side to pay for its proposal, or the necessity of passing increasing health care costs onto the other party, must be considered in light of cost implications of the entire collective bargaining agreement(s). Such consideration is a double-edged sword: The Employer argues it can only absorb a limited health care costs, and that it must achieve deeper provider discounts, because it is already committed to wage increases for various bargaining units over the next few years. At the same time, employees argue they can little afford to absorb increased costs because their wages will not increase to cover increasing health care costs – resulting in a wash or a loss as far as take-home pay. Furthermore, the unions argue they “left money on the table” during wage negotiations, accepting below-average salary increases for the next year or two, in anticipation of negotiating minimal health care cost increases for the same time period.

The Fact Finder is also mindful of the budget reductions faced by the University and, ultimately, by the employees represented by these labor organizations. The decision on health care benefits cannot be made in a vacuum. While tuition may be raised, it can not be raised in a sufficient amount to cover projected deficits.

The Fact Finder recognizes the University has a fiduciary responsibility to explore cost reductions in the budget, in this instance in health care costs, to help reduce projected deficits and to avoid unnecessary reductions in services and programs or layoff of employees.

Conversely, the Union has the duty to not just consider health insurance costs and benefits, but must look to the long term welfare of its members. It has a vital interest in seeing that the University of Toledo succeeds in its mission, and that the continued support of the community and student body is fostered.

The problem is that health care costs are nationally out of control. The rising cost of prescription drugs, the pharmaceutical industry's expensive and effective use of commercials to promote newer patented drugs, and their increased rates of use, tax the system beyond its ability to cope. A drive through Toledo confirms that it is following national trends. There is a growing surplus of drug stores, opening even on opposite street corners. The geographic anomaly confirms an economic reality

The economy labors under the increased 'tax' levied by the pharmaceutical industry and the drug delivery companies. These increases are out of all proportion to inflation in the rest of the economy as a whole.

Over and above that, the State of Ohio has done away with the statutory requirement for a “certificate of need” before competing health care facilities are built in the area. In the greater Toledo area, huge new hospitals are now being built across the street from one another. This has resulted in short term competition, which the University is exploiting to its benefit. However, the long term implication is that the health care system will ultimately have to pay for a large and arguably unneeded investment. Somebody will have to pay: hundred of millions of dollars; parallel health care facilities do not appear with a wave of a magic wand, and the investors expect to make a profit. Moreover, the enhanced infrastructure is the tip of the iceberg. There will be more operating costs than there would have been otherwise.

While in the past 12 months inflation has gone up near 1%, health care costs increased in double digits, with drug costs leading the way. Neither employers nor employees can afford the cost of health care, in public and private sectors alike.

No one can predict where costs will be next year, and there are no easy solutions. Everyone must understand that continued health insurance coverage, without some employee contribution, is not an inalienable right. It is not a “gimme,” but an important, expensive, and earned benefit. As this Fact Finder has written many times previously: for those of you who have not yet figured out that the health care system is broken, here is a wake-up call.

The situation presented to the Fact Finder in this case is fairly unique with regard to health care cost problems. Typically, the Employer needs to change its system of delivery to include cost containment measures, while the employees are asked to shoulder some portion of the escalating health insurance costs. However, in the instant case, the process of adopting cost containment measures and accepting shared responsibility for escalating health care costs was initiated during negotiations four years ago.

These parties went to great expense and cooperative effort in 1999 to switch to the Plan that is now in effect. For the above mentioned reasons, I do not recommend the discontinuation of the present EV/CHN provider system.

At the same time, the Employer should be permitted to explore any discounts available through the MMO and Paramount, PPO/POS, and EPO alternatives. An economic incentive is appropriate to encourage eligible employees to move into those systems so that the Employer can enjoy the deeper discounts which were confirmed by the outside accountants who reviewed the RFP submissions and supporting data of the providers.

The Fact Finder is especially concerned that the benefits of the prior plan not be discarded. The costs that have been incurred previously were an investment in future cost containment. I recommend that monthly employee premium contributions be modified to provide economic incentives to participation in the networks offered providers. Monthly premiums are to be tiered based upon wage/salary levels.

Moreover, the Fact Finder firmly believes in the potential efficacy of the joint labor management health care committee. While the prior university administration cancelled its operations, it is apparent that administration of health care is a joint problem which requires a joint effort to regain understanding and control. It is a 365 day a year problem, which should not be addressed only biannually or through administrative fiat. Management cannot expect the Unions to accept a unilateral prescription when they have not been given basic information about how the system works. The prior information provided by the health insurance providers was abysmal, and must not be accepted by the University or the bargaining units in the future. Mere lip service will not do.

Overall, there are no pretty solutions. The University cannot continue to absorb increasing insurance costs. Employees cannot afford to pick up costs and reductions in benefits. It is obvious that the health care system is broken. It continues to pit employers against employees because of out of control health care cost increases.

While it is recognized that employees have shouldered their share of cost increases with the shift to self insurance, the University's costs also increased significantly during the same time period. That is the unfortunate reality of the health care market.

This Fact Finder cannot undo the past, nor is he inclined to attempt to mediate what happened then or why. The past is past. The simple fact is the parties are where they are and it is the Fact Finder's responsibility to recommend where the parties go in the future.

We are here to fix the problem, not fix the blame.

The Fact Finder has also considered both internal and external comparables. Internally, all employees, whether represented by a labor organization or not, participate in the same health care plan. It is my recommendation that should continue. It is an important safeguard against potential abuse by the University, since all the various bargaining units' employees will be given the benefit of "most favored" employee treatment. Indeed, it is unlikely that administrators who are in the same benefit pool will cavalierly cut their own throats.

Looking at external comparables, it is clear other Universities and their employees are battling the same health care demons as the University of Toledo and its employees. A significant number of other Universities have plan options which contain networks that do not have unlimited access to all providers (hospitals or physicians) in a given market place. Also, while employees share in premium costs in varying degrees, in a number of those institutions where a contribution is required, an employee's monthly premium contribution varies based upon the plan selected by the employee, the employee's base salary or wage, or both factors.

Therefore, my recommendations will include multiple network options with employee premium contributions varying based upon the plan selected by the employee and the employee's base salary or wage.

Based upon these considerations and the overall factors I am to consider under the statute, I make the following

recommendations:

1. That the University's proposed networks, as set forth in Exhibits 113 and 114 reflecting the current PPO option through the Cooperative Health Care Network and the EPO and PPO/POS options offered through Medical Mutual and Paramount, be adopted. The increased benefit levels set forth in Exhibit 113 are also to be adopted. Exhibits 106, 148 and 159 are incorporated into this recommendation as though set forth in full, and shall be deemed to be an illustration of how the plans are intended to work.
2. That the proposed Memorandum of Understanding for each respective bargaining unit as reflected in Exhibits Numbers 107, 108, 109, and 110 be adopted. The memorandum for each bargaining unit reflects appropriate contract language. That language includes employee premium contributions which vary by plan option and also by the employee's income level. The language includes a commitment to develop a Wellness program which the Fact Finder believes is critical to the success of a self insured medical care program.⁹ The memorandum also includes appropriate language empowering the Joint Benefits Committee and requires a uniform health care (medical, prescription, dental, and vision) plan for all University employees. The Fact Finder is of the opinion that the Board of Trustees needs to retain its ability to drop a particular carrier, if exigent circumstances so require.¹⁰ For example, if a carrier is recalcitrant in providing information need by the University or the joint Benefits and Wellness Committee, this would be a good reason to drop them. If the performance of a health care provider becomes unacceptable, surely the Joint Benefits and Wellness Committee and the Board of Trustees should be empowered to act, and not locked in to a derelict provider. Further, it is the fact finder's recommendation that the Board of Trustees will follow the Joint Benefits and Wellness Committees recommendations on implementing a wellness program. This committee is to have authority for governance, and is not merely a recommendatory body
3. That the current dental and vision coverage remain in effect and that the parties utilize Caremark as their pharmacy benefits manager through the Inter University Council program.
4. That the prescription drug co-payment schedule set forth in the Exhibit 111 be adopted along with the Caremark formulary as set forth in Exhibit 112 and as may be modified from time to time by Caremark.
5. That the medical plan be amended to include a) dependent pregnancy coverage as provided in the past and in accordance with applicable law, and b) kinesiotherapy treatment provided such treatment is received through the University's Kinesiotherapy program.
6. That the Union's proposal to include benefits for Domestic Partners to the health care plan not be adopted.

I am of the opinion that this benefit will eventually be granted. It will be a matter of recruiting competitiveness and labor economics. As the Unions point out, a great many corporations and national universities (many in Michigan, for example, including my *alma mater*, the University of Michigan) have already put it in place. More will follow. Presumably, these institutions and corporations are pragmatic, and were not being mere altruists.

Experience in those plans demonstrates that it is also a relatively low cost option that is not much used in practice.

The university would do well to follow their example.

Such an event would be a positive signal to members of the gay and lesbian community that they are full partners in

⁹Every dollar spent on a Wellness Plan can more than pay for itself. The fulcrum for that lever is to create a program that will provide meaningful incentives for employees to actually take advantage of the program. If they do, then the costs of health care will go down, and their lives and lifestyles will improve. Potentially, this is a true win/win situation.

¹⁰ In the past at least one of these carriers treated information that should have been available to the university, which is after all paying at least most of the bill, as "proprietary." In this context, information is power, and those who have a monopoly on information can be tempted to abuse the relationship. This cannot stand unchallenged.

the institution. It can be anticipated that such a change will inevitably aid in recruiting staff with needed skills from a broader population base.

Union polling purportedly shows that the Union membership very heavily favors granting the benefit. All the same, giving away other people's money is not much of a test.

Ultimately, I also believe that the time is not yet ripe. This is a serious issue and a change in course for the University's benefit plan. Importantly, no public university in Ohio has yet granted it. At the state level, the legislative process continues to debate related issues.

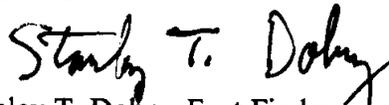
The fact finding process is by its nature conservative. It is an extension of collective bargaining. It is primarily evolutionary, not revolutionary. Ordinarily fundamental changes should be inaugurated by the parties' mutual agreement, and not by recommendation of a Fact Finder. The parties' representatives are the ones who can best balance out the competing interests of their respective constituencies.

Thus, predictions are not controlling today. Whatever the fact finder's personal views of the issue may be, he does not believe that it is appropriate at this time to recommend inclusion of the benefit, since it will likely jeopardize the efficacy of the rest of the fact finder's recommendations.

PART FOUR: CERTIFICATION

This Report and Recommendations of the Fact Finder is based upon all of the foregoing considerations as set forth above. It is based upon the evidence and testimony presented to me at the fact finding hearing. This award is made and entered this 1st day of April, 2002.

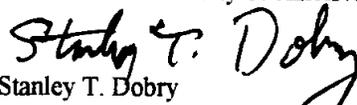
Respectfully Submitted,


Stanley T. Dobry, Fact Finder

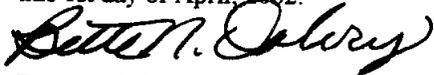
Dated: April 1, 2002

Proof of Service: Mailing

STANLEY T. DOBRY states that he served all representatives of records at their addresses as indicated above, by placing a copy of this report filed in this cause, to wit into an envelope, which had typed upon it the name and address indicated above, and the return address of Stanley T. Dobry, Attorney at Law, written thereon, with Federal Express charges fully prepaid thereon, and also placing same into a United States mail receptacle in the United States Post office in the City of Harrisville, Michigan, on April 1, 2002.


Stanley T. Dobry

Subscribed and sworn to before me
this 1st day of April, 2002.



Bette N. Dobry, Notary Public
Macomb County, Michigan

My Commission expires: August 22, 2003

EXHIBIT 106
UNIVERSITY OF TOLEDO
HEALTH CARE BENEFITS PROPOSAL
March 18, 2002

1. University of Toledo employees who meet the Plan's eligibility requirements may select, during the Plan's annual election period, from either of the three following plans of benefits:
 - A. An Exclusive Provider Organization (EPO) Benefit Plan, as appended, utilizing either the Paramount Health Care or the Medical Mutual of Ohio Provider Networks.
 - B. A Preferred Provider Organization (PPO) Benefit Plan, as appended, utilizing either the Cooperative Health Care Network, or the Medical Mutual of Ohio Provider Network.
 - C. A Point of Service (POS) Benefit Plan, as appended, utilizing the Paramount Health Care Network.

The scope of covered services and terms of participation, unless otherwise modified by the EPO, PPO, or the POS Plans of Benefits shown on Exhibit 113, shall remain consistent with the current Plan of Benefits.

The administration of benefits applicable to covered services, unless otherwise modified by the EPO or POS Plans of Benefits, shall, to the extent administratively feasible, remain consistent with the current Plan of Benefits.

2. Employee contributions for the plans shall be in accordance with the appended schedules.
3. Prescription Drug benefits shall be modified in accordance with the appended proposal.
4. Dental benefits shall remain unchanged.
5. Vision benefits shall remain unchanged.

EXHIBIT 111
UNIVERSITY OF TOLEDO
PRESCRIPTION DRUG PLAN PROPOSAL
March 18, 2002

<u>Prescription Drug Employee Co-Pay</u>	<u>Effective Date</u>
\$4.00 Generic	July 1, 2002
\$8.00 Brand Formulary	July 1, 2002
\$16.00 Brand Non-Formulary	July 1, 2002

- Formulary may be subject to change based upon changes made by the University of Toledo's Pharmacy Benefits Manager.

- Current Caremark formulary previously provided to the Unions on January 14, 2002.

- All other plan provisions remain consistent with the current plan.

University of Toledo

Proposed Monthly Employee Premiums by Pay Classification

Pay Ranges	Plan Option 1 - CHN PPO								
	2002			2003			2004		
	Single	2 Party	Family	Single	2 Party	Family	Single	2 Party	Family
< \$30,000	\$15.45	\$31.31	\$47.46	\$15.91	\$32.25	\$48.88	\$16.39	\$33.22	\$50.35
\$30,000 - \$100,000	\$20.53	\$42.08	\$63.61	\$21.15	\$43.34	\$65.52	\$21.78	\$44.64	\$67.48
> \$100,000	\$37.76	\$76.55	\$115.30	\$38.89	\$78.85	\$118.76	\$40.06	\$81.21	\$122.32

Pay Ranges	Plan Options 2-3 PHC (POS) or MMO PPO								
	2002			2003			2004		
	Single	2 Party	Family	Single	2 Party	Family	Single	2 Party	Family
< \$30,000	\$7.37	\$14.74	\$22.10	\$7.59	\$15.18	\$22.76	\$7.81	\$15.64	\$23.44
\$30,000 - \$100,000	\$9.82	\$19.65	\$29.46	\$10.11	\$20.24	\$30.34	\$10.42	\$20.85	\$31.25
> \$100,000	\$17.68	\$35.37	\$53.03	\$18.21	\$36.43	\$54.62	\$18.75	\$37.53	\$56.26

Pay Ranges	Plan Options 4-5 PHC or MMO EPO								
	2002			2003			2004		
	Single	2 Party	Family	Single	2 Party	Family	Single	2 Party	Family
< \$30,000	\$2.25	\$4.50	\$6.75	\$2.32	\$4.64	\$6.95	\$2.39	\$4.77	\$7.16
\$30,000 - \$100,000	\$3.00	\$6.00	\$9.00	\$3.09	\$6.18	\$9.27	\$3.18	\$6.37	\$9.55
> \$100,000	\$5.40	\$10.80	\$16.20	\$5.56	\$11.12	\$16.69	\$5.73	\$11.46	\$17.19

Plan Options 4-5 PHC/MMO POS

<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 2.25	\$ 4.50	\$ 6.75	\$ 2.32	\$ 4.64	\$ 6.95	\$ 2.39	\$ 4.77	\$ 7.16
\$30,000-\$100,000	\$ 3.00	\$ 6.00	\$ 9.00	\$ 3.09	\$ 6.18	\$ 9.27	\$ 3.18	\$ 6.37	\$ 9.55
> \$100,000	\$ 5.40	\$10.80	\$16.20	\$ 5.56	\$11.12	\$16.69	\$ 5.73	\$11.46	\$17.19

Pay Ranges = employee's applicable base pay rate or salary as of January 1 each calendar year

13.1.3 The parties agree to delete Section 13.1.3 of the 2002-2003 agreement. In its place the parties agree to the following language:

The UT-AAUP/Adjunct will continue to participate in the University's Joint Benefits Committee for the life of this Agreement. UT-AAUP/Adjunct representatives to the Joint Benefits Committee will be the President of UT-AAUP, or his/her designee, and up to three (3) additional persons designated by the Union. The parties agree that the University shall have the right to choose health insurance carriers and/or to self-insure the health care plan(s) so long as relevant information has been discussed with the Joint Benefits Committee and the Joint Benefits Committee has been provided the opportunity to make recommendations, and provided the types of benefits made available are similar. The parties recognize that the University does not control the types of products marketed by health insurance carriers and current carriers or self-insurance may change; or in changing carriers or to/from self-insurance, changes in provider panels, co-payments or benefits, etc. may occur.

In order to provide stability and the opportunity for the Joint Benefits Committee to operate effectively, it is the intent of the parties to retain the provider networks designated by the fact-finder on April 1, 2002, through at least December 31, 2004. In the event the University determines it necessary prior to December 31, 2004, to eliminate and/or change any of the provider networks designated by the fact-finder on April 1, 2002, the University must provide advance notice thereof to the [Union] and the Joint Benefits Committee. If the Joint Benefits Committee does not recommend such a change, the Joint Benefits Committee must notify the University in writing of its refusal to recommend such change within 21 days of the University's initial notice. Thereafter, the [Union] reserves the right to a limited re-opener under ORC 4117 on only the financial participation (not the provider networks themselves) by employees in the resulting changed Plan. Notice of such re-opener must be given within thirty (30) days of the University's notice to the [Union] of its intent to change and/or eliminate any provider network without the Union recommendation of the Joint Benefits Committee.

Either the Board or the Union reserves the right to a re-opener under ORC 4117 on health care insurance to be effective January 1, 2005. Either party may give notice of such re-opener, however such notice may not be given earlier than May 1, 2004.

The University's Joint Benefits Committee will meet on a regular basis, no less than once each calendar quarter and shall, not less than twice each calendar year, review the claims and cost information for the previous six month period. The Joint Benefits Committee will be provided with any and all information necessary to monitor performance of the health insurance plan. Joint Committee members shall be subject to maintaining confidentiality of any provider or vendor trade secret or proprietary data made available to the Joint Committee. The Joint Committee is empowered to make recommendations during the term and administration of this agreement for changes in coverage and benefits; to take steps to monitor and control utilization; improve the delivery of services and benefits; and to reduce costs. The Administration and/or the Board of Trustees retains the authority to accept or reject the recommendations of the Joint Benefits Committee, subject to the procedures set forth above with regard to changing and/or eliminating any service provider prior to December 31, 2004.

Subject to the employee premium contribution schedule set forth above, the employer shall make available to bargaining unit employees the same health insurance and hospitalization plans, *i.e.*, medical, dental, optical, and prescription drug benefits on the same basis and at the same cost as provided to all non-bargaining unit employees, including those covered by other collective bargaining agreements.

By July 1, 2002, the University will form a Wellness Program Committee which will include among its members a representative from each labor organization and representatives from other health care/wellness related functions or departments on campus, to develop and recommend to the Joint Benefits Committee and the Administration a wellness plan which will include financial incentives for its use. The Wellness Program Committee is to develop and recommend a plan by December 31, 2002, for reducing utilization of medical and drug plans through wellness initiatives, such as but not limited to, healthcare screenings, drug education, fitness/recreation programs, etc. The University shall not unreasonably refuse to implement the recommended plan and shall announce either implementation or rejection of the plan by March 1, 2003. Ongoing review and evaluation of any wellness plan will be part of the responsibilities of the Joint Benefits Committee.

THE UNIVERSITY OF TOLEDO

**THE AMERICAN ASSOCIATION
OF UNIVERSITY PROFESSORS
UNIVERSITY OF TOLEDO CHAPTER**

By: _____
Dr. Daniel Johnson
President

By: _____
Dr. Harvey Wolff
President UT-AAUP

Dr. Allen Goodridge
Provost

Dr. Kathleen Thompson-Casado

Dr. Earl Murry
Vice Provost for Faculty Development

Marilyn Widman

James M. Sciarini
Associate Vice President
Human Resources

Alvin W. Comley
Sr. Director, Business Services

Deithra Glaze

Laura Newman

Joseph Klep

EXHIBIT 107

AAUP TENURE/TENURE TRACK
MEMORANDUM OF UNDERSTANDING

HEALTH CARE – ARTICLE 13.1

This Memorandum of Understanding is made this 1st day of **April**, 2002, by and between The University of Toledo (hereinafter the “Board” or “Employer”) and The American Association of University Professors, University of Toledo Chapter (hereinafter the “Union” or “AAUP”). This memorandum shall be attached to and become part of the parties July 1, 2000 through June 30, 2003 collective bargaining agreement **and this memorandum will continue in effect through December 31, 2004**. The terms of this memorandum will not be retroactive. The parties agree to modify the provisions of Article 13.1 of their 2000-2003 agreement as follows:

13.1.1 The University will continue to offer eligible bargaining unit employees health insurance, consisting of the medical, pharmacy, dental, and vision plans under the benefit structure and employee contributions, co-pays, and deductibles as agreed upon during the parties health care re-opener negotiations on **April 1, 2002**. The agreed upon benefit levels will become effective **July 1, 2002**, thereby allowing sufficient notice to the current carriers and providers of any negotiated changes in benefits and to allow employees time to re-enroll for the benefits provided, including any re-enrollment an employee may wish to make in the current University of Toledo Section 125 Benefit Plan provided under Article 13.1.6.

13.1.3 The parties agree to **delete** Section 13.1.3 of their 2000-2003 agreement. In its place, the parties agree to the following language.

The UT-AAUP will continue to participate in the University’s Joint Benefits Committee for the life of this Agreement. UT-AAUP representatives to the Joint Benefits Committee will be the President of UT-AAUP, or his/her designee, and up to three (3) additional persons designated by the Union. The parties agree that the University shall have the right to choose health insurance carriers and/or to self-insure the health care plan(s) so long as relevant information has been discussed with the Joint Benefits Committee and the Joint Benefits Committee has been provided the opportunity to make recommendations, and provided the types of benefits made available are similar. The parties recognize that the University does not control the types of products marketed by health insurance carriers and current carriers or self-insurance may change; or in changing carriers or to/from self-insurance, changes in provider panels, co-payments or benefits, etc. may occur.

In order to provide stability and the opportunity for the Joint Benefits Committee to operate effectively, it is the intent of the parties to retain the provider networks designated by the fact-finder on April 1, 2002, through at least December 31, 2004. In the event the University determines it necessary prior to December 31, 2004, to eliminate and/or change any of the provider networks designated by the fact-finder on April 1, 2002, the University must provide advance notice thereof to the [Union] and the Joint Benefits Committee. If the Joint Benefits Committee does not recommend such a change, the Joint Benefits Committee must notify the University in writing of its refusal to recommend such change within 21 days of the University’s initial notice. Thereafter, the [Union] reserves the right to a limited re-opener under ORC 4117 on only the financial participation (not the provider networks themselves) by employees in the resulting changed Plan. Notice of such re-opener must be given within thirty (30) days of the University’s notice to the [Union] of its intent to change and/or eliminate any provider network without the Union recommendation of the Joint Benefits Committee.

Either the Board or the Union reserves the right to a re-opener under ORC 4117 on health care insurance to be effective January 1, 2005. Either party may give notice of such re-opener, however such notice may not be given earlier than May 1, 2004.

The University’s Joint Benefits Committee will meet on a regular basis, no less than once each calendar quarter and shall, not less than twice each calendar year, review the claims and cost information for the previous six

month period. The Joint Benefits Committee will be provided with any and all information necessary to monitor performance of the health insurance plan. Joint Committee members shall be subject to maintaining confidentiality of any provider or vendor trade secret or proprietary data made available to the Joint Committee. The Joint Committee is empowered to make recommendations during the term and administration of this agreement for changes in coverage and benefits; to take steps to monitor and control utilization; improve the delivery of services and benefits; and to reduce costs. The Administration and/or the Board of Trustees retains the authority to accept or reject the recommendations of the Joint Benefits Committee, subject to the procedures set forth above with regard to changing and/or eliminating any service provider prior to December 31, 2004.

Subject to the employee premium contribution schedule set forth above, the employer shall make available to bargaining unit employees the same health insurance and hospitalization plans, *i.e.*, medical, dental, optical, and prescription drug benefits on the same basis and at the same cost as provided to all non-bargaining unit employees, including those covered by other collective bargaining agreements.

By July 1, 2002, the University will form a Wellness Program Committee which will include among its members a representative from each labor organization and representatives from other health care/wellness related functions or departments on campus, to develop and recommend to the Joint Benefits Committee and the Administration a wellness plan which will include financial incentives for its use. The Wellness Program Committee is to develop and recommend a plan by December 31, 2002, for reducing utilization of medical and drug plans through wellness initiatives, such as but not limited to, healthcare screenings, drug education, fitness/recreation programs, etc. The University shall not unreasonably refuse to implement the recommended plan and shall announce either implementation or rejection of the plan by March 1, 2003. Ongoing review and evaluation of any wellness plan will be part of the responsibilities of the Joint Benefits Committee.

During the term of this Agreement, the following contributions shall be the employee monthly premium contributions to the Health Care Plan.

July 1, 2002

January 1, 2003

January 1, 2004

Plan Option 1 – CHN PPO

<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$15.45	\$31.31	\$47.46	\$15.91	\$32.25	\$48.88	\$16.39	\$33.22	\$50.35
\$30,000-\$100,000	\$20.53	\$42.08	\$63.61	\$21.15	\$43.34	\$65.52	\$21.78	\$44.64	\$67.48
> \$100,000	\$37.76	\$76.55	\$115.30	\$38.89	\$78.85	\$118.76	\$40.06	\$81.21	\$122.32

Plan Options 2-3 PHC POS/MMO PPO

<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 7.37	\$14.74	\$22.10	\$ 7.59	\$15.18	\$22.76	\$ 7.81	\$15.64	\$23.44
\$30,000-\$100,000	\$ 9.82	\$19.65	\$29.46	\$10.11	\$20.24	\$30.34	\$10.42	\$20.85	\$31.25
> \$100,000	\$17.68	\$35.37	\$53.03	\$18.21	\$36.43	\$54.62	\$18.75	\$37.53	\$56.26

Plan Options 4-5 PHC/MMO POS

<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 2.25	\$ 4.50	\$ 6.75	\$ 2.32	\$ 4.64	\$ 6.95	\$ 2.39	\$ 4.77	\$ 7.16
\$30,000-\$100,000	\$ 3.00	\$ 6.00	\$ 9.00	\$ 3.09	\$ 6.18	\$ 9.27	\$ 3.18	\$ 6.37	\$ 9.55
> \$100,000	\$ 5.40	\$10.80	\$16.20	\$ 5.56	\$11.12	\$16.69	\$ 5.73	\$11.46	\$17.19

Pay Ranges = employee's applicable base pay rate or salary as of January 1 each calendar year.

THE UNIVERSITY OF TOLEDO

THE AMERICAN ASSOCIATION
OF UNIVERSITY PROFESSORS
UNIVERSITY OF TOLEDO CHAPTER

By: _____
Dr. Daniel Johnson
President

By: _____
Dr. Harvey Wolff
President UT-AAUP

Dr. Allen Goodridge
Provost

Dr. Kathleen Thompson-Casado

Dr. Earl Murry
Vice Provost for Faculty Development

Marilyn Widman

James M. Sciarini
Associate Vice President
Human Resources

Alvin W. Comley
Sr. Director, Business Services

Deithra Glaze

Laura Newman

Joseph Klep

Plan Options 4-5 PHC/MMO POS

<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 2.25	\$ 4.50	\$ 6.75	\$ 2.32	\$ 4.64	\$ 6.95	\$ 2.39	\$ 4.77	\$ 7.16
\$30,000-\$100,000	\$ 3.00	\$ 6.00	\$ 9.00	\$ 3.09	\$ 6.18	\$ 9.27	\$ 3.18	\$ 6.37	\$ 9.55
> \$100,000	\$ 5.40	\$10.80	\$16.20	\$ 5.56	\$11.12	\$16.69	\$ 5.73	\$11.46	\$17.19

Pay Ranges = employee's applicable base pay rate or salary as of January 1 each calendar year.

Modify Section 42.5 as follows:

42.5

The UT-CWA will continue to participate in the University's Joint Benefits Committee for the life of this Agreement. UT-CWA representatives to the Joint Benefits Committee will be the President of UT-CWA, or his/her designee, and up to three (3) additional persons designated by the Union. The parties agree that the University shall have the right to choose health insurance carriers and/or to self-insure the health care plan(s) so long as relevant information has been discussed with the Joint Benefits Committee and the Joint Benefits Committee has been provided the opportunity to make recommendations, and provided the types of benefits made available are similar. The parties recognize that the University does not control the types of products marketed by health insurance carriers and current carriers or self-insurance may change; or in changing carriers or to/from self-insurance, changes in provider panels, co-payments or benefits, etc. may occur.

In order to provide stability and the opportunity for the Joint Benefits Committee to operate effectively, it is the intent of the parties to retain the provider networks designated by the fact-finder on April 1, 2002, through at least December 31, 2004. In the event the University determines it necessary prior to December 31, 2004, to eliminate and/or change any of the provider networks designated by the fact-finder on April 1, 2002, the University must provide advance notice thereof to the [Union] and the Joint Benefits Committee. If the Joint Benefits Committee does not recommend such a change, the Joint Benefits Committee must notify the University in writing of its refusal to recommend such change within 21 days of the University's initial notice. Thereafter, the [Union] reserves the right to a limited re-opener under ORC 4117 on only the financial participation (not the provider networks themselves) by employees in the resulting changed Plan. Notice of such re-opener must be given within thirty (30) days of the University's notice to the [Union] of its intent to change and/or eliminate any provider network without the Union recommendation of the Joint Benefits Committee.

The University's Joint Benefits Committee will meet on a regular basis, no less than once each calendar quarter and shall, not less than twice each calendar year, review the claims and cost information for the previous six month period. The Joint Benefits Committee will be provided with any and all information necessary to monitor performance of the health insurance plan. Joint Committee members shall be subject to maintaining confidentiality of any provider or vendor trade secret or proprietary data made available to the Joint Committee. The Joint Committee is empowered to make recommendations during the term and administration of this agreement for changes in coverage and benefits; to take steps to monitor and control utilization; improve the delivery of services and benefits; and to reduce costs. The Administration and/or the Board of Trustees retains the authority to accept or reject the recommendations of the Joint Benefits Committee, subject to the procedures set forth above with regard to changing and/or eliminating any service provider prior to December 31, 2004.

Subject to the employee premium contribution schedule set forth above, the employer shall make available to bargaining unit employees the same health insurance and hospitalization plans, *i.e.*, medical, dental, optical, and prescription drug benefits on the same basis and at the same cost as provided to all non-bargaining unit employees, including those covered by other collective bargaining agreements.

By July 1, 2002, the University will form a Wellness Program Committee which will include among its members

a representative from each labor organization and representatives from other health care/wellness related functions or departments on campus, to develop and recommend to the Joint Benefits Committee and the Administration a wellness plan which will include financial incentives for its use. The Wellness Program Committee is to develop and recommend a plan by December 31, 2002, for reducing utilization of medical and drug plans through wellness initiatives, such as but not limited to, healthcare screenings, drug education, fitness/recreation programs, etc. The University shall not unreasonably refuse to implement the recommended plan and shall announce either implementation or rejection of the plan by March 1, 2003. Ongoing review and evaluation of any wellness plan will be part of the responsibilities of the Joint Benefits Committee.

THE UNIVERSITY OF TOLEDO

COMMUNICATION WORKERS OF AMERICA, AFL-CIO

By: _____
Date
William R. Decatur
Vice President
Finance & Administration

By: _____
Date
Jeffrey A. Rechenbach
International Vice President
District 4, CWA, AFL-CIO

James M. Sciarini
Associate Vice President
Human Resources

**BARGAINING COMMITTEE
LOCAL 4530**

William Bain
CWA District 4

Alvin W. Comley
Sr. Director, Business Services

Michael Ledford

Deithra Glaze

Wayde Bockert

Laura Newman

Michael Kosmatak

Joseph Klep

Sherry Lewallen

Richard Seward

EXHIBIT 110
UTPPA
MEMORANDUM OF UNDERSTANDING
HEALTH CARE – ARTICLE 40

This Memorandum of Understanding is made this 1st day of April, 2002, by and between The University of Toledo (hereinafter the “Board” or “Employer”) and The University of Toledo Police Patrolman’s Association, Local No. 70 (hereinafter the “Union” or “UTPPA”). This memorandum shall be attached to and become part of the parties October 1, 2001 through September 30, 2004 collective bargaining agreement **and this memorandum will continue in effect through December 31, 2004**. The terms of this memorandum will not be retroactive. The parties agree to modify the provisions of Article 40 of their 2001-2004 agreement as follows:

- 40.1 The University will continue to offer eligible bargaining unit employees health insurance, consisting of the medical, pharmacy, dental, and vision plans under the benefit structure and employee contributions, co-pays, and deductibles as agreed upon during the parties health care re-opener negotiations on April 1, 2002. The agreed upon benefit levels will become effective July 1, 2002, thereby allowing sufficient notice to the current carriers and providers of any negotiated changes in benefits and to allow employees time to re-enroll for the benefits provided, including any re-enrollment an employee may wish to make in the current University of Toledo Section 125 Benefit Plan provided under Article 40.9.
- 40.2 During the term of this agreement, the following contributions shall be the employee monthly contributions to the Health Care Plan.

	July 1, 2002			January 1, 2003			January 1, 2004		
	<u>Plan Option 1 – CHN PPO</u>								
<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$15.45	\$31.31	\$47.46	\$15.91	\$32.25	\$48.88	\$16.39	\$33.22	\$50.35
\$30,000-\$100,000	\$20.53	\$42.08	\$63.61	\$21.15	\$43.34	\$65.52	\$21.78	\$44.64	\$67.48
> \$100,000	\$37.76	\$76.55	\$115.30	\$38.89	\$78.85	\$118.76	\$40.06	\$81.21	\$122.32

	<u>Plan Options 2-3 PHC POS/MMO PPO</u>								
<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 7.37	\$14.74	\$22.10	\$ 7.59	\$15.18	\$22.76	\$ 7.81	\$15.64	\$23.44
\$30,000-\$100,000	\$ 9.82	\$19.65	\$29.46	\$10.11	\$20.24	\$30.34	\$10.42	\$20.85	\$31.25
> \$100,000	\$17.68	\$35.37	\$53.03	\$18.21	\$36.43	\$54.62	\$18.75	\$37.53	\$56.26

	<u>Plan Options 4-5 PHC/MMO POS</u>								
<u>Pay Ranges</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>	<u>Single</u>	<u>2-Party</u>	<u>Family</u>
< \$30,000	\$ 2.25	\$ 4.50	\$ 6.75	\$ 2.32	\$ 4.64	\$ 6.95	\$ 2.39	\$ 4.77	\$ 7.16
\$30,000-\$100,000	\$ 3.00	\$ 6.00	\$ 9.00	\$ 3.09	\$ 6.18	\$ 9.27	\$ 3.18	\$ 6.37	\$ 9.55
> \$100,000	\$ 5.40	\$10.80	\$16.20	\$ 5.56	\$11.12	\$16.69	\$ 5.73	\$11.46	\$17.19

Pay Ranges = employee’s applicable base pay rate or salary as of January 1 each calendar year.

Delete current Article 40.6. Modify current Article 40.7 as follows (and renumber sections):

The UT-UTPA will continue to participate in the University's Joint Benefits Committee for the life of this Agreement. UT-UTPA representatives to the Joint Benefits Committee will be the President of UT-UTPA, or his/her designee, and up to three (3) additional persons designated by the Union. The parties agree that the University shall have the right to choose health insurance carriers and/or to self-insure the health care plan(s) so long as relevant information has been discussed with the Joint Benefits Committee and the Joint Benefits Committee has been provided the opportunity to make recommendations, and provided the types of benefits made available are similar. The parties recognize that the University does not control the types of products marketed by health insurance carriers and current carriers or self-insurance may change; or in changing carriers or to/from self-insurance, changes in provider panels, co-payments or benefits, etc. may occur.

In order to provide stability and the opportunity for the Joint Benefits Committee to operate effectively, it is the intent of the parties to retain the provider networks designated by the fact-finder on April 1, 2002, through at least December 31, 2004. In the event the University determines it necessary prior to December 31, 2004, to eliminate and/or change any of the provider networks designated by the fact-finder on April 1, 2002, the University must provide advance notice thereof to the [Union] and the Joint Benefits Committee. If the Joint Benefits Committee does not recommend such a change, the Joint Benefits Committee must notify the University in writing of its refusal to recommend such change within 21 days of the University's initial notice. Thereafter, the [Union] reserves the right to a limited re-opener under ORC 4117 on only the financial participation (not the provider networks themselves) by employees in the resulting changed Plan. Notice of such re-opener must be given within thirty (30) days of the University's notice to the [Union] of its intent to change and/or eliminate any provider network without the Union recommendation of the Joint Benefits Committee.

The University's Joint Benefits Committee will meet on a regular basis, no less than once each calendar quarter and shall, not less than twice each calendar year, review the claims and cost information for the previous six month period. The Joint Benefits Committee will be provided with any and all information necessary to monitor performance of the health insurance plan. Joint Committee members shall be subject to maintaining confidentiality of any provider or vendor trade secret or proprietary data made available to the Joint Committee. The Joint Committee is empowered to make recommendations during the term and administration of this agreement for changes in coverage and benefits; to take steps to monitor and control utilization; improve the delivery of services and benefits; and to reduce costs. The Administration and/or the Board of Trustees retains the authority to accept or reject the recommendations of the Joint Benefits Committee, subject to the procedures set forth above with regard to changing and/or eliminating any service provider prior to December 31, 2004.

Subject to the employee premium contribution schedule set forth above, the employer shall make available to bargaining unit employees the same health insurance and hospitalization plans, *i.e.*, medical, dental, optical, and prescription drug benefits on the same basis and at the same cost as provided to all non-bargaining unit employees, including those covered by other collective bargaining agreements.

By July 1, 2002, the University will form a Wellness Program Committee which will include among its members a representative from each labor organization and representatives from other health care/wellness related functions or departments on campus, to develop and recommend to the Joint Benefits Committee and the Administration a wellness plan which will include financial incentives for its use. The Wellness Program Committee is to develop and recommend a plan by December 31, 2002, for reducing utilization of medical and drug plans through wellness initiatives, such as but not limited to, healthcare screenings, drug education, fitness/recreation programs, etc. The University shall not unreasonably refuse to implement the recommended plan and shall announce either implementation or rejection of the plan by March 1, 2003. Ongoing review and evaluation of any wellness plan will be part of the responsibilities of the Joint Benefits Committee.

The UTPPA will continue to participate in the University's Joint Benefits Committee. UTPPA representatives to the Joint Benefits Committee will be the Association President, or his/her designee, and one additional person designated by the

Association

THE UNIVERSITY OF TOLEDO

THE UNIVERSITY OF TOLEDO
POLICE PATROLMAN'S ASSOCIATION

By: _____
William R. Decatur Date
Vice President
Finance & Administration

By: _____
Andrew (Mick) Dier
President

James M. Sciarini
Associate Vice President
Human Resources

Charles Williams

Alvin W. Comley
Sr. Director, Business Services

Paul Csurgo

Deithra Glaze

Laura Newman

Joseph Klep

University of Toledo

Benefit Plan Comparison

Revised 2/25/02

PLAN PROVISIONS	Current Plan EV/CHN PPO		Proposed EPO Plan PARAMOUNT or MMO		Proposed POS/PPO Plan CHN or PARAMOUNT or MMO	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK **
LIFETIME MAXIMUMS Per Covered Person		\$1,000,000		No benefit	\$2,000,000	\$1,000,000
DEDUCTIBLE Per Covered Person Per Family of Two Per Family of Three or more		\$100 \$200 \$300		No benefit	\$100 \$200 \$300	\$100 \$200 \$300
CO-INSURANCE Plan Employee		90% 10% (subject to plan deductible)		0% 100%	90% 10% (subject to plan deductible)	70% 30% (subject to plan deductible)
Calendar Year Out-of-Pocket MAXIMUM (excludes co-pay and deductible) Per Covered Person Per Family of Two Per Family of Three or more		\$500 \$1,000 \$1,500		No maximum	\$500 \$1,000 \$1,500	\$1,000 \$2,000 \$3,000
Physician Office Services						
Primary Care Physician Office Visits	\$10 co-pay, 100% to \$150, balance paid at 90% after deductible	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	\$10 co-pay (balance paid at 100%) (not subject to plan deductible)	No benefit	\$10 co-pay (balance paid at 100%) (not subject to plan deductible)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Specialty Care Physician Office Visits	\$20 co-pay, 100% to \$150, balance paid at 90% after deductible	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	\$20 co-pay (balance paid at 100%) (not subject to plan deductible)	No benefit	\$20 co-pay (balance paid at 100%) (not subject to plan deductible)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Primary Care Physician Gatekeeper (does not apply to OB-GYN services)	None	None	applies to specialist referrals and ER visit follow-up*	None	applies to specialist referrals and ER visit follow-up*	n/a
Hospital Services						
Hospital Inpatient	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Hospital Outpatient Surgery (includes freestanding ambulatory surgery facilities)	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
All Other Outpatient Hospital and Physician Services (not specified elsewhere)	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Emergency Room	\$50 co-pay, balance paid at 90% after deductible	\$50 co-pay, balance paid at 90% after deductible	\$50 co-pay, balance paid at 90% after deductible	\$50 co-pay, balance paid at 90% after deductible	\$50 co-pay, balance paid at 90% after deductible	\$50 co-pay, balance paid at 90% after deductible

University of Toledo

Benefit Plan Comparison

Revised 2/25/02

PLAN PROVISIONS	Current Plan EY/CHN PPO		Proposed EPO Plan PARAMOUNT or MMO		Proposed POS/PPO Plan CHN or PARAMOUNT or MMO	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK **
Urgent Care	\$35 co-pay, balance paid at 90% after deductible	\$35 co-pay, balance paid at 90% after deductible	\$35 co-pay, balance paid at 90% after deductible	\$35 co-pay, balance paid at 90% after deductible	\$35 co-pay, balance paid at 90% after deductible	\$35 co-pay, balance paid at 90% after deductible
Preventive Care						
Through 12 months	100% to \$1,500, balance paid at 90% after deductible	No Benefit	100% to \$1,500, balance paid at 90% after deductible	No benefit	100% to \$1,500, balance paid at 90% after deductible	No benefit
1 through 9	100% to \$500, balance paid at 90% after deductible	No Benefit	100% to \$600, balance paid at 90% after deductible	No benefit	100% to \$600, balance paid at 90% after deductible	No benefit
Age 10 +	100% to \$400, balance paid at 90% after deductible	No Benefit	100% to \$600, balance paid at 90% after deductible	No benefit	100% to \$600, balance paid at 90% after deductible	No benefit
Mental Health						
Inpatient Mental Health (combined with Substance Abuse)	90% after deductible to \$500 out-of-pocket 100% thereafter (15 day limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (15 day limit)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 day limit)	No benefit	90% after deductible to \$500 out-of-pocket 100% thereafter (30 day limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 day limit)
Outpatient Mental Health (combined with Substance Abuse)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 visit limit)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	No benefit	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 visit limit)
Inpatient Substance Abuse *** (combined with Mental Health)	90% after deductible to \$500 out-of-pocket 100% thereafter (15 day limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (15 day limit)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 day limit)	No benefit	90% after deductible to \$500 out-of-pocket 100% thereafter (30 day limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 day limit)
Outpatient Substance Abuse *** (combined with Mental Health)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 visit limit)	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	No benefit	90% after deductible to \$500 out-of-pocket 100% thereafter (30 visit limit)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (30 visit limit)

University of Toledo

Benefit Plan Comparison

Revised 2/25/02

PLAN PROVISIONS Other Services	Current Plan EV/CHN		Proposed EPO Plan PARAMOUNT or MIMO		Proposed POS/PRO Plan CHN or PARAMOUNT or MIMO	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK **
Lab Services	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Radiology	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Physical, Speech, and Occupational Therapies	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	90% after deductible to \$500 out-of-pocket; 100% thereafter	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Dependent Maternity (covers pre-natal care and delivery charges only; newborn charges excluded)	90% after deductible to \$500 out-of-pocket; 100% thereafter	70% after deductible to \$1,000 out-of-pocket; 100% thereafter	Covered based upon place and type of service	No benefit	Covered based upon place and type of service	70% after deductible to \$1,000 out-of-pocket; 100% thereafter
Kinesiotherapy (combined with Neuro/Muscular Manipulations or adjustments)	\$20 co-pay (Specialist) 100% up to \$150, balance paid at 100% after deductible (\$500 annual maximum)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter (\$500 annual maximum)	\$20 co-pay (Specialist) (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	No benefit	\$20 co-pay (Specialist) (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	No out-of-network benefit
Neuro/Muscular Manipulations or adjustments (combined with Kinesiotherapy)	\$10 co-pay (PCP), \$20 co-pay (Specialist) 100% up to \$150, balance paid at 100% after deductible (\$500 annual maximum)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter (\$500 annual maximum)	\$10 co-pay (PCP), \$20 co-pay (Specialist) (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	No benefit	\$10 co-pay (PCP), \$20 co-pay (Specialist) (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter (\$500 annual benefit maximum)
Skilled Nursing Facility	90% after deductible to \$500 out-of-pocket; 100% thereafter (120 day limit)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter (120 day limit)	90% after deductible to \$500 out-of-pocket; 100% thereafter (120 day limit)	No benefit	90% after deductible to \$500 out-of-pocket; 100% thereafter (120 day limit)	70% after deductible to \$1,000 out-of-pocket; 100% thereafter (120 day limit)
Allergy testing (when billed with Office Visit)	\$20 co-pay (not subject to plan deductible)	No benefit	\$20 co-pay (balance paid at 100%) (not subject to plan deductible)	No benefit	\$20 co-pay (balance paid at 100%) (not subject to plan deductible)	No benefit
Allergy/Serum Injection (when billed with Office Visit)	\$10 co-pay (not subject to plan deductible) (\$500 annual maximum)	No benefit	\$10 per injection co-pay (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	No benefit	\$10 per injection co-pay (balance paid at 100%) (not subject to plan deductible) (\$1,000 annual benefit maximum)	No benefit

PLAN PROVISIONS	Current Plan EV/CHN		Proposed EPO Plan PARAMOUNT or MMO		Proposed POS/PPO Plan CHN or PARAMOUNT or MMO	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK **
Chemotherapy	\$10 co-pay (PCP). \$20 co-pay (Specialist) 100% up to \$150, balance paid at 90% after deductible	70% after deductible to \$1,000 out-of-pocket 100% thereafter	\$10 co-pay (PCP). \$20 co-pay (Specialist) 100% up to \$150, balance paid at 90% after deductible	No benefit	\$10 co-pay (PCP). \$20 co-pay (Specialist) 100% up to \$150, balance paid at 90% after deductible	70% after deductible to \$1,000 out-of-pocket. 100% thereafter
Acquisition of Human Organ per Covered Year	\$10,000	\$10,000	\$15,000	No benefit	\$15,000	\$15,000
TMJ Covered Expenses	\$750	\$750	\$750	No benefit	\$750	\$750
Private Duty Nursing	90% after deductible to \$500 out-of-pocket 100% thereafter (\$5,000 annual maximum)	70% after deductible to \$1,000 out-of-pocket 100% thereafter (\$5,000 annual maximum)	90% after deductible to \$500 out-of-pocket (balance paid at 100%) (\$5,000 annual benefit maximum)	No benefit	90% after deductible to \$500 out-of-pocket (balance paid at 100%) (\$5,000 annual benefit maximum)	70% after deductible to \$1,000 out-of-pocket. 100% thereafter (\$5,000 annual benefit maximum)
Prescription Drug Plan Generic Formulary Non-Formulary (Brand)	20% with \$2.00 minimum via 20% with \$10.00 maximum		co-payment of \$4.00 co-payment of \$8.00 co-payment of \$16.00		co-payment of \$4.00 co-payment of \$8.00 co-payment of \$16.00	

* Gatekeeper requirements may be subject to change and/or additional administrative requirements as from time to time specified by the health care networks, not applicable for CHN or MMO.