BEFORE THE ARBITRATOR

In the Matter of the Arbitration
of a Dispute Between

LAKESHORE EDUCATION ASSOCIATION

and

LAKESHORE VTAE DISTRICT

Case 28
No. 47518
MA-6583

Appearances:

Godfrey & Kahn, S.C., 219 Washington Avenue, P.O. Box 1278, Oshkosh, WI 54902-1278 by Mr. John E. Thiel, Attorney at Law appearing on behalf of the Lakeshore Technical College.

Kettle Moraine UniServ Council, N7778 Rangeline Road, Sheboygan, WI 53083 by Ms. Ellen M. Mac Farlane, UniServ Director appearing on behalf of the Lakeshore Education Association.

ARBITRATION AWARD

Pursuant to the grievance procedure contained in their collective bargaining agreement, the Lakeshore Education Association (hereinafter referred to as the Association) and the Lakeshore VTAE District (hereinafter referred to as the District) requested that the Wisconsin Employment Relations Commission designate a member of its staff to serve as arbitrator of a dispute concerning the availability of of long term disability benefits to teacher Dennis Grace. The undersigned was designated and a hearing was held on September 14, 1992 in the District offices at Cleveland, Wisconsin at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant to the dispute. The parties submitted post-hearing briefs and reply briefs. The record was closed on December 12, 1992. Now, having considered the evidence, the arguments of the parties, and the record as a whole, the undersigned makes the following Award.

ISSUE

The parties stipulated that following issue was to be determined herein:

"Does the failure of the insurance carrier to extend long-term care coverage to the grievant constitute a violation of the collective bargaining agreement by the District? If so, what is the appropriate remedy?"

RELEVANT CONTRACT PROVISIONS

(Note: There is a dispute over an agreement reached during consensus bargaining, whereby the parties added a long-term care insurance benefit. Article 16 sets forth the insurance benefits, and the District drafted language at §16.1(E) to describe the new benefit. Owing to the instant dispute, the Association has not executed the new contract, but there is no dispute over the contract terms other than §16.1(E). The Association relies on documents used by the consensus bargaining team as the documentary basis for its arguments. The undisputed contract provisions, disputed contract provisions and documents used to describe the long-term care benefit by the Association's consensus team are set forth below.)

Undisputed Contract Provisions

. . .

16.0 INSURANCE

16.1 The district shall provide the following fringe benefits and shall pay the full premium (except for the premium increases attributed to the long-term care coverage and future long-term care increases which will be shared equally by the faculty member and the employer) for the plan selected by the faculty member (single, family, or option) on behalf of the faculty member and his/her eligible covered dependents:

A. HEALTH: Wisconsin Education Association Insurance Trust Plan #690-731, Group Plan

B. DENTAL: WEAIT Plan #703 H-731, Group Plan

C. LTD: WEAIT Plan #683, A-731, Group Plan

D. LIFE: WEAIT Plan #676, A-731, Group Plan

. . .

16.6 Certificates and amendments applicable to any of the benefits mentioned above, as amended from time to time by the carrier, and the usual, reasonable, and customary benefit levels and administrative standards are incorporated herein by reference.

. . .

. . .

20.0 GRIEVANCE PROCEDURE

20.1 Definition.

20.1.1 A grievance is a complaint by a faculty member in the bargaining unit, or the Association, where a policy or practice within the confines of this contract is considered improper or unfair; where there has been a deviation from or the misapplication of a practice or policy; or where there has been a violation, misinterpretation, or misapplication of any provision of this Agreement existing between the parties hereto. Where there is a conflict between the language of the policies of the employer and a term or condition specified by this Agreement, the latter shall apply.

. . .

20.3 Procedures for the Adjustment of Grievance.

Step 4. If the aggrieved party is not satisfied with the decision rendered by the Board, said party, or the Association, may appeal this decision directly to the Wisconsin Employment Relations Commission for arbitration within fifteen (15) schools days after having received the decision in Step 3, Section C.

A. The arbitration shall be held under the rules of arbitration of Wisconsin Employment Relations Commission.

B. The decision of the arbitrator, if made in accordance with his/her jurisdiction and authority under this Agreement, shall be binding upon both parties and shall be final, except for a decision which would reduce or eliminate aid provided for school operation from the state or federal government or other sources, or change or abridge mandatory school law.

C. Nothing in the foregoing shall be construed to empower the arbitrator to make any decision amending, changing, subtracting from, or adding to the provisions of this Agreement.

D. Arbitration is limited to terms and conditions set forth in this Agreement and to the conditions set forth by the Wisconsin Employment Relations Commission.

Disputed Contract Provisions
(From the District's draft of the 1991-93 Agreement)

160.0 INSURANCE

16.1 . . .

E. LONG TERM CARE: WEAIT Plan #333-731, Individual Evidence of Insurability Required for Faculty Member and Spouse.

. . .

DOCUMENTS DESCRIBING THE OBJECTIVES OF THE JOINT INSURANCE COMMITTEE, THE COMMITTEE'S RECOMMENDATIONS, AND DESCRIPTIONS OF THE AGREED-UPON INSURANCE PLAN.

Association Exhibit #4A - (1)

Association Exhibit #4A - (2)

Association Exhibit #4A - (3)

Association Exhibit #4A - (4)

Association Exhibit #4B

Association Exhibit #4C - (1)

Association Exhibit #4C - (2)

Association Exhibit #4C - (3)

Association Exhibit #4C - (4)

Association Exhibit #4C - (5)

BACKGROUND

The District provides technical and adult education services to citizens in the area of Sheboygan and Manitowoc in eastern Wisconsin. The Association is the exclusive bargaining representative for the District's teachers. The grievant, Dennis Grace, has been an automotive maintenance instructor in the District since 1973. He suffers from multiple sclerosis.

By the terms of the predecessor collective bargaining agreement, the parties agreed to engage in consensus bargaining over the 1991-93 contract. One issue dealt with was insurance, where the consensus goal was:

> The parties agree to a Joint Study Committee with equal representation from the LEA and LTC for the purpose of studying the insurance benefits. Such review shall include all possible options for delivering service as well as cost control measures.

The Joint Committee met and, in late April or early May of 1991, arrived at a number of changes in the insurance benefits, including an increase in prescription drug co-payments, some cost sharing, improved insurance coverage for early retirees, and the introduction of a new benefit, long term care coverage through the Wisconsin Education Insurance Group (WEAIG). Long term care is a new benefit, providing nursing home and home health care, which was developed by WEAIG as part of a new package of insurance benefits called the WeCare Lifetime Protection Plan. In discussing the long term care coverage, the members of the Joint Committee were made aware of the fact that the coverage was subject to underwriting, and that an employee might be excluded from the plan because of pre-existing conditions.

The Joint Committee presented its recommendations to the bargaining teams, and consensus was reached on an economic package on May 3rd. Jack Sullivan, a faculty member, and Mary Bowden, an administrator, were members of both the bargaining teams and the Joint Committee. No mention was made of the underwriting requirements for the long term coverage by either Sullivan or Bowden. The possibility of exclusion for pre-existing conditions was not discussed by the bargaining teams.

WEAIG asked that quick action be taken on approving the insurance portion of the consensus tentative agreements, so that coverage could be instituted by July 1st, the beginning of the contract year. The Board ratified the economic package, including the pay raise, the new early retirement benefit and the insurance plan changes. At the time of the ratification, specific contract language had not yet been drafted.

The Joint Committee held a series of three informational meetings for all District employees, on May 8, 9 and 13th. The meetings were opened with comments by the College's President, followed by a summary presentation by a faculty member of the Joint Committee, Lee

Villeneuve, and either Fred Evert or James Utrie of WEAIG. Villeneuve used Association Exhibits 4A, B and C as handouts at these meetings. None of these documents mentioned an exclusion for pre-existing conditions. Evert answered questions, and used a number of overhead projections, including a copy of WEAIG's application form for long term care coverage, which was entitled in bold print "EVIDENCE OF INSURABILITY FOR LONG TERM CARE". This form includes, as question #1:

> 1. Have you ever had or been treated for any of the following conditions?
>
> Arthritis, alcohol or drug abuse, hypertension, cardiovascular disease, diabetes, kidney disease, multiple sclerosis, Alzheimer's disease, stroke or other neurological or brain disorders, emphysema, cancer, pneumocystic pneumonia, Karposi sarcoma, blood disorders, lymphatic disorders, any immunological disorder (this does not include tests for HIV), chronic flu-like symptoms, chronic fatigue, or unusually rapid weight loss?

At the bottom of the form was a declaration and signature line:

> By signing this application, I, the undersigned, represent that I am now in good health and free from physical and cognitive impairments (except for those indicated above), and I represent that all answers are true and complete. I understand that the proposed insurance coverage will not become effective unless and until the Company approves this application and notifies me in writing.
>
> CAUTION: Underwriting decisions are made on the basis of information provided to the Company. All claims for applicants will be monitored for two years following approval. If, during that two year period, the Company learns that information it relied on was correct, or pertinent information regarding the physical or mental health of any applicant was omitted, coverage for you or your spouse approved as a result will be retroactively terminated to the date of the application. The Company will actively pursue recovery of any claims erroneously paid.

After the informational meeting on May 9th, the regular Spring meeting of the Association was held. The results of the consensus bargaining process were presented in the form of statements of consensus, rather than contract language. Evert was present to answer questions about the insurance.

A mail ballot was sent to Association members asking whether they approved or disapproved of the consensus settlement. Some members of the Association sent letters out, urging that the economic package be approved, but that the consensus statements dealing with contract language be rejected until specific language was presented. The membership approved the economic package, and rejected the consensus statements in language areas, with comments

indicating that specific language should be presented before approval was sought in those areas.

The new insurance provisions were implemented on July 1st. On July 8, 1991, the grievant was denied long term care coverage because of his pre-existing multiple sclerosis. Thirteen other employees were also denied coverage because of pre-existing conditions. Appeals were pursued through the processes of WEAIG, but coverage was not extended to these employees.

The consensus process continued after approval of the economic package. The Joint Committee wrote contract language addressing the long term coverage, and proposed it for inclusion in the contract at Article 16.1:

> E. LONG TERM CARE: WEAIT Plan #333-731, Individual Evidence of Insurability Required for Faculty Member and Spouse.

The District prepared a draft of the overall agreement, including the Joint Committee's proposed 16.1. The Association refused to sign the 1991-93 Agreement with the insurance language, taking the position that evidence of insurability was not part of the bargain.

The instant grievance was filed on April 1, 1992, alleging that the materials presented to Association members at the ratification meeting had made no mention of any underwriting restrictions. A variety of other litigation was also commenced. The grievance was not resolved at the lower steps of the grievance procedure and was referred to arbitration. Additional facts, as necessary, are set forth below.

THE POSITIONS OF THE PARTIES

The Principle Arguments of the Association

The Association takes the position that the controlling factor in this grievance is the parties' understanding of the concepts agreed to in consensus bargaining and ratified by the District's Board and the Association's membership. The Association stresses that no specific contract language was ever agreed to by the negotiators, and that there was never an agreement in bargaining to allow bargaining unit members to be excluded from the long term care plan. The overwhelming evidence, the Association avers, is that all members of the unit were to receive the new benefit. This intent is enforceable against the District, and should yield an order making the grievant whole.

In addition to the clear and enforceable intent of the parties, the Association asserts that relief should be extended to the grievant because of the District's misconduct. Mary Bowden was a member of both the negotiating committee and de facto chair of the Joint Insurance Committee. As such, she had an obligation to inform other members of the negotiating teams of all relevant

facts concerning the long term care insurance. Further, the District sponsored informational meetings, at which time the President of the College introduced the presentation. No mention was made in these meetings of any eligibility requirements for long term care. Since the District failed to inform the membership of vitally important information connected with the new benefit, and allowed ratification to proceed on a false premise, it should be estopped from claiming that the grievant may be denied coverage.

For these reasons, the Association asks that the grievance be sustained and the grievant made whole for his losses.

The Principle Arguments of the District

The District takes the position that the arbitrator has no authority to grant relief in this case. The arbitrator is confined to interpretation of the Agreement, and is barred from making additions or changes in deciding a grievance. The only language in the contract applicable to this case is Article 16.1 (E): "LONG TERM CARE: WEAIT Plan #333-731, Individual Evidence of Insurability Required for Faculty Member and Spouse." This language was drafted by the Joint Committee, with equal representation of both labor and management.

The District argues that there is no evidence of any agreement to extend coverage to all employees. Association members of the Joint Committee were well aware of the exclusions for pre-existing conditions. No person involved in studying the insurance program and formulating the consensus ultimately adopted by the negotiators intended that there be automatic coverage for all unit members. Furthermore, Evert discussed medical screenings for pre-existing conditions at the informational meetings held for all employees and at the Association meeting on May 9th. The restrictions on this coverage are consistent with the provisions of Article 16.6:

> Certificates and amendments applicable to any of the benefits mentioned above, as amended from time to time by the carrier, and the usual, reasonable and customary benefit levels and administrative standards are incorporated herein by reference.

This language indicates that there have always been restrictions on coverage and benefit levels, and the long term care plan is no exception.

The Association's claim that the handouts from the informational meetings fully define the new benefit and form an enforceable contract term is, the District maintains, simply ridiculous. Even granting that "concepts" were ratified rather than contract terms, there is nothing that suggests the concept went beyond instituting the WeCare Plan as offered by WEAIG. This includes the pre-existing condition exclusion that was known by all members of the committee developing the Plan, and explained by Evert to the Association's Spring meeting.

If, as claimed by the Association, there is no specific agreement between the parties to include a pre-existing condition limitation in the insurance coverage, the District asserts that there

is no contrary agreement either. Absent a meeting of the minds on the subject of long term care coverage, the status quo prior to negotiations would control insurance benefits. This would preclude coverage for any employee under the WeCare package, since the entire plan is a newly bargained benefit.

For all of the foregoing reasons, the District asks that the grievance be denied.

The Association's Reply Brief

The Association argues that the record is completely devoid of any evidence that the negotiators were told of the pre-existing committee limitations in the long term care plan. Thus there can not have been a mutual intent to impose such limitations. The negotiators agreed to add a benefit, without any intent to limit its availability. That is the intent that controls in this case, rather than the unilateral knowledge of people on the Joint Insurance Committee, or the intent of the insurance carrier in offering the benefit. The membership ratified the insurance plan on the assumption that all employees would be covered. The District should not now be allowed to ignore the understanding of the negotiators and the membership and unilaterally impose limitations never intended or discussed at the bargaining table.

The District's Reply Brief

The Association utterly failed to address the issue in this case, which is whether the insurance carrier's refusal to extend coverage constituted a violation of the contract. The Association ignores the fact that the denial of coverage was consistent with the procedures of the carrier and the terms set forth on the application form filled out by the grievant.

The Association's claim that Article 16.1(E) is not part of the contract ignores the fact that it was drafted by a joint committee having responsibility for insurance issues. Even if the specific language of 16.1(E) is found not to be a part of the contract, the only evidence of a consensus agreement is that long term care coverage should be added through the WEAIG. That coverage carries with it a requirement for proof of insurability. Thus no matter how the agreement of the parties is interpreted or expressed, it contains a pre-existing condition limitation. Given that the committee reviewing and agreeing to this insurance plan was comprised of equal numbers of Association members and management representatives, any misunderstanding on this point is a function of poor communications within the Association rather than some act of deception by the District.

DISCUSSION

The Association has two theories of this case. First, the Association contends that the District should be estopped from refusing coverage because, if there is in fact a misunderstanding of the tentative agreement, it flows from misleading and inaccurate information provided by the

District. Second, it asserts that the failure to extend long term care coverage to the grievant violates the terms of the agreement reached by the negotiating teams in the consensus process, and as represented to the membership when they ratified the economic package. Each theory is addressed in turn.

Estoppel

The Association's claim of that the District should be estopped from opposing this grievance springs from the facts that (1) Dean Mary Bowden, a management representative, served on both the Joint Committee and negotiating team, and refused to inform the bargainers of the pre-screening requirement; and (2) the District sponsored the informational meetings at which misleading information about eligibility was presented.

Bowden was described by Association witnesses as the de facto chair of the Joint Committee. One member of the Association bargaining team testified that, when Bowden made a brief presentation about insurance to the negotiators on April 26th, she refused to answer questions about the insurance package:

> "When we did get into committee questioning of insurance progress by our members, Mary Bowden and Jack Sullivan, who served jointly on the insurance and negotiations team, we were told that we're not renegotiating this whole thing again, we shouldn't be asking those questions, the process is not finished, it's not all together yet and therefore we moved on to other items in the negotiations process." (Transcript, pages 70-71)

There are several difficulties with the Association's attempt to portray Bowden's refusal to discuss specifics at the April 26th meeting as a management effort to conceal the medical pre-screening requirement. The first is factual. There is nothing in the testimony to show that it was Bowden, rather than Association representative Jack Sullivan, who made the statement. Assuming it was Bowden, there is no reasonable way to read this statement as an effort to mislead. She declined to provide specifics on the insurance package because the package was not finished. There is no gentle way to ask "so, what?" in an arbitration decision, but that is the only possible response to this evidence. Even the most naive bargaining team member could not have translated her statement into a promise of some sort on the issue of eligibility for long term care coverage. Furthermore, if they were left confused after Bowden's presentation, the Association team was not without means of finding out the specifics of the insurance package. The package was put together by a joint committee with equal representation from labor and management. Three Association members, including one member of the negotiating team, were intimately familiar with the plan. Suggesting that management has the sole obligation to provide information about the committee's deliberations ignores the very character of the joint process the parties were using, as well as the realities of bargaining even when done on a consensus basis.

Turning to the claim that management sponsored informational meetings at which misleading and incomplete information about the insurance plan was disseminated, I find this at best an arguable interpretation of the facts. The sessions were certainly sponsored by the District in that employees were allowed to attend during work hours and campus facilities were used. Aside from brief opening comments by the College President, the content of these sessions was determined by Association member Lee Villeneuve, who had taken a leading role in the Joint Committee's work. He prepared the handouts, conducted the briefing and fielded the questions, along with a representative of WEAIG. Given this division of responsibilities, it is probably fairer to characterize the informational meetings as an extension of the cooperative process used by the Association and the District than as strictly District sponsored events.

Even assuming that the informational meetings were the sole responsibility of the District, acceptance of the Association's estoppel theory would require these meetings to have been the vehicle for misleading the teachers about the medical pre-screening requirement. As discussed below, the evidence of what was said and done at these meetings does not support the Association's interpretation of events.

Contract Violation

The grievance alleges a contract violation by the District, and as a threshhold issue it must be determined what the contract provides. The combination of a first effort at consensus bargaining, the insurance company's pressure for quick ratification of the new insurance package and the failure of the parties to promptly reduce their tentative agreements to contract language make this a more difficult task than is usually the case. While there is no dispute over the parties' mutual ratification of the tentative agreement to add long term care coverage through WEAIG, language to implement this change was not drafted until long after the ratification. By the time the language was presented to the Association's bargaining team, the instant dispute was already brewing and the Association declined to sign the contract.

The District claims that Article 16.1(E) represents the actual agreement of the parties, should be considered part of the collective bargaining agreement, and disposes of this grievance:

> 16.1 The district shall provide the following fringe benefits and shall pay the full premium (except for the premium increases attributed to the long-term care coverage and future long-term care increases which will be shared equally by the faculty member and the employer) for the plan selected by the faculty member (single, family, or option) on behalf of the faculty member and his/her eligible covered dependents:
>
> . . .
>
> E. LONG TERM CARE: WEAIT Plan #333-731, Individual Evidence of Insurability Required for Faculty Member and Spouse.

Subsection E was drafted well after denial of coverage became an issue. This specific language clearly represents the understanding of the Joint Insurance Committee that worked on the new insurance plan, as well as the District's position at the time the language was presented, but it has been rejected by the Association's negotiating team and has not been ratified by the Association's membership. Thus I cannot conclude that this particular formulation represents contract language, as that term is commonly understood.

As noted, both parties admit that there was an agreement to add the WeCare package, with its innovative long term care insurance, and that this agreement was ratified. The question is whether this agreement incorporated the limitations of WEAIG's plan, or instead contemplated an ongoing open enrollment in which employees could receive coverage without medical screening. The Association's only evidence of the latter point of view is that no mention was made of limitations in negotiations, or in the documents distributed at the ratification meetings, and that one of those documents, entitled "Long Range Objectives For Joint Insurance/Early Retirement Options Committee", listed the following points:

Prioritize long range cost containment

All 230 employees will be covered by one insurance company and have identical coverage

New plan will stress catastrophic insurance protection for all employees

The new health insurance package premiums must be within 1% of the 1990 family rate

The plan will provide hassle free claims procedure for employer and employee

All employees will share more incurred claims costs

Develop a long term relationship with one insurance company

This document was prepared by insurance committee spokesperson and teacher Lee Villeneuve as a summary of the Committee's objectives. The underscored portion could, by inference, lead one to believe that there were no limitations which would cause any employee to have coverage different from that of all other employees. Standing completely alone, this evidence might be persuasive in support of the Association's view. The evidence, however, does not stand alone.

Informational meetings were held on three different days. The materials distributed by the Joint Committee were supplementary to the presentations made by Villeneuve and WEAIG representatives Utrie (on May 8th) and Evert (on May 9th and 13th). Utrie made no mention of

medical screenings in his presentation. Evert, however, used a copy of the application form as an overhead at these meetings, and told employees that they would be required to submit these applications. The application forms are headed: "EVIDENCE OF INSURABILITY FOR LONG TERM CARE" and consist largely of requests for information regarding pre-existing conditions. They contain language at the bottom making it clear that applicants can be rejected on the basis of the information provided.

There was some dispute as to whether this presentation was repeated by Evert at the Association's Spring meeting on May 9th when ratification was discussed, with Evert and Villeneuve asserting that he had, and other Association members testifying that he had not. In either event, the scant evidence of an intent to provide coverage without exclusions is completely inferential, and is balanced in this case against rather clear evidence that a majority of those persons attending the informational meetings should reasonably have understood that some medical screening would be required for the long term care coverage. I believe the evidence concerning information provided to Association members prior to ratification, though far from conclusive, is weighted in favor of a finding that the Association members had notice of the medical screening precondition for long term care coverage. Some doubtless did not have actual knowledge of this requirement, either because they attended the meeting with Utrie, who did not use the overhead, or because they attended no meeting, or because they were not paying attention. Thus there was inferential evidence that there might be no exclusions, direct evidence that there would be exclusions, and no explicit discussion on the issue at all. In this case the Association bears the burden of proving a mutual intent to offer insurance without medical screening. This conclusion cannot reasonably be drawn from the record evidence of the ratification process.

The Association has argued that the negotiating teams were under the impression that no limitations on enrollment were contemplated by the WEAIG plan. The actual evidence is that two members of the Association team did not recall any discussions of eligibility, and that Jack Sullivan and Mary Bowden, negotiating team members who were also members of the Joint Committee, were fully aware of the requirement. The record does not establish the knowledge of the negotiating teams, but it does suffice to draw the conclusion that they did not discuss the issue. The subcommittee structure used in the consensus process apparently led the parties to an economic agreement without a detailed discussion of the WeCare plan by the full negotiating teams. There is, however, absolutely no doubt that the negotiators had certain mutual intentions, and acted on them. The bargaining teams intended to add a unique long term care benefit, they intended to consolidate their insurance coverages with a single carrier, and they chose WEAIG, which does not offer long term care coverage without medical screening. That the negotiators made a decision without fully understanding its implications does not translate into a lack of mutual intent to make the decision. The decisions made by the negotiating teams and acknowledged by parties to this proceeding are inconsistent with the Association's claim that there was a mutual intent to provide long term care coverage to employees with disqualifying medical histories.

I can find no evidence that the parties to this contract had a conscious, mutual intent to provide long term coverage to all employees, regardless of medical condition. The documents allegedly conveying this intent are ambiguous, were prepared by an Association member who was not on the negotiating team, and were effectively rebutted by other, clearer evidence to the contrary. More significantly, the mutual decisions of the negotiators to select WEAIG as the sole carrier, and to purchase long term care coverage from WEAIG, are at odds with the claim that the agreement was for universal coverage of employees. WEAIG initiated this unusual benefit, and will not write the plan without medical exclusions. The objective evidence of what the negotiators did cannot be reconciled with the subjective intent claimed by the Association.

CONCLUSION

There is no evidence of a pattern of conduct by either party which would show an attempt to mislead either the negotiators or their constituents about the provisions of the new insurance package. A careful review of the evidence rather strongly suggests that there was no conscious mutual intent with respect to medical screenings for long term care insurance. Some members of the bargaining teams knew that screenings were inherent in this new benefit, others certainly did not. However ill-informed the negotiators were, they made a conscious, mutual decision to contract for a specific policy from a specific carrier, recommended that decision to their principles, and received ratification. Given this decision, and in light of Article 16.6, which incorporates the specific policies and practices of the insurance carriers into the contract, I conclude that the District did not violate the contract or fail to meet its negotiated obligations, when the grievant was subjected to a medical pre-screening for long term care coverage.

On the basis of the foregoing, and the record as a whole, I have made the following

AWARD

The failure of the insurance carrier to extend long-term care coverage to the grievant does not constitute a violation of the collective bargaining agreement by the District. Accordingly, the grievance is denied.

Signed this 7th day of March, 1993 at Racine, Wisconsin:

By Daniel Nielsen /s/
Daniel Nielsen, Arbitrator