BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

ONEIDA COUNTY

and

ONEIDA COUNTY DEPUTY SHERIFFS' ASSOCIATION

Case 133
No. 56920
MA-10461

(Grievance of Dan Hess)

Appearances:

Mr. Mark Hollinger, Attorney at Law, Wisconsin Professional Police Association, 340 Coyier Lane, Madison, Wisconsin 53713, appeared on behalf of the Association.

Mr. Carey L. Jackson, Personnel Director, Oneida County, Courthouse Building, P.O. Box 400, Rhinelander, Wisconsin 54501-0400, appeared on behalf of the County.

ARBITRATION AWARD

On October 27, 1998, the Oneida County Deputy Sheriff's Association and Oneida County requested that the Wisconsin Employment Relations Commission appoint William C. Houlihan, a member of its staff to hear and decide a grievance pending between the parties. Hearing on the matter was conducted on March 15, 1999, in Rhinelander, Wisconsin. The proceedings were not transcribed. Post-hearing briefs were submitted and exchanged by April 26, 1999.

This Award addresses a dispute as to the effective date of health insurance coverage for a child born to bargaining unit member Dan Hess.

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BACKGROUND AND FACTS

Oneida County and the Oneida County Deputy Sheriff's Association have been signatories to a series of collective bargaining agreements, one of whose provisions provides health insurance benefits to bargaining unit members. The County has self-funded its health insurance benefits since July 1, 1987. From July 1, 1987 thorough May 31, 1993, the self-funded plan was administered by National Benefit Consultants (NBC), a third party administrator. Effective June 1, 1993, Midwest Securities Administrators (MSA) took over the administration of the health care plan.

When National Benefit Consultants managed the county health care plan, it provided a benefits booklet, which summarized the benefits available under the County's group medical insurance plan. The booklet defined "dependent" as including the "unmarried children of the subscriber and spouse." The booklet went on to provide: "Subject to the exclusions, conditions and limitations of this contract, a member is entitled to covered services during any one calendar year. . ." The booklet also provides, "Benefits described in this booklet are subject to all provisions and limitations found in the Master Plan document." The then-operative Master Plan document is not a part of this record.

On January 28, 1994, shortly following the change in third party administrators, the Oneida County Personnel Department distributed a health insurance plan document over the following memorandum:

> TO: All Employees on Oneida County Health Insurance
>
> FROM: Lisa Catlin, Administrative Assistant
>
> . . .
>
> Attached you will find a new copy of your health plan document. It has been revised and written in a manner that is easier to understand. There have been no changes made to your current coverage.
>
> Also, there is an insert which explains the procedure necessary when you or your family are having inpatient procedures done. It is extremely important that the guidelines are followed . . .

The plan document consists of 67 numbered pages, and currently includes an additional 17 pages of attached amendments. The document is effective June 1, 1993. The following provisions are found on page 21 of the plan document:

. . .

> Effective Date of Coverage
>
> The employee must submit a completed health insurance application for either individual or family coverage to the Plan within thirty calendar days of the first day worked in a qualifying position. Coverage shall become effective on the first day of the month following thirty calendar days of qualifying employment, provided the employee is actively employed on the initial effective date. If not actively employed on the initial effective date, the effective date of coverage will be postponed until the employee returns to active employment in a qualifying position.
>
> Late Entrant Position
>
> Any employee who fails to complete a health insurance application within the initial thirty calendar days of employment in a qualifying position, or any dependent whom the employee fails to add to his/her coverage within the specified time limits, will be considered a "late entrant" to the Plan. A late entrant must complete a health statement application, and furnish evidence of insurability satisfactory to the Plan at no cost to the Plan. The Plan will then determine if the late entrant will be provided coverage. If coverage is approved, coverage will become effective on the first day of the month following approval by the Plan of the employee's application for enrollment. All late entrants are subject to the pre-existing conditions provision of the Plan.
>
> Changes In Dependent Coverage
>
> Any employee who desires to add an eligible dependent to his or her coverage, must submit a completed application to the Plan within thirty calendar days of the date of marriage, birth or adoption. The date of adoption is considered to be the date that a court makes a final order granting adoption, or the date that the child is placed for adoption, whichever occurs first. After this time, the dependent will be considered a late entrant.
>
> If the application to add an eligible dependent is received within the thirty calendar day period, the effective date will be: (1) for a new spouse, the date of marriage; (2) for a newborn child of the employee, the date of birth. . .

Lisa Charbarneau (formerly Catlin) testified that she delivered the Plan documents under the cover letter set forth above to the Police Department, for distribution. A number of bargaining unit members testified that they had never been given the Plan document. Mr. Hess testified that he could not recall receiving the Plan document.

The Plan, as currently administered, has a pre-certification procedure for certain services. Employes are provided with an insurance card which bears the name and symbol of Midwest Security Administrators, Inc. on both sides, and contains the following printed directive:

> "All hospital admissions and outpatient diagnostic and surgical procedures (any course of treatment costing $500 or more) must be pre-certified with Associates for Health Care, Inc. at 1-(800)-952-8661 at least three business days prior to service being performed. Associates for Health Care, Inc. must be notified the first business day following any emergency admission. Failure to follow the above procedure may result in an additional financial responsibility."

Dan Hess, the grievant, has been employed as a Deputy Sheriff since March 15, 1993, and has been a subscriber to the family medical plan throughout his employment. Hess has three children; a daughter Callie, born prior to his employment with Oneida County; a daughter Cassie, born April 17, 1994, and a son, Brandon, born May 5, 1998. It was the insurance consequences of the birth of Brandon that has led to this proceeding.

Hess secured pre-certification authorization from Associates for Health Care, Inc. It was his testimony that hospital personnel made the required telephone call. As a part of the pre-certification process, Hess provided certain information to AHC in the process. AHC sends a pre-certification letter to Midwest, which includes the required information. Hess did not fill out and submit an application to add Brandon to his policy within thirty days of Brandon's birth.

Following the birth of Brandon, Hess took a one week's vacation. He did so with the approval of John Sweeney, his supervisor. Hess told Sweeney and others his family had just had a baby.

Hess testified that he was unaware of the thirty day enrollment obligation. Midwest Security notified Lisa Charbarneau by letter dated June 24, and received June 26, 1998, that "claims have been submitted for the following family members of your employes. We have not received notification to add these members to your plan. . ." The form goes on to note Daniel Hess, lists his Social Security number and identifies Brandon as a dependent.

Hess' first tangible evidence that a problem existed occurred 44 days following the birth of his son. Lisa Charbarneau sent him an enrollment form, which he filled out and returned the same day. Charbarneau returned the completed form to Midwest Security over a cover letter dated June 30, 1998. An explanation of benefits form denying payment of $1,750 for medical expenses related to the birth of Brandon was received following submission of the enrollment form. Medical bills incurred by Hess' wife, the birth mother, were paid.

Hess called Midwest Security to complain, and to seek to have the bills paid. It was his testimony that it was suggested that he have the County change the enrollment date on the application. That was not done. Hess did not appeal the decision of the administrator to deny the claim.

Mr. Hess' actions were identical to those employed when his daughter Cassie was born. Hess testified that he did not submit an application to include Cassie on his family plan within the thirty-day period following her birth. There was no insurance gap applicable to her. Charbarneau testified that the administration of the plan relative to Cassie's birth was an error. It was her testimony that it was the only such error made by the then-new third party administrator.

The Employer introduced records to demonstrate that four bargaining unit employes had followed the thirty-day application format, requested and filled out the enrollment form applications, and received benefits. Those births occurred in June, 1989, November, 1993, August, 1998 and February of 1999. The Employer further introduced two late applications, including births, one from the bargaining unit and one from another bargaining unit covered by the same plan. Those births, both occurring in April of 1997 resulted in a gap in insurance coverage and obligated the individual to demonstrate proof of insurability.

ISSUE

The parties were unable to stipulate to the issue. The County believes the following three issues govern this proceeding:

1. Is the grievance arbitrable?

2. Did the grievant follow the proper procedure in attempting to obtain health benefits for Brandon Hess?

3. Did the County violate Article XIV, Section 14.01, when MSA followed the health plan document in adding Brandon Hess to the health plan?

The Association takes issue with the County's arbitrability issue. The Association contends that those matters were first raised at the arbitration hearing. The Association contends that there is but a single issue:

> Did the County violate the collective bargaining agreement when it denied medical insurance coverage to the newborn son of Deputy Hess? If so, what is the appropriate remedy?

This Award will address each issue advanced by the parties.

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENT

ARTICLE IV – GRIEVANCE PROCEDURE

Section 4.01 – Definition: A grievance shall mean a dispute concerning the interpretation or application of this contract. The grievance shall state the factual basis for the grievance and the specific section of the contract or part thereof which has been allegedly violated.

Section 4.02 – Steps of the Grievance Procedure:

. . .

Step 3: Any grievance which cannot be settled through the above procedures may be submitted to arbitration. . .

. . .

(c) Authority of Arbitrator: The decision of the Arbitrator shall be limited to the subject matter of the grievance and shall be restricted solely to the interpretation of the terms of this contract. The arbitrator shall confine his/her determination to the grievance as stated and to the specific sections identified in the grievance.

. . .

ARTICLE XIV – INSURANCE

Section 14.01 – Hospitalization: All employees who desire hospital and sickness insurance, shall be included in the regular County program of hospital and sickness insurance now in force, or as the same may be hereinafter modified or improved, with the County to pay one hundred percent (100%) of the premium which may be administered and funded by the County under a partially self-funded insurance plan to be implemented on July 1, 1987. Effective January 1, 1991 – All employees who desire hospital and sickness insurance, shall be included in the regular County program of hospital and sickness insurance now in force, or as the same may be hereinafter modified or improved, with the County to pay ninety-five (95.0%) percent of the premium and the employee will pay five (5.0%) percent of the premium, which may be

administered and funded by the County under a partially self-funded insurance plan to be implemented on July 1, 1987. Employees who have retired at age 55, shall be allowed to be continued by paying One Hundred Percent (100%) of the premium if this does not raise the premiums for the balance of the Oneida County employees and subject to its approval by the insurance carrier for the County. The present medical and hospitalization benefits will not be reduced but the County may from time to time change the insurance carrier if it elects to do so. The County agrees to notify the Association before any such change is implemented and to advise the Association of the terms of the proposed change. If a change in insurance carriers is grieved, the sole issue to be determined is the comparability of benefits expressed in total dollar value to the insured.

The hospital and surgical care insurance shall be equivalent to the co-pay aggregate liability plan provided by Blue Cross/Blue Shield, a copy of which shall be attached to the contract, which plan is further explained. . .

The County agrees to reimburse any portion of the final $250 of the $500 deductible which has been incurred and paid each calendar year subject to a maximum reimbursement of $500 each calendar year under the family plan. Under the family plan, family members who have pooled their charges to satisfy the deductible would be reimbursed any portion of the final $500 incurred and paid by the employee in excess of $500.

. . .

ARTICLE XXIV – ENTIRE MEMORANDUM OF AGREEMENT

Section 24.01 – Amendments: This Agreement constitutes the entire Agreement between the parties and no verbal statements shall supersede any of its provisions. Any amendment or agreement supplemental hereto shall not be binding upon either party unless executed in writing by the parties hereto.

POSITIONS OF THE PARTIES

The County contends that the first issue for the Arbitrator to decide is whether or not this matter is arbitrable. The County contends that there is nothing in the labor agreement which permits grieving the administration of health benefits. The Agreement allows the Union to arbitrate a change in insurance carriers provided the sole issue to be determined ". . .is the comparability of benefits expressed in total dollar value to the insured." The County contends that there is simply no basis in the contract for allowing the Association to take a grievance, pertaining to the administration of the health plan, to arbitration. To so allow would create new contract language, something the Arbitrator is specifically prohibited from doing.

The County contends that the Association is precluded from claiming that the thirty-day notice rule violates the management rights clause because no such claim was made on the grievance.

The County contends that the Association failed to tender proof that the County changed any rule. There was no evidence entered into the record relative to the prior Blue Cross/Blue Shield health plan as it pertained to Oneida County. Absent the Blue Cross/Blue Shield language and its application, there can be no showing that a change occurred. To the contrary, the County entered into evidence a long-standing practice of consistent application of the enrollment requirements of the health plan. The County contends that the matter is not grievable because Hess failed to follow proper procedures to obtain health plan coverage for his newborn son. The County points out that the plan contains an appeal procedure that Hess could have followed, but chose not to. The County contends that that appeal mechanism, and not the grievance procedure, is Hess' correct remedy. By failing to utilize the review process, Hess precluded the Plan's supervisor from administering the health plan in a fair and consistent manner. The County contends that should the Association prevail in this grievance, arbitration will become the first step in the appeal process for all health claims that are denied.

The County contends that it did not violate Article XIV of the labor agreement. It is the County's position that the requirement that all newborns be enrolled in the health plan in a timely manner is a long-standing requirement. The third party administrator has required employes to enroll their newborns in the health plan through the completion and submission of an enrollment application in a timely manner. The Employer, pointing to the four employes who submitted 30 day notifications contends that employes both knew of the requirement and complied with it. The County further demonstrated that the two employes who failed to add their newborn dependent children within the 30 days following birth found themselves uninsured. The County acknowledges that MSA made a mistake in adding Mr. Hess' second child, Cassie, to the plan without proper documentation. The mistake is an exception to an otherwise well-documented practice that exists.

The Employer contends that it did not violate Article XIV. The contract is silent on dependent coverage and on enrollment procedures. The health plan defines each of those. The Employer contends that the two provisions in Section 14.01; i.e. "that present medical and hospitalization benefits will not be reduced" and "shall be included in the regular County program of hospital and sickness insurance now in force, or as the same may hereinafter be modified or improved", is ambiguous and unclear. The County contends that the provisions contradict one another.

The County contends that it is not for the undersigned to determine whether or not the enrollment procedure is reasonable. If it were otherwise, arbitrators would find themselves in the unenviable position of opening the door to decide every facet of every health plan.

The Employer acknowledges that Hess gave verbal notification of the birth of his child to his supervisor. The Employer notes that the health plan document requires a written enrollment application. Verbal notice to a supervisor does not measure up. The Employer further acknowledges that Hess went through the utilization review requirement. The Employer contends that that program has nothing to do with the enrollment requirements of the health plan or approved benefit levels.

The Association contends that at no time has the County asserted that it made the plan document administered by National Benefit Consultants, Inc. (hereinafter referred to as the "pre-1993 plan document") available to employes. The pre-1993 summary of the plan document was available and in the possession of Hess. That summary makes no mention of any rule requiring that an employe fill out an application within 30 days to change dependent care coverage. After Hess' second child, Cassie was born in April of 1994, Charbarneau wrote Hess and told him that the County had been billed and instructed Hess to fill out an enclosed form and return it to her, which he did. There was no testimony indicating that Charbarneau informed Hess of the 30-day rule at, or after, the time of Cassie's birth. Yet Cassie was covered by the Hess family health insurance plan.

Prior to receiving medical services, Hess was required to seek pre-authorization of services by contacting Associates for Health Care. AHC, in turn, contacted the plan administrator, Midwest Security Inc. Thus, the plan administrator, the agent for the County, was notified that Hess' wife was entering the hospital to give birth. Furthermore, Hess received pre-authorization for medical services for both his wife and the newborn.

The Association contends that the subject matter of the grievance is arbitrable. The Association is grieving the application of unilaterally adopted rules for adding newborns as covered dependents, not the change in insurance carriers.

The Association contends that it has followed the correct procedure in processing this grievance through the grievance procedure, rather than through the appeal process set forth in the post-1993 plan document. Were the County's argument to the contrary to be valid, the County would then be able to unilaterally alter the negotiated grievance procedure, and replace the agreed-upon trier of fact, an arbitrator, with an agent of the Employer, the plan administrator. The Association cites arbitral support for the proposition that disputes over the application of contractually-created health insurance are a proper matter for arbitration. The parties never negotiated and agreed upon any portion of the post-1993 plan document, much less the appeal process which appears on page 61 of that plan document. The contractual definition of a grievance is broad, encompassing any difference arising between the parties concerning the interpretation or application of the contract. The instant dispute is alleged to be arbitrable, in that it involves a challenge to the manner in which the County has interpreted and applied Article XIV, Section 14.01 of the collective bargaining agreement. The

Association argues that the County essentially contends that this is a dispute between Hess and Midwest Securities. Rather, the Association argues that the County is self-insured and a party to this dispute.

The Association notes that Hess' complaint is based on an allegation that the County violated the explicit language of the collective bargaining agreement by failing to provide dependent hospitalization and sickness coverage. That same provision of the contract specifically describes the family plan, thus making it a type of insurance ". . .now in force. . ."

The Association contends that the thirty-day rule is, in the case of newborns, unreasonable on its face, and in its application because no conceivable condition exists which would make a newborn ineligible for medical insurance other than the 30-day rule itself. Unlike other categories of dependents, newborn babies of actively-employed bargaining unit employes are always eligible for coverage under his or her parents' family plan coverage. Other than providing a loophole by which the County can claim "gotcha", the 30-day rule, as applied to newborns, is contrary to the intent of the parties, and just plain meanspirited. Clearly, the medical services of a newborn cannot be paid until such time as the County's plan administrator is aware of the child's birth. There is no disadvantage to the County by being made aware of the additional newborn dependent beyond 30 days.

The Association contends that Hess never received notice of the 30 day rule, and, therefore, cannot be penalized for adhering to such a rule.

The Association contends that Hess communicated the essential information required in the County's application, and therefore, satisfied the 30-day rule. Hess provided AHC with the necessary information, and pre-authorization was granted by the plan administrator at Midwest Security Administrators. Hess testified that the information relayed to the plan administrator to obtain pre-authorization included name, date of birth, Social Security number, proposed treatment plan of both his wife and the newborn, and the anticipated length of stay. This information constitutes substantially the information provided on the "application" called for by the plan document. Midwest Securities plan administrator had already received detailed information about the proposed treatment plan, and officially pre-authorized coverage for the mother and the newborn. The Association contends that Hess should be considered in compliance with the 30-day rule, because he sufficiently notified the plan administrator through the pre-authorization process.

DISCUSSION

Arbitrability

The first issue for decision is the arbitrability of this matter. On its face, the grievance is arbitrable. The grievance alleges the following: "Violation Article XIV – Insurance Section 14.01, Hospitalization and any other article that may apply." The grievance goes on to claim:

> "On May 9th, 1998, a child was born to Dan Hess and his family. On June 22nd, 1998, Hess received the insurance enrollment form from the County. He completed this form and returned it the same day.
>
> On Monday, August 10, 1998, Hess was informed that the newborn child would not be covered by the present insurance plan as Hess had filed the enrollment form after the 30-day window of the child's birth."

The parties' collective bargaining agreement, particularly Section 4.01, defines a grievance as: "A dispute concerning the interpretation or application of this contract. The grievance shall state the factual basis for the grievance and the specific section of the contract or part thereof which has been allegedly violated." Hess' grievance lays out its factual basis, and identifies Section 14.01 as having been allegedly violated.

Step 3 of the grievance procedure provides: "Any grievance which cannot be settled through the above procedures may be submitted to arbitration." The parties to this dispute exhausted the grievance procedure without settling the dispute raised by the grievance.

The strong federal policy favoring the arbitration of grievances arising under a collective bargaining agreement (UNITED STEELWORKERS V. WARRIOR AND GULF NAVIGATION CO., 363 U.S. 574, (1960)) is mirrored by the law applicable to Wisconsin's public sector. In JOINT SCHOOL DISTRICT NO. 10 V. JEFFERSON EDUCATION ASSOCIATION, 78 Wis. 2D 94 (1977), Wisconsin's Supreme Court set forth a standard which parallels federal law. In JEFFERSON, the Court provided as follows:

> "The Court has no business weighing the merits of the grievance. It is the arbitrator's decision for which the parties bargained. . .The Court's function is limited to a determination whether there is a construction of the arbitration clause that would cover the grievance on its face and whether any other provision of the contract specifically excludes it." 78 Wis. 2D 111.

The Court went on to elaborate the duty to arbitrate standard as follows:

> "An order to arbitrate the particular grievance should not be denied unless it may be said with positive assurance that the arbitration clause is not susceptible to an interpretation that covers the asserted dispute. Doubts should be resolved in favor of coverage." 78 Wis. 2D at 113.

The judicial standards have been adopted and applied by the Wisconsin Employment Relations Commission. (SAUK COUNTY, Case 126, No. 54365, MP-3204, DEC. NO. 29055-A, B, 3/98).

The County alleges that Article XIV controls the arbitrability of this matter. In essence, the County contends that Article XIV specifically excludes arbitration of this matter, notwithstanding the general provisions of Article IV. I disagree. Article IV of the parties' collective bargaining agreement provides a general directive to arbitrate disputes arising between the parties, and processed through the grievance procedure. Article XIV provides a narrow exception to the scope of the arbitration clause. Section 14.01 provides: "If a change in the insurance carriers is grieved, the sole issue to be determined is the comparability of benefits expressed in total dollar value to the insured." The sentence is specific to a Union challenge to the Employer's change in insurance carriers. That is not the dispute presented for decision here. The Employer has long ago changed carriers. The Union long ago acquiesced in that change. The dispute here challenges the administration of what is alleged to be a contractually-provided health insurance benefit. As such, it falls within the general mandate to arbitrate.

The County argues that Hess should use the insurance plan appeal process, in lieu of the grievance procedure. The existence of an internal appeals process does not alter the collective bargaining agreement's provisions which submit disputes over contractually-created benefits to an arbitrator. Hess could have, and perhaps should have, filed an appeal. However, that forum is designed to resolve disputes between Hess and the third-party administrator. The collective bargaining agreement, and its grievance arbitration provision, serves to resolve disputes between the County and the Union.

Review of the Merits

Article IV, Section 4.02, Step 3(c), Authority of Arbitrator, directs an arbitral examination of the grievance, and the contractual section identified by the grievance. The grievance in this matter references Section 14.01. That section provides to "all employees who desire. . ." access to health insurance. The section allocates premium responsibility for hospitalization insurance and provides for a plan ". . .administered and funded. . ." by the County. The parties to this dispute have construed those words to allow the County to use a third party administrator to administer the plan. Section 14.01 sets a standard for the program and/or insurance benefit levels. It permits the County to modify or improve the plan in two places and further directs "the present medical

and hospitalization benefits will not be reduced. . ." Finally, the provision goes on to set an insurance standard, identifying Blue Cross/Blue Shield aggregate liability plan and indicates that a copy of such plan shall be attached to the contract. As noted above, no such plan is attached to the contract, nor has been submitted into this evidentiary record.

The County contends that the provisions regulating its ability to change carriers are inconsistent. I disagree. These provisions can be reconciled. The County is free to modify or improve its insurance plan. It is free to change the carrier. However, the County is not free to reduce medical and hospitalization benefits. The threshold standard in assessing the question of whether or not the County has reduced benefits is the referenced Blue Cross/Blue Shield plan, and ". . .the present medical and hospitalization benefits. . ."

Step 3(c) of Section 4.02 addresses my authority, which is limited to interpreting the terms of the contract and the grievance. The question presented in this dispute is the propriety of the 30-day notification rule. This rule, like the balance of the health plan, is found in the plan document, and not in the collective bargaining agreement. The procedural question thus raised is: does the collective bargaining agreement invite/require a grievance arbitrator to review the elements of the health plan found in the plan document? I believe the answer to be yes.

Article XIV sets a standard for the health plan. The Employer-provided health plan is to be the "equivalent to the co-pay aggregate liability plan provided by Blue Cross/Blue Shield. . ." and is not to reduce present medical and hospitalization benefits. The Employer has rights to change health insurance plans subject to the contractual standard. In this dispute, the Employer has changed plans. As noted, that is not in dispute. What is in dispute is whether or not the Employer has maintained the standard of benefits required by the collective bargaining agreement. The Association contends that question is before the Arbitrator. The Employer contends that is a question properly before the third party administrator.

Necessarily, Article XIV operates to incorporate the elements of the health insurance plan into the collective bargaining agreement, at least for purposes of contract administration review. The only way to determine whether the current health insurance plan is the equivalent of the Blue Cross/Blue Shield plan is to review both plans. The Blue Cross/Blue Shield plan is to be attached to the contract for that very purpose. The only way to determine whether "present" benefits have been reduced is to examine the benefit in question. The provisions of this contract do not tolerate a contrary result. The collective bargaining agreement establishes a benefit standard by reference to the *status quo* and another plan. The contract provides that the Employer is free to change plans under certain circumstances. The collective bargaining agreement says that if the parties have a dispute over the interpretation or application of the contract, a grievance may be filed, and if unresolved proceed to arbitration. For me to conclude that I am without authority to examine benefit levels renders the

foregoing meaningless. Such an award would create a _de facto_ result that Article XIV is not enforceable under Article IV, a result contrary to both articles.

As to the merits, the County contends that I cannot determine whether the 30-day notice rule constitutes a change from the prior plan in the absence of that plan document. I agree. The Union argues that I should use the group benefits booklet under NBA and compare that document to the plan document. I regard this as an "apples and oranges" comparison. The booklet is a mere summary of the plan document. By its very nature, it does not purport to be an all-inclusive document. I cannot tell from this record whether there was a 30-day notification requirement under the prior plan. Union witnesses testified they were unaware of any such requirement. However, these are the same witnesses who testified that they were unaware of a 30-day notification requirement under the current plan. Clearly, the current plan document contains such a notice requirement. I note that the first example of a 30-day application predates MSA.

The County contends that it has established a practice of consistent administration of the 30-day notice requirement. However, the County's practice in this regard is not pure. In determining whether or not a binding practice exists, arbitrators examine the clarity and consistency of the pattern of conduct (See, Mittenthal, Richard: *Past Practice and the Administration of Collective Bargaining Agreements*, 59 Michigan Law Review, 1017, 1961) in search of a constant, unequivocal pattern of behavior. (See, CELANESE CORPORATION OF AMERICA, 24 LA 168, Justin)).

Here, the Employer has administered the 30-day notice provision, as applied to newborns, even where the administration of that provision has had significant consequences for the employe in question. However, the administration of this provision has not been unequivocal. There has been one demonstrated exception. That exception involves the very employe whose actions and behavior are at the center of the question posed in this proceeding. The County contends that the third-party administrator erred in paying out benefits in the absence of a timely enrollment application, following the 1994 birth of Hess' daughter, Cassie. Assuming that to be the case, there is no indication that the Employer advised Hess at the time that he had failed to submit a required application. There is no indication that either the Employer or the third-party administrator ever pointed out to Hess the consequences of his failure to submit such a document. To the contrary, the record establishes that the Employer knew that Hess was not in compliance, and said nothing.

The County contends that it is not for the undersigned to review the enrollment procedure and evaluate its reasonableness. I agree. My task is limited to an analysis of whether the process, as administered, violates the collective bargaining agreement. There are legitimate reasons to have a provision for adding dependents to the plan, and for having a time frame to do so. Whether such a provision is inherently reasonable is not a matter for my review.

Here, however, Article XIV makes available to "all employes" a certain health insurance benefit.

The contractual language makes express reference to “a family plan”. The language of the Agreement and the administration of the benefit extends the plan benefits to the employe’s

family. There is no dispute in this proceeding that the $1,750 in denied claims were for medical services that, but for the absence of a timely application, would have been paid. The consequence of the untimely 30-day application is that it serves to deny health insurance coverage which is otherwise provided under Article XIV.

The County contends that Hess notice to his supervisor, and the open character of the birth is not sufficient to satisfy the plan requirement of a written notice to the third-party administrator. The Employer is right. The plan calls for specific notice. Hess did not provide that notice. The departmental supervisor is an entirely different entity from the administrator of the health plan.

The Union contends that Hess was not given sufficient notice to be held to a strict application of the 30-day application rule. The most basic notice as to the benefits and procedures of the health insurance plan are found in the plan document. The Employer was unable to establish that Hess had that document. The Employer demonstrated delivery to the Department. A number of employes disclaimed receipt. I am unwilling to infer that Hess had the document. This is not a situation where he stands alone. It is entirely possible that the document was never distributed.

The Employer demonstrated that it administers and enforces the 30-day application provision. The single exception involved an identical prior occurrence involving the grievant. Hess’ daughter was born ten and one-half months following the effective date of the plan document. Her birth occurred three months following distribution of that document. The third party administrator paid the claims arising from that birth in the absence of an application to add Cassie to the plan. The plan document lists Oneida County as the administrator and lists Midwest Security Administrators as the supervisor. Both were thus on actual notice that Hess did not understand his responsibility under the plan. Their subsequent failure to notify Hess of his obligation is unexplained. Hess was left to continue to believe that he had satisfied his insurance plan obligations surrounding the birth of his daughter, Cassie. Given his personal experience, Hess would have no reason to believe his insurance compliance actions relating to Brandon fell short of those required by the plan document.

Conclusion

I believe the Employer has established a practice of administering the 30-day application provision. I believe the Hess incident of 1994 was a mistake. As such, the mistake does not compromise the viability of the practice. However, the third-party administrator and the County were aware that Hess did not submit an application in 1994 and said nothing, leaving Hess to err again. Given the circumstances of this dispute, and the significant consequences of untimely notice, the Employer is estopped from denying the disputed benefits to Hess as a result of his failure to apply for

coverage within 30 days.

AWARD

The grievance is sustained.

REMEDY

The Employer is directed to make Hess whole for any and all benefits relating to the birth of his son, Brandon, which arose and were unpaid, prior to Brandon's enrollment in the plan.

Dated at Madison, Wisconsin this 26th day of May, 1999.

William C. Houlihan /s/
William C. Houlihan, Arbitrator

WCH/gjc

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