GATEWAY TO THE NORTHWEST

Fire Union Negotiation Meeting Minutes

Meeting Date & Time:	7/6/2016; 10:01am-11:43am	
Attendee	**Position**	**Company/Department**
Scott Marotz	Professional Negotiator	
Tom Sanford	Assistant Chief	Fire
Joyce Stroschein	CFO	Finance
Nichole Harms	HR Consultant	HR
Lynette Sampson	Legal Asst.	Legal
Absent: David Gates, Anne Butler		
Ryan O'Hearn	President, IAFF 187	Fire
Curtis Smith	Negotiation member, IAFF 187	Fire
Andy Moldenhauer	Vice President, IAFF 187	Fire
David Scott	Negotiation member, IAFF 187	Fire
Eric Anderson	Negotiation member, IAFF 187	Fire
Mick Coward	Negotiation member, IAFF 187	Fire

Meeting Notes	
City of Pocatello and IAFF #187 Union Negotiation	▪ Meeting opened at 10:01a.m. by Ryan O'Hearn.
Session #5:	▪ R. O'Hearn started the meeting by reviewing an email from S. Marotz that stated that the City is facing some issues and that the parties would have to work together and compromise to address problems. This is the 5th Session of negotiations and substantial issues have not yet been addressed. R. O'Hearn stated the Union has been in contact with their attorney and feel they have a strong anticipatory breach of contract suit. R. O'Hearn stated that the City has not presented the Union with a proposal to entice them off that point. R. O'Hearn stated that the Union is concerned when they hear about the City Council's motivation including breaking the contract, reorganizing the department, and potential fire district. All those elements cause the Union concern as the Union does not know where the City Council is coming from or what their end-game is, and they have no substantial proposals to show why the Union should stay in the City's insurance. S. Marotz stated he could say the same about the Union; the Union has not presented a proposal addressing the $323,000 cost to the City of the Union leaving the insurance pool. S. Marotz stated that if the Union wants to threaten litigation then bring it. R. O'Hearn stated it was not a threat of litigation; S. Marotz stated that is how he took the statement and he will not negotiate under a threat of litigation. C. Smith stated the

Union is being forced to negotiate under a threat of reorganization. Discussion ensued regarding the City Council managing City funds, reorganization, and rumors. Discussion moved to the City's insurance proposal and the City's inability to overlook the over $300,000 the Union leaving will cost the City and other employees. S. Marotz stated that they could not compare insurance numbers as the City has not received any from the Union despite requesting them. Discussion ensued regarding insurance numbers and the lack of presentation of any numbers or insurance counter proposals to these negotiations.

- R. O'Hearn presented two handouts with the Union's estimated insurance numbers and plan breakdown. Discussion ensued regarding what the numbers represented, how they were developed, and if they were estimates or hard numbers; R. O'Hearn stated the FY17 numbers were estimated.
- S. Marotz asked the Union if they had any counter proposals to present; R. O'Hearn answered in the negative. M. Coward asked if the City had any counters to the Union's proposals. S. Marotz stated that the City did not and that the City doesn't know what the Union wants or what the Union thinks they should be paid. S. Marotz stated that the Union hasn't even presented a starting point for these discussions; therefore, he does not know where to go. C. Smith asked if Marotz wants the Union to bring their wage proposals and stated that the Union gave the City those numbers last year. S. Marotz responded that he did not care what was presented last year and that if the Union wants to discuss wages, a proposal must be brought to the table and attached to the minutes.
- **Caucus 10:16am to 11:07am**
- R. O'Hearn stated a proposal where the Union would remain in the City's insurance in exchange for a 3 year contract with an increase to base wages of 1.5% in FY17, 2% in FY18, 3% in FY19. The proposal would include a provision wherein the Union would agree to work with a committee of HR and Finance representatives to figure out a long-term salary plan. S. Marotz asked for the proposal in writing; S. Marotz asked for the proposal to include the items that have been Tentatively Agreed to for comparison. R. O'Hearn stated he believes the Union's proposal is good for both parties and the 1.5% addresses some of the salary issues. S. Marotz asked if there were no openings for negotiation in the three year contract; R. O'Hearn answered that there are no contract openers. C. Smith stated that the Union feels that the three year contract gives time to mend labor relations. S. Marotz stated that binding fact finding is a sticking issue; binding fact finding is not legal and he would be hard-pressed to agree or recommend the City Council sign such a contract. R. O'Hearn stated that binding fact finding has been in the contract for 15 years and it has only been used one time. S. Marotz reiterated his position that the City Council cannot delegate its authority to a three person board where there is no way to test the panel's decision. C. Smith asked for caucus.
- **Caucus 11:10am to 11:38am**
- R. O'Hearn presented **Fire Counter to F-4** and stated that if the City agrees to the Union's proposal, the Union will agree to **C-2**. S. Marotz stated that he would take the Union's proposal to the City Council and get their input on this counter proposal. R. O'Hearn asked S. Marotz to convey to the City Council that the Union feels like they made a strong good faith proposal to the City. S. Marotz stated that he did see some

	issues with the proposal that he will work through. ▪ The Union and City agreed for the next meeting to take place on Tuesday July 19th at 1:00pm. ▪ Documents attached to the July 6, 2016 meeting minutes: Two documents presented by R. O'Hearn regarding the Union's insurance; Fire Counter to Fire Proposal F-4. ▪ **Session #5 adjourned at 11:43a.m.**

By: _____
Lynette Sampson, Legal Department

Approved as to Substance and Form:

By: _____
Ryan O'Hearn, President
IAFF #187

	EE	E + Spouse	E + Child	E + Children	E + Family 1	E + Family 2+	
# Employees	19	17	3	4	6	37	
2016 Monthly Rates	$412.88	$901.96	$673.33	$810.31	$1,162.42	$1,299.39	
2017 Monthly Rates	$433.52	$947.06	$707.00	$850.83	$1,220.54	$1,364.36	
2017 Cost:	$98,843.47	$193,199.83	$25,451.87	$40,839.62	$87,878.95	$605,775.62	**$1,051,989.37**

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Northw : Fire Fighters Benefits Trust Medical P

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Eligible Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** claimant / **$3,000** family per calendar year. Doesn't apply to **preferred** and participating preventive care or outpatient mental health and substance abuse. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$2,000** claimant / **$4,000** family per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (866) 240-9580 for lists of **preferred** or participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit, other services 20% coinsurance	$20 copay / visit, other services 40% coinsurance	40% coinsurance	**Copayment** applies to each **preferred** or participating office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$20 copay / visit, other services 20% coinsurance	$20 copay / visit, other services 40% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for acupuncture and spinal manipulations	40% coinsurance for acupuncture and spinal manipulations	40% coinsurance for acupuncture and spinal manipulations	Coverage is limited to 24 acupuncture visits / year and 24 spinal manipulations / year. **Deductible** waived for acupuncture and spinal manipulation services.
	Preventive care/ screening/immunization	No charge	No charge	40% coinsurance	No charge for childhood immunizations from non-participating **providers**.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for inpatient services; no charge for outpatient services	40% coinsurance	40% coinsurance	**Deductible** waived for outpatient radiology and laboratory services for **preferred providers**.
	Imaging (CT/PET scans, MRIs)	20% coinsurance for inpatient services; no charge for outpatient services	40% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com.	Generic drugs	$5 copay / retail prescription $10 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			Coverage is limited to a 90-day supply retail (1 copay per 30-day supply) or mail order. Coverage is limited to a 30-day supply for injectable drugs, specialty drugs and self-administrable cancer chemotherapy drugs. No charge for FDA-approved women's contraceptives prescribed by a health care **provider**. No charge for generic tobacco use cessation drug coverage when obtained with a prescription order at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the **copayment** and/or **coinsurance**. For specialty drugs, the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy.
	Preferred brand drugs	$25 copay / retail prescription $50 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			
	Non-preferred brand drugs	$50 copay / retail prescription $100 copay / mail order prescription No charge for self-administrable cancer chemotherapy drugs			
	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance for ambulatory surgery centers; 20% coinsurance for all other facilities	40% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance after $100 copay	20% coinsurance after $100 copay	20% coinsurance after $100 copay	**Copayment** applies to the facility charge for each visit (waived if admitted), whether or not the **deductible** has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	Covered the same as the **If you visit a health care provider's office or clinic** or **If you have a test** Common Medical Events.			——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	40% coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay / visit	$20 copay / visit	40% coinsurance	**Deductible** waived for outpatient services. **Copayment** applies to each **preferred** and participating outpatient therapy visit.
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	$20 copay / visit	$20 copay / visit	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	40% coinsurance	Maternity services for children are not covered.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 130 visits / year.
	Rehabilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 30 inpatient days / year and 40 outpatient visits / year.
	Habilitation services	20% coinsurance	40% coinsurance	40% coinsurance	Coverage for outpatient neurodevelop-mental therapy is limited to 25 visits / year.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 60 inpatient days / year.
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	——none——
	Hospice service	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	——none——
	Glasses	Not covered	Not covered	Not covered	——none——
	Dental check-up	Not covered	Not covered	Not covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (866) 240-9580. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (866) 240-9580 or visit www.Regence.com. You may also contact your state insurance department at 1 (800) 562-6900 or www.insurance.wa.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

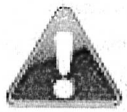
Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,870
- **Patient pays:** $2,670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$10
Coinsurance	$1,010
Limits or exclusions	$150
Total	**$2,670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,990
- **Patient pays:** $1,410

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$290
Copays	$1,080
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,410**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Northwest Fire Fighters Benefits Trust Vision Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 - 12/31/2016

Coverage for: Individual and Eligible Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (866) 240-9580.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	This plan has no **deductible**.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (866) 240-9580 for lists of in-network or out-of-network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 2. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1 (866) 240-9580 or visit us at www.Regence.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (866) 240-9580 to request a copy.

Claims Administrator: Regence BlueShield
WW0116SVISCX

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered vision care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a vision examination is $50, your **coinsurance** payment of 20% would be $10. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network **provider** charges $150 for a vision examination and the **allowed amount** is $50, you may have to pay the $100 difference. (This is called **balance billing**.)

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit an eye care provider's office or clinic	Routine vision examination	No charge	No charge	No charge	Coverage is limited to 1 routine eye exam / year.
	Vision hardware	No charge up to $200 hardware maximum	No charge up to $200 hardware maximum	No charge up to $200 hardware maximum	Coverage is limited to $200 for covered vision hardware / year and you pay any balance.

Excluded Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Contact fittings
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical services
- Non-direct patient care
- Personal comfort items
- Prescription medication
- Vision therapy and surgery

POCATELLO FIRE FIGHTERS LOCAL #187
NEGOTIATION PROPOSAL # Counter F-9

Proposal: Multi-year contract with wage increases

1) The union agrees to the City's proposed Aetna Healthcare Plan.
2) The contract will be in effect through September 30, 2019.
    a. For FY17 there will be a 1.5% increase in base wages.
    b. For FY18 there will be a 2.0% increase in base wages.
    c. For FY19 there will be a 3.0% increase in base wages.
3) The City and Union agree to form a committee to create a long term approach to compensation.
4) The Union recognizes that the following items have been tentatively agreed upon:
    a. C1, C5, C7, C11, C12, C13, C16
    b. F6, F7 ?
5) All other other proposals from both sides, except City Proposal #2, will be pulled from the table.
6) Union tentatively agrees to City Proposal #2.

7.6.16
@ 1:00PM