

IN THE MATTER OF ARBITRATION BETWEEN

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TEAMSTERS LOCAL UNION NO. 160)	ARBITRATION
)	AWARD
Union,)	
)	
and)	
)	HEALTH BENEFITS
)	GRIEVANCE
)	
CYTEC ENGINEERED MATERIALS,)	
INC.,)	
)	
Employer.)	FMCS CASE NO. 100222-54161-3
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Arbitrator: Stephen F. Befort

Hearing Date: June 17, 2010

Date post-hearing briefs received: July 2, 2010

Date of decision: July 29, 2010

APPEARANCES

For the Union: Frederick Perillo

For the Employer: Jeffrey H. Koenig

INTRODUCTION

Teamsters Local 160 (Union) is the exclusive representative of a unit of production and maintenance employees employed by Cytec Engineered Materials, Inc. (Employer). The Union claims that the Employer violated the parties' collective bargaining agreement by unilaterally altering the level of health benefits provided to unit employees. The grievance proceeded to an arbitration hearing at which the parties were

afforded the opportunity to present evidence through the testimony of witnesses and the introduction of exhibits.

ISSUES

- 1) Did the Employer violate the parties’ collective bargaining agreement when it modified health benefits provided for diagnostic and/or preventative care for unit employees?
- 2) If so, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

2004 Coordinated Bargaining Agreement

Attachment: Cyttec Primary Medical Plan

Medical Plan	In-network employee cost sharing	Out of network employee cost sharing
	* * *	
Diagnostic X-rays and Lab (for tests performed outside of a physician’s office)	10% (subject to deductible and out of pocket limit)	30% (subject to deductible and out of pocket limit)

2008 Coordinated Bargaining Agreement

Cyttec Industries Inc. . . . and the Coordinated Bargaining Negotiating Committee . . . having met in negotiations agree that the following changes to the Cyttec Employee Benefits Plans and to other matters noted herein;

* * *

Details of the plan(s) are contained in the official plan document(s) that legally govern the operation of the plan(s). If there is any conflict between this Agreement and the plan document(s), the document which includes the negotiated changes will always govern.

FACTUAL BACKGROUND

The Employer manufactures defense and other products at facilities throughout the United States. The Employer purchased the Winona facility – formerly Fibrite of Winona – in 1998. The Union represents the non-supervisory employees working at the Winona plant.

The grievance at issue concerns the amount of Employer responsibility for the cost of cancer screening services, such as mammograms and prostate blood tests, under the Employer-sponsored health care benefit plan provided to unit employees. The Union claims that the Employer is responsible for 100% of the cost for such services, while the Employer contends that it is responsible for only 90% of such costs.

The Employer has a practice of engaging in coordinated bargaining on the topic of employee benefits with the unions representing its various facilities. The Employer's goal in this process is to establish a single benefit plan that can be uniformly administered throughout the country.

When the Employer first purchased the Winona plant in 1998, the Union did not participate in coordinated bargaining, but simply adopted the resulting employee benefit plan. At that time, the benefit plan summary distributed by the plan administrator stated that the Employer would pay the full cost of employee preventative care, including cancer screening tests. The Union first participated in the coordinated bargaining process during the 2000 round of bargaining. The resulting 2000 coordinated agreement made no changes to the preventative care funding formula.

The next round of coordinated bargaining in 2004 did result in several changes to the Cytex Primary Medical Plan. A chart incorporated in the 2004 memorandum of

Understanding indicates that “Diagnostic X-rays and Lab [services] (for tests performed outside of a Physician’s Office” are subject to a 10% employee cost sharing. According to the Employer, this language means that while the Employer is responsible for 100% of the cost of services performed in a doctor’s office, it is responsible for only 90% of the cost of routine cancer screening services provided outside of a doctor’s office. The Union, on the other hand, maintains that the 2004 agreement affected only “diagnostic” testing, without changing the Employer’s obligation to fund “preventative” care services at a 100% level.

Following the execution of the 2004 agreement, the Employer conducted employee meetings at each site to explain medical and other benefit changes. One of the power point slides presented at the Winona meeting explained that 10% coinsurance applies to charges after deductible for “non-office services (Hospital, Out-patient surgery, Er, lab, X-ray, etc.).”

The Employer provided Blue Cross/Blue Shield of Minnesota (Blue Cross), the health care plan administrator, with the agreed upon changes to the 2004 benefit package. Nonetheless, when Blue Cross disseminated copies of the plan description in 2005, the document stated that “preventative care” services, including routine cancer screening for such purposes as mammograms and PSA testing, were to be reimbursed at the 100% level.

The 2008 coordinated bargaining agreement only identified changes to the pre-existing benefit plans, and no changes were noted with respect to preventative or diagnostic care. The 2008 agreement, however, contains the following language:

Details of the plan(s) are contained in the official plan document(s) that legally govern the operation of the plan(s). If there is any conflict between this

Agreement and the plan document(s), the document which includes the negotiated changes will always govern.

Following the 2008 agreement, the Employer took steps to consolidate its medical health insurers. Toward that end, the Employer transferred health benefits administration for the Winona unit from Blue Cross to Horizon Blue Cross/Blue Shield of New Jersey (Horizon). Shortly thereafter, Horizon began to limit reimbursement for cancer screening lab tests to 90% of cost. Several participants covered by the Winona plan complained to the Employer's Human Resources Department about the reduced reimbursement for cancer screening services. The Employer undertook an investigation and concluded that Blue Cross had incorrectly paid claims for cancer screening activities performed outside of a physician's office at 100% since 2005 when, in fact, the Employer's contractual responsibility was limited to a 90% level of reimbursement. The Employer informed the Union that it would continue to limit reimbursement for cancer screening services at the 90% level, but would not seek the repayment of overpayments made to participants between 2005 and 2009. The Union responded by filing a grievance challenging the Employer's unilateral reduction in the level of reimbursement.

POSITIONS OF THE PARTIES

Union:

The Union asserts two arguments in support of its position that the Employer violated the parties' agreement by unilaterally reducing the level of reimbursement for cancer screening preventative care services. The Union first argues that the 2004 Coordinated Bargaining Agreement did not reduce the reimbursement level for cancer screening services. The Union maintains that the 2004 agreement only altered the

reimbursement level for “diagnostic” tests, but not for “preventative” services such as cancer screening tests. Second, the Union contends that the 2008 Coordinated Bargaining Agreement expressly incorporates the level of coverage described in the plan description. Here, the plan description states that the plan will provide 100% cost coverage for preventative care services including such cancer screening tests as mammograms and PSA tests. The 2008 agreement also provides that the plan description will control unless in conflict with “the negotiated changes.” Since the 2004 agreement has expired and the 2008 agreement contains no language limiting reimbursement for preventative care, the Union claims that there is no conflict between the plan and the current negotiated agreement, such that the coverage described in the plan should be deemed controlling.

Employer:

The Employer, in turn, asserts two defenses to the Union’s claim. First, the Employer claims that the Union may not rely on extrinsic evidence, i.e. the 2005 plan description, in order to vary the unambiguous language of the coordinated bargaining agreements. Second, even if such extrinsic evidence is admitted, the Employer contends that such evidence is trumped that the fact that the parties expressly agreed in the 2004 Coordinated Bargaining Agreement to establish a 90% reimbursement rate for diagnostic x-rays and lab tests. The Employer claims that cancer screening services are subsumed within the “x-rays and lab tests” category and that the coordinated bargaining agreement does not recognize an alternative category of “preventative” care subject to a different reimbursement level. Any conflict between the plan description and the negotiated

agreements, the Employer urges, must be resolved in favor of the terms of the negotiated agreement.

DISCUSSION AND OPINION

A. The Admissibility of the 2005 Plan Description

The Union seeks the admission of the 2005 plan description in which Blue Cross states that the Employer's health benefit plan for the Winona unit includes full 100% cost coverage for "preventative care" services, including routine cancer screening testing. The Employer, however, contends that the plan description constitutes extrinsic evidence which is not admissible unless the terms of the collective bargaining agreement are ambiguous. The Employer maintains that no ambiguity exists in this instance because neither the 2004 or 2008 agreement says anything about coverage levels for preventative care.

I find that the 2005 plan description is admissible for two reasons. First, the language of the collective agreements is ambiguous. Since the 2004 and 2008 coordinated bargaining agreements only indicate changes to the parties' agreement, the parties' prior understanding is not clearly explicated. Perhaps the best evidence in the record of any prior understanding are the 1998 and 2000 benefit summaries which list "lab and X-ray" services as a subset of both "preventive" and "diagnostic" care. Thus, when the parties agreed to a 90% reimbursement level for "diagnostic X-rays and lab" in the 2004 round of bargaining, at least a plausible argument existed, as the Union now asserts, that the change applied only to "diagnostic" services, but not to "preventative" care services.

Second, the 2008 Coordinated Bargaining Agreement expressly incorporates the earlier plan description by the following language:

Cytex Industries Inc. . . . and the Coordinated Bargaining Negotiating Committee . . . having met in negotiations agree that the following changes to the Cytex Employee Benefits Plans and to other matters noted herein;

* * *

Details of the plan(s) are contained in the official plan document(s) that legally govern the operation of the plan(s). If there is any conflict between this Agreement and the plan document(s), the document which includes the negotiated changes will always govern.

The logical meaning of this language is that the official plan document represents a valid summary of the parties’ overall agreement as to benefits, except insofar as the plan document conflicts with the terms of the Coordinated Bargaining Agreement. Thus, the principal issue in this matter is not whether the plan description is admissible as evidence, but whether the terms of the plan and the agreement are in conflict.

B. The 2004 Agreement Changes

A key interpretive battle in this dispute centers on the meaning of the changes adopted in the 2004 Coordinated Bargaining Agreement. The following attachment to that agreement summarizes the most important change agreed upon by the parties for the purposes of this grievance:

Attachment: Cytex Primary Medical Plan

Medical Plan	In-network employee cost sharing	Out of network employee cost sharing
	* * *	
Diagnostic X-rays and Lab (for tests performed outside of a physician’s office)	10% (subject to deductible and out of pocket limit)	30% (subject to deductible and out of pocket limit)

The Employer maintains that this language means that while the Employer remains responsible for 100% of the cost of services performed in a doctor's office, it is responsible for only 90% of the cost of routine cancer screening and other diagnostic services provided outside of a doctor's office. In contrast, the Union contends that the 2004 agreement only affected "diagnostic" testing, without changing the Employer's obligation to fund "preventative" care premiums at a 100% level as described in the 1998 and 2000 benefit summaries.

The Employer has the better of this argument. While the 2004 agreement sets a specific rate for diagnostic services performed outside of a doctor's office, no contract provision – in 2004 or at any other time – mentions a category of "preventative" care. As a matter of definition, cancer screening services are "diagnostic" in nature. If the parties had intended a different reimbursement rate for preventative services, one would have expected that the 2004 agreement would have provided some guidance as to which services were to be reimbursed at a 90% rate as opposed to those subject to a 100% rate. Instead, the most obvious meaning of the 2004 provision is that the parties intended to adopt a single category of "diagnostic" services with the reimbursement rate determined by whether the service is provided within or outside of a doctor's office.

C. Conflict Between the Plan and the 2008 Agreement

The Union finally argues that, regardless of the 2004 agreement, the 2008 Coordinated Bargaining Agreement expressly incorporates the terms of the 2005 plan description unless such is in conflict with the terms of the negotiated agreement. The 2005 plan description states that the plan will provide 100% cost coverage for preventative care services including such cancer screening tests as mammograms and

PSA tests. Thus, according to the Union, since the 2004 agreement has expired and the 2008 agreement contains no language limiting reimbursement for preventative care, there is no conflict between the plan and the current negotiated agreement and the coverage described in the plan is controlling.

The problem with this line of argument is that the 2008 agreement only describes *changes* made to the prior agreements. As such, the provisions of the 2004 agreement that are not changed by the 2008 agreement do not expire, but are implicitly incorporated in the 2008 agreement. Accordingly, the plan description's reference to 100% reimbursement for preventative care is in conflict with the 2008 agreement, with the result that the agreement's 90% level of reimbursement for diagnostic services controls.

At bottom, this case involves a conflict between the terms of the 2004 agreement and the terms of the 2005 plan description. While the 2004 agreement reduced the reimbursement level for outpatient diagnostic services to 90%, the plan disseminated by Blue Cross mistakenly continued the prior 100% reimbursement description. The 2008 agreement resolves this conflict by expressly providing that "the negotiated changes will always govern." The fact that Blue Cross mistakenly provided a higher level of reimbursement from 2005 to 2009 does not estop the Employer from correcting the mistake upon its discovery.

AWARD

The grievance is denied.

Dated: July 29, 2010

Stephen F. Befort
Arbitrator