TENTATIVE AGREEMENT

Memorandum of Understanding
Between
Kaiser Foundation Health Plan of Washington ("KFHPWA")
and
Unions United, a coalition of unions at KFHPWA that includes
SEIU Healthcare 1199NW, UFCW Local 21, and OPEIU Local 8

Medical Benefit

The parties to this Memorandum of Understanding ("MOU") agree that KPFHPWA will provide medical benefits to eligible union-represented staff in accord with the health plan design developed and agreed to by the parties during the Unions United Benefits Coalition bargaining which resulted in a comprehensive program to encourage overall employee wellness ("Wellness Works"). The health plan design for Wellness Works will be maintained through 2021 (See attached Appendix A) and will be incorporated in the Summary Plan Description ("SPD").

The parties agree that union-represented employees who earn the required credits in each applicable year shall pay a premium that is less than the premiums paid by union-represented employees who do not participate in Wellness Works and earn the required credits. Premium costs for both participants and non-participants are set forth in Appendix B.

New Participants

Any union-represented employee entering the benefit plan after January 1 of any year will qualify for the lower participant rate for premiums paid in the following year. They do not need to complete their health screenings or take any other action. However, an employee on the benefit plan on or after October 1 of any given program year (October 1 – September 30) must complete the Wellness Works requirements for that year in order to receive the lower premium the following year. To qualify for the lower participant premium after this the employee must meet the credit requirements for the applicable year. The intent of this paragraph is that no employee would be required to complete all the activities in less than nine (9) months from entering the benefit plan.

Spousal/Domestic Partner Surcharge

Spouses/domestic partners of employees who decline coverage offered through the spouse's employer may enroll in the KFHPWA plan through the employee at an additional premium cost of $100 per month. The spousal/domestic partner surcharge will not apply under these conditions:

1. The employee's spouse or domestic partner (DP) is not employed
2. The employee's spouse or DP is employed and enrolls in their own employer's coverage (coordination of benefits would take effect between both plans)
3. The employee's spouse or DP is employed but his/her employer does not offer medical coverage
4. The employee's spouse or DP is not eligible to receive medical coverage from his/her employer

The employee will be asked to attest that one of these conditions is true. The failure to provide the attestation will result in the surcharge being applied.

Appeal Process

KFHPWA will notify employees regarding whether they qualify for a lower participant rate by October 31, of every year. An employee wishing to appeal a determination must submit a written appeal to Human Resources department by 180 days from the date they were notified of their participant rate for the following year. Human Resources will notify employees of appeals decisions within 30 days.

The parties agree that from 2018 through 2021, the project manager of the Wellness Works program will review and issue a decision in the first level of appeal for union-represented employees who challenge qualification for the lower participant premium. If the project manager of the Wellness Works program denies a first level appeal, an employee can

request a second level review by the Appeals Committee. A request for a second level review must be submitted in writing to the Appeals Committee within 30 days of the employee's receipt of the first level decision. If the employee disagrees with the Appeals Committee's decision, then the employee may request a review by the third party determined by the Appeals Committee for a third level review. A request for a third level review must be submitted in writing to the Appeals Committee within 30 days of the employee's receipt of the second level decision. The decision of the third party shall be final and binding on the employee, the union that represents the employee, and KFHPWA. Notwithstanding the grievance and arbitration provisions of any collective bargaining agreement or the claims and appeals procedures set forth in the SPD, the appeal process set forth herein shall be the sole avenue for resolving any disputes regarding whether or not an employee qualifies for a lower participant premium.

The Appeals Committee will be comprised of 3 members from the union coalition, 3 members from the Administration, with alternates for each member, and a representative from Labor Relations, who will chair the committee and be the deciding vote in case of a vote that is tied. The Appeals Committee will review appeals at the second level based on the eligibility criteria of the Plan. At least 2 voting members (1 from union and 1 from Administration) and the Chair are needed for a quorum to hold a meeting.

Dental Plan

Dental plans and employee cost share percentages currently in place will continue through 2021.

Benefits Labor Management Committee

The parties agree to continue a Benefits Labor Management Committee ("BLMC") to meet at least quarterly to discuss issues related to medical and dental benefits. The BLMC will be comprised of employee representatives from all the bargaining units in the coalition in addition to union staff representatives. Management representatives will include the employee benefits manager, the wellness coordinator and Group Health Labor Relations representatives. The BLMC will review and provide input regarding various aspects of Wellness Works, including data relating to utilization and utilization trends, plan design and requirements and focused outcomes of containing costs. The BLMC will also review and provide input regarding dental renewals, plan design and cost.

Attendance and Absenteeism Committee

Within thirty (30) days of ratification, the parties agree to form an Attendance and Absenteeism Committee (AAC) to meet at least quarterly to discuss issues and identify best practices to improve attendance at KFHPWA. The goal of the committee is to support employee wellness and improve attendance through addressing the root causes of absenteeism. The AAC will be comprised of employee representatives from all the bargaining units in the coalition in addition to union staff representatives. Management representatives will include Human Resources, Providers and operational leaders. Areas of focus will include but are not limited to: identification of root causes of absenteeism, encouragement of appropriate uses of leave, creation of a toolkit to address holistic concerns, regular and standardized data-sharing regarding attendance, development of best practices for communication between managers and employees about their attendance status, improved wellness of employees, improved engagement, and additional opportunities around absenteeism.

Nondiscrimination

The parties agree that participation or non-participation in Wellness Works will not impact job performance evaluations, nor will there be any penalty or discrimination based upon participation or non-participation in the program.

Termination and Renewal

This MOU shall be in full force and effect until the expiration date of December 31, 2021, and shall continue in effect from year to year thereafter unless any party gives notice, in writing, no earlier than December 1, 2020 and no later than December 31, 2020 of its desire to terminate or modify such Agreement; provided that, in the event that any party serves written notice in accordance with this Section, any strike or stoppage of work after the expiration date shall not be deemed in violation of any provision of this Agreement, or any other provision of an existing collective bargaining agreement between the parties. It is anticipated that existing collective bargaining agreements between the parties will expire prior to the expiration of this MOU. The terms set forth in this MOU shall not be subject to bargaining during the negotiations for the collective bargaining agreements unless both parties agree in advance.

No later than March 30, 2021, any party to this agreement may terminate their participation in the Benefits Coalition and shall have the right to propose to modify existing terms or provisions of the health plan as provided in this MOU; and separate from any other agreements that may be reached.

The parties to this agreement acknowledge the time-sensitive nature of implementing any successor agreements that would require health plan or wellness program changes in 2022. As a result, the unions and KFHPWA commit to completing negotiations by June 30, 2021.

_____ _____

On behalf of Kaiser Foundation Health Plan of Washington (KFHPWA) Date

_____ _____

On behalf of SEIU Healthcare 1199NW Date

_____ _____

On behalf of OPEIU Local 8 Date

_____ _____

On behalf of UFCW Local 21 Date

Appendix A

Benefit Summary
Kaiser Foundation Health Plan of Washington (KFHPWA) – Wellness Works Union Plan

Group Number: 1206900/4206900
Effective Date: 1/1/2018

This is a brief summary of benefits based on current information, not to be mistaken for a contract or Certificate of Coverage. This summary is for general information purposes only. Based on final benefit determinations, KFHPWA reserves the right to modify, this summary, in whole or in part.

Benefits	Inside Network
Annual plan deductible	Employee pays $100 individual /$200 family
Plan coinsurance	No plan coinsurance
Annual Out-of-pocket limit	$1,000 individual /$2,000 family (all cost shares for covered services count towards this limit)
Lifetime maximum	Unlimited
Pre-existing condition (PEC) waiting period	No PEC
Office visit - primary	$20 copay Includes, but is not limited to, family practice, general practice, internal medicine, nutrition, obstetrics & gynecology, occupational medicine, osteopathy, pediatrics, respiratory therapy, urgent care, and women's health care
Office visit - specialty	$25 copay Includes, but is not limited to, allergy & immunology, anesthesiology, cardiology, critical care medicine, dentistry, dermatology, endocrinology, gastroenterology, genetics, hepatology, infectious disease, neonatal-perinatal medicine, nephrology, neurology, nematology/oncology, ophthalmology, ENT/otolaryngology, pathology, physiatry, podiatry, pulmonary medicine/disease, radiology (nuclear medicine/radiation), rheumatology, sports medicine, general surgery (all specific surgeries) and urology
Hospital services	Inpatient: $100 copay, per admit Outpatient: $50 copay
Prescription drugs (some injectable drugs may be covered under outpatient services)	$15 generic/$30 copay brand for 30-day supply Certain chronic condition medications (determined by KPHPWA) subject to a $5 copay for 30-day supply
Prescription mail order	$5 discount per 30 day supply. Copay waived for 90-day supply of certain chronic condition medications.
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: $100 copay, per admit
Devices, equipment, and supplies - Durable medical equipment - Orthopedic appliances - Post-mastectomy bras limited to two (2) every six (6) months - Ostomy supplies - Prosthetic devices	20% coinsurance, with cost shares waived for specific devices

Diabetic supplies	Insulin, needles, syringes and lancets – see prescription drugs External insulin pumps, blood glucose monitors, testing reagents and supplies – see devices, equipment and supplies. When devices, equipment and supplies or prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and x-ray services	Inpatient: covered under hospital services Outpatient: covered in full. $50 copay for high-end imaging (MRI, CT, PET), up to $200 maximum per calendar year. High-end radiology imaging services such as CT, MRI and PET must be medically necessary, and requires prior authorization except when associated with emergency or inpatient services.
Emergency services (copay waived if admitted)	$100 copay at a designated facility $150 copay at a non-designated facility
Hearing hardware	Plan pays $300 per ear every 36 months
Manipulative therapy	Subject to office visit copay. Covered up to 10 visits per calendar year without prior authorization.
Massage services	See rehabilitation services
Maternity services	Inpatient: $100 copay, per admit Outpatient: subject to office visit copay. Routine care not subject to copay.
Mental health	Inpatient: $100 copay, per admit Outpatient: Covered in full for the first ten (10) visits, all additional visits are covered subject to the office visit copay.
Naturopathy	Subject to office visit copay. Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan.
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period Inpatient: $100 copay, per admit Outpatient: subject to office visit copay
Preventive care Well-care physicals, immunizations, pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.
Rehabilitation services (occupational, speech, physical including services for neurodevelopmentally disabled children)	Inpatient: $100 copay, per admit; 60 days per calendar year Outpatient: subject to office visit copay; 60 visits per calendar year Rehabilitation visits are a total of combined therapy visits per calendar year.
Skilled nursing facility	Covered in full, up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	Inpatient: $100 copay, per admit Outpatient: subject to office visit copay
Temporomandibular Joint (TMJ) **services**	Inpatient: $100 copay, per admit Outpatient: subject to office visit copay Plan pays $1,000 per calendar year; $5,000 lifetime maximum
Tobacco cessation	Quit for Life program – covered in full
Optical hardware Lenses, including contact lenses and frames	Plan pays $150 per 12 months

Appendix B

Wellness points and premium costs

Wellness Plan –The Wellness Works plan will focus on cardiovascular health (heart health). Key heart health factors are body mass index (BMI), blood pressure (BP), and tobacco use (nicotine). The Wellness Works Plan will provide medical premium discounts by earning points. The key areas of the plan are:

- Health Screenings
- Health Assessments
- Journeys
- Points
- Wellness Works Champions
- Volunteer Activities

- **Health Screenings** – Health screenings will be an option for the employee to earn a discount on the medical plan premium. The screening will provide employees with their key numbers (BMI, BP and nicotine) to better manage their health. Healthy ranges are as follows:

  - **Nicotine** is no tobacco use
  - **Blood Pressure** is less than or equal to 140/90 mmHg
  - **BMI** is less than 30 or there is a 5% body weight loss from prior year's results.

  Screenings administered by a third party will be available annually at KFHPWA sites for convenience. Or, numbers can be verified by a provider by completing the *Health care provider form.*

- **Health Assessments** – To be eligible for a premium discount, employees are required to complete the online Health Assessment. The assessment gives a health score indicating potential for improvement and recommendations for action. The recommendations are called "Journeys".

- **Journeys** – Employee can earn points by taking a journey. A journey is a personalized online tool to help individuals engage in activities and track progress towards their health goals. Journeys focus on nutrition, weight management, physical activity and better management of chronic conditions.

- **Points** - Employees will have an opportunity to qualify for a discount on medical plan premiums by earning points. One (1) point is equal to one dollar ($1.00). The health assessment is required to be completed by the employee every year to be eligible for a discount.

Wellness Works Points Program

- Health Assessment required, plus:

Employees	
Activity	Points
Biometric screening	400
BMI – YoY improvement	100
BP – Healthy Factor	100
Health Assessment	200 (required)*
Tobacco non-user (self-report from the HA)	200
Journey (up to 3/year)	200/Journey
Track (earned for 300 on daily wellness meter)	8 per day (cap at 400 points)
Weight Watchers	200
Quit For Life	200
Wellness champion or Volunteer credit	200
Rally	Prize drawing
***get-what-you-earn model but must complete HA by EOY**	
Total points available	2600
Maximum points earned	1200
Total incentive available	$1200

Standard premium WITHOUT discount (2018-2021)

Employee only	$130/mo.
Employee + spouse/partner	$155/mo.
Employee + children	$155/mo.
Family	$185/mo.

Discounted premium after applying *MAXIMUM* points (2018-2021)

Employee only	$30/mo.
Employee + spouse/partner	$55/mo.
Employee + child	$55/mo.
Family	$85/mo.

[Below is the Medical Insurance article from each coalition union CBA, with amended language per this Memorandum of Understanding, underlined]:

OPEIU

Section 13.01 Health Insurance. The Employer shall provide its generally applicable employee medical, surgical and hospital services coverage for all regular employees from the first of the month following two (2) months of regular employment, subject to the conditions set forth in the Plan and subject to the employee's agreement to make the bi-weekly premium-share contribution. Medical, surgical and hospital services coverage shall be provided to employees assigned an FTE of .50 or greater. The Employer shall provide complete dependent coverage (including dependent children who are under the age of twenty-six (26) and are eligible to enroll in this plan) for regular employees assigned a .75 or more FTE. The Employer agrees not to reduce the current level of medical, surgical, and hospital services coverage for medical insurance under this Article during the term of this Agreement without negotiating with the Union. This shall include the conditions of co-payments and deductible. This commitment shall not apply to administrative (non-benefit) changes that may occur to the plan.

SEIU

12.1 Medical Insurance. The Employer shall provide a medical plan for eligible regular, full-time and part-time employees assigned 0.5 FTE or greater, effective the first of the month following two (2) months of continuous eligible employment. As an exception to this Article, employees enrolled in the medical plan as of January 22, 2005 who are 0.26 - 0.49 FTE shall not lose eligibility for coverage during the term of this agreement. Provided however, that if such an employee's FTE subsequently increases to 0.5 or above, the employee will become ineligible for coverage if his/her FTE later drops back below 0.5 FTE.

The Employer shall also provide family member coverage (including dependent children who are under the age of twenty-six (26) and are eligible to enroll in this plan) for regular employees assigned a 0.75 FTE or greater, subject to the employee's agreement to pay the required monthly premium cost share. Employees with a 0.5-0.74 FTE can enroll their eligible family members into the medical plan, subject to the employee paying the full cost of the family member's coverage.

UFCW

14.01 Health Insurance. The Employer shall provide medical, surgical and hospital services coverage for all regular full-time and part-time employees effective the first of the month following two (2) months of eligible employment. Medical, surgical and hospital services coverage shall be provided to employees assigned an FTE of .5 or greater. The Employer shall also provide dependent coverage (including dependent children who are under the age of twenty-six (26) and are eligible to enroll in this plan) for regular employees assigned a .75 or more FTE status, subject to the employee's agreement to pay the required monthly premium-share contribution.