

2021

NATIONAL AGREEMENT

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KAISER PERMANENTE
THE ALLIANCE OF HEALTH CARE UNIONS

LMP LABOR MANAGEMENT
PARTNERSHIP

NATIONAL AGREEMENT

This National Agreement (the Agreement) is entered into this first day of October, 2021, by and between the labor organizations participating in the Alliance of Health Care Unions (the Alliance) and the organizations participating in the Kaiser Permanente Medical Care Program (the Program), including Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals (KFHP/H) and the Permanente Medical Groups (collectively Kaiser Permanente or Employers, or individually, Employer), which are signatories hereto.





IN MEMORY OF

KATHY SACKMAN



BERNARD J. TYSON

This National Agreement is dedicated to Kathy Sackman and Bernard J. Tyson, two pathbreaking national leaders who left indelible marks on our country, our unions, and Kaiser Permanente.

UNAC/UHCP Founding Member and Former President Kathy Sackman, RN

was a visionary leader who was by turns witty, irreverent, and inspirational in service of her steadfast commitment to raising standards for workers and patients. As one of the founding organizers of UNAC/UHCP in 1972, she devoted nearly 40 years to building the union into a powerhouse of organizing and advocacy. Kathy was one of the key architects of the Labor Management Partnership and co-founder of the Coalition of Kaiser Permanente Unions. Anyone who heard her speak at a conference, rally, or bargaining table came away with an appreciation for her ability to move listeners to action. Workers everywhere are the beneficiaries of her leadership and accomplishments, and her legacy will continue to improve the lives of healthcare professionals, their families, and their patients. “The partnership is a commitment by the employer and by the unions that the workforce will be involved. It’s recognition that the employer understands that the workers know how to do the work and have ideas on how to do it better.”

Kaiser Permanente CEO (2013-2019) Bernard J. Tyson was a committed, compassionate innovator unafraid to speak the truth and seek solutions on affordable health care, care disparities, care for transgender and other vulnerable populations, income inequality, climate change, racial profiling, and homelessness. When other insurance providers pulled out of the new ACA marketplaces, he made it clear that Kaiser Permanente would remain, ensuring the survival of the marketplace. Bernard understood and communicated the value of Partnership. “We have tapped into the potential of smart people all over the organization coming here every single day trying to figure out, ‘How do I improve quality, how do I improve service, how do I improve affordability?’ That’s an incredible competitive advantage for the organization.”

NATIONAL AGREEMENT: INTRODUCTION1

SECTION 1: PRIVILEGES AND OBLIGATIONS OF PARTNERSHIP.....2

A. Commitment to Partnership2

B. Partnership Governance and Structure4

1. Partnership Structures.....4

 a. Integration4

 b. Partnership in Shared Services, National Functions and
 Cross-Regional Functions5

 c. Unit-Based Teams.....5

 d. Pathway to Partnership Performance8

 e. Joint Accountability8

2. Governing Bodies9

3. Joint Partnership Trust.....9

C. Organizational Performance10

1. Performance Improvement 10

 a. Successful Practices 11

 b. Flexibility..... 11

2. Service Quality..... 14

 a. Leadership Commitment and Service Behavior 14

 b. Systems and Processes 15

 c. Environment 15

3. Attendance..... 16

 a. Philosophy 16

 b. Sponsorship and Accountability..... 16

 c. Time-Off Benefit Enhancement..... 16

 d. Implementation 19

 e. Attendance Intervention Model 19

 f. Staffing and Backfill (Planned Replacement) 20

4. Affordability and Competitiveness Task Force 20

5. Scope of Practice 21

6. Joint Marketing and Growth 22

 a. AHCU Growth 23

D. Workforce Planning and Development.....23

1. Taft-Hartley Trust 23

 a. Funding 23

 b. Governance 24

2. Structure 24

 a. Workforce Planning and Development Coordination and
 Implementation Structure 24

 b. National Workforce Planning and Development Team
 (National Team) 24

c. Regional Workforce Planning and Development Teams (Regional Teams)	25
d. Facility Workforce Planning and Development Teams (Facility Teams)	26
3. Joint Workforce Planning and Development	26
a. Workforce Planning and Development	26
b. Career Development	27
c. Education and Training	28
d. Redeployment	29
E. Education and Training	29
1. Principles	29
2. Types of Training	29
3. Steward Education, Training and Development	30
4. Integrated Approach to Education and Training	31
F. Staffing, Backfill (Planned Replacement), Budgeting and Capacity Building	32
1. Oversight	32
a. Planned Replacement and Budgeting	32
b. A Joint Staffing Process	33
c. Labor-Management Staffing Committees	34
2. Contract Specialists	37
3. Per Diem/On-Call Review	38
G. Racial Justice	38
1. Infrastructure	38
2. Health Equity	39
3. Employee Experience	39
4. Workforce Equity	40
H. Total Health	40
1. Unit-Based Team Engagement in Total Health	41
2. Total Health Agreement	41
a. National Health, Safety and Well-Being Committee (NHSWBC)	42
b. Educating and Engaging Employees as Active Leaders in Their Health and Well-Being	43
c. Alliance and Management Leadership	43
d. Health Assessment Tools	43
3. Community Engagement	43
4. Programs and Services	44
a. Health and Well-Being Promotion	44
b. Employee Assistance Program (EAP)	44
c. Referral Services	44
d. Donating Days	44
5. Mandatory Overtime and Assignments	45

CONTENTS

I. Just Culture	45
J. Worker and Patient Safety	45
1. Patient Safety	45
a. Creating a Culture of Safety	45
b. Flu Prevention	46
2. Workplace Safety	46
a. Creating a Culture of Safety	46
b. Comprehensive Approach to Safety	47
c. Patient and Worker Safety Recognition Program	47
d. National Data System	47
3. Bloodborne Pathogens	48
4. Integrated Disability Management	48
5. Prevention of Workplace Violence	49
6. Ergonomics	49
7. Union Indemnification	49
K. Union Security	50
1. Union Leaves of Absence	50
2. Corporate Transactions	50
3. Voluntary COPE Check-off	51
4. Subcontracting	51
5. Union Representation of New Positions	51
6. Accretion	53
7. Recognition	53
8. New Employee Orientation	53
L. Problem-Solving Processes	54
1. Issue Resolution and Corrective Action Procedures	54
a. Summary of Issue Resolution	54
b. Summary of Corrective Action	54
c. Tools and Resources for Successful Issue Resolution	55
M. Labor Management Partnership Side Letters of Agreement	56
N. Term of the Partnership	57
SECTION 2: WAGES AND BENEFITS	58
A. Compensation	58
1. Across-the-Board Wage Increases (ATBs) and Lump-Sum Payouts	59
2. Performance Sharing	59
a. Affordability Goal	62
B. Health and Welfare Benefits	62
1. Medical Benefits	62
a. Eligibility	62
b. Basic Comprehensive Plan	63
c. Parent Coverage	65

d. Health Care Spending Account.....	65
e. Healthcare Reimbursement Account.....	65
f. Preferred Provider Option (PPO)/Point of Service (POS) Plans.....	66
g. Supplemental Medical.....	66
2. Retirement Benefits.....	66
a. Defined-Contribution Plan.....	66
b. Defined-Benefit Retirement Plan.....	68
c. Pension Protection Act (PPA) Compliance.....	69
d. Continuation of Certain Retirement Programs.....	70
e. Pension Service Credits.....	70
f. Investment Committee Briefings.....	70
g. Appeals Subcommittee.....	71
h. Pre-Retirement Survivor Benefits.....	71
i. Retiree Medical Benefits.....	71
3. Initial Contracts for UNAC/UHCP with Effective Dates of October 1, 2021 — United Pharmacists of Hawaii (UPHI); United Therapists of Hawaii (UTH); and United Therapists of NCAL (UTNC).....	77
4. Other Benefits.....	78
a. Dependent Care Spending Account.....	78
b. Survivor Assistance Benefit.....	78
c. Workers’ Compensation Leaves of Absence.....	78
d. Disability Insurance.....	79
e. Employee Health Care Management Program.....	79
f. Revised Dental Benefit.....	79
g. Life Insurance.....	79
h. Benefits by Design Voluntary Programs.....	80
i. UFCW Local 1996 and Employers Legal Assistance Fund.....	80
j. Flexible Benefits.....	80
k. Citizenship Fee Assistance.....	80
5. Maintenance of Benefits.....	80
6. Referrals to the Strategy Group.....	81
SECTION 3: SCOPE OF AGREEMENT.....	82
A. Coverage.....	82
B. The National Agreement and Local Agreements.....	82
C. National Agreement Implementation.....	83
D. Dispute Resolution.....	83
E. Duration and Renewal.....	84
F. Grievance Arbitrability.....	85
G. Living Agreement.....	85
Signatures.....	86

CONTENTS

SECTION 4: NATIONAL AGREEMENT EXHIBITS..... E.1

- 1.A.** Labor Management Partnership Playbook..... E.1
- 1.B.1.c.1.(1)** 2005 Performance Improvement BTG Report, Page 7 E.2
- 1.B.1.c.3.** The Path to Performance..... E.4
- 1.C.1.b.** 2010 LMP Subgroup Recommendation: Flexibility E.7
- 1.C.4.(1)** 2005 Scope of Practice BTG Report, Pages 14–17 E.7
- 1.C.4.(2)** 2005 Scope of Practice BTG Report, Pages 9–11 E.13
- 1.F.1.a.** 2005 Attendance BTG Report, Concept No. 3,
Pages 20–23..... E.15
- 1.F.1.c.6.** Sample Labor-Management Staffing Committee Charter E.18
- 1.H.2.** Kaiser Permanente Well-Being Model E.23
- 1.H.5.** Mandatory Overtime Documents May 22, 2003 E.23
- 1.J.5.** Prevention of Workplace Violence E.28
- 1.K.4.** MOU Regarding Subcontracting Dated July 15, 2005 E.29
- 2.A.1.** ROC (Georgia, Hawaii, Mid-Atlantic States, Washington)
ATB Increases..... E.33
- 2.A.2.** Elements of an Effective Performance Improvement
Reward Program E.33
- 2.B.1.c.** Letter of Agreement Parent Medical Coverage..... E.34
- 2.B.1.g.** Supplemental Medical— Chiropractic and
Acupuncture Benefits..... E.38
- 2.B.2.b.** List of LMP Defined-Benefit Plans Sponsored by
Kaiser Permanente..... E.39
- 2.B.2.i.** Retiree Medical Benefits — Base Eligibility E.48
- 2.B.2.i.6** Rehired Retirees E.51
- 2.B.4.d.** General Description of Disability Plan Benefit Levels E.53
- 2.B.4.f.** Revised Dental Benefit E.55
- 3.D.1.** Procedure for Dispute Resolution E.56
- 3.D.2.** Guide for Dispute Resolution E.56
- 3.E.** Local Union Agreements E.58
- Index..... E.60
- Notes..... E.63

NOTE TO READER: In this contract, references to a grandfather clause have been changed to Legacy as appropriate, with the same intended meaning.

INTRODUCTION

In 1997, and again in 2018, unions of the Alliance of Health Care Unions and Kaiser Permanente entered into National Labor Management Partnership Agreements. By involving employees and unions in organizational decision making at every level, the Partnership is designed to improve the quality of health care, make Kaiser Permanente a better place to work, enhance Kaiser Permanente's competitive performance, provide employees with employment and income security, and expand Kaiser Permanente's membership. The cornerstone of the Partnership is an innovative labor management relationship. Over the course of several rounds of national bargaining, the parties identified the need to further integrate the Labor Management Partnership into the way Kaiser Permanente does business.

The Agreement describes an organization in which unions and employees are integrated into planning and decision-making forums at all levels, including budget, operations, strategic initiatives, quality processes and staffing. In this vision, decisions are jointly made by unit-based teams — giving people who provide the care and service the ability to decide how the work can best be performed.

The Labor Management Partnership is supported through the engagement of regional and local partnership teams, as well as teams that operate across regions and functions. In some instances, this document provides specific timeframes required to assure progress toward Partnership goals. The Agreement promotes nationwide consistency

by determining wages, benefits and certain other terms and conditions of employment. It is a blueprint for making Kaiser Permanente the Employer and care provider of choice.

Section 1 of this Agreement covers the privileges and obligations, and reflects the Parties' continued commitment to work in Partnership. Specifically, this Agreement provides solutions for improving performance, quality of service and attendance. It identifies the systems needed to support high performance through education and training, workforce development and planning, and staffing, backfill and capacity building. Lastly, it captures the work environment elements needed to provide for patient safety, workplace safety, racial justice and just culture, balance between work life and personal life, and collaborative examination of scope of practice issues. Section 1 provides mechanisms for spreading partnership, collaboration and organizational transformation throughout our organization. It defines how workers and managers engage in all areas. Section 1 also covers areas such as union security, Partnership governance and problem-solving processes, and elaborates on other privileges and obligations of Partnership.

Section 2 identifies the specific provisions of the Agreement that pertain to compensation and benefits.

Section 3 describes the scope, application, dispute resolution process and term of the Agreement.

Section 4 contains the National Agreement exhibits.



SECTION 1

Privileges and Obligations of Partnership

A. COMMITMENT TO PARTNERSHIP

The essence of the Labor Management Partnership is involvement and influence, pursuit of excellence and accountability by all. The parties believe people take pride in their contributions, care about their jobs and each other, want to be involved in decisions about their work and want to share in the success of their efforts.

Market-leading organizational performance can only be achieved when everyone places an emphasis on benefiting all of Kaiser Permanente. There is an indisputable correlation between business success and success for people. Employees throughout the organization must have the opportunity to make decisions and take actions

to improve performance and better address patient needs. This means that employees must have the skills, knowledge, information, opportunity and authority to make sound decisions and perform effectively. Engaged and involved employees will be highly committed to their work and contribute fully.

By creating an atmosphere of mutual trust and respect, recognizing each person's expertise and knowledge, and providing training and education to expand those capabilities, the common goals of organizational and individual success and a secure, challenging and personally rewarding work environment can be attained. With this Agreement, the parties will continue to invest in and support a wide array of activities

designed to increase individual employee skills training, learning opportunities, and growth and development.

The Value Compass sets forth the way in which this National Agreement becomes a key operating strategy for Kaiser Permanente. To improve performance measures by focusing on the needs of our patients and members requires involvement from everyone. We seek to move from projects to pilots to whole systems improvement, recognizing that all four points of the Value Compass impact the whole value that the organization creates.

The Value Compass is designed to achieve the KP Promise, which ensures our members always have the best health care experience.

The KP Promise is a commitment to our members to provide health care that is:

- » quality you can trust;
- » convenient and easy access;
- » caring with a personal touch; and
- » affordable.



Section 1 presents an integrated approach to service quality, performance improvement, workforce development, education and training, and creation of an environment responsive to organizational, employee and union interests. In addition, it provides a process to solve problems as close to the point at which they arise as possible, respecting the interests of all parties. The Alliance-Kaiser Permanente Dispute Resolution process in Section 3.D. is meant to be used as a last resort.

With this Agreement, the Alliance and Kaiser Permanente assume a set of privileges and obligations. These include, but are not limited to, employment and income security, union security, access to information, including the responsibility to maintain confidentiality concerning sensitive information, participation in the governance structure and participation in performance-sharing plans.

There is a joint commitment to identify, and by mutual agreement, incorporate our own successful practices and those of other high-performance organizations into each facility. The parties will work diligently to increase and enhance flexibility in work scheduling and work assignments to enhance service, quality and financial performance while meeting the interests of employees and their unions. We share a willingness to work in good faith to resolve jurisdictional issues in order to increase work team flexibility and performance, and we share a commitment to marketing Kaiser Permanente as the Employer and care provider of choice.

In addition, it is absolutely critical for KP to grow its membership and adapt to a changing health care market. We believe that much of the new growth opportunities could come from new government initiatives that emerge out of national health care reform.

The parties commit to the involvement of high-level Union, Kaiser Permanente and Kaiser Health Plan leaders to work together on growth strategies. The parties will work in a proactive manner on other growth potential, including discussing both contiguous and non-contiguous opportunities, new geographies and regions, mergers and acquisitions that best position opportunities for KP to grow more quickly and respond to opportunities, and will explore new health care vehicles that could be made available to union trust funds, multiemployer trust funds and single employers.

The parties shall work together to explore and utilize available growth opportunities. This requires positioning to ensure that we are a major player in current and future debates over national health care reform and KP supporting the growth of Partner unions. The parties shall emphasize the unique advantages of the Kaiser Permanente model.

In 2018, the parties established a Code of Conduct, which includes the following:

» Members of the LMP, including KP and all individual local unions of the Alliance, shall not pursue, sponsor or support legislation or ballot initiatives that are specifically targeted at and the primary purpose of which is to harm a member of the other party.

» Members of the LMP agree to follow the spirit and intent of the National Agreement, and where disputes arise, the parties will follow the Section 3.D. Dispute Resolution process.

Additionally, a Labor Management Partnership Playbook is available for use and reference on the LMP website.

B. PARTNERSHIP GOVERNANCE AND STRUCTURE

The National Labor Management Partnership Agreement describes the vision of a workplace environment where diversity of opinion is valued and all stakeholders share a voice in decisions that affect them and their work. The vision of this Partnership is an integrated structure, where the unions and their members are part of the decision-making forums.

1. PARTNERSHIP STRUCTURES

a. Integration

A variety of Partnership structures exist at the national, regional, service area, facility, department and/or work-unit levels. In addition, there are various business structures that attempt to solve the same problem or achieve like goals. Partnership should become the way business is conducted at Kaiser Permanente at all levels, including national functions and shared services, as well as regional and local levels. In order to achieve this goal, these parallel Labor Management Partnership structures should be integrated into existing operational structures of the organization at every level. This results in dissolution of parallel

labor management committees that are redundant with ongoing business committees (e.g., department meetings, project teams, planning committees). Parallel structures may still be required where there is no existing function, where existing structures are not adequate for a particular function, initiative, or area of focus, or where they are necessary because of legal or regulatory requirements. New initiatives should include labor participation from their inception.

Integration of labor into the normal business structures of the organization does not mean co-management, but rather full participation in the decision-making forums and processes at every level of the organization as described on pages 14–16 of the *Labor Management Partnership Vision: Reaffirmation & Understandings*, and subject only to the capacity of the unions to fully engage and contribute. The parties will work together to ensure that union capacity issues are adequately addressed.

b. Partnership in Shared Services, National Functions and Cross-Regional Functions

Alliance unions represent employees in a number of functions across KP that provide national, cross-regional, or shared services to KP members or other KP business units. The National Agreement applies to management and Alliance union-represented employees in these functions, regardless of the building or regions in which they are located. This includes the privileges and responsibilities of the Labor Management Partnership and the commitment to

continuously improve performance along the Value Compass.

A regular and ongoing forum for key labor and management leaders will be created to focus on business and operational needs unique to these functions. Existing regional LMP councils will provide the model for composition and approach to support the forum's work. This approach will be tested and revised, as needed, based on its effectiveness in meeting the goals in the National Agreement; in particular, to become an organization in which unions and employees are integrated into planning and decision-making forums at all levels.

c. Unit-Based Teams

1. Shared Vision

The establishment of teams based in work units is a core mechanism for advancing Partnership as the way business is conducted at Kaiser Permanente, and improving organizational performance (attached as Exhibit 1.B.1.c.1 (1)).

A unit-based team includes all of the participants within the boundaries of the work unit, including supervisors, stewards, providers and employees. Engaging employees in the design and implementation of their work creates a healthy work environment and builds commitment to superior organizational performance. Successful engagement begins with appropriate structures and processes for Partnership interaction to take place. It requires the sponsorship, commitment and accountability of labor, management, and medical and

dental group leadership to communicate to stakeholders that engagement in Partnership is not optional, but the way that Kaiser Permanente does business.

Members of a unit-based team participate in:

- » planning and designing work processes;
- » setting goals and establishing metrics;
- » reviewing and evaluating aggregate team performance;
- » budgeting, staffing and scheduling decisions; and
- » proactively identifying problems and resolving issues.

The teams need information and support, including:

- » open sharing of business information;
- » timely performance data;
- » department-specific training;
- » thorough understanding of how unions operate;
- » meeting skills and facilitation; and
- » release time and backfill.

Senior leadership of KFHP/H, medical and dental groups and unions in each region and cross-regional, shared services and national functions will agree on a shared vision of the process for establishing teams, the methods for holding teams and leaders accountable, and the tools and resources necessary to support the teams. Unit-based team goals will be aligned with national, regional, facility and unit goals.

Implementation of unit-based teams will be phased in, beginning with Labor

Management Partnership readiness education and training of targeted work units, providing supervisors and stewards with the knowledge and tools to begin the team-building work. It is expected that unit-based teams are the operating model for Kaiser Permanente.

The parties agree that five key success factors for unit-based teams are:

- (1) **Leadership:** Develop strong joint leadership, shift to coaching style of leadership and share information, including financial data.
- (2) **Line of sight:** Make ongoing use of meaningful metrics, encourage systems-thinking and show how the work of the team connects to regional goals.
- (3) **Team cohesion:** Make time for face-to-face communication, create a safe learning environment and focus on the work—with the member and patient in the middle.
- (4) **Processes and methods:** Be proficient in the Rapid Improvement Model and use daily huddles to discuss problems and build solutions.
- (5) **Infrastructure and support:** Develop and recognize strong sponsors and provide ongoing training.

2. Unit-Based Team Roles

Stewards and supervisors play a critical role in high-performance partnership organizations. Where work is organized and performed by unit-based teams, the roles are substantially different from those of traditional work situations. References to supervisors in this Agreement refer to management representatives.

In unit-based teams, supervisors will continue to play a crucial role in providing leadership and support to frontline workers. The role should evolve from directing the workforce to coaching, facilitating, supporting, representing management through interest-based procedures and ensuring that a more involved and engaged workforce is provided with the necessary systems, materials and resources. The role of stewards should evolve into one of work-unit leadership, problem solving, participating in the organization and design of the work processes, and representing co-workers through interest-based procedures.

Each regional LMP council and the National Functions/Shared Services LMP council will review the various positions established under the National Agreement as well as positions funded through the National LMP Trust or local areas. The review should assess the effectiveness of the roles and leverage them to support unit-based teams and the work of the Partnership.

The regions, medical centers, medical facilities and national functions will assess whether the caseload for support positions (e.g., Sponsors, UBT Consultants, etc.) is sustainable and conducive to UBT development. The regions and medical centers will consider goals for these caseloads, which could vary based on such factors as team Path to Performance levels, team size and available resources.

3. Unit-Based Team Targets

The commitment of the Partnership is that 100% of Alliance-represented

employees will be on UBTs to achieve and sustain high performance. All unit-based teams should be high-performing with the expectation that all UBTs will be performing at a Level 3 or better. Any team that drops below a Level 3 should return to Level 3 or better within six months. All regions and National Functions/Shared Services will support UBTs in all departments and achieve or exceed the target of 85% for high-performing teams (Levels 4–5). (Eighty-five percent represents the ratio of high-performing teams to the total number of existing teams as of the second Friday in January for each calendar year.) All regions have the same target.

The performance status of a unit-based team is defined by the *Path to Performance* (attached as Exhibit 1.B.1.c.3.).

4. Unit-Based Team Assessment

A uniform, national UBT rating system is established based on observable evidence and behavior and is described in the *Path to Performance*. Each region, cross-regional, shared service and national function will ensure consistent application and assessment of the *Path to Performance* following national criteria, standards and interpretation across teams and sites.

UBTs will be evaluated during face-to-face assessment meetings conducted by the team's UBT Consultant and Alliance Partnership Representative (APR). High-performing UBTs will be recognized and rewarded:

- » Level 1 through 3 UBTs will be assessed in person quarterly.

- » Level 4 and 5 UBTs will be assessed in person annually, or more often if necessary.
- » Sponsors must sign off on the assessments but do not need to be present.
- » The LMP leadership group in each region will evaluate what resources are needed to support implementing the face-to-face assessment process.

Each region will verify Level 4 and 5 teams by evaluating a small, random sample of teams to ensure assessments of team levels are accurate. As part of the assessment process, an action plan will be developed that gives the team clear guidance on the steps it needs to take to move up the *Path to Performance* in each dimension, as appropriate. This assessment process can be modified by a consensus of the LMP Executive Committee and Alliance Steering Committee.

5. Unit-Based Team Sponsorship

The LMP regional leadership will:

- » facilitate the development of working agreements between labor and management sponsors that will include a specific discussion about how the labor sponsor is going to be released; release time is critical for sponsors to be able to effectively support their teams;
- » recommend a maximum number of teams that can effectively be sponsored by a labor or management sponsor; and
- » plan how to build union capacity for sponsorship;

- » develop a forum for sponsors to share information about teams, soliciting input from the voice of the customer.

UBT sponsors have primary accountability for taking an active role with their teams to identify resources and remove barriers that impede their teams' success. Sponsors will receive more comprehensive support to be effective in their role. Sponsors will support UBT co-leads to be effective in their roles and hold co-leads accountable for following the *Path to Performance* and achieving results on the Value Compass. If local problem-solving attempts to remove barriers and allocate resources are not successful, UBT sponsors will escalate the issue in accordance with the Section 3.D. Dispute Resolution process. Sponsors should focus their energy on helping teams achieve and ultimately sustain high performance, and accomplish line-of-sight performance outcomes.

d. Pathway to Partnership Performance

The approach used for measuring UBT performance extends to the "middle" and "macro" levels of the organization.

The LMP Executive Committee will establish *Pathway to Partnership Performance* goals annually.

e. Joint Accountability

To ensure consistency and accountability to the principles of partnership, the National LMP Tri-Chairs will implement systems to ensure joint accountability of trust-funded staff. The system will consider such aspects as collaborative goal setting, joint feedback and evaluations, shared input on incentives

and other aspects of program management. The National LMP Tri-Chairs will report annually on the results to the LMP Executive Committee.

2. GOVERNING BODIES

The governing body for the Labor Management Partnership is the Labor Management Partnership Strategy Group (the Strategy Group), which currently comprises the regional presidents, a subset of the KFHP/H National Leadership Team, representatives from the Permanente Medical Groups, the Permanente Federation, the Office of Labor Management Partnership and the Alliance. The Strategy Group provides direction and oversight on the strategic priorities for the Partnership and meets at least annually.

The Executive Committee of the Strategy Group (the Executive Committee) is appointed from among the members of the Strategy Group. The Executive Committee acts on behalf of the Strategy Group between meetings and generally focuses on the implementation of Partnership activities within the overall strategic framework set out by the Strategy Group. The Executive Committee meets as often as necessary.

The parties acknowledge that as integration progresses, governance structures may need to evolve accordingly.

Kaiser Permanente and the Alliance provide administrative and operational support to the Strategy Group and the Board of Trustees of the Kaiser Permanente — Alliance of Health Care Unions Labor Management Partnership

Trust (the Partnership Trust), and co-lead and implement the work of the Partnership at all levels.

3. JOINT PARTNERSHIP TRUST

The Partnership Trust has been established for the purpose of funding labor management administration and Partnership activities. Changes in the Employer's overall funding of Partnership expenses, including Partnership Trust contributions, training and education development, administration and technical and consulting support expenses necessary to implement/advance the Partnership, shall be at least proportional to employee contributions as described below. An amount equal to nine cents per hour per employee will be contributed to the Partnership Trust throughout the term of this Agreement, consistently across the Program. The purpose of the employee contribution is employee ownership of the Partnership, sponsorship of increased union capacity and shared ownership of outcomes and performance gains.

Effective October 1, 2021, the Employer will contribute to the Kaiser Permanente-Alliance of Health Care Unions Labor Management Partnership Trust at the rate of \$8 million annually. Each year of this Agreement, the Employer will contribute an additional amount equal to 2% of the parties' total combined contributions. In addition, on April 1, 2022, Kaiser Permanente will make a one-time contribution of \$1 million for reserves/additional expense to support the work of the Affordability and Competitiveness Task Force.

The Partnership Trust is jointly administered by a Board of Trustees consisting of union and management representatives. There will be up to 10 trustees consisting of equal numbers of union and management representatives.

The Board of Trustees has overall responsibilities for managing the Partnership Trust, including the adoption of a budget designed to advance the purposes and priorities of the Partnership as established by this National Agreement and the Strategy Group.

C. ORGANIZATIONAL PERFORMANCE

The parties are dedicated to working together to make Kaiser Permanente the recognized market leader in providing quality health care and service. This can be accomplished through creating a service culture, achieving performance goals, developing the Kaiser Permanente workforce, increasing employee satisfaction, promoting patient safety programs, and focusing attention on employee health and work-life personal-life balance. The goal is to continually improve performance by investing in people and infrastructure, improving communication skills, fostering leadership and supporting involvement in the community.

1. PERFORMANCE IMPROVEMENT

Kaiser Permanente and the Alliance are competing in a challenging market that is characterized by a limited workforce, changes in technology, changes in clinical practice, cultural diversity, changing

demographics and high demand for quality service. The parties are committed to the enhancement of organizational performance so that working in Partnership is the way Kaiser Permanente does business. Under this Agreement, the parties will work together to:

- » develop and invest in people, including the development of and investment in managers, supervisors and union stewards;
- » engage employees at all levels;
- » align the systems and processes that support the achievement of organizational and Partnership goals;
- » enhance the ability of Alliance unions to advance their social mission and the welfare of their members;
- » recognize and reduce parallel structures;
- » ensure joint management-union accountability for performance;
- » grow membership;
- » redesign work processes to improve effectiveness, efficiency and work environment;
- » develop and foster unit-based teams;
- » share and establish expectations regarding broad adoption of successful practices in areas such as service, attendance, workplace safety, workforce development, cost structure reduction, scope of practice and performance-based pay; and
- » communicate with employees on an ongoing basis regarding performance goals and targets, as well as performance results at all levels of the organization.

Each regional and National Function/ Shared Services LMP council shall develop approaches aimed at reducing variation between medical centers, facilities and departments in the resources available for partnership. In particular, such a plan should:

- » ensure at a regional level there is adequate time for teams to review performance, identify opportunities for improvement, and develop and test changes to drive improvement; and
- » provide regional or facility support to departments as needed to cross-cover or backfill and jointly determine the most cost-effective manner to provide the support.

a. Successful Practices

Implementation of a comprehensive, web-based system for sharing and transferring successful practices will be a significant contribution to performance improvement.

This system will identify and capture successful practices and toolkits related to regional and program-wide goals, such as:

- » service;
- » attendance;
- » workplace safety;
- » workforce development;
- » cost structure reduction;
- » scope of practice;
- » performance-based pay;
- » quality;
- » patient safety; and
- » others.

The OLMP is responsible to:

- » act as the sponsor for the transfer of successful practices;
- » coordinate with regional and national function leadership to provide funding, incentives, education, support and tools; and
- » implement and maintain the system to ensure that successful practices are, in fact, transferred.

The National UBT Tracker, LMP website and other tools throughout the organization shall be regularly updated and made available to the organization so as to accelerate knowledge of and use of best practices, categorized by type (e.g., quality, patient safety, service, etc.).

Regions or facilities where business goals are not being met for a specific function will be accountable to adopt demonstrated successful practices specifically applicable to that function, in order to improve performance.

b. Flexibility

Kaiser Permanente and the Alliance are committed to enhancement of organizational performance by developing and investing in people and aligning the systems and processes that support the achievement of organizational and partnership goals. Further, the parties are committed to Kaiser Permanente becoming a high-performance organization and to the KP Promise and the Labor Management Partnership as a foundation for reaching this goal.

Market-driven change has created a challenging competitive situation that is characterized by a limited number of skilled workers and new entrants into the workforce, changes in technology, changes in clinical practice, cultural diversity, changing demographics and high demand for quality service. To become a high-performance organization in this environment requires organizational change.

Becoming a high-performance organization also requires a pledge from Partner unions and Kaiser Permanente to modify traditional approaches, to work diligently to enhance flexibility in labor contracts, to willingly explore alternative ways to apply seniority and to address jurisdictional issues in order to achieve organizational performance goals. It is expected that the parties will undertake this in a way that is consistent with the Partnership, while at the same time preserving the principles of seniority and union jurisdiction.

The following is minimally required to create an environment that balances Kaiser Permanente's need for flexibility in removing barriers to enhanced performance with Partner unions' need to honor seniority and jurisdiction. The goal is to create a climate based on trust that promotes achievement of Partnership outcomes and fosters an environment in which Kaiser Permanente, Partner unions and employees effectively respond to and address issues at the local level. It is not the intent of the parties to undermine the principles of seniority and union jurisdiction or to reduce the overall level

of union membership. Management is not looking for the right to make changes unilaterally to achieve greater flexibility, but expects the unions to work with them to address flexibility needs. The need for and desirability of joint decision making is acknowledged.

Management recognizes the unions' interest in a balanced approach that will not disadvantage one union relative to another and acknowledges that a broad, long-term perspective should be adopted.

Commitment to performance improvement through joint, continuing efforts to redesign business systems and work processes. This includes simplifying workflow, eliminating redundant or unnecessary tasks and coordinating workflow across boundaries. It also requires alignment with and implementation of the business strategy and the principles of the Labor Management Partnership.

Incorporation of Labor Management Partnership principles in redesign efforts. These include:

- » involving affected employees and their unions in the process;
- » assessing impact on employees;
- » minimizing impact on other units due to bumping and other dislocation;
- » providing fair opportunity for current employees to perform new work;
- » retraining or redeploying affected employees; and
- » applying the principles of employment and income security.

Creation of mutually agreeable local work design processes to address local conditions while ensuring high levels of quality, service and financial performance. Flexibility will enhance management's ability to meet its employment security obligations, just as flexibility will be enhanced by joint labor management influence over workplace practices. Principles to be observed include:

- » respect for seniority and union jurisdiction;
- » flexibility for employees' personal needs; and
- » flexibility in work scheduling, work assignments and other workplace practices.

Commitment of local labor management partners to exhibit creativity and trust to resolve difficult issues, such as:

- » contractual and jurisdictional issues that are inconsistent with Partnership principles and/or that are barriers to achievement of Partnership goals;
- » considering reciprocity of seniority between bargaining units to facilitate employee development and performance improvement;
- » enhancing employee mobility across regions and Partner unions and into promotional opportunities;
- » cross-training staff across job classifications and union jurisdictional lines where it makes operational or business sense or where union and employee interests are accommodated;

- » enabling team members to perform operational functions across boundaries (job classification, department and/or union jurisdiction) within their scope of practice and licensure to serve members/patients; and
- » utilizing a joint process to resolve issues of skill mix, classification and the application of the provisions of the National Employment and Income Security Agreement.

Mechanisms for flexibility include, but are not limited to:

- » expanding skills of staff;
- » developing innovative and flexible scheduling and work assignments to balance staffing and workload;
- » alternative work assignments and schedules to accommodate variations in staff workload;
- » shifting tasks to accommodate periods of peak demand;
- » temporary assignments to other work;
- » using supply-demand management tools to anticipate staffing needs; and
- » other innovative employment options, such as seasonal employment and job sharing.

In applying the principles of the Partnership, local labor management partners may create a variety of joint agreements or practices to enhance organizational performance and to accommodate employee interests.

In order to encourage creativity and joint risk taking, such agreements will be non-precedent setting and not apply to other units, departments, medical

centers or service areas. However, sharing and adoption of successful practices is highly encouraged. See Exhibit 1.C.1.b.

Regional Flexibility Subgroups. Each regional LMP council will identify a joint subgroup that will work on issues related to flexibility. These subgroups will operate by joint decision making (Consensus Decision Making) and will:

- » be guided by the principles of the Labor Management Partnership, the Value Compass and the existing flexibility language (above);
- » create a charter undertaking a flexibility review that is consistent with the National Agreement;
- » explore innovative concepts and approaches to flexibility, where either labor or management has an interest, that may be leveraged in partnership to address patient and KP member needs;
- » review and help spread:
 - › successful practices across the region;
 - › practices that optimize KP staff and resources; and
 - › practices that improve the employment experience.
- » report out on their progress annually to the LMP Executive Committee; and
- » this process will be subject to the Dispute Resolution process in Section 3.D. of the National Agreement.

2. SERVICE QUALITY

Kaiser Permanente and the Alliance are dedicated to working together to make Kaiser Permanente the recognized leader in superior service to each other, to our members and to purchasers, contracted providers and vendors. In order to become the recognized leader in superior service, the parties agree to pursue a Labor Management Partnership strategy in which every region will have a plan to implement the following critical elements of service quality.

a. Leadership Commitment and Service Behavior

Labor Integration. Labor, management, physician and dental leaders will assume a leadership role in the design and implementation of the service promise or credo.

Working in partnership, labor and management are accountable for creating a service culture at the facility, department and work-unit levels. Partner union representatives will be integrated into planning, development and implementation of a service culture. Union partners will be integrated into any new or ongoing service initiatives or committees that manage service programs at the national, regional or local levels.

A service culture can best be achieved by utilizing unit-based teams. High member, employee and provider satisfaction will result from well-trained teams that are empowered and supported to meet or exceed service expectations. Key components for achieving high service quality performance by unit-based teams

include employee involvement in point-of-service decision making, systems that support the team in the delivery of superior service, orientation and training, accountability and an organizational commitment to service quality.

Accountability. Individuals, teams and leaders are accountable for service quality at Kaiser Permanente. All members of a team own their individual service behavior, as well as the service provided by their team. Leadership is accountable for supporting individuals and teams in building and maintaining a service culture, and implementing the critical elements of the service plan. Accountability will be enhanced by establishing and monitoring service quality metrics.

Resources. National and regional leadership will designate funding sources for service quality improvement, including development of defined service budgets, which are jointly planned and reviewed by management, labor, physicians and dentists.

b. Systems and Processes

Alignment. To make Kaiser Permanente the recognized leader in superior service, organizational systems and processes must be aligned with that goal. The parties will evaluate, develop or improve systems that support employees and departments in delivering superior service.

Recruitment and Hiring. In order to integrate a service focus into the organization's recruitment and hiring practices, the parties agree that all job descriptions, performance evaluations

and job competencies will include a jointly developed service component. All job postings will include language that emphasizes service skills.

Recognition and Reward. Recognition is a critical component in fostering and reinforcing a culture of service excellence. The parties will work to align service quality incentives throughout all levels of the organization, with increased emphasis on service.

Metrics and Measurement. Service quality should be measured and given appropriate weight to reach and maintain superior service at all levels of the organization. The parties will develop a "Balanced Scorecard" measurement program, and strengthen customer satisfaction measurement tools.

Orientation and Training. The service training program will continue to be delivered as needed at a regional, facility, work-unit or individual level, including the service recovery section.

Service Recovery. Service recovery is a critical element of a service quality improvement strategy to prevent member terminations. Medical centers or departments will provide resources for implementation of consistent service recovery programs.

c. Environment

The physical and social environment affects service quality. The parties at the national and regional level will work to strengthen the involvement of union leaders and frontline staff in the design of existing facility modification, template development and new construction.

3. ATTENDANCE

a. Philosophy

Optimal attendance is imperative to achieve superior customer service, employee satisfaction, efficiency and quality of care for health plan members. Appropriate use of time-off benefits, including sick leave when employees are injured or ill, is essential to employee well-being and organizational performance. A healthy work environment and a committed workforce are critical success factors for achieving optimal attendance. Sick leave is not an entitlement, but a benefit, like insurance, to be utilized only when needed.

b. Sponsorship and Accountability

The parties share the goal of ensuring that attendance performance at Kaiser Permanente is in the forefront of high-performing health care organizations. In order to achieve optimal attendance, sponsorship must occur from the highest leadership levels within Kaiser Permanente and the Alliance. This includes:

- » National Leadership Team members;
- » regional presidents;
- » regional medical and dental directors; and
- » local Union leaders.

Accountability for the attendance program will be integrated into the operational structures of management and the leadership of Alliance local unions. A chain of accountability for the attendance recommendations will be

established that is clear at all levels of the respective organizations. Accountability includes clear expectation of roles and responsibilities as well as rewards and consequences, as appropriate, for performance and non-performance.

c. Time-Off Benefit Enhancement

Labor and management have established a benefit design to improve attendance by providing economic incentives for appropriate use of sick leave, as well as flexible personal days. This benefit design includes three key components: flexible personal days, annual sick leave and banked sick leave. This benefit does not affect vacation, and does not apply to employees covered by ETO/PTO plans.

Flexible Personal Days. Each local collective bargaining agreement may designate from two to five flexible personal paid days off (personal days) that employees may use for personal needs in increments of not less than two hours.

Requests for a single personal day off, or for hours within a single shift, shall be granted upon receipt of at least two weeks' notice. Last-minute notice is acceptable for personal emergencies.

Requests with less than two weeks' notice, requests for consecutive days off, for days before or after a holiday, or for other days designated by mutual agreement, will be reviewed and approved or denied on a case-by-case basis in order to meet core staffing needs. Denials will be tracked and compiled, by department, on a quarterly basis.

All unused personal days will be converted at 50% of value to cash at the end of each year.

Effective January 1, 2022, USW Local 7600 and UFCW employees in the Southern California market who are eligible to receive Life Balance Days shall have all unused Life Balance Day hours at the end of the calendar year rolled over into the employee's vacation account. Life Balance Day hours deposited into the employee's vacation account shall remain in the vacation account for the employee's use as vacation time.

Personal days may not be cashed out upon resignation or termination; however, upon retirement personal days may be cashed out at 50% of value. For the purposes of this Section 1.C.3., retirement means that the employee has retired from the organization pursuant to the terms of a qualified Kaiser Permanente retirement plan.

These provisions will not supersede local collective bargaining agreements with superior conditions regarding notice requirements, granting of requests or cash-out provisions.

Sick Leave Benefit. There are two types of sick leave benefits. Annual sick leave is the sick leave days credited each year to each employee in accordance with the provisions of the local collective bargaining agreements. Banked sick leave is previously accumulated unused sick leave to which unused annual sick leave may be added at the end of each anniversary year.

Annual Sick Leave. Employees will be credited with their entire annual allotment of sick leave days provided in the local collective bargaining agreements at the beginning of the pay period in which each employee's anniversary date of hire falls. For purposes of annual sick leave days, in cases where an employee's anniversary date of hire has been adjusted, the "leave accrual service date" will be used.

Special Note for Part-Time Employees. Part-time employees' annual sick leave will be credited proportionately, based on scheduled hours. Throughout the year (no more frequently than quarterly) the credited annual sick leave will be adjusted based on actual compensated hours. This will ensure that employees who work, on average, more hours than they are scheduled will receive proper annual sick leave credit.

Banked Sick Leave. At the end of each anniversary year, 100% of unused annual sick leave days may be credited to banked sick leave at 100% of value. Banked sick leave is made up of accumulated unused sick leave with no limit on the amount that may be accumulated, regardless of limitations on accumulation that may be contained in local collective bargaining agreements. Existing accumulated sick leave balances for all employees will be credited to banked sick leave upon implementation of this program.

Banked sick leave may only be used following exhaustion of annual sick leave, or for statutory leaves (e.g., CESLA, FMLA, OFLA, workers' compensation,

etc.), or when the employee is hospitalized. Medical verification may be required for use of banked sick leave. Banked sick leave accrued after December 31, 2005, will be used following exhaustion of any banked sick leave accrued prior to January 1, 2006.

Options for Unused Annual Sick

Leave. At the end of each calendar year, employees who meet the eligibility requirements set forth below may elect to:

- » convert up to 10 days of unused annual sick leave days to cash as set forth below; or
- » credit unused days to banked sick leave at 100% of value.

Employees may select either a conversion option or the credit option, or a combination of a conversion option and the credit option.

This election will take place at the end of the calendar year. However, conversion and/or credit will occur at the end of the employee's anniversary year and will be based on available balances of unused annual sick leave at the end of the employee's anniversary year.

Conversion of Unused Annual Sick

Leave. Employees will be eligible to cash out unused annual sick leave as described in either Option 1 or Option 2 below.

- » **Option 1:** At the end of each year, employees with at least 10 days of banked sick leave (or the proportional equivalent for part-time employees) may elect to cash out up to 10 days of unused annual sick leave at 50% of value. Employees with fewer than

10 days of banked sick leave must first apply unused annual sick leave toward reaching a minimum balance of 10 days (or the proportional equivalent) of banked sick leave. Once that minimum balance is reached, additional unused annual sick leave may be cashed out, up to a maximum of 10 days, at 50% of value.

- » **Example 1:** An employee has no banked sick leave and 12 days' unused annual sick leave at the end of the year. Ten days must be credited to banked sick leave and two days may be cashed out at 50% of value.
- » **Example 2:** An employee has five days' banked sick leave, and 12 days' unused annual sick leave at the end of the year. Five (5) days must be credited to banked sick leave and seven days may be cashed out at 50% of value.
- » **Option 2:** At the end of each year, employees with at least one year's worth of annual accrued sick leave in their post-January 1, 2006, bank may elect to cash out up to 10 days of unused annual sick leave at 75% of value.
 - » **Example 1:** An employee has 20 days' banked sick leave and 12 days' unused annual sick leave at the end of the year. This employee's annual sick day allotment is 12 days. Ten days may be cashed out at 75% value and two days will be credited to banked sick leave; or, all 12 days' unused annual sick leave may be credited to banked sick leave.

All unused annual sick leave days that are not converted to cash under Option 1 or Option 2 above will be automatically credited to banked sick leave at 100% of value.

Retirement Conversion. Upon retirement, banked sick leave accrued prior to January 1, 2006, will be recognized as credited service for pension purposes (excluding Taft-Hartley plans).

Healthcare Reimbursement Account (HRA). A Healthcare Reimbursement Account (HRA) will be set up for eligible employees who become plan participants when they retire in accordance with the plan document. However, UFCW Pharmacy Clerks in Southern California covered under the UFCW Pharmacy Health & Welfare Trust (“Trust”) are also eligible for reimbursement of the following health care expenses incurred under any plan of benefits offered by the Trust.

The HRA may be used to reimburse participants for medical, dental, vision and hearing care expenses that qualify as federal income tax deductions under Section 213 of the Internal Revenue Code. Eligible employees shall convert 80% of unused sick leave accrued during or after 2006 to fund the HRA.

For further information or clarification, please refer to the HRA Plan Document.

d. Implementation

The parties agree that the benefit structure that became effective as of January 1, 2006, continues for the term of this Agreement. The National Attendance Committee develops detailed timelines for initial and long-

term implementation of the attendance program with identified goals and performance expectations. The Committee defines the kinds of data needed and the methods to be used, collects the necessary data and provides reporting that is consistent across regions. The committee establishes a framework that defines the level of attendance performance at which an attendance review is triggered. The 2005 Attendance BTG report guides the work of the committee.

The National Attendance Committee will convene no later than January 1, 2019, to develop an attendance program and recommend a policy by June 1, 2019. The committee will consider local contracts, current attendance policies, best practices, and industry best practices.

e. Attendance Intervention Model

The intervention model developed by the OLMP will be utilized to provide expertise and tools that can assist departments or units with poor attendance to discover and understand root causes and develop solutions in partnership that will improve attendance.

The National Attendance Committee will:

- » modify the intervention model based on experience to date and successful practices;
- » develop a toolkit for use by the regions or national functions;
- » develop and offer training to regional or national personnel for intervention skills and use of the toolkit; and

- » provide consulting and back-up services to the regions or national functions.

Each region or national function will:

- » fund and develop resources for intervening in units with attendance issues;
- » establish intervention teams with administrative support; and
- » determine the number of teams needed based on the number of units requiring intervention.

f. Staffing and Backfill (Planned Replacement)

The success of the attendance program depends on a number of key elements, all of which are essential. This includes adequate staffing, planned replacement and commitment to providing appropriate time off when requested. Section 1.F., Staffing, Backfill (Planned Replacement), Budgeting and Capacity Building, provides the details regarding these obligations.

4. AFFORDABILITY AND COMPETITIVENESS TASK FORCE

Within 30 days of ratification, the Alliance and Kaiser Permanente agree to form a national, high-level task force to explore issues of affordability, market position and competition affecting the future of KP in each of its markets.

Mission: The mission of this work is to ensure sustainability and prosperity (superior organizational performance) in each market/submarket, and to leverage

the skills, knowledge and abilities of frontline employees, managers, union leaders and stakeholders. The task force will reach a common understanding among labor and management leaders on the challenges and opportunities facing Kaiser Permanente, and identify cost-saving and efficiency opportunities.

Structure and Resources: The executive director of the Alliance, the CHRO of the Health Plan and the COO of the Permanente Federation will be the executive sponsors of this work.

The task force will consist of five team members each from the Alliance and Kaiser Permanente. The task force will meet at least monthly during the term of the National Agreement. The national task force will provide sponsorship and accountability for the establishment of affordability and competitiveness task forces by the Alliance and Kaiser Permanente in each market. The parties agree to support this task force with staff, data analysts, communications and executive sponsorship. Facilitation will be provided through the LMP Trust. Analysis, data collection and review will be undertaken jointly, using a Partnership interest-based approach and full transparency of relevant data.

Action Steps: The task force will commission a market wage survey to be completed by July 1, 2022, by a neutral third-party consultant for use by the task force. The parties will jointly agree upon the parameters and comparators to be used in the study.

The task force will explore issues of affordability, market position and

competition affecting the future of Kaiser Permanente in each of its markets and submarkets. To that end, the task force will jointly assess:

- » how to define markets and submarkets;
- » KP's competitive position within each market and submarket in which it operates regarding sustainability, price position/affordability, cost structure, operating margin, quality, service and other factors; and
- » important metrics of KP success: growth and membership retention, operating margin, rate position, payer mix, care equity, employee experience, access to care, member experience, brand reputation, magnet status, and employee recruitment and workforce needs.

The task force will consider ways to promote Kaiser Permanente's success and affordability, such as:

- » using the right person for the right work;
- » innovative models of care;
- » improved integration;
- » expense reduction;
- » becoming more nimble;
- » attendance;
- » innovation in partnership;
- » automation and technology;
- » engaging unions to promote KP growth; and
- » recruitment, retention and compensation.

Recommendations to address competitiveness and related issues

proposed by labor or management will be evaluated by the task force in partnership.

The task force will identify cost-savings initiatives that can be implemented in order to meet the affordability goal under the Alliance PSP.

Task force recommendations will be by mutual agreement, and findings of fact and recommendations may also be referred to the next round of national bargaining.

Communication and Education:

The parties will partner in creating joint messaging featuring labor and management leaders and frontline staff to educate on issues of competitiveness, affordability and sustainability. The parties will collaborate to ensure that information spreads to the front line, including UBT's and other forums for educating and engaging frontline employees in identifying improvement and cost-saving initiatives.

5. SCOPE OF PRACTICE

The people of Kaiser Permanente will work collaboratively in the Labor Management Partnership to address scope of practice issues in a way that ensures compliance with laws and regulations while valuing the strengths, contributions and employment experience of all members of the health care team. The parties agree to work in Partnership to promote knowledge and understanding of scope of practice issues, proactively influence scope of practice laws and regulations as appropriate, create a safe environment

to address scope of practice issues in a non-punitive manner, and provide opportunities and resources for all employees to advance personally and professionally in order to take advantage of full scope of practice in accordance with certification and/or licensure.

To the extent possible, to achieve these objectives, union representatives should be fully integrated into national, regional and local scope of practice decision-making structures within Kaiser Permanente as outlined in the 2005 Scope of Practice BTG Report, pages 14–17 (attached as Exhibit 1.C.4.(1)). Where disagreements arise regarding the legal scope of practice of employees covered under this Agreement, the Issue Resolution process in Section 1.L.1. may be utilized on an expedited basis. If such a disagreement is not fully resolved through an expedited Issue Resolution process, management, acting in good faith, will apply relevant law and regulatory requirements and reserves the right to make a final determination to ensure compliance with laws and regulations.

Scope of practice education and training programs will be developed and communicated broadly throughout the organization. The Strategy Group, working together with the National Compliance, Ethics & Integrity Office, will be accountable for the implementation of these provisions. Guidance for education and training programs and timelines for implementation are provided on pages 9, 10 and 11 of the 2005 Scope of Practice BTG Report (attached as Exhibit 1.C.4.(2)).

6. JOINT MARKETING AND GROWTH

The Alliance unions and Kaiser Permanente acknowledge the untapped opportunities for membership growth among union-affiliated workers. In the 1997 Labor Management Partnership agreement and the updated 2018 agreement, the unions and management committed to work together to “expand Kaiser Permanente’s membership in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve.”

The parties reaffirm their commitment to market Kaiser Permanente to new and existing union groups and to establish the necessary strategic and policy oversight, as well as appropriate funding, to ensure the joint Labor Management Partnership marketing effort becomes a successful sustainable model, resulting in increased enrollment in the Kaiser Foundation Health Plan. The Alliance and its affiliated unions, acting in the interest of and in support of the Partnership, will use their influence to the greatest extent possible to assure that unionized employers, union health and welfare trusts and Taft-Hartley trusts operating in, or providing benefits to, union members in areas served by Kaiser Permanente, offer the Kaiser Foundation Health Plan. National oversight and sponsorship of the joint marketing effort will be provided by the Strategy Group, with the input and involvement of regional and local labor representatives in the evaluation of marketing options. The foundation of the joint marketing efforts will require organizational

alignment, integration (e.g., participating in the regional rate-setting process) and coordination between the Alliance and departments engaged in promoting Kaiser Permanente at the regional level.

The parties have developed Joint Labor Management Partnership Marketing Program recommendations. These recommendations identify the need for:

- » consistent data collection;
- » education programs;
- » communication strategies and tools;
- » mechanisms to measure outcomes and progress “at the regional and local level”; and
- » a joint structure, including the long-term vision of integration, to accomplish these goals.

A Joint Labor Management Partnership Marketing Action Plan will be submitted annually to the Strategy Group for approval and implementation. The action plan should be based on the Labor Management Partnership Joint Marketing Program recommendations, and should identify the annual goals and objectives, resources, responsibilities, accountabilities and outcomes for the following year. The action plan will focus member growth activities throughout the year on:

- » programs that support the visibility of the Kaiser Permanente brand to employers — both through marketing materials and onsite activities; and
- » those segments of the market that provide the greatest potential for new growth.

Regional Partnership teams will utilize existing forums where possible (e.g., regional/local LMP Councils, regional marketing councils, etc.) to replicate the Senior Work Group on Growth. This may include extending the charter, the organizational structure, and the growth and retention strategy to local markets.

a. AHCU Growth

Kaiser Permanente and the Alliance unions agree to leverage the LMP as part of our joint interests in making sure that we deliver high-quality patient care and service, create the best place to work and receive affordable quality care. In doing so, the parties agree to ingrain a culture of growth of the Alliance unions by all throughout the organization and in Partnership.

D. WORKFORCE PLANNING AND DEVELOPMENT

1. TAFT-HARTLEY TRUST

a. Funding

A Taft-Hartley trust for Alliance unions representing employees of KFHP, KFH and the affected Permanente Medical Groups (the Ben Hudnall Memorial Trust), will be funded to provide for base services as well as comprehensive training and education programs and services in such areas as:

- » hard-to-fill/critical need, market-challenged positions;
- » qualified bilingual skills training;
- » preparation for new technology and new workflows;

- » health care reform impacts; and
- » workforce equity and inclusion.

For the duration of this agreement, the parties agree that the Joint Educational Trust will be funded annually. The funding calculation will be determined by a 0.50 percentage of the gross annual payroll of Alliance-represented employees participating in the Trust as of December 31 of the preceding year. Funds will be transferred to the trust annually according to the trust agreement. In addition, the Employer will contribute \$3 million annually to the Ben Hudnall Memorial Trust.

Effective June 1, 2022, the Employer will make a one-time payment of \$15 million to the Ben Hudnall Memorial Trust.

Furthermore, the Employer will contribute another \$1 million annually to the Ben Hudnall Memorial Trust for the purpose of providing enhanced training benefits for employees in the redeployment process, in addition to those benefits provided by the Employment Income Security Agreement.

b. Governance

The Taft-Hartley trust will be governed by an equal number of labor and management trustees. Labor trustees are selected by labor; management trustees by management.

The Trust will establish the most appropriate staffing structure and levels to meet its goals.

2. STRUCTURE

a. Workforce Planning and Development Coordination and Implementation Structure

Workforce planning and development activity will be coordinated across the regions and the trust fund through an integrated national, regional (and, if appropriate, facility) workforce development team structure. The activity will include:

- » workforce forecasting, analysis and strategies;
- » development of systems to support forecasting, tracking and data collection at all levels;
- » Workforce Planning and Development Team setup, orientation and support;
- » filling workforce development positions;
- » facilitation of the sharing of successful practices across regions;
- » updating the Workforce Planning and Development communication plan to include information about the education trusts, existing career paths, and new opportunities for training and education; and
- » leveraging UBTs, LMP councils and joint management/steward trainings to communicate training and education opportunities.

b. National Workforce Planning and Development Team (National Team)

The National Team will include co-leads, one from management and one from

the Alliance, and will be accountable to the Strategy Group. The team will also include representatives from HR functions, including Recruitment, Compensation and Learning Services, as well as Workforce for Tomorrow, operations and the co-leads from each regional Workforce Planning and Development team, and other representatives as appropriate. The national team will align, integrate and coordinate all workforce development and training efforts. The team will identify grants, federal, state and private money to leverage additional funding for education and training. The team will communicate using trust plan documents, including an annual report with financial and participant data, about the process and criteria of trust benefits and programs to broader labor and management groups. The team will be charged with the oversight and training of workforce development teams and will work directly with trustees of the Taft-Hartley and Partnership trusts and the regional and facility (as appropriate) teams to develop and coordinate policies to support workforce development. The national team will be staffed sufficiently to ensure timely implementation.

c. Regional Workforce Planning and Development Teams (Regional Teams)

The regional teams will be chaired by labor and management co-leads, and will be accountable to regional Labor Management Partnership Councils/Steering Committees/Strategy Groups (or their equivalent). Participants will include representatives from HR

functions, including: Recruitment, Compensation and Learning Services, as well as Work of the Future, operations and other representatives as appropriate. Regional teams will create and maintain a program to meet the goals set out in this Agreement and the 2005 Workforce Development BTG recommendations.

They will also align, integrate and coordinate all workforce planning and development efforts on a regional level. Regional teams will work directly with the national team to:

- » assess needs;
- » deliver and implement programs;
- » create policies to support workforce development;
- » coordinate the delivery of programs to ensure that barriers to job placement and training opportunities are eliminated; and
- » provide guidance and oversight in order to effectively coordinate with facility teams (as appropriate).

Regional Workforce Planning and Development, in collaboration with regional operations, will identify training positions based on operational needs. Such training opportunities will be explored with labor in partnership, with the intent of enabling employees to meet the minimum experience requirements and promote career mobility.

Regional Workforce Planning and Development teams will integrate work and jobs of the future into their scope. The teams will identify and learn about organizational strategies and innovation trends, assess impact on job

and skills, and recommend training, recruitment, job redesign and new jobs, as appropriate. Team composition and resources will be evaluated in order to accomplish the work. Regional and national Workforce Planning and Development teams will work together to share innovations, spread successful practices and engage UBTs in workforce transformation. National LMP Tri-Chairs will coordinate the work and report at least annually to the LMP Executive Committee of the Strategy Group on progress nationally and in each region.

d. Facility Workforce Planning and Development Teams (Facility Teams)

Facility teams will be established, where appropriate. These teams will assess needs and barriers to training and report findings to the regional teams.

3. JOINT WORKFORCE PLANNING AND DEVELOPMENT

Workforce Planning and Development is one of the highest priorities of Kaiser Permanente and the Alliance. The success of the organization and the Partner unions is attributed to the work, skill and education of Kaiser Permanente employees. In order to adapt to the rapidly changing health care environment, there is a need to invest even more fully in partnerships, people and new technologies, while continuing to provide the highest quality of care and service to health plan members.

The Alliance and management agree that a comprehensive workforce planning and development program will be jointly

developed and implemented. The goal is to create a culture that values and invests in lifelong learning and enhanced career opportunities. Once the local union has been notified of the need for redeployment or position elimination, Workforce Planning and Development will be engaged. The joint efforts will also result in the development of infrastructure and tools to realize the full intent of the Employment and Income Security Agreement. By achieving these goals, employee retention and satisfaction will be increased, hard-to-fill vacancies filled, quality and service improved, and the Labor Management Partnership strengthened.

Significant investments are being made in Workforce Planning and Development programs and activities. In order to be successful, these programs and activities require organizational alignment, integration, coordination and efficient use of resources. The parties will assess the effectiveness of these activities and determine how to improve the overall program, including determining the appropriate yearly level of resources and investments.

The five key components to this work are Workforce Planning and Development, career development, education and training, redeployment, and retention and recruitment.

a. Workforce Planning and Development

As Kaiser Permanente and the Alliance plan for the workforce of today and tomorrow, it is necessary to develop a set of ongoing processes that determine

current workforce skill levels, current and future workforce needs and formulate a strategy to assure alignment. The parties agree that Workforce Planning and Workforce Development must be integrated processes, and that successful workforce planning must include a commitment to internal promotions in the filling of vacancies. Therefore, existing policies, practices and contract language will be jointly reviewed and new policies developed to support internal promotions, including the harvesting of vacancies, development of redeployment processes, studies to determine the feasibility of in-sourcing career counseling services/functions that are currently performed by external providers and new incentives for managers to promote from within. Further, Labor will be provided with access to their job postings and engaged to build new jobs for future health care models. The regional Workforce Planning and Development teams will need to share direction changes brought on by federal and state regulations that affect Labor positions so that Labor can be engaged in the development of future workforce strategies.

b. Career Development

In order to provide employees with opportunities for personal and professional development and provide the necessary resources to achieve their career goals, the Alliance and management agree that career counseling services will be made available in each region or national function to offer skills and interest assessments, individual and group career counseling, and the development

of individual employee development plans. In addition, a comprehensive infrastructure, including career ladders and lattices, career pathways mapping, occupational index tools, a career website, pipeline tracking database system and project management support will be established. The parties will jointly promote a communication strategy and approach to systematically capture core competencies, skills, education, licensure, certification and work experience, in order to enhance opportunities for Alliance-represented employee career mobility. The national team will be accountable for oversight and coordination with the regional and functional teams to ensure that the career counseling infrastructure is developed and deployed.

Further, the National Workforce Planning and Development team will continue to jointly develop career paths on a jointly agreed-upon schedule for Alliance-represented employees. The schedule will identify the next group of career paths to be achieved and the timelines for this work. The regional Workforce Planning and Development teams will explore ways to connect and coordinate career counseling resources with employees in transition. Specifically, these teams may jointly develop a job-shadowing process that will afford employees an on-the-job experience of a new job choice prior to the employee entering into education programs.

Also, regional Workforce Planning and Development teams will establish a joint group to examine, set goals and develop criteria regarding preceptorships and

mentorships. Preceptorship programs will be monitored and evaluated consistent with determined funding. Employees interested in career development will need to develop individual career development plans with the support of organization resources and systems, in collaboration with management.

c. Education and Training

The Workforce Planning and Development education and training objectives are to:

- » prepare individuals to engage in learning processes and skills training;
- » support employees in meeting their professional and continuing educational needs;
- » train professional and technical employees for specialty classifications;
- » provide education and training in new careers and career upgrades;
- » support employees in adapting to technological changes;
- » propose and test opportunities for building broader innovation capabilities for the front line; and
- » ensure alignment with the needs of the organization.

To achieve these objectives, the parties will jointly develop criteria to determine which training is a priority. The parties will also solicit higher learning institutions and maximize Kaiser Permanente's leverage with outside learning organizations. Education and training programs should be able to accommodate multiple styles of learning, and the trust should work toward

offering consistent, online prerequisite curriculum. Following the completion of a training program, labor and management will work jointly to remove hiring barriers for employees.

The parties recognize the need to raise awareness of the availability of tuition reimbursement opportunities. Each regional team is responsible for determining the current utilization of tuition reimbursement, education leave (including continuing education units) and other allocated budgeted resources. The teams should then determine how to remove barriers to access (e.g., degree requirements) and increase participation in these programs. This may require amendment of local collective bargaining agreements and/or policies. The national team, working with the regional teams, will develop a communications strategy to raise the awareness levels in each region.

Tuition reimbursement may be used in conjunction with education leave by employees for courses to obtain or maintain licensure, degrees and certification. Tuition reimbursement dollars may also be used for basic skills programs (e.g., computer, basic math, second language and medical terminology courses). Tuition and continuing education reimbursement is offered at \$3,000 per calendar year for all benefits-eligible Alliance employees scheduled 20 hours per week or more and who have been employed for at least 90 days. The tuition reimbursement benefit will be administered by a human resource function in a shared services environment.

Of the overall total annual reimbursement, represented employees may submit up

to seven hundred fifty dollars (\$750) effective January 1, 2019, for travel, room/lodging expenses (excluding meals) for courses, workshops, seminars, professional conferences, educational meetings and special events taken/attended for continuing education (i.e., CEU, PDU, CME, contract hours) in order to advance skills and obtain or maintain position-required licensure, or certification, provided they are taken at an accredited institution, professional society or governmental agency. This shall include obtaining required licensure for a position.

Travel reimbursement is not available for college undergraduate or graduate degree programs.

d. Redeployment

Each region shall develop and implement a consistent redeployment process, which will include local union leaders, national and regional Workforce Planning and Development, career counselors, recruitment, labor relations and operational leaders. The parties will build or refine redeployment process maps. This task will be supported by long-term and short-term forecasting of strategic and operational changes that may lead to redeployment. These efforts will be both collaborative and transparent.

E. EDUCATION AND TRAINING

1. PRINCIPLES

In order to achieve the KP Promise, the vision of the Pathways to Partnership and enhanced organizational

performance, a significant commitment must be made to the training and education of the workforce.

Furthermore, most of the policies, commitments and plans described in this Agreement cannot be successfully accomplished without the committed efforts of Kaiser Permanente employees. Meaningful participation requires a high level of knowledge and understanding of the business of health care, the operations of Kaiser Permanente and the principles of the Labor Management Partnership. Therefore, the goal is a comprehensive, jointly administered, integrated approach to education and training. There will be a joint design and oversight team that provides new and ongoing training programs to all appropriate staff, including evaluation of training effectiveness.

2. TYPES OF TRAINING

There are a variety of educational requirements necessary to advance the Partnership, support the development of high-performing, committed work teams and enhance the growth, advancement and retention of employees.

All newly hired partner union and management employees should complete Labor Management Partnership training within 3 months (90 days) of being hired; all newly accreted/organized employees into the National Agreement should complete Labor Management Partnership training within 3 months (90 days) from the effective date of inclusion into the National Agreement as defined by the region and the National LMP Executive Committee.

Types and categories of training, grouped by funding source, include:

- » Career development (supported by national funding); for example, training current employees to:
 - › acquire basic skills and prerequisites for advancement;
 - › fill new or hard-to-fill positions/ technology changes; and
 - › advance lifelong learning.
- » General Partnership and National Agreement training (funded through the Partnership Trust); for example:
 - › implementation of the National Agreement;
 - › program development for unit-based teams;
 - › application of the flexibility provisions of this Agreement;
 - › Partnership orientation and other Labor Management Partnership training; and
 - › performance-sharing programs.
- » Key business strategies and initiatives (funded through operating budgets or local or national business initiatives); for example:
 - › attendance;
 - › service;
 - › business education;
 - › Kaiser Foundation Health Plan product offerings;
 - › KP HealthConnect®;
 - › employee health and wellness;
 - › scope of practice;

- › benefits;
- › regulatory compliance; and
- › diversity.

3. STEWARD EDUCATION, TRAINING AND DEVELOPMENT

The parties agree to support union steward training and education and agree that stewards have time available each month to participate in training and development activities. The parties agree to support stewards in training and development, such as:

- » education and training programs;
- » Stewards Council;
- » Labor Management Partnership Council;
- » Partnership-sponsored activities; and
- » Partnership environment.

Training programs for stewards may be developed in the following areas:

- » foundations of unit-based teams;
- » improvement in Partnership principles;
- » contract training on the National Agreement;
- » fundamentals of Just Cause;
- » leadership skills;
- » effective problem solving; and
- » consistency and practice.

Labor and management will work jointly on steward development. Accountability will rest with senior operational and union leaders on the Labor Management Partnership Council (or equivalent) in each region.

4. INTEGRATED APPROACH TO EDUCATION AND TRAINING

There are common themes and elements of training that should become consistent across Kaiser Permanente. Sufficient resources will be committed, as specified in this Agreement and by the regions, to create and deliver training programs and to enable employees to take advantage of those programs, supported by planned replacement where necessary. Integrated development of program-wide training programs should provide efficiency, cost effectiveness, higher-quality training and a more consistent experience for employees across Kaiser Permanente.

The National LMP Tri-Chairs will be responsible for ensuring an integrated approach to education and training, which will jointly address initiatives and topics identified as priorities for the Program. Criteria for prioritization will be:

- » National Agreement implementation plans;
- » organizational strategic objectives; and
- » Partnership priorities.

The parties have identified the goal of creating a learning system that supports sustained behavior and culture change, partnership and performance. To achieve this goal, the parties will:

- » continue to engage LMP learning experts in assessing current learning systems;
- » develop approaches that accommodate a range of learning styles, and deploy best practices in adult learning;

- » offer a range of learning modalities and conduct tests of change to determine which are most effective;
- » develop training, coaching and mentoring specifically to support mid-level leaders, who include management supervisors, union leaders and staff;
- » develop a means of measuring outcomes and ensure that evaluation, feedback and continuous improvement are part of the learning system;
- » create a system for selecting, coaching and certifying facilitators and trainers; and
- » strive for consistency across the program to achieve the same partnership and employment experience wherever one works in KP.

Mid-level leader support shall include:

- » joint, in-person training to set foundational expectations; Union and Management will receive the same curriculum and regular refresher trainings;
- » refresher trainings occurring at least annually; they may include supplemental curricula delivered via new media and emerging technologies, such as online, mobile applications, WebEx, Skype and communities of practice; and
- » separate training programs and/or educational forums that Management or Labor may choose to create to address specific needs.

The Inter-Regional Steering Committee will be repurposed and renamed the

National LMP Learning Group. This group will develop a plan to implement LMP training for new hires, middles (management and labor) and the front line as follows:

- » Report to LMP Executive Committee quarterly; take recommendations to the LMP Executive Committee for final endorsement and sponsorship;
- » Develop and update standardized LMP curriculum and content, including minimum hours for each specific class, to be curriculum, content and audience driven;
- » Obtain feedback on learning programs, measure against defined objectives and update as needed;
- » Include representation from the appropriate subject matter experts from the Employer and the Alliance:
 - › Each regional LMP Council to nominate two representatives (one labor, one management) with the assumption that whomever from the region is on the national body will report back to and gain feedback from regional constituents;
- » Review recommendations from Regional LMP Councils for new trainings;
- » Focus on moving from “training” to “learning”;
- » Track course completion; and
- » Recommend the appropriate delivery methods of each class to meet the curriculum requirements. Regional LMP councils may submit alternate delivery methods to the National LMP Learning Group for approval.

F. STAFFING, BACKFILL (PLANNED REPLACEMENT), BUDGETING AND CAPACITY BUILDING

1. OVERSIGHT

No later than January 1, 2019, the Tri-Chairs will identify the appropriate LMP sponsorship team to oversee this section. Where regional LMP sponsorship does not exist, then Business Unit or National Shared Services LMP sponsorship will be identified.

LMP councils are encouraged to sponsor backfill and staffing work to prioritize and help remove barriers, including but not limited to sick calls and attendance, and will revisit Partnership values as an agenda item in June and December meetings.

a. Planned Replacement and Budgeting

Providing a work-unit environment where quality of care and employee satisfaction are not compromised by fluctuations in staff is a crucial concern. The parties commit to resolving the complex issues of staffing and planned replacement in a comprehensive manner. Planned replacement means budgeted replacement time for employees’ time away from their work unit (e.g., to participate in training, Partnership activities, approved union work or to take contractual time off, including unpaid leaves of absence).

In addressing the issue of planned replacement, the objectives are to jointly define the circumstances in which

planned replacement will occur, using the following criteria:

- » plan for and schedule replacement activities wherever possible, so that planned replacement objectives can be successfully achieved;
- » provide planned replacement so employees are able to use leave benefits appropriately and take time off related to activities listed above;
- » provide adequate staffing within the budget to cover the work operations and other work-related requirements by creating a planned replacement line item at all budgeting levels;
- » ensure forward-looking and realistic planning to anticipate and provide for future staffing needs;
- » support the attendance provisions of this Agreement;
- » budget and plan realistically to provide for all components of legitimate time off from work and apply those budget components as intended; and
- » accurately track time off requests and responses to provide managers and employees with transparent data on time off.

The parties will conduct and complete a gap analysis (i.e., the difference between needed average amount of time off and current budget practice) for planned replacement in each region prior to the rate-setting process. Planned replacement will be incorporated into rate-setting and budgeting processes for all departments. The parties will mutually agree on the phasing in of additional resources for planned replacement and

regional market conditions will be a factor in those considerations.

In departments where management and the unions agree that the budgetary process meets the objectives as outlined above, the process does not need to be modified. Those departments without an effective joint staffing, budgeting and planning process in place will observe the joint staffing provision below and incorporate the recommendations taken substantially from the 2005 Attendance BTG Report, Concept No. 3, and pages 20–23 (attached as Exhibit 1.F.). Timing will be determined jointly at the regional level.

The LMP Tri-Chairs will designate an LMP subgroup to review existing best practices and to develop a template that communicates the financial performance, including indicators specific to budget, at the Regional level. The template should be used by labor and management leaders to guide conversations at all levels.

b. A Joint Staffing Process

As unions and management continue to integrate Labor Management Partnership structures into existing operational structures, Partner unions will become more involved in business planning and resource allocation decisions. These decisions are intricately tied to the shaping of staffing plans and decisions to adjust resource allocations during budget cycles.

Therefore, the parties agree that throughout this integration process, they will implement joint staffing processes. This

work will include jointly developed staffing plans that consider the following factors:

- » mutually acceptable numbers, mix and qualifications of staff in each work unit;
- » planning for replacement needs;
- » patient needs and acuity;
- » technology;
- » inpatient and outpatient volume;
- » department/unit size;
- » geography;
- » standards of professional practice;
- » experience and qualification of staff;
- » staff mix;
- » regulatory requirements;
- » nature of services provided;
- » availability of support resources;
- » model of care;
- » needs and acuity of the entire medical facility as well as specific department/unit;
- » consideration and support for meals and breaks; and
- » departmental/area budgets.

Adherence to any and all guidelines promulgated by any reviewing or regulatory agency and any other applicable laws or regulations is mandatory. A staffing and budgeting model appears in the 2005 Attendance BTG Report, Concept No. 3, pages 20–23; (attached as Exhibit 1.F.). The joint staffing language in this Agreement, together with the model in the BTG report, should provide the framework for staffing discussions and decision making.

c. Labor-Management Staffing Committees

By the end of the first full quarter following ratification of this agreement, Alliance union leaders and senior KP leaders in each region will meet and establish a labor-management staffing committee for each of the regions and for each Alliance bargaining unit.

This committee is not intended to supersede or replace any existing staffing committees established by local bargaining agreements. For regions and bargaining units that do not currently have a labor-management staffing committee, the aforementioned parties will determine the structure(s) to be established that would best meet the region's needs.

The committees will meet, at a minimum, on a monthly basis, but may mutually agree to change the meeting frequency at any time. The topics to be discussed include, but are not limited to, position vacancies, posting and filling of positions, backfill, time off, hard-to-fill-positions, staff utilization (including contingent staff, use of non-bargaining unit personnel, and scenarios where staffing challenges lead to contracting outside services), staffing models, flexibility as defined in the National Agreement, budgets, and member/patient needs. (See sample Labor-Management Staffing Committee Charter and Agenda in Exhibit 1.F.1.c.6. "Sample Charter and Agenda"). The committee will develop recommendations to address issues raised and strive to reach consensus, and jointly develop plans to implement those recommendations.

Issues regarding staffing at the department or unit level may be escalated to these committees when attempts to resolve concerns at the department or unit level are unsuccessful.

If consensus on recommendations cannot be reached, or issues brought to the committee by departments or units remain unresolved, the parties may bring issues to the local and/or regional LMP council. Each party retains their respective rights under their local or national agreement.

The Labor-Management Staffing Committee(s) will oversee the following staffing-related provisions of the National Agreement:

1. Posting and Filling Vacancies

Labor and management will work together to develop strategies for hard-to-fill positions. To this end, the union and the employer will meet to consider options both short-term and long-term to ensure the timely filling of positions with appropriately qualified employees. These solutions could include, by way of example but not limitation:

- » **Short-Term:** Collaboration between labor and management on recruitment, signing bonuses and other incentives. Wage scale considerations impacting recruitment may be referred, as appropriate, to procedures under local collective bargaining agreements.
- » **Long-Term:** Develop joint training programs potentially utilizing jointly (Ben Hudnall) and employer-funded training funds; create internal career ladders with appropriate mentorship/

preceptorship/apprenticeship opportunities; and identify external and internal sources for future candidates for these positions.

2. Position Control

On a monthly basis, the designated labor leader(s) for an impacted bargaining unit and manager(s) will review the status of all vacated and modified positions at the unit or department level and discuss backfill needs and strategies to meet them. Any decision to not fill a vacated position or to modify the position must be discussed with the labor leader(s).

Management will keep the UBT or UBT representative group informed on the status of filling the position.

In the event the union and the employer disagree with respect to any decision to hold replacement or modify the position, the union may escalate that decision to the appropriate Labor-Management Staffing Committee.

The Labor-Management Staffing Committee(s) will discuss and review position control processes and any changes to the process or targets (position add or elimination goals).

3. Traveler and Registry

Labor and management have a mutual interest in reducing the use of traveler and registry (staffing provided through outside agencies). In an effort to do so, the parties will meet on a quarterly basis, at the service areas or regional level, to review the usage of traveler and registry (for example, traveler and/or non-bargaining temporary employee use exceeding 13 weeks), and the reason for the traveler or registry usage. The parties

will also develop alternatives such as voluntary temporary upcoding of current employees, development/expansion of a float pool which can be a long-term assignment for float staff at employee choice, the creation of additional part-time positions which can be used to pick up additional hours, and the appropriate level of per diem/on-call staffing.

Non-bargaining unit temporary employees (traveler/registry) will not be extended beyond 180 days without labor and management meeting to discuss alternatives as mentioned above.

It is recognized that certain units/classifications can be impacted by seasonal fluctuation in patient volume/workload demand. For such positions, on request of the local union, discussions will begin to evaluate and consider opportunities to account for seasonal fluctuation with bargaining unit employees including, but not limited to, the use of temporary bargaining unit seasonal positions, the creation of positions which have seasonal hours (higher FTE during periods of peak/higher demand), and the appropriate level of part-time and per diem/on-call staffing which can be used to flex up. Any such discussions would be by consensus between the local union and their management counterparts in the region. On request, either party may seek assistance through facilitation and engagement of the national labor management parties.

4. Disseminating Information

The employer will provide the following information to the Labor-Management Staffing Committee on a monthly basis for

the purposes of disseminating the data, as appropriate, to departments to enable them to develop successful projects aligned with the Value Compass, improve the service and quality of care provided to patients by frontline staff, and foster staff well-being and job satisfaction.

» **Vacancies:** Monthly, the employer shall provide a report on status of vacancies by classification, department, and bargaining unit to the Labor-Management Staffing Committee. The report will include the following information:

- › Position status: active (vacant or filled) or inactive (the business has determined position no longer needed, has been purposed for another position, or created erroneously and needs to be deleted);
- › Requisition status: requisition number is present if posted; field is blank if not posted; and
- › Action reason
 - Create requisition — currently in the approval queue
 - Requisition status update — currently posted
 - Non-requisition — no action taken with the position.

» **Service, Patient Access and Patient Satisfaction Data:** Monthly, the employer shall provide the following information to the Labor-Management Staffing Committee:

- › Data related to patient satisfaction scores and care experience; and
- › Data related to access.

» **People Pulse Scores:** Aggregate People Pulse scores will be provided to the Labor-Management Staffing Committee within 30 days of the scores becoming available.

5. Budgeting and Backfill

The employer shall share the backfill calculations, backfill strategy, and budgeting information on a quarterly basis. (See Exhibit 1.F.1.a. as an example).

The information will be shared at the departmental/UBT level, and at the regional or service area level with the appropriate local union representatives.

6. Charter Language

The LMP Tri-Chairs have appointed a joint Labor-Management Committee to craft a sample Labor-Management Staffing Committee Charter, which can be found in Exhibit 1.F.1.c.6.

2. CONTRACT SPECIALISTS

The ability to fully engage frontline workers in Partnership activities has been limited by a lack of union capacity. Stewards have had the difficult task of balancing their traditional representational duties related to the administration of collective bargaining agreements and engaging in Partnership activities. To empower stewards to fully assume their leadership roles in Partnership activities, the parties agree to the establishment of a new role, Employer-paid Contract Specialists. It is anticipated that this role will advance the Partnership by:

- » allowing stewards more time to focus on Partnership implementation at the facility and work-unit level;
- » building expertise and promoting consistency in contract interpretation and implementation through Contract Specialists who partner with local HR Consultants; and
- » building capacity through the development of many contract experts.

Each Alliance bargaining unit will be allocated a minimum of one full-time-equivalent (FTE) Contract Specialist, or portion thereof, for every 1,200 bargaining unit employees. In each region, each Alliance International Union will apply the 1:1,200 ratio to its total membership to determine the number of Contract Specialists. The Contract Specialists will be appointed by the union, with Employer input, and will be directed by and accountable to the local union. Their duties will include, but not be limited to, contract interpretation and administration, contract education, guidance in grievance and problem resolution, improvement in shop steward capacity and consistent contract application. The Contract Specialist will partner with the HR Consultant or equivalent. Normally, it is expected that Contract Specialists will serve a single, one-year, non-renewable term. The pay, benefits and conditions of the Contract Specialists will be in accordance with the standard Labor Management Partnership Lost Time Agreement.

Many unions currently have Employer-paid liaison positions. Management and the local union will collaborate and

attempt to reach a consensus decision on converting current liaison positions into Contract Specialist positions. It is possible that a union may elect to maintain the current number of liaison positions in lieu of a Contract Specialist, or choose a combination of Contract Specialist and liaisons, or eliminate all liaison positions and replace them with Contract Specialists. In the event that a local union does not have a liaison, it may choose to select a liaison(s), instead of a Contract Specialist, at the ratio described above. Local unions will set policies for liaison and Contract Specialist positions such as term length (e.g., single one-year, non-renewable term, etc.). Local unions that currently have liaison positions exceeding the 1:1,200 ratio cited above will maintain their current FTE ratio.

3. PER DIEM/ON-CALL REVIEW

The parties are committed to ensuring that individuals working more than 1,040 hours per year receive benefits. Conversion to benefited positions will be based on the local collective bargaining agreement guidelines.

Going forward, the parties will utilize the process set forth in the respective collective bargaining agreements. The parties further agree to undertake a systematic review of the balance of FT/PT, per diem and on-call positions under the auspices of the LMP Executive Committee, with the objective of finding an appropriate balance of positions. Regular quarterly reports shall be made to the LMP Executive Committee until the review is complete.

G. RACIAL JUSTICE

The parties agree that Racial Justice is of such paramount importance that we are committed to working together to form a National Labor Management Partnership Equity Inclusion Diversity and Racial Justice Task Force that reports up to the Alliance LMP Executive Committee. The LMP EID and Racial Justice Task Force will work on various matters to imbed EID principles and spread them throughout the enterprise.

The four areas covered under this section are:

- » Infrastructure
- » Health Equity
- » Employee Experience
- » Workforce Equity

The Alliance LMP Executive Committee will oversee the timeframe for the Task Force and the charter in alignment with KP's National Equity, Inclusion and Diversity (NEID) department. The Task Force will start working 90 days after ratification.

1. INFRASTRUCTURE

The parties will Integrate EID and Racial Justice into the LMP and model it after existing effective structures such as Workforce Wellness and Workforce Development. NEID-developed accountability measures and processes will be incorporated into the Task Force's jointly developed processes to ensure Speak Up culture and belonging is fully actualized. In order to impact change and increase success, the parties will embed Racial Justice and EID principles into the operational strategy; ensure Alliance representation in EID councils and

committees where they exist in regions and facilities; and allocate dedicated time for participants to work on annual LMP EID goals and work plans.

2. HEALTH EQUITY

a. Unit-Based Teams (UBTs)

UBTs should apply an EID lens to all projects and activities. EID projects will be tracked in the “Quality” category in the UBT Tracker. Teams will be provided the time, support and resources needed for project work and success consistent with UBT practices.

The Alliance, NEID and other parties will develop and/or update existing UBT toolkits to include sample projects, resources (local resources such as Regional EID, websites, etc.) and education. The parties will develop communication plans to promote the projects and resources for the UBTs and those who support the teams. This information will be available on the LMP website.

b. Employees

In partnership with Workforce Wellness, the Task Force will develop targeted goals and strategies, materials, existing staff, and necessary resources to eliminate employee care gaps and health disparities. The parties will develop a plan to increase cultural responsiveness training leveraging current contracts for clinicians of color to provide employee mental health/EAP.

c. Members/Patients

The parties will partner with Quality and Care Delivery to identify priority

areas where the LMP could support the improvement of culturally responsive practices targeted to people of color.

1. To measure improvement in specific chronic diseases (e.g., A1C, BP, BMI);
2. Jointly determine internal causes or barriers impacting the ability to address health inequities more effectively within our organization and communities, we will develop approaches, action plans and implementation timelines for improvement; and
3. Spread effective practices throughout the organization.

3. EMPLOYEE EXPERIENCE

We understand the need to engage employees based upon their experiences related to, but not limited to, race, microaggression, equity, etc. To develop a better KP culture and environment, we shall, among other things, do the following:

- » Conduct listening sessions on paid time for all classifications (employees will have the opportunity to attend annually).
 - › Sessions will be held at least twice per year by trained facilitators; and
 - › Sessions will include follow-up and action plans.
- » Pilot healing/restorative circles which are helpful for racial trauma/fatigue. These shall be accessible to everyone;
- » Enhance the current processes and make design improvements across the various employee complaint processes related to racism and discrimination;
- » Advance KP's value of creating a culture of speaking up and belonging

through increased access to training of the national EID program *Belong@KP*, *Leading with Emotional Intelligence* and *SpeakUp*;

- » Make *Belong@KP* a part of new employee orientation within the first 90 days; and
- » Jointly develop goals, action plans, and accountability measures for completion of all EID trainings.

4. WORKFORCE EQUITY

The parties will improve workforce equity by:

- » Providing education and training to hiring managers and interview panelists on importance of and how to utilize inclusive hiring and selection practices;
- » Ensuring staff reflect the diverse communities in which they serve;
- » Adding strong Racial Justice and EID statement(s) to all job descriptions and posting requirements;
- » Identifying job roles or segments of the workforce lacking diversity:
 - › Create strategies to identify interest in and support mobility into those job roles; and
 - › Develop strategies to increase talent pipelines internally and externally.
- » Eliminating bias from promotion and hiring practices by supporting internal candidates through:
 - › Ben Hudnall Memorial Trust (BHMT) education and experience programs;*
 - › providing represented employees

opportunities to gain exposure to other jobs and gain experience required for placement; and*

- › identifying situations causing employees to be bypassed or prevented from obtaining position(s) or promotion(s).*

* *These provisions are not intended to supersede local contract provisions*

- » Supporting workforce equity by:
 - › Developing targeted BHMT programs to help close representation gaps;
 - › Creating programs to support Alliance employees' mobility into an increased variety of job roles;
 - › Piloting Workforce Development and EID programs with diversity objectives; and
 - › Enabling employees to gain experience (on the job) needed for placement.

H. TOTAL HEALTH

Kaiser Permanente and the Alliance are committed to the total health and well-being of employees and to work-life practices, programs and services that balance work, mental health and lifecycle challenges. The Total Health program is a long-term business strategy for KP. KP's ability to offer a fully integrated and high-quality model of care is an imperative that needs to be reinforced at all levels of the organization. To the extent that employees can model Total Health, such personal leadership creates a competitive advantage for KP. As such, it is critical to educate all employees about the business

case for Total Health, including the costs associated with health risks and the benefits associated with limiting such risks. Employees who are supported in balancing their work and personal lives and reducing their health risks are more effective in their work, more productive as team members, and better able to deliver quality health care and service to members/patients. The organization's responsiveness to individuals' needs, both on and off the job, is a powerful predictor of productivity, job satisfaction, commitment and retention. Accordingly, Kaiser Permanente and the Alliance will work in Partnership to establish an infrastructure to support and manage total health services, and all joint partnership bodies will address Total Health and its programs.

Infrastructure resources will include a management partner, a dedicated labor partner, analytical staff and Employee Assistance Program resources. Working in partnership, the parties will identify additional resources at the regional and local level as needed and should be integrated with unit-based team infrastructure to the extent practical. The LMP Strategy Group will provide program-wide oversight, and each Region will have an annual joint workplan and provide at least semiannual reports to the Regional LMP Councils on progress against the workplan.

1. UNIT-BASED TEAM ENGAGEMENT IN TOTAL HEALTH

The parties agree the current 4-hour "UBT Health and Safety Champion Training" is the program-wide orientation

program for UBT Health and Safety Champions. Updates or revisions, if needed, will come from a jointly led group and will be approved by the National LMP Learning Group.

Consistent with operational needs, UBT Health and Safety (H&S) Champions should receive the training as early as possible upon becoming champions. In order to support and understand the role, managers are urged to attend the training along with their UBT H&S Champion.

Consistent with KP's policy on Healthy Workforce Activities, managers are encouraged to build activity and stress relief into the workday. The parties recommend that managers engage with their UBT H&S Champions, and the monthly health and safety UBT activities, as one way to satisfy this responsibility.

LMP Communications will design a strategic program, beginning no later than three months after ratification, that will engage frontline management UBT co-leads by providing them with simple, practical tips and tactics to support their UBT H&S Champion, encourage healthy activities in the UBT, and describe why it is important. The program should be a companion to the current UBT H&S Champion monthly activities and program.

Participation in monthly, 30-minute tele-town halls is strongly encouraged for UBT H&S Champions.

2. TOTAL HEALTH AGREEMENT

Kaiser Permanente (KP) and the Alliance of Health Care Unions (Alliance) share the goal of creating the most resilient, thriving

workforce in health care by improving the quality and length of employees' lives and enhancing the effectiveness and productivity of the organization.

The parties, through the Labor Management Partnership, commit to creating a psychologically safe workplace environment and culture that supports employees' health and well-being and helps them to collectively reduce their health risks, including their risk of occupational injury and illness.

The parties share a commitment to measure and regularly report aggregate data for the employee population with respect to clinical indicators of the health and well-being of all employees, in keeping with our joint tradition of being a continually improving, learning organization that responds to data and evidence.

The parties agree to jointly create and promote a healthy workplace environment. The parties shall address, but are not limited to, the following issues: a healthy physical workplace environment; healthy and affordable food options at the workplace; and opportunities for employees to engage in healthy activities at the workplace on non-work time. (See Exhibit 1.H.2.)

a. National Health, Safety and Well-Being Committee (NHSWBC)

The LMP Strategy Group will empower the National Health, Safety and Well-Being Committee to address the issues of psychological safety and creating a just culture through an integrated and collaborative approach. Members of the

committee will include representation from all markets and national functions, as well as subject matter experts.

Committee members will be identified and convene within three months of ratification, a charter will be finalized within six months of ratification and develop a national framework/program that integrates psychological safety and Just Culture into the workstreams that impact safety and wellness of patients and workers through its strategies, principles and goals within one year of ratification.

KP and the Alliance will work together in Partnership to 1) adhere and uphold the Alliance National Agreement, 2) develop a national framework/program that integrates psychological safety and Just Culture into the workstreams that impact safety and wellness of patients and workers through its strategies, principles and goal which could inform policies, and 3) standardize practices across the enterprise to ensure consistency in areas of education, data collection, reporting and evaluation.

Charter guidance and project management support to be provided, and tasks of the committee include:

- » Develop action plans which include the goals, tools, education and training, communications, and mechanisms for monitoring and evaluation to create a standardized approach across KP;
- » Develop a "Just Culture" framework: identify the key elements, tools and resources;
- » Conduct a gap analysis at local and regional levels:

- › Identify and utilize best practices
- › Identify opportunities for improvement
- › Catalog existing applicable training and identify new areas for development;
- » Maximize use of existing resources;
- » Conduct regular reviews of the work of existing national committees; and
- » Identify suggestions regarding what, where and how communication should be applied.

b. Educating and Engaging Employees as Active Leaders in Their Health and Well-Being

In order to achieve the vision of the most resilient, thriving workforce in health care, the parties agree that employees be educated about their health and well-being so they can make knowledgeable, healthy choices. The parties will evaluate successful practices that allow the parties to provide consistent education for employees across Kaiser Permanente.

c. Alliance and Management Leadership

In order to achieve the vision of creating the most resilient, thriving workforce in health care, the parties acknowledge the necessity of thousands of rank-and-file union leaders and their management counterparts playing an active and ongoing leadership role in creating a transformative culture of health and psychological safety at Kaiser Permanente.

d. Health Assessment Tools

To engage employees in their own health and well-being, and provide them information and action steps, the parties will promote the use of online physical and mental health assessment tools available to Kaiser Permanente Health Plan members.

3. COMMUNITY ENGAGEMENT

The parties agree to continue, where labor determines it has the capacity, the following opportunities to promote total health in the communities where we live and work:

- » Integrate Labor into regional and service area community health councils and committees.
- » Establish a Labor Community Health Partner (LCHP) and Community Benefit (CB) lead in each region or service area, where Labor determines it has the capacity, to work with local community benefit teams. The LCHP should review community needs assessments, develop collaborative interests, strategies and activities, and provide regular updates to the LMP Council and local unions. The parties will work together to obtain appropriate release time for the LCHP.
- » Continue KP Cares (or a similar program) to allow union members to contribute to community benefit, and encourage regions to recognize KP employees for volunteer and community benefit efforts.

4. PROGRAMS AND SERVICES

a. Health and Well-Being Promotion

Health and well-being promotion focuses on keeping people healthy and thriving. Kaiser Permanente will offer services to enable its employees to focus on prevention by actively promoting a healthy and balanced lifestyle. To achieve this, local facilities will in Partnership implement and coordinate health and well-being activities aimed at improving the well-being of all employees. Programs and services may include, but are not limited to, mental health resources and training, self-help classes, mindfulness courses and support groups.

b. Employee Assistance Program (EAP)

The Employee Assistance Program is intended to maximize employees' ability to cope and remain productive during stressful events and life crises. Such services should be sponsored nationally and implemented locally. They may include, but are not limited to, work-life problem assistance, such as support for work and family relationship difficulties, drug and alcohol assistance assessment and referral, short-term family counseling and manager/union consultation services. Life crisis services include emergency financial aid, grief counseling and a 24- hour EAP line. Promoting EAP resource awareness will be integrated into LMP processes.

c. Referral Services

Referral services provide a caring environment that is sensitive to the

variety of employee needs. Company-sponsored, -arranged or -subsidized services may be provided, including discounts for goods and services. This should benefit employees with minimal added cost. Examples include mass transit incentives, financial counseling services, concierge services and computer discounts. Some of these services are provided currently through regional employee activity programs. Expansion of these services nationally may be evaluated by the Strategy Group during future years of the contract.

The parties agree to explore opportunities for a strategic approach, leveraging KP market reach, to voluntary health and well-being benefits/discounts (e.g., discounts for gym membership, weight management programs), and provide recommendations and best practices to regions and facilities within 12 months of ratification. The parties will explore recognitions that could be provided to UBTs who attain Levels 4 and 5 on the P2P. The recommendations may include a phased approach to leveraging KP market reach, bringing best practices in line over time.

d. Donating Days

The Partnership should create a mechanism for employees to voluntarily donate some earned time off, vacation or life-balance days to employees in need.

In addition, Kaiser Permanente will establish a recognition week celebrating the founders of Kaiser Permanente, and a Memorial Day tribute to recognize and honor deceased employees on the Friday before Memorial Day.

5. MANDATORY OVERTIME AND ASSIGNMENTS

The parties' vision is to make Kaiser Permanente the best place to work, as well as the best place to receive care. Through the Partnership, unions, management and employees share responsibility, information and decision making, to improve the quality of care and service, and enrich the work environment. The ability to rely on a stable schedule is fundamental not only to this equation, but to achieving balance between work life and personal life as well. As a result, the parties have committed to discontinue mandatory overtime practices, with the overall goal of avoiding the mandatory assignment of any unwanted work time. *The Mandatory Overtime — Principles and Tools* document agreed to by the parties is attached as Exhibit 1.H.5.

I. JUST CULTURE

Kaiser Permanente and the Alliance believe that patient and worker safety is an essential ingredient of high-quality, affordable care and the responsibility of every physician, dentist, manager, union leader and employee. In order for Kaiser Permanente to be the safest place to give and receive care, we must jointly create a learning and trusting environment that views errors as an opportunity for continued, systematic improvement. This environment must encourage all employees to openly report errors or near misses, and participate in analyzing the reason for the error, and the determination of the resolution and appropriate responsive actions needed to

prevent reoccurrence while maintaining professional accountability and standards appropriate to profession and specific to role.

A Just Culture framework jointly developed in partnership by the Alliance and Kaiser Permanente will be utilized to ensure quality service and achieve safety for patients and the workforce. The parties will work together to create and sustain an environment of Just Culture by ensuring key elements of Just Culture are transparent, standardized, understood, and used by employees and management. Just Culture is distinct from the agreed-upon Issue Resolution/ Corrective Action process in Section 1.L. of the National Agreement. The parties recognize the importance of building a Just Culture and will empower a group of appropriate representatives and experts to achieve the objectives as outlined in the National Health, Safety and Well-Being Committee charter.

J. WORKER AND PATIENT SAFETY

1. PATIENT SAFETY

a. Creating a Culture of Safety

Improving the quality of care delivered to members and patients requires significantly increasing the reporting of actual errors and "near misses." It is recognized that the reporting of such errors can only improve if employees are assured that punitive discipline is not seen as the appropriate choice to handle most errors. The reporting system will include the following components:

- » reporting of errors, with systematic, standardized analysis of errors and near misses;
- » communication of learning to help make needed policy and procedure changes;
- » confidentiality of involved employees unless prohibited by statute or law;
- » involvement of staff in error analysis and/or resolution;
- » positive reinforcement for reporting;
- » training and education programs that enhance skills and competency to help prevent future errors;
- » maintenance of the integrity of privileged information; and
- » ability to collect and trend data across the organization.

Information regarding errors reported through this system will be handled through the Issue Resolution/Corrective Action process of this Agreement and will not be used as the basis for discipline except in rare cases when punitive discipline is indicated, such as the employee:

- » was under the influence of drugs or alcohol;
- » deliberately violated rules or regulations;
- » specifically intended to cause harm; or
- » engaged in particularly egregious negligence.

Reporting through this system does not relieve the employee of the responsibility to complete an incident report when indicated by policy.

b. Flu Prevention

The Alliance and Kaiser Permanente are committed to the highest standards of patient safety and employee health. Accordingly, Kaiser Permanente and the Alliance agree that all health care workers will be required to have received a seasonal influenza vaccination or, if they decline for any reason, to wear a surgical mask for the duration of the influenza season while working in patient care areas.

2. WORKPLACE SAFETY

Working in Partnership, we are establishing the health care industry standard by setting the goal of eliminating all causes of work-related injuries and illnesses to create a workplace free of the risk of injury and illness, where people feel free and safe to report work-related injuries and illnesses.

a. Creating a Culture of Safety

Kaiser Permanente's goal is zero workplace injuries for all Kaiser Permanente employees, physicians and dentists. In order to be successful, a culture of safety must be created in which safety is a core business and a personal value, and prevention is more effective than injury management.

The leaders of Kaiser Permanente and the Alliance have committed to continuing support for cultural change, the implementation of systems and alignment among all contributing Kaiser Permanente departments, which are necessary to reach the goal.

The Principles of Partnership will be used to engage frontline staff and supervisors in implementing the remedies that will eliminate hazards that cause injuries. The parties agree to:

- » provide sponsorship and resources necessary for a broad and sustainable approach to workplace safety (WPS);
- » identify and/or develop early joint communication and planning for emergency preparedness to ensure engagement of all workers, regardless of job classification, in the event of a potential crisis, from planning to implementation;
- » use the People Pulse learning climate index to improve the safety culture for workers and expand it to include KP members. This index will be shared annually with labor consistent with the national process and timeline for People Pulse dissemination and action planning; and
- » institute joint planning to identify activities, such as direct-report rounding and huddles, that support psychological safety, worker safety, health and well-being (national, regional and local levels), similar to the WPS planning segment in the 2012 National Agreement.

b. Comprehensive Approach to Safety

Successful WPS efforts are comprehensive and require strong leadership from the health plans, hospitals, dental group, medical groups and unions. To that end, the parties commit to implement a comprehensive plan for each region that sets challenging

goals, defines accountabilities and creates a supportive environment with active work-unit engagement.

The plan should include sustainable implementation goals and a timeline with milestones for progress. The program requires that accountability for WPS be integrated into health plan, hospital and medical or dental group operations, business plans, performance metrics, budgets and strategic planning efforts, and emphasizes the collective responsibility for WPS in each work unit. The parties will include the regions in benchmarking workplace safety investments and providing guidelines for regional and local implementation.

In order to ensure successful implementation of the WPS program, the Employer and the unions agree to support training, Partnership activities and work team engagement related to WPS, in accordance with the Planned Replacement provisions of Section 1.F.1

c. Patient and Worker Safety Recognition Program

In order to encourage the reporting of injuries, incidents and near misses, each market will develop and implement a recognition program for patient and worker safety, or utilize an existing program such as Good Catch and Mahalogram.

d. National Data System

The parties will:

- » continue to develop and enhance the utilization of a national data system and structure that supports the needs of WPS teams, leadership and operations;

- » design an enterprise-wide safety hazard and follow-up reporting system and establish an oversight and escalation process through existing safety committees. Follow-up should address learnings from incident analyses and preventive measures beyond specific event and location. This work is to be completed as soon as practical, but not later than December 2017 and implemented across KP by December 2018; and
- » establish a national KP library of effective WPS practices and educate labor, staff and managers in safer practices. Develop and implement a plan to spread these effective practices across the program.

3. BLOODBORNE PATHOGENS

The parties will continue support of the National Sharps Safety Committee (NSSC), chartered by the Labor Management Partnership to pursue the goal of selecting and recommending the provision of the safest sharps safety devices. In the event of an issue or disagreement arising out of National Product Council actions regarding a recommendation from the NSSC, the appropriate problem-solving processes under Section 1.L. and 3.D. of the Agreement may be utilized.

4. INTEGRATED DISABILITY MANAGEMENT

As part of a comprehensive approach to WPS, an integrated disability management (IDM) program, appropriate for each region, will continue during

the term of this agreement. IDM is defined as a comprehensive program that provides a rapid return to work for employees with occupational and non-occupational injuries, illnesses or disabilities to best meet the needs of employees by improving and supporting overall workforce health, productivity and satisfaction while reducing costs for the Employer in lost time and productivity.

An integral part of a successful IDM program involves removing barriers for employees who are able to return to temporary, alternative or modified work after an injury, illness or disability. To that end, the Employer agrees to facilitate an employee's return to work by making every effort to liberalize work requirements, and the unions will work collaboratively with the Employer to identify temporary, available and appropriate work assignments for the affected employees. While in the IDM program, the affected employees may be placed into temporary work that may include assignments in another bargaining unit, as long as the assignment does not affect the process for filling vacancies and the work available for current employees in the workgroup. When assigning work to affected employees, the Employer will attempt to assign them to duties in their own bargaining unit before placing employees temporarily into another bargaining unit. Temporary assignments into different bargaining units should occur infrequently, and will require collaboration and coordination. In the event it is not possible to assign the employee duties within their own bargaining unit, the parties will jointly

determine if temporary assignment within another bargaining unit is possible.

The affected employee may remain in a temporary assignment for up to 90 days. During this time, the employee's bargaining unit status will be maintained with all rights and responsibilities. After 90 days, the parties will meet and must mutually agree to the extension of any such temporary work assignment as appropriate.

5. PREVENTION OF WORKPLACE VIOLENCE

The parties made a joint commitment to a shared goal of zero tolerance for violence in the workplace. The National LMP Tri-Chairs will appoint a national team to conduct a program-wide analysis to improve violence prevention. This team will consider the following subject areas in its analysis and ensuing recommendations:

- » education and training;
- » communications;
- » EAP;
- » organizational consistency; and
- » data and reporting.

Once the team has completed its analysis, it will create recommendations for developing consistent violence prevention programs. The team will report recommendations to the National LMP Tri-Chairs, who will review and consider appropriate next steps. Labor may also independently make recommendations to management regarding possible workplace violence

prevention policy changes based upon the analysis.

The parties agree to establish in each market, where none currently exists, an LMP PWV Committee. The national PWV Committee will create a reporting mechanism for the local/regional PWV committees to the national PWV Committee.

See Exhibit 1.J.5. for the implementation timeline and additional information.

6. ERGONOMICS

The parties agree to pursue implementation of proactive ergonomics programs, including safe patient handling, office ergonomics and material handling. This will include educating staff about existing resources, standards and policies with a goal of prevention.

7. UNION INDEMNIFICATION

In consideration of full and active participation by the member organizations of the Alliance in the WPS program, and in recognition of the potential liability which might result solely from that participation, Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc., agree that they, or one of the subsidiary health plan organizations of Kaiser Foundation Health Plan, Inc., will indemnify Alliance unions and their officers and employees, and hold them harmless against any and all suits, claims, demands and liabilities arising from or relating to their participation in WPS with Kaiser Permanente.

K. UNION SECURITY

1. UNION LEAVES OF ABSENCE

In support of the Partnership relationship, upon request, the Employer will grant time off to employees for official union business as long as the number of employees absent for union business does not impose an unreasonable burden on the Employer and the Employer receives reasonable notice.

Union leaves will be defined according to the following:

Short-Term Leaves are defined as leaves up to 30 days. Employees will continue to accrue seniority, service credit and benefits during the time of the absence, at the expense of the Employer. The impact of multiple short-term leaves on the operations must be considered.

Long-Term Leaves are defined as leaves of absence for more than 30 days and up to a maximum of one year. Such leaves will be granted by the Employer in increments of three months and shall be jointly reviewed, on a periodic basis, at the regional level. Seniority, service credit, credited service and health, dental and life insurance benefits will continue during the leave as long as the union reimburses Kaiser Permanente for the associated costs.

Elected Official Leave. Any employee elected to a union office will be automatically granted a leave of absence for the duration of the term or three years, whichever is less. Employees must return to work after the completion of one term. Seniority, health, dental and life insurance benefits will continue

during this time, as long as the union reimburses Kaiser Permanente for the associated cost. Service credit and credited service will be applied for a maximum of two years, as long as the union reimburses the Employer for such costs. As provided in local agreements, leaves beyond one term may be granted, but will not include service credit.

Kaiser Permanente will pay employees for absences in order to participate in grievances, issue resolution meetings, Kaiser Permanente work committees and interest-based negotiations under Section 3.E. of this Agreement. Paying employees for participation in panel arbitrations will be the decision of senior union and management leaders in the region.

The Employer and the leaders of the Partner unions will work together to ensure reasonable notice and to minimize impact on service and care delivery associated with this provision.

2. CORPORATE TRANSACTIONS

The parties recognize that unions and Employers do not stand still. Unions merge with each other, or in some cases, split into smaller parts. Employers buy and sell operations, spin off business units, merge with other entities or otherwise restructure their operations.

Through implementation of the Partnership principles embedded in this Agreement, the parties expect to establish open communication concerning business and organizational issues affecting their respective operations. The parties anticipate that in most instances through such

communication and the Partner unions' ongoing involvement in Kaiser Permanente's business matters, the unions will be aware of business issues that may cause Kaiser Permanente to consider transactions such as those described above. In such circumstances, the parties contemplate that they will move to more formal discussions concerning such contemplated transactions as Kaiser Permanente's consideration of options proceeds. The parties intend that the Alliance and the affected Partner unions will be involved in such consideration in a manner consistent with Partnership principles and that the legal and contractual rights of the affected employees will be honored in any resultant transaction.

3. VOLUNTARY COPE CHECK-OFF

The Employer agrees to administer a voluntary check-off of employee contributions to Partner union political education and action funds, consistent with the private letter ruling received from the IRS in 2001. The program includes the following provisions:

- » contributions to the political education and action funds are voluntary for employees;
- » the union is responsible for obtaining check-off authorization from each employee who wishes to have a voluntary payroll deduction; and
- » the union will reimburse Kaiser Permanente for the costs of administering the payroll deductions.

4. SUBCONTRACTING

Consistent with current practice, management reserves the right to meet immediate day-to-day operational needs by contracting for services, for example, through registries, temporary services, etc.

The Parties reaffirm a Partnership presumption against the future subcontracting of bargaining unit work.

This section has been supplemented by the Memorandum of Understanding Regarding Subcontracting (attached as Exhibit 1.K.4.).

5. UNION REPRESENTATION OF NEW POSITIONS

a. Principles. The parties agree that Partner unions maintain strong fundamental interests in preserving the integrity of the bargaining units. The parties also agree that achieving the Labor Management Partnership's goals of making Kaiser Permanente the health care employer of choice in all of its markets and maximizing workforce engagement as a principle means of achieving success requires that all parties commit to maintaining and enhancing bargaining unit integrity. The parties further agree that it is not in the interest of either Kaiser Permanente or the Partner unions for jobs to be created or restructured for the purpose of removing work from a bargaining unit. Furthermore, the parties agree that it is essential for them to work together to assure that newly created and restructured jobs that are appropriately included within bargaining units are not improperly excluded from them.

For these reasons, the parties have adopted the following procedures for reviewing and determining the status of newly created and restructured jobs with duties and responsibilities similar to those of positions included in Labor Management Partnership bargaining units.

While this process is intended for newly created jobs, this process may be used to determine the bargaining unit status of current positions that are in dispute, provided the parties mutually agree, at a local and national level, that it would be beneficial to use this process for that purpose.

If the local parties have an agreed-upon process for reviewing newly created positions that provides for an expedited and timely resolution to the issue, that local process should prevail or they may mutually agree to use the process below.

b. Process. When the Employer creates a new position or restructures, including replacement of a union position with a non-union position with duties similar to those of employees in a Labor Management Partnership bargaining unit, the Employer will notify the appropriate union at least five working days before posting.

The Employer and the union will meet to review the position jointly within five working days of notification. The Employer and the union will present their reasons and recommendations concerning the bargaining unit status of the position. The parties will jointly discuss the position, the reasons for the Employer's determination, and attempt to reach agreement on the status of the new or revised job.

If the Employer and the union agree that the job is a bargaining unit position, it will be evaluated and posted under the contractual process for bargaining unit positions. When a position is determined to be a bargaining unit position, any identical positions that subsequently become available in the region will be posted as bargaining unit positions.

If the parties agree that the job is not a bargaining unit position, it will be evaluated and posted under the applicable regional process for such positions.

If the parties are unable to agree whether the job is a bargaining unit position, then the matter may be submitted as a dispute to an expedited Issue Resolution process. The parties will appoint a standing panel with the responsibility of expeditiously reviewing the facts with each party's perspectives and issuing a timely determination. Optimally, the standing panel would include several neutral parties with an inherent understanding of the complex issues involved in such determinations, and sufficient flexibility in their schedules to expeditiously hear pending issues. The panel will be accountable to the LMP Executive Committee, who will ultimately determine the composition of the panel and who may elect to appoint one or more Strategy Group members, or their designees, to the standing panel.

The expedited process may be initiated by notification to the OLMP. The OLMP will notify the members and convene the panel. The panel will be available for a meeting, in person or by teleconference, within two weeks of notification, with the

purpose of reaching a decision in the matter. If a decision cannot be made in the initial meeting, another meeting will be scheduled as soon as possible. If the decision has not been made within the two-week period following the notification to the OLMP, the position may be posted and the posting will clearly indicate:

- » the position is under review;
- » whether or not the position is a union or non-union position is undetermined at this time; and
- » if it is determined that the position is appropriately within the bargaining unit, the incumbent will be required to be part of the bargaining unit.

If it is ultimately determined that the position is a bargaining unit position, and a job offer has not been made to a candidate before that determination, the position will be reposted as a bargaining unit position.

The Labor Relations Subcommittee of the Strategy Group will review activity and provide reports to the LMP Executive Committee as necessary.

6. ACCRETION

Kaiser Permanente and the Alliance agree that in the accretion of newly represented groups, the expectation is that in normal circumstances the new represented unit will convert to the existing contractual provisions. In the absence of agreement, outstanding issues will be referred to expedited binding interest arbitration.

7. RECOGNITION

Kaiser Permanente and the Alliance of Health Care Unions agree that respect for union recognition rights creates a stable atmosphere for positive labor-management relations. In the event that Kaiser Permanente becomes aware of a union organizing drive or a requested accretion that has the potential to affect the recognition of employees who may appropriately belong in an existing Alliance bargaining unit, the Employer will notify the Alliance and the affected local union. Before entering into any accretion or organizing agreement affecting such employees, Kaiser Permanente will afford the affected Alliance union the opportunity to demonstrate that the workers in question fall within the scope of its contractual recognition provisions until there is a resolution.

8. NEW EMPLOYEE ORIENTATION

In the interest of promoting the Labor Management Partnership, the Employer shall provide Alliance Unions access to new employee orientation (NEO) meetings to explain Union membership, the local Union contract, the National Agreement and the cooperative partnership relationship between the Alliance Unions and the Employer. The Union portion of NEO meetings shall be a minimum of one hour, with mandatory attendance by new employees. Employees changing from one bargaining unit to another bargaining unit, and employees changing from non-represented to represented, may be invited to attend NEO meetings. The

Employer shall provide Alliance Unions the dates and times of NEO meetings at least one week in advance and shall provide the names of new bargaining unit employees attending NEO sessions at least two days in advance of the meeting. The Employer agrees to provide a positive image of the Union and Union representation and shall remain neutral with regard to Union membership.

L. PROBLEM-SOLVING PROCESSES

This Agreement contains two different problem-solving processes, each with a different purpose. The first is the Issue Resolution process. Issue Resolution is used in conjunction with Corrective Action, and to problem solve any department issue in an interest-based, rather than in a more traditional, adversarial manner. For most practical purposes, this is the problem-solving process that will be used most by the parties on a local level.

The second problem-solving process is the Dispute Resolution Process found in Section 3.D. of this Agreement.

1. ISSUE RESOLUTION AND CORRECTIVE ACTION PROCEDURES

An effective procedure for resolving issues is fundamental to the long-term success of the Labor Management Partnership. Solving workplace concerns quickly and by those most directly involved is essential to reducing conflicts, grievances and patient/member complaints. It will also contribute to better relations and a more constructive

work environment. Issue Resolution and Corrective Action work in tandem to achieve these outcomes. To that end, the procedure has two components:

- » a system for raising and quickly resolving workplace issues using interest-based problem solving by those directly involved with the issue; and
- » a method of resolving performance and behavior issues in a non-punitive fashion in which employee, supervisor and union representatives work together to identify the problem and craft the solution.

a. Summary of Issue Resolution

Issues are raised at the work-unit level and the stakeholders within the work unit will meet to attempt to resolve the concern. Issues unresolved at the work-unit level are reviewed by the local Partnership team. If the concern remains unresolved, the issue may be referred to the senior union and management regional strategy group, council or equivalent for resolution. Issue resolution is an alternative to, but does not replace, the grievance procedure.

b. Summary of Corrective Action

Corrective action is designed to be a non-punitive process. It is divided into two phases. The first phase, problem solving, follows a joint discovery process. Problem solving consists of levels one and two, which are neither adversarial nor disciplinary in nature. The goal of this phase is to determine the root cause of the problem by identifying all of the issues affecting performance, and to

collaboratively develop options to resolve them. The first phase is informal, with no documentation in the personnel file.

The second phase, containing levels three through five, constitutes discipline. While there is no punishment, such as suspension without pay, the consequences of failure to resolve the issues may ultimately result in termination of employment. An employee who disputes any action at any level under this procedure shall have the right to file a grievance.

An *Issue Resolution/Corrective Action User's Guide* is available through the OLMP to provide a thorough orientation on successful utilization of the procedures for all covered employees.

c. Tools and Resources for Successful Issue Resolution

This section provides tools and training necessary for effective issue resolution. Successful issue resolution is foundational to our Partnership.

1. Annual Refresher

The Learning Team will develop a 30- to 60-minute annual refresher for UBTs and LMP councils on how to use interest-based conversations in everyday interactions and problem solving. The refresher will be provided to each UBT during normal meeting time and will be accessible online.

The UBT and LMP council refresher should be:

- » Experiential (story based), so it resonates and sticks with people and positions them to apply the concepts to everyday working and personal lives;

- » Short (30-60 minutes);
- » Based on the Interest-Based Problem Solving/Consensus Decision Making (IBPS/CDM) training that is currently being redesigned by the Learning team. The redesigned training will have 2 components:
 - » How to use interest-based conversations in everyday interactions and problem solving;
 - » More advanced content for issue resolution and facilitators;
- » Accessible on KP Learn;
- » Provided to each UBT using normal meeting time; it could be facilitator-led or via KP Learn in either case, the UBT (labor and management together) should receive the refresher in person;
- » Provided to each LMP council, including clarification on the escalation process and their role in it;
- » Using existing resources (e.g., UBT Consultant, APR, LMP trainers, the folks that support UBTs) to do the training, if facilitator-led;
- » Provided for those who missed the refresher in a make-up session (virtual/KP Learn); and
- » Added to UBT P2P (training dimension, level 2).

2. Just-In-Time Training

Before or at the onset of issue resolution, just-in-time training will be provided for issue resolution participants, if needed. Training content will come from the Learning team's IBPS/CDM redesign and should include information on how the issue resolution process works, and

tips for success. The training could be delivered by a facilitator or accessed via KP Learn. If the training is facilitator-led, the facilitator would determine the content and length of training based on need and information provided by labor and management participants in the issue resolution.

3. Development of Internal Capacity

All regions are expected to build capacity to train and facilitate issue resolution, starting with jointly assessing needs, resources, capacity and gaps. Regions should leverage available resources to develop and utilize appropriately trained facilitators from existing UBT consultants, Alliance Partnership Representatives or other Trustfunded staff. Facilitators will be provided observation, feedback, mentoring and IR collaboration to support them in building their skills. To support the facilitators, the Learning team will develop a training on how to facilitate IBPS and IR based on the redesigned IBPS/CDM training. Any new resources are expected to be approved and funded by the LMP Trust.

4. Uses and Purposes of Issue Resolution

The LMP Learning Group will incorporate the following concepts into existing Partnership training, where appropriate:

- › Why do we have issue resolution?
- › What is in scope and what is not?
- › Why is issue resolution fundamental to partnership?
- › What makes the process effective?
- › What is expected of participants?

This material may also be used for the annual refresher and for just-in-time training.

5. Developing Guidance on How to Get “Unstuck” in Issue Resolution

The National LMP Learning Staff, overseeing a small group of subject matter experts (SMEs), will develop short and simple guidance on techniques for facilitators and participants to get unstuck in IR. The group would engage with other SMEs for input, as needed, including SMEs within the national Learning group and representatives of the 2021 National Bargaining Problem and Dispute Resolution subcommittee. (Corrective action is outside the scope for this group)

- a. The group will determine the output, which may not need to include new material and could include one of the following:
 - › A “quick guide”: a short (1-page), narrowly focused guide on techniques to get unstuck
 - › A virtual toolkit posted on the LMP website, with resources/guidance that will help participants work through issues; and
 - › FAQs.
- b. The group should start work within 3 months of ratification and finish within 6 months.

M. LABOR MANAGEMENT PARTNERSHIP SIDE LETTERS OF AGREEMENT

The Parties intend, consistent with the terms of their Partnership, to enter

into and be bound by the provisions of multiple “side” agreements to which the Kaiser entities and the AHCU-member unions previously were parties, prior to the AHCU’s formation. Accordingly, the Parties hereby adopt, except as provided otherwise below, all terms of such former Labor Management Partnership agreements, in their entirety, including but not limited to the 1999 Employment and Income Security Agreement, as amended by the 2013 Employment and Income Security Clarification, the 1999 Recognition and Campaign Rules, and the 2014 Ebola Education and Safety Agreement. In each such agreement, the terms “Coalition of Kaiser Permanente Unions” or “CKPU” shall be amended to “Alliance of Health Care Unions” or “AHCU.” The Parties may, by mutual agreement, amend or update any such agreements in a Partnership process separate from the periodic national Coordinated Bargaining.

N. TERM OF THE PARTNERSHIP

In recognition that the substance, as well as the spirit and intent, of this Agreement is largely dependent upon the existence of the Labor Management Partnership, the labor and management signatories commit to continue participation in and support of the Partnership throughout the term of this Agreement.

The Labor Management Partnership Agreement, inclusive of clarifying addenda of Employment and Income Security and Recognition and Campaign Rules, provides for a 60-day notification period for either of the

parties to disengage from the Partnership relationship; however, the review process in Section 1 of this Agreement substitutes for that notification an alternative process of reviewing and resolving issues that could otherwise individually or collectively result in the dissolution of this Partnership.

Notwithstanding the parties’ commitment to this ongoing relationship, there may be instances where either side may engage in such egregious non-partnering behavior that the corresponding partner takes unilateral action and may also withdraw some or all of the Partnership privileges extended to the other party. Such behavior, unilateral action or withdrawal of privileges should likewise be submitted to the review process for determination and resolution.

As the Partnership matures, the parties recognize that, on occasion, either party may engage in behavior that conflicts with Partnership principles and elicits corresponding behavior from the other party. It is expected that this review process will also be instrumental in providing guidance to the parties for those occurrences.

Although the commitment to use the review process as the alternative to serving a 60-day notice of termination of the Partnership agreement runs concurrently with the National Agreement, the Labor Management Partnership Agreement continues in effect and does not terminate with the expiration of this Agreement.



SECTION 2

Wages and Benefits

Wages, performance-sharing opportunities and benefits as identified in this Section 2 are considered to be ongoing obligations and will terminate at the extended expiration of local agreements, rather than at the expiration of this Agreement.

A. COMPENSATION

To promote Partnership principles and support the guiding principle that Kaiser Permanente will be the employer of choice in the health care industry, Partnership employees should receive excellent wages. The parties recognize, however, that wages alone will not support an “employer of choice” strategy. In addition to wages, the parties are committed to investing in benefits, workforce engagement,

training and development opportunities, and leadership development as critical elements in pursuing this goal.

In valuing and rewarding employees for length of service with Kaiser Permanente, the parties agree that wages should be tenure based. In addition to length of service, the parties agree to consider these factors in developing and adjusting compensation levels: labor market conditions, changes in cost of living, internal alignment, recognition of the value of the Labor Management Partnership and ability to recruit new employees.

Compensation changes agreed to under the terms of this Agreement include three components:

- » annual cross-the-board (ATB) wage increases;

- » special adjustments; and
- » potential for performance-sharing bonuses in each year of the contract.

1. ACROSS-THE-BOARD WAGE INCREASES (ATBS) AND LUMP-SUM PAYOUTS

a. Overview

ATBs will be effective on the first day of the pay period closest to October 1 in each year of the Agreement. Lump sums pursuant to this Agreement will be paid out in the first pay period following October 1 in each of Years 3 and 4 of this Agreement.

ATBs (ACROSS-THE-BOARD) WAGE INCREASES AND LUMP SUMS				
	2021	2022	2023	2024
Wages	3%	3%	2%	2%
Lump Sums	–	–	2%	2%

b. Southern California Wage Equity

Bargaining Units: IBT Local 166; USW Local 7600; UFCW Local 770 Kern Main and Kern Admin.

Effective July 1, 2022, the parties will allocate an amount equivalent to 1.25% of payroll of each affected bargaining unit for the purpose of adjusting wage scales. The parties will determine the allocation of this amount to wage scale adjustments by mutual agreement. Effective July 1, 2023, the parties will allocate an additional 1.25% of payroll of each affected bargaining unit for this purpose.

2. PERFORMANCE SHARING

Performance sharing is intended to recognize that, through the Labor Management Partnership, employees and their unions have a greater opportunity to impact organizational performance, and employees, therefore, should have a greater opportunity to share in performance gains (See Exhibit 2.A.2.). The parties support the Alliance Labor Management Partnership Performance Sharing Program (APSP) as a way to continue the transformation of the organization, through Partnership, to a high-performing organization, and to share the success of the organization with employees covered by this Agreement.

The Alliance-Kaiser Permanente Strategy Group will be accountable for the APSP. The Strategy Group may, but is not required to, establish national factors each year that will be included in all regional and local programs, together with regional and local factors. The APSP goals will be aligned with national, regional, facility and unit goals. The APSP goals will be based on the principle of “line of sight” as much as possible. Regional APSP goals must include Quality, Affordability, Service, Workplace Safety and Attendance. It is recommended that the Attendance goal be measured at the individual level.

Performance sharing is over and above base wage rates and will be based on mutually agreed-to performance factors and targets. The APSP is self-funded through operating margin. Performance targets will be set by region or national function. Regional APSP goals must

include quality, affordability, service, workplace safety, and attendance.

If targets are met, performance sharing opportunities will be as shown below for each year the Agreement is in effect.

All amounts will be based on total payroll for employees covered by the Partnership in each region or national function. The 3% payout is a calculation based on total represented payroll by region or national function. A full explanation is contained later in this section.

- » **Year 1:** 3% payout at target to be paid out in First Quarter 2022, based on 2021 performance.
- » **Year 2:** 3% payout at target to be paid out in First Quarter 2023, based on 2022 performance.
- » **Year 3:** 3% payout at target to be paid out in First Quarter 2024, based on 2023 performance.
- » **Year 4:** 3% payout at target to be paid out in First Quarter 2025, based on 2024 performance.

The APSP depends on Partnership structures and processes that empower employees to have an impact on the program's targeted factors. To afford employees a reasonable opportunity to earn the annual payouts, Partnership structures and processes must achieve critical thresholds to support the APSP. Further, jointly determined factors must be measurable against mutually agreed upon predetermined targets, with progress reported to employees quarterly throughout each year, where possible.

As the Labor Management Partnership continues to grow and evolve, an

important element is to ensure that employees share in the success of the organization as enhanced performance is achieved through the Partnership. Specifically, all Alliance union-represented employees will participate in the APSP, which provides an annual cash bonus opportunity based upon regional or functional area performance in the areas of quality, affordability, service, workplace safety, and attendance. The jointly designed program will reward Partnership employees for reaching mutually agreed-upon national, regional and/or local targets.

The following agreements are currently reflected in the APSP:

- » All Kaiser Permanente employees covered under this Agreement shall participate in the APSP. This includes full-time, part-time, short-hour, casual, on-call and per diem employees.
- » At any time during the term of this Agreement additional subregional (local) plans may be mutually developed. In these instances, the covered employees will not receive a payment from both programs, but will receive a payment from the program that provides the highest payment.
- » The program year shall be the calendar year, with a maximum of five mutually agreed-upon factors set by no later than year-end for the following year and communicated in January. Effective starting with the 2023 APSP plan (paid in 2024), the affordability target is set forth as outlined below. The APSP shall run for the calendar year, with final results determined

and payments issued during the first quarter of the year following the end of the program year.

- » The APSP will establish mutually agreed-upon regional or functional annual targets with a bottom threshold (minimum payment) and an upper limit stretch target (maximum payment) in the areas of quality, affordability, service, workplace safety and attendance. A financial gate will be established for all Regions. Regional or functional factors should be aligned with, and to the extent appropriate and mutually agreeable, may be similar or identical to physician and/or managerial incentive programs. The percentage payouts listed above will be paid for achieving performance at targeted levels. Proportional payouts (i.e., higher or lower than listed above at target level) will be made for performance achieved that is either above or below targeted levels.
- » In the event that the Region does not meet its financial gate, the maximum APSP payout will be capped at \$1,000 for eligible full-time status employees. This alternative payout will be paid in proportion to the share of APSP attributed to each goal, based on performance toward each individual goal. (For example, a goal assigned 10% of the overall APSP formula would pay out \$100 if target is met).
- » While the factors measuring quality, affordability, service, workplace safety and attendance may be different from region to region, the opportunity for reaching the selected targets shall be consistent across all regions.
- » Targets should be set to stimulate and reward improvement; however, from region to region there must be a reasonable and relatively equal opportunity to reach each of the targets.
- » Employees must be in job classifications covered by this Agreement during the program year and be active on December 31 to receive a payment under the APSP for that year; however, employees who retire during the program year or prior to the payment date or transfer to another Kaiser Permanente job classification not covered under this Agreement shall receive a prorated payment based upon compensated hours attained during the program year in a job classification covered under the Partnership.
- » Distribution of the performance sharing pool will be calculated as a percentage of the regional or functional total payroll, defined as total compensated hours times the established weighted average rate (WAR) for all employees represented by local unions who are party to this Agreement.
- » Payouts will be made in the form of lump-sum bonuses proportional to the compensated hours of each employee; however, employees with 1,800 compensated hours or more in the program year shall be considered full-time employees for the purposes of the APSP and have their hours capped at 1,800 hours. Employees with compensated hours less than 1,800 hours shall receive a bonus pro-rated for compensated hours.

a. Affordability Goal

The Task Force will identify and agree upon recurring savings from Alliance employment costs and operational costs impacted by the work of Alliance members. The parties will use an interest-based consensus decision-making process.

The projects will be reviewed and approved by mutual agreement, and the parties will mutually agree on the method of measuring cost savings. Costing will be verified by a neutral third party where the Task Force is unable to reach agreement on costing.

In support of the Task Force's work, effective with the 2023 APSP (paid in 2024), the affordability goal will constitute 67% of the APSP formula. The target for the affordability goal will be the cost savings as defined below:

- » The cost savings target for each year will be recurring savings of 1.5% of the total wage cost of all Alliance union represented-employees for the calendar year prior to the bonus plan year ("total wage cost"), incrementally, in each of the following years: 2023, 2024, 2025. (For example, in the 2023 APSP program year, to be paid in March of 2024, the 2022 total wage cost will determine the base.) Wage cost will be actual total payroll and will not include fringe and roll-up costs.
- » Credit will be given for savings in the year generated and will not be annualized. For example, if a single initiative realizes \$10 of savings in year one and \$90 in year two, \$10 will be credited in Year one and \$90 will be realized in Year two.

The other 33% of the APSP goal will be divided among quality, workplace safety, service and attendance.

If the 1.5% annual recurring savings are realized in the calendar year, the affordability target will be met. Credit will be paid on a prorated basis, however 0.25% of targeted savings will be a minimum threshold to trigger a prorated payout. Savings and payouts will be determined regionally, or by service area where that is the current practice.

New recurring savings must be realized in each bonus year to support the payout.*

** The intention of the parties is that credited savings will recur on an ongoing basis. However, in the event that a savings that is anticipated to recur does not in fact recur due to unanticipated circumstances, there is no penalty in subsequent years.*

B. HEALTH AND WELFARE BENEFITS

1. MEDICAL BENEFITS

a. Eligibility

- (1) All employees who are regularly scheduled to work 20 or more hours per week are eligible for medical benefit coverage.
- (2) Medical benefit coverage is effective the first day of the month following eligibility (e.g., date of hire, benefit eligible status, etc.). Initial coverage under flexible benefit plans is temporary, basic medical coverage. The selected medical coverage and other benefits in the flexible benefit plan will be effective the first day of

the month following three months of benefit-eligible service.

b. Basic Comprehensive Plan

1. Kaiser Foundation Health Plan, Inc.

(KFHP) has established a national account to enable the Employers to act as a national purchaser of health care benefits. The parties agree that discussions concerning any changes in benefits or benefit coverage contemplated by KFHP, Inc. should be joint and should be initiated no less than six months prior to the effective date of any proposed changes, and that such discussions should be conducted no less than three months prior to the new effective date.

Effective January 1, 2019, IUOE Local 501 will transition to the Southern California non-flex HMO plan. Other than IUOE Local 501, there will be no changes to active medical benefits for Alliance members in any region in 2019.

There shall be no changes to the Colorado active medical flex plans covering IUOE Local 1, UFCW Local 7 Professionals, and UFCW Local 7 Mental Health during the term of this agreement.

There shall be no changes to the active medical plans applicable to UFCW Local 3000 Pharmacy and UFCW Local 3000 Pro Tech in Washington during the term of this agreement. UFCW Local 3000 Pharmacy and UFCW Local 3000 Pro Tech hereby withdraw from the KP Washington benefits coalition effective with the reopener negotiations for the January 1, 2022, active medical plans.

Effective January 1, 2020, the parties agree that all eligible employees in the Georgia, Northwest, Southern California and Mid-Atlantic States regions shall transition to the regional non-flex HMO plans with a \$10 office visit copay based on a "Kaiser Foundation Health Plan Traditional HMO Plan." There shall be no cost share for these plans except as noted below:

- » The 2018 Mid EPO premium cost-sharing methodology will apply to the Georgia region plan (no cost sharing for employee-only coverage for full-time employees.)
- » The existing premium cost-sharing methodology will apply to the Mid-Atlantic States region plan. The Mid-Atlantic States Point of Service plan will be available to employees who remain active in the plan subject to Section 2.B.1.f.
- » The 2018 flex Plan B cost-sharing methodology will apply in the Northwest region (no cost sharing for full-time employees). All eligible employees subject to fixed-premium cost sharing under a local agreement will remain subject to the fixed-premium cost sharing. Part-time eligible employees (20 or more scheduled hours and less than 32 scheduled hours) in OFNHP Professionals, OFNHP Lab Professionals and ILWU Local 28 who are actively covered by flex Plan C or flex Plan D during 2019 will have no premium cost sharing beginning January 1, 2020. During December 2019, OFNHP Professionals, OFNHP

Lab Professionals and ILWU Local 28 employees actively covered by flex Plan B during 2019 will have a "2019 net medical credit amount" calculated, if any. The "2019 net medical credit amount" is the sum of actual net medical credits provided to employees enrolled in Plan B in 2019 based on actual coverage level and scheduled hours per month during 2019. In March of 2020 and 2021, each eligible employee with a "2019 net medical credit amount" will receive a taxable lump sum equal to that amount.

- » Effective January 1, 2022, the imaging, lab tests and special procedures copays for KPNW will be eliminated and be covered at 100%.
- » Effective January 1, 2022, the hospital admission copay for KPGA will be reduced from \$250 per admission to \$100 per admission.
- » Effective January 1, 2022, the out-of-pocket maximum for KPMAS will be reduced from \$3,500 for individuals and \$9,400 for family coverage to \$1,500 for individuals and \$3,000 for family coverage.

For all options, emergency room visit copays for active employee medical plans will be as follows:

- » California and Northwest: \$50
- » Georgia, Mid-Atlantic States and Colorado: \$100

It is understood that if a member is admitted as a result of an emergency room visit, the emergency room copay will be waived.

This provision will supersede any contrary provisions in the local collective bargaining agreements.

The provisions of Sections 2.B.1.b. (1 and 2) shall not apply to employees covered under the UNITE HERE Local 5 trust, which is provided for in Section 2.B.1.b.3. below.

2. Transition from Flex Plans

Effective January 1, 2020, UNAC UPSC, UNAC KPMWON, UNAC SCNSC, UNAC UTSC, OFNHP Local 5017 Professional, OFNHP Local 5017 Lab Professional, ILWU Local 28, UFCW Local 1996 Clerical/Technical and UFCW 1996 Professional shall transition to the appropriate new regional non-flex HMO plans, and the existing active medical flex plans shall be discontinued. (Colorado IUOE Local 1, UFCW Local 7 Professionals and UFCW Local 7 Mental Health will remain in the current active medical flex plans.)

Effective January 1, 2020, UNAC UPSC, UNAC KPMWON, UNAC SCNSC, UNAC UTSC, OFNHP Local 5017 Professional, OFNHP Local 5017 Lab Professional, ILWU Local 28, UFCW Local 1996 Clerical/Technical, UFCW 1996 Professional, IUOE Local 1, UFCW Local 7 Professionals and UFCW Local 7 Mental Health shall transition to the appropriate new national Alliance dental plan, and the existing dental flex plans shall be discontinued.

The remaining components of existing regional flex plans, including but not limited to supplemental medical, ADD, life insurance, and disability plans, shall continue unchanged. The flex pricing

and associated credits shall remain unchanged, except for the credits associated with the above plans removed from flex.

3. UNITE HERE Local 5 Trust

Effective January 1, 2022, the monthly employer contribution paid to the AFL Hotel and Restaurant Workers Health and Welfare Fund (Trust) covering members and retirees of UNITE HERE Local 5 shall be increased to a total composite rate per eligible bargaining unit employee made up of (1) the monthly total premium charged by the Kaiser Foundation Health Plan to the Trust, provided the Trust timely pays the full amount of premiums charged by Kaiser Foundation Health Plan, for the Alliance non-flex HMO Hawaii plan and (2) \$388 monthly for dental, optical, retiree coverage and other benefits supplemental to the KP plan as determined by the trustees of the Trust, increasing to \$400 effective January 1, 2025.

It is understood the active medical, retiree medical, dental and other benefits provided through the Trust are established by the Trust and are not subject to the active medical, dental, retiree medical and other provisions outlined in this National Agreement.

c. Parent Coverage

Parents and parents-in-law of eligible employees residing in the same service area will be able to purchase health plan coverage, in accordance with the Letter of Agreement between the parties made effective May 1, 2002, and modified by

a subsequent agreement between the parties dated May 22, 2003 (attached as Exhibit 2.B.1.c.).

d. Health Care Spending Account

A Health Care Spending Account (HCSA) option will be provided to employees eligible for benefits. This account is a voluntary plan that allows the employee to set aside pretax dollars to pay for eligible health care expenses. The maximum contribution level shall be the IRS maximum limit in effect as of March 31 of the year preceding the applicable year. Unused amounts will be rolled over to the next year per IRS guidelines. HCSA may be used to pay for certain expenses for the employee and eligible family members as permitted under Internal Revenue Code.

e. Healthcare Reimbursement Account

Effective January 1, 2010, the parties agreed to establish a Healthcare Reimbursement Account (HRA) for bargaining unit employees covered by the National Agreement. The details of the HRA benefits are contained in Section 1.C.3.c. of this Agreement. For further information or clarification, please refer to the HRA plan document.

Education of workforce on HRA benefit:

Within 60 days of settlement, a full education and communication plan should be implemented. Part of the work of the National Attendance Committee is to determine the method for gathering data as to the impact of the HRA on absenteeism.

f. Preferred Provider Option (PPO)/Point of Service (POS) Plans

The parties agree that PPO plans and POS plans remain available in all regions to the applicable bargaining units through December 31, 2016 except as follows:

- » These plans will be closed to all new entrants in all regions effective January 1, 2016.
- » For all regions except Mid-Atlantic, all Preferred Provider Option plans and Point of Service plans have been discontinued as of January 1, 2017.

g. Supplemental Medical

Effective January 1, 2023, chiropractic and acupuncture services copays will change to \$10 per visit applicable only to those who are eligible under their supplemental medical plan as listed in Exhibit 2.B.1.g.

All other plan provisions and eligibility will remain the same.

2. RETIREMENT BENEFITS

a. Defined-Contribution Plan

- (1) The Employer will establish the following Employer contribution programs in the existing salary deferral plans:
 - » Beginning in 2006 and continuing throughout the term of the Agreement, a performance-based contribution of 1% of each represented employee's annual payroll earnings will be made

if the region's performance equals or exceeds the budgeted margin plus 0.25. For example, if budgeted margin is 2%, actual margin of 2.25% is required for payment of the performance-based contribution, and if budgeted margin is 4%, actual margin of 4.25% is required for payment.

- » Beginning in 2008, and continuing throughout the term of this Agreement, a match program will be established in addition to the performance-based opportunity described above. This program matches 100% of the employee's contribution, up to 1.25% of the employee's salary.
- » Beginning January 1, 2017, the Employer will establish a voluntary employee after-tax Roth contribution option and a Roth in-plan conversion option as plan features of the 401(k)/403(b) TSA.

New hires will be automatically enrolled in the 401(k)/403(b) TSA at 2% of eligible pay with an opt-out provision available. All employees with one or more years of employment will be eligible for the Employer contribution programs described above. The Employer contributions will be vested in increments of 20% per year of employment, with participants becoming fully vested after they have completed five years of employment. Employees covered by defined-contribution plans established under local collective bargaining agreements will receive the higher of the benefit provided under the local agreement, or the benefit provided under this plan.

After the first year of the match program, the parties agree to meet and review factors and participation trends under the match program, in order to determine if any adjustments in enrollment practices or the Employer contribution rate are appropriate.

The Employer shall optimize its 1.25% match, to ensure that so long as the employee remains employed by Kaiser Permanente on December 31 of the applicable year and contributes 2% of their annual eligible pay from KP into the DC plan throughout the course of the year, the Employer will match 1.25% into the plan. The Employer will reconcile the year-end match for the applicable DC plan year for each affected employee no later than the deadline to make contributions to a DC plan as set forth in applicable tax guidance.

In 2009 and 2010, the Ohio, Georgia and Mid-Atlantic States regions will each make a supplemental annual contribution (Contribution) to their respective defined-contribution plans if the region achieved its three-year cumulative budgeted margin for the 2006, 2007 and 2008 calendar years. The total amount of each Contribution will be equal to the additional annual pension expense the region would have incurred in that year had the region increased its defined-benefit plan multiplier to 1.45 at the beginning of that plan year. The assumptions used to calculate this value will be those in effect for the calculation of pension expense in the year in which the Contribution is to be made. No amounts will be contributed under this provision for any year in which

the region has actually applied a 1.45 multiplier under its defined-benefit plan. No past service credit will be included in determining Employer Contribution amounts. The design of the participant allocation of the Contribution will be determined prior to the date of the first Contribution, by agreement between the Alliance and management.

(2) Washington Region Benefits

In lieu of the defined-contribution benefits above, effective January 1, 2021, the following provisions shall be the only defined-contribution benefits provided for the Washington region.

» **Employer defined contribution.**

All newly hired or existing defined-contribution plan eligible employees in the Washington region shall transition to and participate in the Employer Defined Contribution (EDC) benefit. An eligible employee automatically participates upon the first day of employment in an eligible employee status and will receive an Employer Contribution of 6.3% of EDC eligible pay. All EDC contributions will be immediately vested.

» **Employer match.** For all newly hired employees or existing eligible employees, the Employer shall make contributions to match 100% of an employee's contribution up to 2.7% of the employee's eligible pay. An employee must contribute 3% of eligible pay to receive the full 2.7% match. The matching contributions will be optimized consistent with the terms above. All matching contributions will be immediately vested.

This provision will supersede any contrary local collective bargaining agreements. This change does not affect employees participating in the UFCW pension trusts or in the KP defined-benefit trust.

b. Defined-Benefit Retirement Plan

Employees represented by Alliance unions are covered by the defined-benefit retirement plans listed in Exhibit 2.B.2.b. The benefits will be governed by the plan documents in effect for each plan, as well as the Letter of Agreement between the parties regarding pension multipliers made effective January 7, 2002, and modified by a subsequent agreement between the parties dated May 22, 2003, as well as the Letter of Agreement regarding early reduction factors made effective August 19, 2002 (all attached as Exhibit 2.B.2.b.).

Those bargaining units with higher multipliers currently provided under local collective bargaining agreements will maintain the higher multipliers in accordance with those agreements.

The parties remain committed to working on a joint vision and consistent strategy for retirement programs. To that end, a joint committee will be established in the first year of this agreement to review the pension benefits provided in Section 2.B.2.b. and reflected in Exhibit 2.B.2.b. The purpose of the review will be to explore retirement income programs for the purposes of recruiting and retaining employees, controlling costs and liabilities, and ensuring meaningful and predictable income to KP retirees.

The joint committee will provide annual reports on its progress and will make consensus pension recommendations at the next round of national bargaining.

Southern California UFCW Pharmacy Pension Trust Funding. For employees who are represented by the UFCW in the Southern California region and participate in the Taft-Hartley trusts, pension contributions may be increased as follows:

- » In the event that (1) the actuary certifies that the Plan is in an endangered status or seriously endangered status under Section 432(b)(1) of the Internal Revenue Code, or (2) the actuary certifies that the Plan is projected to be in critical status within five years, but the Trustees do not elect for the Plan to be in critical status under Section 432(b)(4) of such Code, or (3) the actuary certifies that the Plan is not in endangered status by reason of Section 432(b)(5) of such Code, then, in addition to the contribution rate, the Employer shall make supplemental contribution of \$0.085 per employee per hour, beginning with the hours worked in the month of June during the year in which such actuarial certification is made. In the event that the actuary certifies that the Plan is in critical status with respect to any year following a year in which supplemental contributions are due under this paragraph, the Employer will no longer owe such supplemental contributions for hours worked beginning 30 days after the Employer has been notified by the Trustees that the Plan is in critical

status, and the automatic Employer surcharge under Section 432(e)(7) will be determined on the basis of the hourly contribution rate of \$1.696.

UFCW Local 3000 Optical and Pharmacy Units.

Employees who are represented by the UFCW Local 3000 Optical and Pharmacy Units and who are participants in Taft-Hartley trusts will receive an increase in the current Employer contribution equal to an additional \$0.06 cents per hour beginning the first of the month following ratification of the agreement; an additional increase of \$0.136 cents per hour beginning January 1, 2022; an additional increase of \$0.136 cents per hour beginning January 1, 2023; and an additional increase of \$0.03 cents per hour beginning January 1, 2024. But in no event shall the Employer contribution rate be less than the required hourly contribution rate under the SRT rehabilitation plan applicable schedule.

Effective January 1, 2025 employees who are represented by the UFCW Local 3000 and participate in the Sound Retirement Trust (SRT) will transition future service accruals from the SRT to the UFCW Variable Annuity Pension Plan (Sound VAP). Employer contributions to the Sound VAP will begin January 1, 2025. For each eligible employee of the UFCW Local 3000 Optical unit, the Employer will contribute a minimum combined total amount of 7.0% of salary to the SRT and the Sound VAP. For each eligible employee of the UFCW Local 3000 Pharmacy unit, the Employer will contribute a minimum combined total amount of 6.3% of salary to the SRT and

the Sound VAP. Employer contributions to the Sound VAP shall not be less than 125% of the respective base contribution amount to the SRT on January 1, 2025.

Year	Optical	Pharmacy
1/1/2025	7.0%	6.3%

IUOE Local 501. Effective October 1, 2021, the Employer agrees to increase its contribution to the Central Pension Fund of the International Union of Operating Engineers and Participating Employers from five dollars and fifteen cents (\$5.15) to five dollars and thirty cents (\$5.30) for all hours paid and/or worked for each bargaining unit employee. The Employer contribution will increase to five dollars and 40 cents (\$5.40) on October 1, 2022, to five dollars and 50 cents (\$5.50) on October 1, 2023, and to five dollars and sixty cents (\$5.60) on October 1, 2024.

Pension Multiplier Changes. Effective January 1, 2020, the Georgia, Hawaii and Mid-Atlantic States regions will increase the pension multiplier from 1.40% to 1.45%, as applied to all service earned by the eligible participants.

c. Pension Protection Act (PPA) Compliance

The parties agree to continue the methodology for calculating lump sums by using the Pension Protection Act-required corporate bond rates and mortality tables.

In addition, effective January 1, 2010, the parties agree to a new 100% joint and survivor (J & S) annuity with a

15-year certain period, and a pop-up feature wherein upon the death of the joint annuitant prior to the death of the retiree, the retiree's monthly benefit will revert from the 100% J & S to the life-only benefit. In the event both the retiree and the joint annuitant die within the 15-year certain period and the retiree was receiving the pop-up benefit, the life-only benefit will revert to the prior 100% joint and survivor monthly benefit for the remainder of the certain period.

d. Continuation of Certain Retirement Programs

During the 2000–2005 term of the National Agreement, a number of unrepresented employee groups chose to become represented and form new bargaining units. At that time, the parties agreed that where a new bargaining unit was formed of employees who were participants in the Kaiser Permanente Salaried Retirement Plans A and B, or Permanente Medical Group Plans 1 and 2, those benefit formulas would be temporarily maintained, despite the employees' transition into a new bargaining unit, in order to explore the possibility of developing a joint, consistent recommendation on how to handle retirement benefits in these circumstances. The parties agree that the bargaining units that retained these benefits under that side letter will continue to keep those benefits for the duration of this Agreement, unless the parties mutually agree to convert them to another plan.

The parties remain committed to working on a joint vision and strategy for retirement programs. To that end, the joint Labor Relations Subcommittee of the Strategy Group will be commissioned to explore the feasibility of a joint vision. Within that, the Labor Relations Sub Group will submit to the LMP Executive Committee a recommendation on how to handle future employee groups who choose to become newly represented groups, and how to handle non-union employees who are accreted into existing bargaining units.

e. Pension Service Credits

Members of the RN, Dental Hygienist and Technical bargaining units in the Northwest region who converted from a defined-contribution plan to a defined-benefit plan in 2003–2004 will be eligible for pension service credits in accordance with the September 2005 Letter of Agreement between the health plan and OFNHP and ONA at the local level.

f. Investment Committee Briefings

The Alliance of Health Care Unions Executive Board shall receive a briefing, at least annually, from the Kaiser Permanente Retirement Plan Investment Committee on the funded status of the retirement plans and the performance of the plan assets related to AHCU members and from the Kaiser Permanente Administrative Committee on any administrative actions that affect AHCU members.

g. Appeals Subcommittee

One representative of the Alliance of Health Care Unions (the “AHCU Representative”) will attend meetings, subject to required parameters, of the Appeals Subcommittee of the Kaiser Permanente Administrative Committee. Meeting attendance shall be limited to the review of appeals submitted by active or retired AHCU members. The AHCU Representative shall serve a minimum of a one-year term as a non-voting attendee.

h. Pre-Retirement Survivor Benefits

Under the pension plans, a pre-retirement survivor benefit is payable to the spouse of a deceased employee. The survivor benefit has been expanded to include domestic partners and/or qualified dependents of employees.

Domestic Partner Benefits Under the Pension Plan. Under the pension plans, a survivor benefit will be payable to an employee’s designated domestic partner upon the employee’s death, provided that an affidavit certifying the partnership has been completed by the domestic partner and employee. This is not applicable to Taft-Hartley plans.

Non-spouse Survivor Qualified Dependent. Under the pension plans, survivor benefits will be payable to a qualified dependent. A qualified dependent is one or more individuals who, at the time of the employee’s death, meet the definition for a dependent as defined by the Plan. The amount of the monthly benefit will be based on the employee’s accrued benefit as of the

date of death and will be determined as if the employee had retired on the day before death, and had elected the guaranteed years of payment method for 120 months with the qualified dependent as beneficiary.

If a spouse or domestic partner and a qualified dependent survive the employee, the spouse or domestic partner will receive the survivor benefit. If the employee is survived by a spouse or domestic partner and a qualified dependent and the employee’s surviving spouse or domestic partner dies before the 10th anniversary of the employee’s death, the qualified dependent will receive a monthly benefit effective the month following the spouse or domestic partner’s death and ending on the 10th anniversary of the employee’s death.

i. Retiree Medical Benefits

Retiree medical coverage, and eligibility for the retiree and the retiree’s dependents, will be based on the retiree’s last employment position, employment status, employee group and region. Eligibility for retiree medical coverage generally requires that an employee have at least 15 Years of Service, and be at least age 55, as of the employee’s retirement, with exceptions listed in Exhibit 2.B.2.i. Dependent eligibility requirements also are listed in Exhibit 2.B.2.i.

For employees who retired before January 1, 2017, with eligibility for retiree medical benefits, the existing retiree medical plans, including Employer contribution rates or retiree cost share, shall remain the same. Retiree medical

benefits, including co-payments and out-of-pocket maximums, for retirees in a Kaiser Permanente service area shall be the same as the active medical benefits and cost-sharing features at the time the retiree initially enrolls in the Kaiser Permanente retiree medical plan.

For eligible retirees who move from one Kaiser Permanente service area to another Kaiser Permanente service area, a KFHP plan will be offered with a \$5 office visit copay and a \$5 prescription drug copay. This plan will be integrated with Medicare, when applicable.

For eligible retirees who move outside of any Kaiser Permanente service area, an out-of-area plan will be offered and will provide comprehensive inpatient and prescription drug coverage. This plan requires Medicare enrollment when applicable.

Retiree medical benefits for employees who retire on or after January 1, 2017, shall be subject to the following changes. These changes will apply to all eligible post-2016 retirees and their eligible dependents, except previously legacy employees with special retiree medical coverage who meet the eligibility criteria listed in the applicable local agreement:

(1) **The Medical Premium Subsidy/HRA plan** will be effective as of January 1, 2017, for employees who retire on or after January 1, 2017, from positions in the Northwest, Colorado, Hawaii, Mid-Atlantic States or Georgia region. The Medical Premium Subsidy/HRA plan for employees who retire on or after January 1, 2017, from California

regions is described in No. 5. below. Employees hired on or after January 1, 2021, are not eligible for the Medical Premium Subsidy.

(2) **The out-of-area plan** no longer will be offered to post-2016 retirees when that region's post-2016 retirees are converted to the Medical Premium Subsidy/HRA plan.

(3) **The Medical Premium Subsidy/HRA plan** shall be as follows:

Retiree Medical Program "Medical Premium Subsidy" for Eligible Post-2016 Retirees Hired on or Before December 31, 2020. At age sixty-five (65) or older, or Medicare eligibility if earlier, an eligible retiree shall receive a Medical Premium Subsidy toward the monthly premium of the Kaiser Permanente Senior Advantage plan (KPSA plan) where the retiree resides, or as further described in the "Medical Premium Subsidy" rules below. These Kaiser Permanente Senior Advantage plans (KPSA) are offered to individuals in the communities we serve, and have the same premiums, deductibles, copayments and out-of-pocket maximums as the commercially available basic Senior Advantage Medicare plans in the covered location.

The Medical Premium Subsidy for 2017 for a KPSA plan shall be the following for an eligible retiree who retired from a position in the applicable region:

- » \$186 per month for a Northern California retiree;
- » \$106 per month for a Southern California retiree;

- » \$80 per month for a Colorado retiree;
- » \$33 per month for a Northwest retiree;
- » \$33 per month for a Georgia retiree;
- » \$33 per month for a Hawaii retiree;
and
- » \$33 per month for a Mid-Atlantic retiree.

Starting in 2018, the Medical Premium Subsidy for each region shall increase by 3% on January 1 of each year.

The Medical Premium Subsidy for an eligible spouse or domestic partner shall be equal to the retiree's Medical Premium Subsidy. The Medical Premium Subsidy for a spouse or eligible domestic partner will not apply until the retiree commences the Medical Premium Subsidy. If the retiree's eligible dependent is not yet Medicare eligible when the retiree commences the Medical Premium Subsidy, the dependent coverage shall be the same as the retiree medical benefit applicable to pre-Medicare dependents of pre-2017 retirees. That pre-Medicare dependent coverage ends when the dependent becomes eligible for Medicare.

Retiree Medical Program “Medical Premium Subsidy” Rules of Application.

If the Medical Premium Subsidy amount exceeds the KPSA premium costs, then the excess amount will be forfeited.

Any cost of medical coverage above the Medical Premium Subsidy shall be borne by the retiree. A retiree who does not pay the retiree's share of KPSA premiums shall lose coverage in accordance with KPSA plan terms. If a retiree does

not pay the retiree's share of KPSA premiums for their Medicare-eligible spouse or domestic partner, the spouse or domestic partner shall lose coverage in accordance with KPSA plan terms. Within any Kaiser Permanente Service Area, Medical Premium Subsidy applies only for the amount of the lowest-cost KPSA coverage (including prescription drug coverage) available to the retiree (and not for any premium plan or non-Kaiser Permanente plan).

A retiree must enroll in Medicare Parts A and B and any other relevant parts of Medicare, assign their Medicare rights to the applicable Kaiser Permanente plan, and take such other action as the applicable Kaiser Permanente plan determines is necessary to assign/coordinate Medicare. The spouse or domestic partner also must take the same actions when eligible for Medicare.

If a retiree and/or their eligible dependents reside outside of a Kaiser Permanente service area, the Medical Premium Subsidy can be used for any Medicare Advantage or Medicare “Medigap” plan premiums.

In the event of an eligible retiree's death, the Medical Premium Subsidy will be available for a surviving spouse or domestic partner, subject to the same rules. Coverage will be available for any eligible surviving child up to age 26. Eligibility of a spouse or domestic partner for survivor retiree medical benefits ends upon remarriage or entering into a domestic partnership.

Retiree Medical Health Reimbursement Account (HRA) for Eligible Retirees.

An eligible retiree will receive an Employer allocation to an unfunded Retiree Medical Health Reimbursement Account (“HRA”) at the time of retirement in the amount of \$2,000 per year of service. An eligible retiree will receive an allocation to an HRA equal to \$10,000 when the retiree reaches age eighty-five (85) (“HRA supplement”).

An eligible retiree who retires on or after January 1, 2021 from the Northwest, Colorado, Hawaii, Mid-Atlantic States, or Georgia region will receive an allocation to an HRA of \$2,500 per year of service.

Retiree Medical HRA and HRA Supplement Rules of Application

The following rules shall apply to reimbursements from the Retiree Medical HRA:

- » A retiree may access the Retiree Medical HRA for reimbursement of eligible expenses (within limitations described below) at age sixty-five (65), or retirement, whichever is later. A retiree who becomes Medicare-eligible prior to age sixty-five (65) may access the Retiree Medical HRA at the time they enroll in Medicare.
- » A retiree may access the HRA Supplement for reimbursement of eligible expenses at age eighty-five (85).
- » A retiree residing within a Kaiser Permanente Service Area may obtain HRA reimbursements for KPSA plan coverage costs, consisting

of premiums and copayments or deductibles for the retiree and their spouse, domestic partner or other KPSA-covered dependents.

- » A retiree residing outside any Kaiser Permanente Service Area may obtain HRA reimbursements for any Medicare Advantage or “Medigap” plan costs, consisting of Medicare plan premiums and Medicare plan copayments or deductibles for the retiree and their spouse, domestic partner or other Medicare-covered dependents.
- » A retiree residing within a Kaiser Permanente Service Area will be provided a debit card to use to provide direct HRA reimbursements to Kaiser Permanente for eligible KPSA plan coverage costs. The Employer intends to develop a similar debit card program for retirees residing outside any Kaiser Permanente Service Area to provide direct HRA reimbursements limited to eligible Medicare Advantage or Medigap plan costs.

In the event of a retiree’s death, any balance in the Retiree Medical HRA and HRA Supplement will be available for the benefit of the retiree’s surviving spouse, or a surviving domestic partner who was an eligible dependent as defined by the Internal Revenue Code. The surviving spouse or domestic partner may access the Retiree Medical HRA and HRA Supplement for reimbursement of eligible medical expenses when the retiree would have been eligible to access the Retiree Medical HRA or HRA Supplement. Eligibility of a surviving spouse or

domestic partner to access the HRA balance ends upon their remarriage or entering into a domestic partnership.

(4) Previously Legacy Employees.

Employees who are eligible for special retiree medical benefits under the eligibility requirements listed in the applicable local agreement will remain eligible for those benefits if they retire on or after January 1, 2017.

(5) For employees retiring from the Northern California region or Southern California region,

the employers' cost share shall be capped at a fixed dollar amount effective January 1, 2017 (the "Fixed Amount"). The Fixed Amounts shall be:

- » Northern California: \$573
- » Southern California: \$279

In the event that, as of May 15, 2017, or May 15 of any subsequent year, the net cost of a retiree medical plan in the prior calendar year exceeded the Fixed Amount for either region, the retiree medical plan for the Northern California region and Southern California region for post-2016 retirees will become the Medical Premium Subsidy/HRA plan described above, effective as of the first day of the next calendar year or January 1, 2028, whichever is later.

Before the Medical Premium Subsidy/HRA plan becomes effective, retiree medical benefits, including copayments and out-of-pocket maximums, for retirees in a Kaiser Permanente service area shall be the same as the active medical

benefits and cost-sharing features at the time the retiree initially enrolls in the Kaiser Permanente retiree medical plan. A retiree must enroll in Medicare Parts A and B and any other relevant parts of Medicare, assign their Medicare rights to the applicable Kaiser Permanente plan, and take such other action as the applicable Kaiser Permanente plan determines is necessary to assign/coordinate Medicare. A retiree will lose coverage for a failure to satisfy the plan enrollment, assignment and coordination requirements. If a retiree does not assign their Medicare rights to the applicable KP plan in a timely manner, KP shall drop the retiree from the group Medicare plan (with no charges to the retiree), with the retiree having the opportunity to re-enroll in the next open enrollment period.

For eligible retirees who move from one Kaiser Permanente service area to another Kaiser Permanente service area, a KFHP plan will be offered with a \$5 office visit copay and a \$5 prescription drug copay. This plan will be integrated with Medicare. For eligible retirees who move outside of any Kaiser Permanente service area, an out-of-area plan will be offered and will provide comprehensive inpatient and prescription drug coverage. This plan requires Medicare enrollment.

(6) Rehired Retirees. In circumstances where employees return to work after retiring with eligibility for retiree medical benefits, eligibility for coverage will be as follows:

RETIRE PRE-2017				
	REHIRED: BENEFITED POSITION		REHIRED: NON-BENEFITED	
	While Working	On Re-Retirement	While Working	On Re-Retirement
California	Active Plan	Post-2016 Plan	Pre-2017 Plan	Pre-2017 Plan
ROC	Active Plan	Post-2016 Plan	Pre-2017 Plan	Pre-2017 Plan
RETIRE POST-2016				
California	Active Plan	Post 2016 Plan	Post 2016 Plan w/regulatory restrictions on/ after 2028	Post 2016 Plan
ROC	Active Plan	Post 2016 Plan	Post 2016 Plan w/regulatory restrictions	Post 2016 Plan

See Exhibit 2.B.2.i.6 for a more detailed explanation.

(7) **Washington Region.** This Section 2.B.2.i. shall not apply to eligible retirees in the Washington Region, except effective January 1, 2019, any retiree who has at least 15 years of service and is at least age 55, as of the date of retirement, shall receive only an Employer allocation to an HRA at the time of retirement in the amount of \$250 per year of service, subject to the “Retiree Medical HRA and HRA Supplement Rules of Application.” Employees of Group Health Cooperative on the date of acquisition will have prior service included in years of service.

Effective January 1, 2020, this HRA will increase from \$250 per year of service to \$350 per year of service. Eligible employees who retire on or after January 1, 2022, shall receive only an Employer allocation to an

HRA at the time of retirement in the amount of \$1,000 per year of service, subject to the “Retiree Medical HRA and HRA Supplement Rules of Application.”

(8) **Medicare Part D Administration.** The Medicare Modernization Act of 2003 added a prescription drug benefit to the Medicare program in the form of premium subsidies for low-income retirees. Kaiser Permanente implemented Medicare Part D effective January 1, 2006. The Patient Protection and Affordable Care Act (PPACA) of 2010 reduced the Medicare Part D premium subsidies for retirees with incomes above \$85,000 per individual and \$170,000 per couple and added a surcharge for these high wage-earning retirees ranging from \$12 to \$69 per month effective January 1, 2011.

KP shall reimburse eligible individual retirees, as defined, who are being surcharged. The eligible individual retirees will be determined as the result of a two-year look-back that is based only on active KP W-2 wages as opposed to retiree income. Where the resulting two-year look-back of active KP W-2 wages exceeds \$85,000, the retiree is determined to be eligible for surcharge reimbursement regardless of marital status. Eligible retirees will be reimbursed for a maximum period of two years. The reimbursements will be executed, beginning with a time table to be determined by KP, using the existing reimbursement process KP has in place for Medicare Part B.

For background and implementation details, see Medicare Part D Grievance Resolution of January 17, 2012, as found on the LMP website.

This section 2.B.2.i. is intended to supersede any contrary Local Agreement provisions, with the exception of No. 4., Previously Legacy Employees, as discussed above.

3. INITIAL CONTRACTS FOR UNAC/ UHCP WITH EFFECTIVE DATES OF OCTOBER 1, 2021 — UNITED PHARMACISTS OF HAWAII (UPHI); UNITED THERAPISTS OF HAWAII (UTH); AND UNITED THERAPISTS OF NCAL (UTNC)

The following terms and conditions will apply to the following bargaining units represented by the United Nurses Associations of California/Union of Health Care Professionals (UNAC/ UHCP), upon ratification of their initial collective bargaining agreements with the Employers: United Pharmacists of Hawaii (UPHI); United Therapists of Hawaii (UTH); and United Therapists of Northern California (UTNC).

Employees will maintain current Rewards for Results incentive plans in all affected units until December 31, 2022. Effective January 1, 2023, employees will transition into the Alliance PSP plan; except, UNAC/UHCP, United Therapists of Northern California will maintain their current Rewards for Results incentive plan until December 31, 2024. Effective January 1, 2025, UNAC/UHCP, United Therapists of Northern California will transition into the Alliance PSP plan.

Benefits: Effective January 1, 2023, the parties agree that all eligible employees in the Hawaii region shall transition to the regional non-flex HMO plan with a \$10 office visit copay based on a Kaiser Foundation Health Plan Traditional HMO Plan with a premium cost share. The employee premium cost share for employees scheduled to work 20 or more



hours per week will be the difference between the monthly premium and the following employer contribution:

KFHP HI HMO EMPLOYER MONTHLY CONTRIBUTIONS	
Coverage Level	Employer Monthly Contributions
Self	100%
Self and Spouse or Domestic Partner	90%
Self and Child(ren)	90%
Self and Family	90%

Effective January 1, 2023, the parties agree that all eligible employees in the Hawaii region shall transition to the welfare and retiree medical benefits in accordance with the Alliance National Agreement.

The parties agree that all eligible employees in the NCAL region will maintain their existing health and welfare benefits.

Effective January 1, 2023, the parties agree that all eligible employees in the NCAL region shall transition to the retiree medical benefits in accordance with the Alliance National Agreement.

The parties agree that all eligible employees in the NCAL and Hawaii regions will maintain benefits equivalent to their existing retirement savings benefits consisting of defined-contribution and defined benefit plans effective on the date of ratification of the national agreement.

4. OTHER BENEFITS

All employees will be offered the following:

a. Dependent Care Spending Account

A Dependent Care Spending Account (DCSA) option will be provided to employees eligible for benefits. This account is a voluntary plan that allows the employee to set aside pretax dollars to pay for eligible dependent care expenses. The maximum DCSA annual contribution will be \$5,000. DCSA may be used to pay for certain expenses for eligible family members as permitted under the Internal Revenue Code.

b. Survivor Assistance Benefit

The survivor assistance benefit will cover employees who are eligible for benefits. This benefit will provide the employee's chosen beneficiary(ies) with financial assistance upon the employee's death. The amount payable is equal to one times the employee's monthly base salary (prorated for part-time employees based on regularly scheduled hours). Should death occur while the employee is on a leave of absence of less than one year, the beneficiary(ies) will continue to be covered by this benefit.

c. Workers' Compensation Leaves of Absence

Effective with workers' compensation leaves of absence commencing on or after October 1, 2000, up to 1,000 hours of workers' compensation leave(s) may be used toward determining years

of service for purposes of meeting the minimum eligibility requirements for retirement or post-retirement benefits.

d. Disability Insurance

Eligible employees in the Southern California and the Northwest regions who are not in a flexible benefits program shall receive short-term and long-term disability insurance coverage in accordance with the general description of the benefit levels as stated in Exhibit 2.B.4.d. A bargaining group in the above-mentioned regions with superior short-term and/or long-term disability coverage provided under local collective bargaining agreements shall maintain that coverage.

e. Employee Health Care Management Program

Kaiser Permanente will offer a comprehensive Employee Health Care Management Program to help employees manage their chronic diseases and other existing health issues. The goal of the program will be to reduce the incidence of these chronic diseases among employees. The Employee Health Care Management Program will be integrated with existing care management and employee health programs at the local level. The parties will jointly design an Employee Health Care Management Program, and prepare an implementation plan to include a staffing plan, in the first year of the Agreement. The program will include metrics that measure the success of and gaps in the program and identify successful practices.

f. Revised Dental Benefit

Effective January 1, 2016, the annual maximum for adults will be \$1,500 for all regions and the lifetime maximum for child orthodontia shall be \$1,500 for all regions. A Preferred Provider Network (PPO) shall be offered in Southern California.

Effective January 1, 2020, Kaiser Permanente will offer only a Preferred Provider Network (KP-PPO) in all regions (as described in Exhibit 2.B.4.f.), except as described below:

- » **Southern California Region:** The dental health maintenance organization (DHMO) period, as described in local agreements, remains effective for the applicable initial service period. The KP-PPO shall be offered as an option following the applicable DHMO period.
- » **Northwest Region:** Only KFHP Dental Plan A provided by the Permanente Dental Associates shall be offered by the employer. Any local with the option of a trust will maintain the option to select the trust. See Exhibit 2.B.4.f.

This provision will supersede any contrary local collective bargaining agreements, except it shall not apply to any Taft-Hartley trusts for dental benefits.

g. Life Insurance

The Employer will provide a minimum of \$50,000 in life insurance coverage for all benefited employees. Employees may purchase additional coverage through the Employer (see 2.B.4.h. below).

**h. Benefits by Design
Voluntary Programs**

Beginning January 1, 2017, insurance benefits found in the Benefits by Design voluntary program, which are offered nationally to non-represented employees, will be made available to employees eligible for benefits on an after-tax basis, subject to the satisfaction of any insurer requirements. The available options may include long-term care insurance, legal services insurance, additional term life insurance, identity theft maintenance, auto and homeowners insurance, and pet insurance. Any improvements made for non-represented employees will be offered to eligible Alliance-represented employees.

**i. UFCW Local 1996
and Employers Legal
Assistance Fund**

Effective October 1, 2015, the Employer shall increase its contribution to the UFCW and Employers Legal Assistance Fund to \$8 per month per benefited employee in the UFCW Local 1996 bargaining unit.

Effective January 1, 2023, the Employer shall increase its contribution to \$9 per month per benefited employee.

j. Flexible Benefits

Effective January 1, 2020, for the following groups medical and dental are excluded from the flexible benefit options and credits: UNAC Pharmacists, UNAC KPMWON, UNAC SCNSC, UNAC UTSC, OFNHP Local 5017 Professional, OFNHP Local 5017 Lab Professional, ILWU Local

28, UFCW Local 1996 Clerical/Technical and UFCW Local 1996 Professional.

Effective January 1, 2020, for IUOE Local 1, UFCW Local 7 Professional and UFCW Local 7 Mental Health, dental is excluded from the flexible benefit options and credits.

The remaining components of existing flex plans will continue unchanged.

This provision will supersede any contrary local collective bargaining agreement and the National Agreement.

k. Citizenship Fee Assistance

Effective January 1, 2023, the Employer agrees to reimburse the eligible employees who are lawful permanent residents for the cost of applying for U.S. citizenship. This cost shall include the filing fee for the application for naturalization (currently Form N-400), the applicable biometrics fee and citizenship classes.

Employees will also receive a paid day off to attend their naturalization ceremony to become a U.S. citizen. To be eligible, employees must be regularly scheduled to work 20 or more hours per week at the time they apply for citizenship.

5. MAINTENANCE OF BENEFITS

- a. KP and the Alliance Unions agree that there will be no benefit changes during the term of this Agreement. All employee health and welfare benefit programs provided under local collective bargaining agreements, including the copays and premium shares paid by the employee,

will be maintained for the term of this Agreement.

Exceptions will be made for:

- › changes that are legally required or mandated by regulators;
 - › minor changes in formularies;
 - › changes that result in a reduction in benefit level, but have a minimal or no impact on members (*de minimis* changes);
 - › treatment modality changes;
 - › changes in technology;
 - › benefit reductions affecting the low option offered under a flexible benefits program, provided the benefit is available under a higher-level option; or
 - › employee-paid benefits within a flexible benefits program, shall be increased to match Employer improvements to non-represented flexible benefit programs.
- b. A joint committee will be established at the national level to perform an annual review of the regional benefit

programs that are subject to this provision, including traditional and flexible benefit plans. The committee will be provided timely annual summaries of such benefit programs and, where appropriate, will agree to changes.

6. REFERRALS TO THE STRATEGY GROUP

In order to maximize the value of retirement and other benefits, employees should be educated periodically throughout their careers to better understand and utilize the benefits provided and to assist in effective retirement planning. The Strategy Group will appoint a committee to develop the content and materials for an education program for all Kaiser Permanente employees to fully understand:

- › the cost of their benefits;
- › how to better utilize services;
- › how to access their care in the most efficient and effective ways; and
- › how they can contribute to holding down the cost of care.





SECTION 3

Scope of Agreement

A. COVERAGE

This Agreement is negotiated and entered into by the parties as a result of voluntary national bargaining conducted pursuant to the national Labor Management Partnership. This Agreement applies only to bargaining units represented by local unions that Kaiser Permanente and the Alliance mutually agreed would participate in the national common issues bargaining process and who, prior to the effective date, agreed to include this Agreement as an addendum to their respective local collective bargaining agreements. Application to any other bargaining unit, other than newly organized bargaining units as described below, will be subject to mutual agreement of the parties.

The parties agree that when a local union signatory to this Agreement is recognized to represent a new bargaining unit of an Employer pursuant to the provisions of the Labor Management Partnership Agreement and the Recognition and Campaign Rules, the local parties shall use an interest-based process to negotiate the terms of a local collective bargaining agreement and the appropriate transition to this Agreement.

B. THE NATIONAL AGREEMENT AND LOCAL AGREEMENTS

The provisions of Local Agreements between the Alliance and Kaiser Permanente establish terms and conditions of employment applicable to the recognized or certified bargaining

units. The provisions of this National Agreement only apply as an addendum to such Local Agreements if employees in these bargaining units are represented by an Alliance union. If a bargaining unit is not represented by an Alliance union, then the provisions of this National Agreement will not apply or establish additional terms and conditions of employment for that bargaining unit beyond those contained in its Local Agreement.

Provisions of local collective bargaining agreements and this Agreement should be interpreted and applied in the manner most consistent with each other and the principles of the Labor Management Partnership. If a conflict exists between specific provisions of a local collective bargaining agreement and this Agreement, the dispute shall be resolved pursuant to the Alliance-Kaiser Permanente Dispute Process in Section 3.D.

If there is a conflict, unless expressly stated otherwise, this Agreement shall supersede the local collective bargaining agreements; however, in cases where local collective bargaining agreements contain explicit terms which provide a superior wage, benefit or condition, or where it is clear that the parties did not intend to eliminate and/or modify the superior wage, benefit or condition of the local collective bargaining agreement, this Agreement shall not be interpreted to deprive the employees of such wage, benefit or condition. It is understood that it is not the intent of the parties to inadvertently enrich or compound wages, fringe benefits or other conditions or to create opportunities for “cherry picking,” “double dipping,” etc.

C. NATIONAL AGREEMENT IMPLEMENTATION

The Partnership Strategy Group oversees and will hold its respective leaders accountable for implementation of the National Agreement, including:

- » coordinating an implementation plan;
- » developing and enforcing accountability;
- » sponsoring and chartering continued work;
- » identifying needed support; and
- » establishing metrics for implementation.

D. DISPUTE RESOLUTION

The goal of dispute resolution is to resolve problems at the level at which the problem arises. It is the intent of the parties that after sharing information and fully discussing and exchanging ideas and fully considering all views about issues of interest and concern to the parties, decisions should be reached that are satisfactory to all. However, understanding that there may be times when disputes arise concerning the interpretation or application of this National Agreement, the parties have agreed to the following:

1. Procedure

Each step has a 60-day timeline. All timelines in the process can be extended with mutual agreement. Disputes should be resolved at the lowest possible level using an interest-based approach.

Step 1: A dispute covered by the National Agreement must be submitted by the filing party within 60 days after the moving party becomes aware of the potential violation of the National Agreement.

Step 2: The dispute is received by a labor and management pair who will review/triage the dispute and determine who the appropriate stakeholders would be to help resolve the dispute. The criteria used to triage the dispute will include, but not be limited to, the following:

- » Is the dispute economic or noneconomic?
- » Is the dispute a national issue or market issue?
- » Does the dispute impact a single market or multiple markets?
- » Is the result of the dispute precedent setting or nonprecedent setting?
- » Who are the appropriate parties needed to resolve the dispute (e.g., Benefits, Total Compensation, etc.)?
- » Has the dispute been fully explored at the market level?

If it is determined the dispute should be resolved in the market, the dispute will be sent to the market and they will have 60 days to resolve, giving regular updates to the triage team. If it is determined the dispute should be resolved nationally, Step 3 starts.

Step 3: A labor and management pair will have 60 days to complete a fact-finding and either resolve the dispute or escalate to Step 4. The fact-finding is to gather information and supporting documentation from the submitting party/parties to use to resolve the

dispute. The fact-finding must be completed at this step.

Step 4: If there is no resolution at Step 3, the dispute will be escalated to the Tri-Chairs or their designees. The Tri-Chairs or designees have 60 days to resolve the issue or escalate to Step 5, a national panel.

Step 5: Dispute is put on the national panel calendar for hearing. See Exhibit 3.D.1. for details.

2. Guide

The LMP Tri-Chairs will appoint a small joint group to develop an easy-to-read, accessible guide showing the purpose of the Dispute Resolution Process. See Exhibit 3.D.2.

E. DURATION AND RENEWAL

- (1) The effective date of this National Agreement shall be October 1, 2021, and it shall continue in effect through September 30, 2025.
- (2) The expiration date of each Local Agreement that adopts this National Agreement as an addendum shall be extended as agreed to and reflected in the attached Exhibit 3.E.
- (3) The durational provisions of each Local Agreement that adopts this National Agreement as an addendum shall incorporate the extended expiration date for that agreement shown in Exhibit 3.E.
- (4) The following shall apply if the National Agreement is not renewed or there is no successor National Agreement:

- › Local Agreements identified in Exhibit 3.E. that expire on or before September 30, 2025 (**Group 1**), will be open for contract negotiations immediately.
- › Employees covered by Local Agreements in the Southern California region identified in Exhibit 3.E. that expire between October 1, 2025, and January 31, 2027 (**Group 2**), will receive a 3% wage increase on October 1, 2025. Employees covered by Local Agreements in the regions outside of California identified in Exhibit 3.E. that expire between October 1, 2025 and January 31, 2027 (**Group 2**), will receive a 2% wage increase on October 1, 2025. Local Agreements in this group will be open for contract negotiations based upon their expiration date identified in Exhibit 3.E.

All provisions of this Agreement shall expire at midnight on September 30, 2025, except for the wages, performance-sharing opportunities, benefits as identified in Section 2 and the provisions of Section 3.E. of this Agreement. Those excepted provisions shall continue in effect until the expiration dates of the relevant Local Agreements.

F. GRIEVANCE ARBITRABILITY

The parties agree that, in all Alliance local bargaining units, grievances that have arisen since the expiration of the applicable collective bargaining

agreements shall be deemed retroactively governed by the renewed contracts, provided the grievances were timely filed and otherwise arbitrable. The parties further agree that National Agreement disputes previously submitted and currently pending are not subject to the timelines provided in the revised dispute resolution process of the 2021 Alliance National Agreement.

G. LIVING AGREEMENT

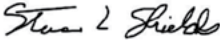
The parties acknowledge that during the term of this Agreement, a party at the national level may wish to enter into discussions concerning subjects covered by this Agreement or to modify specific provisions of this Agreement, or a party at the local level may wish to enter discussions concerning subjects covered by the local collective bargaining agreement or to modify its specific provisions. The parties agree that neither a union nor any Kaiser Permanente entity shall refuse to engage in such discussions. The parties further agree that, consistent with the Partnership principles set forth above, they will engage in such discussions with the intent to reach mutual agreement; however, during the term of this Agreement, no party shall be required to agree to any modifications of either this Agreement or the local collective bargaining agreement.

KAISER PERMANENTE AND THE ALLIANCE OF HEALTH CARE UNIONS

2021 National Agreement

In witness whereof the respective parties hereto have executed this agreement effective October 1, 2021.

Management:



STEVE SHIELDS

Senior Vice President, National Labor Relations & OLMP and Hospitals, Inc.



JIM PRUITT

Vice President, Labor Management Partnership and Labor Relations, The Permanente Federation



CHRISTIAN MEISNER

SVP, Chief Human Resources Officer



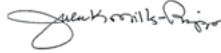
ARLENE PEASNALL

SVP, Human Resources Consulting & Labor Relations



CHRISTOPHER GRANT

Chief Operating Officer and Executive Vice President, The Permanente Federation, LLC



JULIE MILLER-PHIPPS

President, Southern California and Hawaii Markets



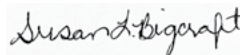
JEFF COLLINS

Regional President, Kaiser Foundation Hospitals / Health Plan of the Northwest



SYLVIA EVERROAD

Chief Operating Officer (COO) of SCAL



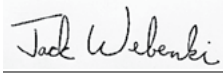
SUSAN BIGCRAFT

Vice President of Administration and People Leadership, General Counsel for Labor and Employment Law

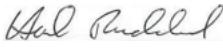


LIONEL SIMS

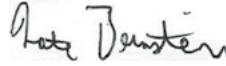
Vice President, Office of Labor Management Partnership & National Labor Relations Strategy

Management continued:**JACK WEBERSKI**

Vice President, National Labor Relations – Economics

**BOB SPAGAT**Vice President & Assistant General Counsel,
Labor & Employment**Union Parties:****HAL RUDDICK**

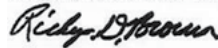
Executive Director, Alliance of Health Care Unions

**NATE BERNSTEIN, JD**

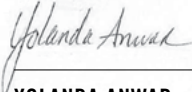
Healthcare Director, UFCW 7

**JULIE KWIEK**

Deputy Director, Alliance of Health Care Unions

**RICK BROWN**

Executive Assistant to the President, UFCW Local 1996

**YOLANDA ANWAR**

Regional Director/VP, UFCW Local 400

**GREG CHAVEZ**

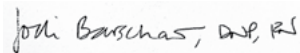
President, ILWU Local 28

**MICHAEL BARNETT**

President, USW Local 7600

**EDWARD J. CURLY**

Business Manager, IUOE Local 501

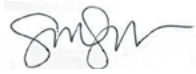
**JODI BARSCHOW, DNP, RN**

President, OFNHP AFT Local 5017

**DENISE DUNCAN, RN**

President, UNAC

Union Parties continued:



SANDRA FLORES

Business Representative, IUOE Local 501



DON HENLEY

Business Representative, IBT Local 166



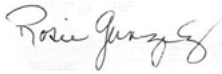
ERIC GILL

Financial Secretary-Treasurer, Unite Here Local 5



TED HERRERA

Business Manager, IUOE Local 1



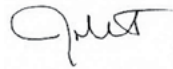
ROSIE GONZALEZ

Staff Representative, USW Local 7600



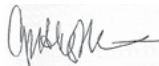
MILTON JONES

Executive Vice President, National Bargaining Director,
UFCW



JOHN M. GRANT

President, UFCW Local 770



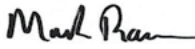
CINDIE MCGINNIS

Vice President, UFCW Local 770 and 1167



FAYE GUENTHER

President, UFCW Local 3000



MARK RAMOS

President, UFCW Local 1428



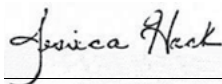
JOE GUZYNSKI

Executive Director, UNAC/UHCP



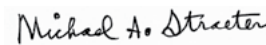
DELIANA SPEIGHTS

Secretary-Treasurer, UFCW Local 1428



JESSICA HACK

Assistant to the President, UFCW Local 27



MICHAEL A STRAETER

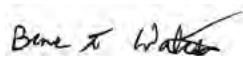
President, UFCW Local 1442

Union Parties continued:



KATHLEEN THEOBALD, MA

Executive Director, KPNAA



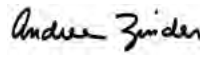
TODD WALTERS

President, UFCW Local 135



GRANT TOM

Secretary-Treasurer, UFCW Local 135



ANDREA ZINDER

President, UFCW Local 324





SECTION 4

National Agreement Exhibits

EXHIBIT 1.A.

LABOR MANAGEMENT PARTNERSHIP PLAYBOOK

In order to align what labor and management can expect from each other as partners, the LMP Executive Committee will commission a workgroup and assign the participants (including some Commitment to Partnership Bargaining Workgroup members) to create a playbook/quick start guide. The Workgroup will:

- » Consider and discuss practical challenges to understanding/utilizing the Partnership Agreement and keep those in mind in structuring and creating the playbook; and

- » Complete the Playbook within 9 months from ratification.

The Labor Management Partnership Playbook should include the “go-to” approach for implementing the LMP. Examples may include but are not limited to:

- » Standard processes for LMP activities;
- » LMP Process workflows;
- » Cultural values that shape a consistent response;
- » Expectations and accountabilities;
- » Behavioral expectations;
- » Role definitions (e.g., of managers, staff, co-leads, etc.) and equitable distribution of work in the partnership;

- » What happens when someone isn't demonstrating partnership behaviors or using the tools (accountability, getting back on track);
- » Resources for UBTs and other components of the Partnership (e.g., facility LMP groups, regional guidance, process mapping, diagrams, details/ examples on "what does it look like?" etc.); and
- » Consideration of best practices for meeting preparation (e.g., data collection, facilitation, agenda, meeting flow, etc.).

The Workgroup should:

- » Review Section 1 (and other relevant portions) of the National Agreement to identify key pieces to include in the playbook;
- » Include the Path to Performance;
- » Keep the playbook user friendly and concise;
- » Use Principles of Responsibility as a reference for content and behavior; and
- » Create a small laminated card or pocket guide as a just-in-time tool.

EXHIBIT 1.B.1.c.1.(1)

2005 PERFORMANCE IMPROVEMENT BTG REPORT, PAGE 7

By centering Partnership on UBTs, we also expect to eliminate parallel, duplicative structures in the organization. There will be fewer meetings, and more will be accomplished because all of the stakeholders are at the table from the

beginning. This should help increase union capacity to partner, as well as reduce backfill issues.

We will know how well UBTs have performed by reviewing their performance on the metrics they have chosen, which will be aligned with the goals developed at the higher levels of the accountability structure in Recommendation 1. We would also expect to see improvements on People Pulse scores regarding influence over decisions, involvement in decisions, knowledge of department goals and use of employees' good ideas.

Developing and implementing UBTs will incur costs, particularly for readiness training, described in more detail in our Recommendation 4, as well as release time and backfill.

Implementation Issues

A key enabler of this recommendation should be the growing sense of urgency, even crisis, among many of us that unless we make Partnership real to frontline employees, supervisors and stewards in the very near future, we will lose the opportunity forever. There is an equally motivating sense of crisis in the health care market—make significant performance improvement now, or lose market share. At the same time, we are well positioned to implement UBTs at this juncture: we have a shared vision of a high-performing Partnership, we are committed to engaging employees, and we have the resources in place to support the development of UBTs.

We will have to overcome some barriers, including competing priorities and difficulty in measuring results across the program.

We will have to work hard to overcome the project mentality that has taken hold of Partnership—it's a separate, parallel, offline activity, rather than the way we do business every day. There may also be some concern over the idea that partnering in the business means shifting supervisor work to the UBT members.

Timeline

We envisioned a phased approach to implementation, with the first year focused on readiness training and education and developing a plan to enable employees, supervisors and stewards to operate differently. Again, some parts of the organization already do use UBTs; this plan will provide support for those that do not.

The remaining years of the 2005 contract would be spent implementing UBTs, and measuring success based on the jointly developed metrics.

2006: Plan for and agree on a plan to prepare employees, supervisors and stewards to partner in Department Based Teams. Plan will cover needs for business education, training, facilitation, etc.

2007: Jointly developed budget and regional performance objectives in place.

2008: Organization begins to see significant performance improvement attributable to UBTs.

2010: 100% of the organization operating in UBTs.

Note: In 2015 the language above was changed to reflect the current term for these teams: unit-based teams (UBTs) from the original department-based teams (DBTs).



EXHIBIT 1.B.1.c.3.

THE PATH TO PERFORMANCE

The Path to Performance:

Labor Management Partnership Team Development Pathway



Key Tip!

Ask yourself:

Where are your teams in the developmental process?

Who is developing and who isn't?

Why aren't they developing?

What do they need?

How can you and your co-sponsors support their evolution to the next level?

Team Development

Stages of Unit-Based Team Development

Leaders and sponsors play an important role in the ongoing development of unit-based teams (UBTs). The more you understand about where your teams are in the developmental process, and what they need to move to the next level, the more effective you can be in supporting their forward momentum.

The faster this process happens, the faster you will see results. Work with your co-sponsors to identify team status, strategize ways to help move them forward and develop a plan for long-term sustainability.

Guidelines for Using the Following Tool

1. Each month, give this tool to your teams and have them assess themselves. They must meet all the criteria in one phase before they can move to the next phase.
2. As the sponsor, part of your role is to track team status monthly. The Team Assessment Tool gives you valuable information you can use to reward teams that are making progress and support those that are not moving forward at a desired rate.

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Pre-Team Climate	Foundational	Transitional	Operational	High-Performing
Unit is learning what a unit-based team is and how UBTS work.	Team is establishing structures and beginning to function as a UBT.	Team is demonstrating progress on engagement and making improvement.	Team has joint leadership, engagement of team members and improved performance.	Team is fully successful and collaborating to improve/sustain performance against targets.

The Path to Performance: Labor Management Partnership Team Development Pathway			
Dimension	LEVEL 1:Pre-Team Climate	LEVEL 2: Foundational UBT	LEVEL 3: Transitional UBT
Sponsorship	Sponsors are identified and introduced to team.	Sponsors trained. Charter completed. Sponsor agreement completed.	Sponsors regularly communicating with co-leads (minimum monthly communication).
Leadership	Team co-leads are identified or process of identification is under way. Team has identified a health and safety champion(s).	Co-leads have developed a solid working relationship and are jointly planning the development of the team. H&S champions complete orientation training.	Co-leads are seen by team members as jointly leading the team. H&S champions complete at least two health and/or safety activities in a year (e.g., champions may do the monthly suggested activities posted on LMPartnership.org).
Training	Co-lead training completed. Team has created initial action plan and keeps it updated.	Team member training (e.g., UBT Orientation, RIM+) completed. IBPS Annual Refresher (1.L.1.c.1) completed.	Advanced training (e.g., business literacy, coaching skills, metrics) completed. UBT Tracker training completed. Representative team members have completed business literacy training subject to regional/ medical center availability.
Team Process	Traditional; not much change evident. Team meetings scheduled and/or first meeting completed.	Staff meetings operating as UBT meetings (no parallel structure). Co-leads jointly planning and leading meetings.	Team meetings are outcome-based; team members are participating actively in meetings and contributing to team progress and decision making. Co-leads moving from direction to facilitation.
Team Member Engagement	Minimal.	Team members understand and use Partnership processes, i.e., consensus decision making. Team has established a communication structure to reach all members of the department.	Team members understand key performance metrics. At least half of team members can articulate what the team is improving and what their contribution is.
Use of Tools	Not in use.	Team members receive training in RIM+, etc.	Team is able to use RIM+ and has completed two testing cycles within one or more projects. Team has begun documenting projects and testing cycles in UBT Tracker.
Goals and Performance	Team does not have goals yet.	Co-leads discuss and present data and unit goals to teams.	Team has set performance targets, and targets are aligned with unit, department and regional priorities.

¹ This is not intended to supersede the UBT charter.

LEVEL 4: Operational UBT	LEVEL 5: High Performing UBT
Sponsors visibly support teams (minimum monthly contact plus quarterly in-person visit). Minimal outside support needed.	Sponsors holding teams accountable for performance and reporting results to senior leadership.
Co-leads are held jointly accountable for performance by sponsors and executive leadership. Trust has been built to such an extent that either co-lead can lead meetings in the other's absence. Health and safety champion(s) have begun work with team.	Team beginning to operate as a "self-managed team," with most day-to-day decisions made by team members. Self-managed teams have developed a level of trust that allows them to proceed with work/meetings in the absence of both co-leads. ¹
Advanced training (e.g., training in process improvement tools, change management training; depends on team needs). Focus area-specific training (e.g., patient safety or improvement tools to address human error-related issues). In consultation with their sponsors, teams should determine which types of training are appropriate using the examples listed above.	Focus area-specific training. Advanced performance improvement training (e.g., deeper data analysis, control charts, improvement methods). In consultation with their sponsors, teams should determine which types of training are appropriate using the examples listed above.
Co-leads jointly facilitate team meetings using outcome-focused agendas, effective meeting skills and strategies to engage all team members in discussion and decision making. Team makes use of huddles to reflect on tests and changes made. Team collects own data and reviews to see whether changes are helping improve performance. Team completes a wellbeing project with successful rating (per SMART goals in UBT Tracker).	Team beginning to move from joint management to self-management, with most day-to-day decisions made by team members. Unit culture allows team to respond to changes quickly. Team can move from first local project to next improvement project and can apply more robust changes. Team measures progress using annotated run charts. In consultation with their sponsors, member-facing departments are getting direct input from the voice of the customer. Team must spread or adopt a successful practice.
Unit performance data is discussed regularly. Large majority of team members are able to articulate what the team is improving and their contribution.	Team members able to connect unit performance to broader strategic goals of company. Full transparency of information. Team is working on tests of change related to staffing, scheduling, financial improvement, and other daily operations issues. Team establishes a sustainable culture of safety and health. ²
Team has completed three or more testing cycles, making more robust changes (e.g., workflow improvement rather than training). Team documents all projects and testing cycles in UBT Tracker at least every 90 days.	Team using advanced performance improvement training. Team can move from initial project to next improvement effort, applying deeper data and improvement methods.
Team has achieved at least one target on a key performance metric. UBT can demonstrate improvements on at least two areas of the Value Compass (to be implemented when UBT Tracker allows projects to be listed under more than one category).	Team is achieving targets and sustaining performance on multiple measures. UBT can demonstrate improvements in all areas of the Value Compass (to be implemented when UBT Tracker allows projects to be listed under more than one category). Team demonstrates a culture of health and safety.

2 May be demonstrated in the following ways:

- » Team adopts one sustainable well-being, health or safety goal that impacts the culture of health and provides documentation of improvement

- » Team demonstrates improvement on one or more Culture of Health Index questions on People Pulse
- » Team repeats the project from Level 4 but demonstrating further improvement

EXHIBIT 1.C.1.b.

**2010 LMP SUBGROUP
RECOMMENDATION: FLEXIBILITY**

- (1) Labor and management should address issues regarding flexibility using IBPS.
- (2) Agreements reached are non-precedent setting.
- (3) The Executive Committee of the LMP Strategy Group shall appoint

a group to assist with the enhancement of best practices in implementation of flexibility as it exists in the NA. Some guidelines for this enhancement include:

- a. That management will engage labor in a discussion beginning in the initial stages of the development of an initiative or program; and
- b. The committee shall review and problem solve issues where disputes develop.

EXHIBIT 1.C.4.(1)

2005 SCOPE OF PRACTICE BTG REPORT, PAGES 14–17

SECTION X: REFERENCES

Reference 1: National Compliance Plan

Reference 2: Regional Scope of Practice Committee Structure and Process

Region SOP Committee Structure and Process Summary	
COLORADO	
Purpose	<p>The purpose of the Scope of Practice Oversight Committee is to provide region-wide monitoring, leadership and oversight for compliance with legal, accreditation and organizational scope of practice requirements. To achieve this purpose, the committee will:</p> <ul style="list-style-type: none"> » Assure alignment of Health Plan, CPMG and union leadership to address scope of practice risks; » Identify and prioritize clinical areas at risk for Scope of Practice violations; » Assure clear delineation of accountabilities between practitioners (physicians and allied health professionals) in job descriptions, care delivery documentation and information systems; » Assure that a process to identify and stay current on scope of practice and related billing laws, regulations and accreditation standards for all practitioners is in place;

EXHIBIT 1.C.4.(1) CONTINUED

Region		SOP Committee Structure and Process Summary
COLORADO (CONTINUED)		
Purpose	<ul style="list-style-type: none"> » Communicate physician responsibility for assuring the quality of medical services found in care delivery models, clinical guidelines, clinical policies and quality standards; » Assure that reviews of existing and new care delivery models are conducted, in consultation with Compliance, Risk Management and Legal as appropriate, for scope of practice consideration; and » Assure scope of practice corrective action plans are developed and implemented as appropriate. 	
Membership	<p>CHAIR AND MEMBERSHIP</p> <p>The Regional Compliance Officer and Director of Business and Clinical Risk Management co-chair this committee. The membership shall consist of representatives from Behavioral Health, Pharmacy, Nursing, Operations, CPMG, Local 7, Local 105, HR and Coding.</p>	
Reporting	<p>At least annually, representatives of the SOP Oversight Committee shall meet with and report to the Colorado Compliance Executive Committee. The report shall include:</p> <ul style="list-style-type: none"> » Assessment of current SOP risk areas, and recommendations to mitigate risk; » Information on monitoring and internal controls present in operational areas; and » A summary of significant SOP activities undertaken since the last report. 	
GEORGIA		
Purpose	<ul style="list-style-type: none"> » Assure scope of practice review is completed for all applicable clinical staff in health plan and medical group. » Identify and clarify all scope of practice issues identified. » Report findings of scope of practice review to Regional President and Medical Director. » Develop a process and identify accountabilities to assure corrective action plans are developed, implemented, evaluated for effectiveness and monitored over time to assure required practice changes have occurred. 	
Membership	<p>Membership consists of representatives from health plan, medical group, risk management, labor and HR functions for Health Plan and Medical Group. Sponsors are Dr. Debra Carlton and Leslie Litton as leaders of the HealthConnect Implementation Project.</p>	

EXHIBIT 1.C.4.(1) CONTINUED

Region SOP Committee Structure and Process Summary	
GEORGIA (CONTINUED)	
Reporting	<ul style="list-style-type: none"> » Regional President » TSPMG Medical Director » Chief Compliance Officer
MID-ATLANTIC STATES	
Purpose	<p>The Committee will:</p> <ul style="list-style-type: none"> » Develop and maintain an inventory of scope of practice requirements by position type; » Review and approve protocols, policies and procedures created by the Committee to meet scope of practice regulations and requirements for unlicensed and licensed clinical and support staff; » Develop and oversee implementation of annual scope of practice work plan and action items; » Establish a mechanism for recurring review of clinical position descriptions; » Evaluate existing and proposed clinical practices for scope of practice risks and/or violations and the impact on scope of practice; » Develop and oversee scope of practice training and education throughout the region; » Coordinate with existing committees and work groups to ensure that scope of practice issues are addressed effectively; » Provide recommendations to Committee sponsors and senior leadership regarding identified opportunities for change; » Monitor corrective actions to ensure continued compliance with prescribed scope of practice requirements and regulations; » Collaborate with appropriate departments to ensure that changes are integrated into existing systems, policies and processes; and » Maintain a reporting relationship with the Regional Quality Improvement Committee and the Compliance Department. Reporting to occur not less than quarterly. <p>Subcommittees may be created as needed to facilitate completion of specialized tasks.</p>

EXHIBIT 1.C.4.(1) CONTINUED

Region	SOP Committee Structure and Process Summary
MID-ATLANTIC STATES (CONTINUED)	
Membership	<p>MEMBERSHIP, LENGTH OF TERM AND VOTING:</p> <p>The Scope of Practice Committee shall consist of the following people or their designees:</p> <ul style="list-style-type: none"> » Clinical Compliance Coordinator (Co-Chair) » Regional Nurse Executive (Co-Chair) » Regional Compliance Officer » Vice President for Strategic Services/Compliance, MAPMG » Director, Quality Management Operations » Regional Manager, Nursing Practice and Education » Assistant Medical Director, Information Management & Research, MAPMG » Labor Management Partnership representative(s) » Medicare Compliance Manager » Senior Compensation Consultant » Director, Human Resources (ad hoc) » Director, Professional Staff Office and Delegation Oversight » Primary Care Physician (Service Chief or Physician Director) » Specialty Physician » Clinic Coordinator
Reporting	<p>The Mid-Atlantic Scope of Practice Committee reports quarterly to the Regional Quality Improvement Committee (RQIC).</p>
NORTHERN CALIFORNIA	
Purpose	<p>Purpose of our Regional Non-Physician Practitioner Scope of Practice Advisory Committee:</p> <p>The Non-Physician Practitioner Scope of Practice Advisory Committee is established to evaluate non-physician practitioner scope of practice issues that exist at Kaiser Permanente and to advise on implementation plans to address these issues.</p> <p>The work of the committee and workgroups includes identifying sources of SOP issues, prioritizing risk of each issue, identifying system gaps, proposing action plans when needed, recommending implementation plans that encompass KP's 7 Element Compliance Template, assigning accountabilities for actions to be taken and advising on the development of an infrastructure for ongoing identification and resolution of SOP issues.</p>

EXHIBIT 1.C.4.(1) CONTINUED

Region	SOP Committee Structure and Process Summary
NORTHERN CALIFORNIA (CONTINUED)	
Membership	<p>Membership includes representation from:</p> <ul style="list-style-type: none"> » Patient Care Services locally and regionally » Medical Group Administration locally and regionally » Regional Compliance » Program Office Legal Department » Accreditation, Regulation & Licensing » Regional Credentialing & Privileging » Local Assistant Administrator for Quality » APIC for Risk » Pharmacy Operations » Patient Business Services <p>Ad hoc members</p> <ul style="list-style-type: none"> » TPMG Legal » TPMG Human Resources » Continuing Care Leader » Human Resources Compliance » Program Office Legal » Work group: Includes labor representation of roles being addressed (2–3)
Reporting	<p>This group reports regularly to the Executive Compliance Committee and will report any quality of care issues to the Quality Oversight Committee.</p>
SOUTHERN CALIFORNIA	
Purpose	<p>SCOPE AND AUTHORITY:</p> <p>Identify areas of risk, facilitate resolution and implementation of actions and monitor Scope of Practice across all care venues</p>
Membership	<p>CO-CHAIRS [names deleted]:</p> <ul style="list-style-type: none"> » AMD, SCPMG » SVP & SAM, KFH/HP

EXHIBIT 1.C.4.(1) CONTINUED

Region	SOP Committee Structure and Process Summary
SOUTHERN CALIFORNIA (CONTINUED)	
Membership (continued)	<p>MEMBERSHIP:</p> <ul style="list-style-type: none"> » Vice President, Quality and Risk Management, KFHK/KFHP » Executive Consultant, Quality and Risk Management, KFHP/KFHP » Executive Director, Patient Care Services, Operations, KFHP » Manager, SCPMG Nursing Administration, SCPMG » Medical Group Administrator, Bellflower, SCPMG » Medical Group Administrator, South Bay, SCPMG » Counsel, KFHP » Senior Consultant, AR&L » Labor Alliance Representative » Ann Sparkman, Director of Health Care Compliance, NCO » Project Support: Management Consulting
Reporting	<ul style="list-style-type: none"> » Southern California Regional Compliance Leadership Committee » Southern California Quality Committee SCQC » Southern California President and Regional SCPMG Medical Director
NORTHWEST	
Purpose	<p>To address regional scope of practice issues for both licensed and unlicensed clinical and support staff in order to identify and address areas for improvement in compliance, patient safety and operational efficiencies.</p>
Membership	<p>REPRESENTATION</p> <p>The committee shall consist of:</p> <p>Management Representatives:</p> <ul style="list-style-type: none"> » Integrity, Compliance and Ethics Manager(s) (stakeholder) » NW Permanente Physician (stakeholder) » Health Plan Legal Counsel (consultant) » Human Resource Manager (consultant) » Director, Ambulatory Nursing (stakeholder) » Pharmacy Manager (consultant) » KP HealthConnect Representative (consultant) » Medical Office Managers (stakeholder) » NW Perm & PDA General Counsel & Compliance (consultant) » Laboratory Services (consultant)

EXHIBIT 1.C.4.(1) CONTINUED

Region SOP Committee Structure and Process Summary	
NORTHWEST (CONTINUED)	
Membership (continued)	<p>Labor Representatives:</p> <ul style="list-style-type: none"> » OFN Health Professional (stakeholder) » OFN – RN (stakeholder) » SEIU – LPN (stakeholder) » SEIU – MA (stakeholder) <p>Staff Support</p>
Reporting	<p>This committee will have a reporting relationship to ROG and Compliance Department and also have access to MOLT (when decisions need to be worked out). Specific senior leaders who have been identified are: [names deleted].</p>

EXHIBIT 1.C.4.(2)

2005 SCOPE OF PRACTICE BTG REPORT, PAGES 9–11

SECTION VI: EDUCATION PLAN

I. Basis for Recommendation

By providing SOP education, we can increase staff awareness and enhance the quality of patient care. Currently, little frontline education is provided to KP employees about SOP issues, and the consequences of non-compliance.

II. Accountabilities for SOP Education for Patient Care Staff, Management and Physicians

National

- » Create SOP Education Toolkit
 - › developed by content experts in LMP context
- » Create annual updates on SOP development

Facility/Service Area/Region

- » Provide a 2- to 4-hour basic SOP training for all staff, managers and physicians
- » Provide release time for training and backfill needs
- » Provide skills training related to SOP to encourage working toward full scope. This includes new and remedial skills training as a result of advances in technology (i.e., KP HealthConnect), changes in regulations and changes in assignments
- » Provide ongoing in-service education on SOP
- » Provide new employee orientation on SOP

Individual

- » Participate in mandatory KP SOP training
- » Attend CEUs as required

- » Know own SOP; be aware of SOP of other team members

III. SOP Education Toolkit Content

Model after LMP Think Out of the Box toolkit. (Toolkit should be developed with input from content experts and in LMP)

Part A (Initial Basic Training Toolkit)

- (1) What is SOP?
 - › Why is it important?
 - › History of KP SOP issues
- (2) Individual SOP/licensure requirements
 - › Laws and regulations impacting SOP
 - › State specific
 - › KP SOP policies
- (3) What is the process to get SOP issues or concerns addressed? How to elevate a concern for resolution:
 - › Tree
 - › FAQs
 - › Decision ADO form
 - › Compliance hotline
- (4) Scope of Practice Limitations:
 - › What are the legal risks and consequences of exceeding SOP?

Part B (Additional/Ongoing Training Materials)

- (1) Video presentation
 - › Legal, NCO, Labor, NLT representatives speaking on importance of SOP
 - › Case studies/dramatizations of SOP situations

IV. Implementation of SOP Education

A. Phase I

- » Identify National LMP task group to develop SOP tool kit by 12/31/2005
- » Produce Part A SOP tool kit by 3/31/2006
- » Design, test, and conduct 2- to 4-hour mandatory basic training for SOP, to include Part A toolkit, by 6/30/2006

B. Phase II (Timing to be determined by CIC)

- » Develop Part B of SOP toolkit
- » Provide ongoing, updated SOP training utilizing department staff meetings, and Part B toolkit
- » Develop and provide skills training programs
- » Develop SOP module for New Employee Orientation Program
- » SOP competency to be part of job descriptions and annual evaluation process

C. Additional Consideration

- » CEUs should be available for participation
- » Labor and management accountability for ensuring participation
- » Integrate concepts in KP HealthConnect training
- » Pre- and post-testing for evaluation and CEUs
- » Fun, creative and engaging training (i.e., Scope of Practice week, “Jeopardy” game, etc.)

V. Costs Associated with Recommendation

- » High initial cost for broad-based employee training and toolkit
- » Preventive expenditure; should prevent fines and penalties for non-compliance; costs of litigation; reputation damage
- » Return on investment will be significant
- » Look at existing internal structures to help support training and toolkit (i.e., KPHC CBA, Department meeting)

VI. Implementation

- (1) Within 90 days of ratification, across the program, leadership will:
 - › assess standing committees that may impact SOP;
 - › determine which committee at each level is best positioned to coordinate and integrate SOP issues; and
 - › assure that committees are operating within LMP process, structure and following the SOP Vision and Principles
- (2) Resource and implement education plan, with initial phase completed by mid-year 2006.
- (3) Establish reporting systems/metrics
 - › Annual regional SOP report to National Strategy Group
 - › Tracking system of SOP issues for regional sharing of successful practices
- (4) Develop and implement a communication plan.

EXHIBIT 1.F.1.a.

STAFFING, BACKFILL (PLANNED REPLACEMENT), BUDGET AND CAPACITY BUILDING

2005 ATTENDANCE BTG REPORT, CONCEPT NO. 3, PAGES 20–23

BUDGETING, STAFFING AND SCHEDULING

Concept 3: Provide budgeting, staffing and scheduling at the unit level to ensure adequate backfill for time off.

Interests/Objectives

- (1) Provide backfill so employees are able to use leave benefits appropriately and take time off when requested.
- (2) Provide adequate staffing within the budget to cover the work operations and other work-related requirements.
- (3) Ensure forward-looking planning to anticipate and provide for future staffing needs.
- (4) Budget realistically to provide for all components of legitimate time off from work and apply those budget components as intended.
- (5) Accurately track requests for time off to provide managers and employees with transparent data on time off.

N. Approach:

Staffing Model

- (1) Each unit develops a unit-level staffing model (core staffing) that specifies the staffing needed to cover operations (refer to joint staffing

language in the National Agreement). The model will include assumptions about productivity and performance that reflect both historical experience and expectations of process improvements.

- (2) The model will include workload factors such as seasonal fluctuations.
- (3) The model will also include all time away from work and work-related assignments.
- (4) The staffing model identifies core staffing levels for various operating levels and identifies triggers for backfill based in part on service level metrics (e.g., if service levels fall below a certain defined point).
- (5) The model must account for specialized skills and hard-to-fill occupations.
- (6) There will be no automatic backfills: it will be based on the staffing model, which may specify different staffing coverage in different operating circumstances.
- (7) The staffing model will be reviewed on an annual basis and adjusted as needed.

Workforce Planning

- (1) Each unit will jointly develop an annual workforce plan to cover the staffing requirements defined in the staffing model.
- (2) The workforce plan will be reflected in the unit staff and backfill budget.

- (3) The plan will project staffing availability based on the current employees, contractual time off, actuarially based illness and injury, and workforce demographics.
- (4) The plan will identify ways to cover short-term staffing needs such as full time, part time, on-call, overtime, float pool, cross-training, flexible assignments, etc., in a way that allows a relatively stable permanent workforce while striving for full workforce utilization.
- (5) The plan will also identify the need to recruit, train and develop employees to fill operational requirements in the future.

Budgeting Process

- (1) At a regional level, the budgetary process will include a line item for backfill/replacement in each unit budget.
- (2) The process for developing the regional budget for backfill will include meaningful labor input and participation.
- (3) A replacement factor will be established as a multiple of the payroll budget that will be based on contractual time off (vacations, holidays, etc.), an actuarially based projection of illness and injury, including FMLA projections based on previous years, and provision for other activities such as training, meetings and LMP projects.

(4) The replacement factor may be adjusted by operating needs as reflected in the staffing model (i.e., replacement staff may not be needed in certain situations).

Budgeting Illustration

Time-off Budget (per employee)	Days
Vacation (average)	20.0
Holidays	6.0
Personal days	3.0
Sick leave (average)	7.3
FMLA	1.8
Workers' Comp	0.9
Education/Training	5.0
Meetings (1 hour/week)	6.0
Projects/improvements (average)	2.0
TOTAL:	52.0

Total time off: 52 days / (52 weeks x 5 days = 260 days) = .20 or 20%

Discount (assuming replacement does not occur in 40% of cases due to workload, scheduling and flexibility):
 $.20 \times .40 = .08$ or 8%

Net time-off factor for budget ($.20 - .08 = .12$) or 12% replacement factor

May need to adjust the factor if the unit chooses to backfill a significant percent of time off with higher-cost sources (overtime or temp agency) instead of permanent staff.

Budget Line Items

Personnel	\$ 1,000,000
Benefits @ 42 percent	\$ 420,000
Backfill @ 12 percent	\$ 120,000
Total Personnel Budget	\$ 1,540,000

Innovative Work Schedules and Scheduling

- (1) Local units should consider flexible work schedules to enhance the ability of the unit to provide scheduled time off. Examples of flexible work schedules include: flex scheduling, telecommuting, job sharing, etc. (See p. 13 of the National Agreement. This states, "Respect for seniority and union jurisdiction, flexibility for employees' personal needs.... Flexibility in work scheduling, work assignments and other workplace practices.").
- (2) Local units should consider self-scheduling concepts, including self-directed teams where work groups would have responsibilities and be allowed to schedule themselves to accomplish them within defined parameters.
- (3) Facilities should consider services, vouchers or referral services to help employees address family issues (e.g., child care or elder care).

Tracking Time Off Requests

Short Term

- (1) Develop a basic system to capture data on requests for time off, approvals, denials and reasons for denials. The system may be a manual tracking sheet or a standalone computer application.
- (2) Use collected time-off data to set targets for time-off requests and to support scheduling.
- (3) Establish reporting of time-off data.
- (4) Complete and file time-off request reports at business-unit level.
- (5) Create monthly summaries of time off requested, taken and denied, and submit to Region to establish a region-wide view.
- (6) Consider limiting requests for denial data to those areas identified as high-absenteeism areas, as part of a specific intervention process.

Timeframe: Implement time-off reports by June 30, 2006

Long Term

- (1) Integrate and automate time-off requests and approval/denial into scheduling and/or time-keeping systems.
- (2) Integrated systems will include reporting at a unit level to facilitate administration of time-off requests as well as roll-up reporting to regional and national levels.

- (3) Each employee will have access to their own time-off request and status tracking via a self-service system such as a website.

Administering Time Off

- (1) Within the staffing plan, management and employees will work together to provide the flexibility, including flexible work schedules, to allow time off. Time off will not be allowed to compromise operating goals such as quality, service levels or safety.
- (2) Management and labor will jointly develop a system for requesting and approving or denying time off that is prompt, fair and transparent.
- (3) Frontline management and labor will jointly develop targets for percentage of requested time off granted.
- (4) Using data from the tracking system, the unit will jointly monitor requests for time off and work together to correct shortfalls.

EXHIBIT 1.F.1.c.6.

SAMPLE LABOR-MANAGEMENT STAFFING COMMITTEE CHARTER

COMMITTEE NAME:

The Committee shall be called the (Region) (Alliance union) (Bargaining Unit) Labor-Management Staffing Committee.

PURPOSE:

The purpose of this committee is to:

- » discuss issues related to staffing impacting the bargaining unit referenced above and develop recommendations, ideally by consensus, to address issues and jointly develop plans to implement those recommendations;
- » aim to find solutions to resolve department or unit level issues when they are brought to this committee for resolution; and
- » identify data that should be shared with departments, other LMP Committees, UBTs, or individuals (labor or management) in the service area or region, and develop a process for doing so.

SCOPE:

Topics to be discussed include but are not limited to:

- » position vacancies;
- » posting and filling of positions;
- » backfill;
- » time off;
- » attendance;
- » hard to fill positions;
- » staff utilization (including contingent staff, use of non-bargaining unit personnel, and scenarios where staffing challenges lead to contracting outside services);
- » staffing models;

- » flexibility as defined in the National Agreement;
- » budgets;
- » patient/member needs;
- » position control process;
- » people pulse scores;
- » data related to service/patient satisfaction; and
- » data related to patient access.

MEETING CADENCE AND DURATION:

The committee shall meet monthly for a two-hour period unless there is mutual agreement to change the duration or cadence of meetings. Labor and management recognize there may be a need to meet more frequently to address particular issues.

COMMITTEE COMPOSITION:

Members of the committee will be composed of senior Kaiser Permanente leaders and a potential combination of Alliance union leaders, members of the Alliance bargaining unit, and labor representatives from the Alliance union. The committee will consist of an equal number of members from the Alliance union and the company, or a greater number of union members.

LEADERSHIP:

The committee will be co-chaired by one labor representative from the Alliance union and one member of management, as identified by the union and Kaiser Permanente.

CO-CHAIR RESPONSIBILITIES:

- » model partnership behavior;
- » facilitate committee meetings;
- » prepare and plan for committee meetings, including: agenda planning, ensuring data is available for discussion, and inviting appropriate subject matter experts (SME) to committee meetings;
- » distribute minutes to committee members; and
- » identify needs and facilitate committee members having time between meetings to complete action items generated by committee decisions that may need to be finalized outside the normal meeting time.

MEMBERSHIP:

- » List of labor and management committee members.
- » Guests/observers/subject matter experts may participate in the discussion, share information and ideas, but will not participate in decision making.

MEMBERSHIP SELECTION:

- » Union membership will be selected by appropriate elected union leadership and/or their designees consistent with internal union procedures.
- » Company representatives will be selected by the senior managers of the relevant and appropriate business units.

MEMBER RESPONSIBILITIES:

- » model partnership behavior;
- » attend meetings and actively participate unless an absence is unavoidable;
- » if absence is unavoidable, member will:
 - › inform the Co-Chairs of absence as soon as possible; and
 - › review minutes from the meeting to ensure they are informed of discussions that occurred.
- » bring vital points of view to the committee for an absent committee member;
- » communicate outcomes and recommendations with committee members' constituents/audience;
- » identify barriers to the success of the committee and present potential solutions; and
- » support the final consensus decision and highlight committee successes.

COMMUNICATION:

- » The Co-Chairs will send out agendas/ meeting minutes to all committee members.
- » Agenda / minutes will capture action items and accountable parties.
- » Minutes will be provided to all committee members not more than 5 business days after a meeting.
- » Agendas will be sent no less than 5 business days prior to the next meeting.

DECISION MAKING:

- » Decisions affecting members not present, even with a quorum, may be deferred pending consideration of the missing party's interests.
- » Decision making quorum: 50% of Alliance members and 50% management members must be present to make decisions.
- » The committee will make all decisions by consensus, within the appropriate scope.
- » While committee members may on occasion send a delegate, any delegates attending will not participate in decision making.
- » Escalation of issues to Local or Regional LMP Council may occur for unresolved issues

EDUCATION:

All Labor-Management Staffing Committee members will have approved Partnership training to include: Introduction to Partnership, Consensus Decision Making, Interest-Based Problem Solving, financial and budget education (i.e. Business Literacy), and other training as determined by the Co-Chairs of the committee.

OVERSIGHT & SPONSORSHIP:

Regional or Local LMP Council

OVERSIGHT & SPONSORSHIP RESPONSIBILITIES:

- » Provide support and resources and remove barriers to backfill and staffing work by the committee.

SAMPLE CHARTER AND AGENDA

LABOR AND MANAGEMENT STAFFING COMMITTEE STANDING AGENDA ITEMS (A)
» Safety Minute.
» Confirm quorum and note taker/Introductions as needed.
» Review minutes/Make corrections/Follow-up items.
» Review 1F language discussion annually.
» Review/Address Staffing (staffing hotspots, temporary positions, leaves and use of registry/travelers, staffing models and mix, etc.).
» Review/Address Position Control (open positions, modified positions, internal and external/length of vacancies).
» Review posting and filling positions.
» Budget review/Backfill.Time off.
» Review/Identify and Address Hotspots of Attendance/Data Based
» Plan for next meeting and future agenda
» Identify information needed for meetings

ANNUAL CALENDAR OF AGENDAS (B)	
January	<ul style="list-style-type: none"> » Vacant positions not posted Q4 YTD » Joint Review of National Goals/Data/Progress (APSP, Big Dots = Access, Quality, Safety, Affordability, People & Systems, Care Experience, Service) Q4 YTD
February	<ul style="list-style-type: none"> » Review meeting Norms/Quorum/Contact Info for members » Joint Review Key Changes in Contract (if new contract year)
March	<ul style="list-style-type: none"> » Review Time Off Tracking Data » Review of staffing utilization for previous 60 days
April	<ul style="list-style-type: none"> » Vacant positions not posted Q1
May	<ul style="list-style-type: none"> » Joint Review of National Goals/Data/Progress (APSP, Big Dots = Access, Quality, Safety, Affordability, People & Systems, Care Experience, Service) Q1 YTD » Review of staffing utilization for previous 60 days
June	<ul style="list-style-type: none"> » Begin Discussion Seasonal/Winter Staffing
July	<ul style="list-style-type: none"> » Vacant positions not posted Q2 (par 1207) » Review/Time Off Tracking Data » Joint Review of National Goals/Data/Progress (APSP, Big Dots = Access, Quality, Safety, Affordability, People & Systems, Care Experience, Service) Q2 YTD » Review of staffing utilization for previous 60 days
August	<ul style="list-style-type: none"> » Follow up on Winter planning/Seasonal planning » Begin Budget Discussion: Backfill, Staffing, Future needs
September	<ul style="list-style-type: none"> » Budget Discussions: Backfill, Staffing, Future needs » Review of staffing utilization for previous 60 days » Winter/Seasonal Planning Update
October	<ul style="list-style-type: none"> » Vacant positions not posted Q3 » Joint Review of National Goals/Data/Progress (APSP, Big Dots = Access, Quality, Safety, Affordability, People & Systems, Care Experience, Service) Q3 YTD
November/ December	<ul style="list-style-type: none"> » Confirm meeting dates/locations for Next Years' calendar » Review Time Off Tracking Data » Review of staffing utilization for previous 60 days

EXHIBIT 1.H.2.

KAISER PERMANENTE WELL-BEING MODEL



EXHIBIT 1.H.5.

May 22, 2003

(Relevant section only)

MANDATORY OVERTIME DOCUMENTS

Applicable to all classifications.

It is the intent to discontinue the practice of scheduling/ requiring mandatory overtime. Effective August 15, 2003, mandatory overtime will not be used

except in a government-declared state of emergency. Even in a state of emergency, the facility/facilities will take all reasonable steps to utilize volunteers and to obtain coverage from other sources prior to mandating overtime. The pre-implementation time will be used to assess practices and develop new scheduling processes to make the discontinuance of mandatory overtime possible.

Specifically, the parties will jointly review where the practice of mandatory overtime exists and work with department staff to develop procedures, processes and solutions to avoid this need in the future. At the end of the pre-implementation period, it is expected that joint processes/procedures will be in place to assure successful implementation of the elimination of mandatory overtime after August 15.

Mandatory Overtime – Principles and Tools

We have a mutual vision to make Kaiser Permanente the best place to work, as well as the best place to receive care. Through the Partnership, unions, management and employees are sharing responsibility, information and decision making to improve the quality of care and service and enrich the work environment. The ability to rely on a stable schedule is fundamental to this equation, and the parties have therefore committed to discontinue mandatory overtime practices. Our overall goal is to avoid the mandatory assignment of unwanted work time outside of schedule requirements of the posted position.

A recent review indicated that there are very few departments or units where the problems resulting in the need for mandatory assignments remain. As a result, the parties have jointly prepared the following principles and tools to assist those areas in problem solving the issues and achieving the goal.

Principles

- » There is value in achieving the goal.
- » Patient care is of utmost importance.

- » Stability in work schedules is of utmost importance.
- » Respecting personal responsibilities and lives contributes to overall morale and commitment.
- » Management, union and employees should work collaboratively to identify the underlying issues and seek solutions.
- » Problems should be approached in an interest-based manner.
- » If the problems creating the situation or solutions are beyond the control of the concerned department, the employees, union and management will prepare a joint summary of the problem(s) and potential temporary and long-term solutions.
- » For situations that are not resolved at the work-unit level, every region will establish a joint review and appropriate problem-solving (i.e., issue resolution) process that provides for escalation to the highest joint partnership body for the Region. Ultimate solutions will be crafted in conjunction with Senior Regional and Union Leadership.

Tools

Departments/units needing assistance in achieving the goal are encouraged to use the following tools in problem solving:

- » Interest-Based Problem Solving
- » Mandatory Work Prevention Process developed by joint team in NCAL (attached)
- » Joint Staffing Processes
- » Root Cause Analyses

Training: What do we need to do in terms of training in order to prevent mandatory overtime?

1. Train managers/staffers, key partners and stakeholders in best practices of core staffing principles, including following contract language and use of tools such as ANSOS.
2. Expand current attendance education program information on mandatory overtime, covering topics such as prevention, staffing, appropriate use, etc.
3. Where appropriate and as needed to prevent mandatory overtime, provide skills training within common or overlapping occupational areas.
4. Implement manager training identified by workforce planning committee.

Communication: What do we need to do in terms of communication to prevent mandatory overtime?

1. Use LMP teams to communicate process, training and other aspects to prevent mandatory overtime.
2. Communicate the outcome of the Mandatory Work Prevention Process (MWPP). Collect data from staffing; then give data to LMP teams to communicate.

Process: What a unit should do if mandatory work seems like it is required.

1. Follow the MWPP as designed by your work group.
2. Evaluate what work could be postponed or prioritized for future time.
3. Read and follow your CONTRACT.
4. Start with the Volunteer List in Department to get someone to work.
5. If no volunteers, contact all available staff in Department and ask them to work.
6. If there are no department staff, ask trained (on-duty) staff from other departments and/or facilities who have made themselves available.
7. WAEF (when all else fails)—be as creative and flexible as possible.
 - › Try creative solutions, i.e., sharing/splitting a shift among staff; ask day staff to stay over or ask night shift staff to come in early; offer to give someone another day off if they come in if that will help.
8. If creativity doesn't work, you can try outside registry.
9. If you are unsuccessful up to this point, re-evaluate need and make the decision, if you must, to initiate mandatory work per agreement.
10. Record and report mandatory work to appropriate parties per MWPP.
 - › Following your unit's plan, bring each episode of mandatory work to your decided-upon forum. Review why the mandatory work happened. Try to figure out how it could be prevented in the future. Identify issues and trends.
 - › Twice a year report to your facility LMP Committee a summary of each of your mandatory episode reviews.
11. Continue to seek volunteers to relieve mandated staff up until the shift starts.

Next Steps**Facilities**

1. Each facility LMP committee should review this document and communicate the information to each department.
2. Each department in the facility should determine how they are going to prevent mandatory work in the future. They should share their ideas with the facility LMP Committee so good ideas can be communicated.
3. Each department should review the process described in the packet and think about how they can be creative in the future.
4. Each department needs to decide on the forum or meeting that they will discuss episodes of mandatory work. Ideas could be: joint staffing meetings, department meetings, etc.
5. At least twice a year each department should send a report of its episodes of mandatory work, issues, ideas, solutions or trends. (Sample attached)
6. The facility LMP groups will monitor the episodes of mandatory work. Share good ideas, identify trends, maintain statistical information and work with those departments that continue to have mandatory work and their respective entity leadership to help prevent future mandatory work.

Northern California Oversight

The LMP Northern California Oversight group will request the facility summaries of mandatory work at least once a year in order to identify Northern California trends, share best practices and influence the prevention (leading to the elimination) of mandatory work.

Office of LMP

The office of the LMP will include the prevention, process and reporting of mandatory work in the ongoing development of Joint Staffing.

Labor Management Steering Committee

Work with the appropriate HR and IT Systems staff to develop a timecard code and procedure to record mandatory work.

MANDATORY WORK REPORT

Presented by: (Name of Facility) _____

Kaiser Permanente Labor Management Partnership

Name of Unit: _____ Date Submitted: _____

Date Mandatory Work Required	# of Hours Required	Was it a		Why Did You Need Mandatory Work	Describe Your Process Before Requiring Mandatory Work	Summary of the Unit's Discussion of Mandatory Work	How Will You Prevent It in the Future?	Is This a Trend?	Issues, Questions, Concerns, Needs or Comments
		Planned Need	Emergent Need						

EXHIBIT 1.J.5.

PREVENTION OF WORKPLACE VIOLENCE

Areas of Focus for the National Team

» Education and Training Focus:

- › Catalog current trainings in the various forums;
- › Spread successful practices and implement consistently; and
- › Develop new trainings, as needed. These trainings should address the various forms of violence in the workplace.

» EAP Focus:

- › Ensure EAP resources are consistent throughout all Regions;
- › Identify inventory and make sure it is known throughout all the Regions; and
- › Identify other opportunities, such as sensitivity training regarding intentional and unintentional bullying.

» Organizational Consistency Focus:

- › Involve Labor, program-wide, in the Threat Management Team (TMT) process;
- › Consistently implement TMT throughout all Regions
- › Educate and promote about available event notification system; and

- › Identify successful violence prevention practices and training (e.g., de-escalation training, Green Blanket program, a violence prevention toolkit available to managers and frontline employees) and make recommendations to spread consistently throughout the Regions.

» Data and Reporting Focus:

- › Provide appropriate/relevant data during the market/level/service area LMP monthly/quarterly meetings; and
- › Identify the opportunity for a single data flow reporting process on events identified for common reporting. Include collecting and analyzing data and trends, and developing strategies to address them.

» Communications Focus:

- › Develop a communication process that includes “Follow-Up” assurance with the originator of the concern or complaint; and
- › Develop a communication strategy to increase awareness of violence prevention programs and resources. For example: Prevention of Workplace Violence (PWV) SharePoint, Annual Awareness week; a Resource Guide; etc.

EXHIBIT 1.K.4.

July 15, 2005, Memorandum of Understanding regarding subcontracting between Kaiser Foundation Health Plan/Hospitals, the Permanente Medical Groups and the Alliance of Health Care Unions (formerly a part of the Coalition of Kaiser Permanente Unions)

Preamble

This MOU is entered into by the parties pursuant to the National Agreement, as a supplement to the provisions of:

SECTION 1: PRIVILEGES AND OBLIGATIONS OF PARTNERSHIP

K: UNION SECURITY 4: SUBCONTRACTING

Kaiser Permanente and the Coalition of Kaiser Permanente Unions have agreed that the achievement of the Labor Management Partnership vision is critical to the success of the organization. The parties are committed as partners to the advancement of each other's institutional interests. This includes an understanding that no party will seek to advance its interests at the expense of the other party. The parties have also agreed to a joint decision-making process in which they will attempt to reach consensus on a broad range of business issues. It is within this framework that the National Agreement reaffirmed a partnership presumption against future subcontracting of bargaining unit work because it does not support the fundamental relationship between the parties.

A core interest of the Unions is to improve the quality, service and performance of Kaiser Permanente and further to improve the lives of their members through effective representation, and their ability to achieve that objective is enhanced by growth and reduced by erosion of their bargaining units; however, the parties agree that there could be extraordinary circumstances under which they might agree that bargaining unit work could be subcontracted. They also wish to consider the possibility of insourcing work that has previously been outsourced.

In order to assure that future subcontracting and insourcing of subcontracted work is aligned with the vision of the Labor Management Partnership, the following provisions have been adopted:

I. Definitions

Extraordinary Circumstances

The Partnership recognizes these interests through a presumption against subcontracting; however, the Partnership also recognizes subcontracting is appropriate in meeting day-to-day business needs, temporary peak workloads and hard-to-fill vacancies. In addition, subcontracting could be appropriate in extraordinary circumstances, defined as significant quality, service, patient safety, workplace safety or cost-savings opportunities that are of sufficient magnitude as to override the presumption against subcontracting.

Bargaining Unit Work

Work currently performed by bargaining unit employees anywhere in the Region.

Future Subcontracting

Any new or additional contracting of bargaining unit work.

Insourcing

Internalizing work that was previously performed in the bargaining unit, or which is Union eligible, that has been outsourced, to be performed by bargaining unit employees.

Feasibility Analyses

A joint process used by labor and management representatives to evaluate the feasibility and necessity of outsourcing or insourcing specific work, considering cost, quality, service, safety and efficiency by consensus decision making.

Costs

Capital expenditures, equipment, supplies and FTE efficiencies, but excluding the cost of wages and benefits.

II. Guidelines**Notification**

Partnership bargaining unit work will not be subcontracted except as described in extraordinary circumstances above. When Kaiser Permanente believes that current or future Partnership bargaining unit work should be subcontracted and further believes that there are reasons to subcontract, such as extraordinary circumstance, Kaiser Permanente will notify the appropriate union and the Coalition of Kaiser Permanente Unions, in writing, of the desire to meet and discuss subcontracting of specific work. A Union wishing to initiate consideration

of insourcing certain contracted work will likewise notify Kaiser Permanente of its desire to meet and discuss the issue.

Process

An initial meeting will occur as soon as possible following the date of written notification to the Union or to Kaiser Permanente. Kaiser Permanente management will be responsible for coordinating the meeting. A Committee of at least two union and two management representatives, with knowledge of the specific work under consideration, will be appointed to establish timelines for completion of the analysis, conduct the analysis, and develop a written report that summarizes the results of the analysis and states the subcontracting or insourcing recommendation to Management and Union leadership.

Interest-Based Problem Solving will be used to define the work done by the Committee. The Key Principles for Subcontracting (see Part 3) should guide the decision-making process.

The feasibility analysis should result in the development of one or more options from which the Committee will recommend one to the parties. One option to consider is the feasibility of implementing a rapid cycle improvement process that could achieve similar or better results when compared to the subcontracting option. The involved Union or Management may submit an alternative option, which will be considered by the Committee before making its final decision.

Once the analysis has been completed, the Committee will reach consensus on a recommendation on whether or not to subcontract or insource the work or consider an alternative course of action. If the committee is unable to reach consensus, either party may submit the issue(s) to the next level for resolution in accordance with the National Agreement.

III. Key Principles

Key Principles will guide the approach to subcontracting and insourcing, leading to consistency and standardization across the organization. Regional outcomes should be consistent with the national guidelines in the following areas:

Category	Subcontracting Principle	Insourcing Principle
Operational Feasibility	There has been consistent demonstration of the organization's inability to acquire or develop the expertise or capability required to effectively provide needed services. Quality, service, cost, workplace and patient safety will be considered in the study.	The potential workforce must have the expertise, capability, flexibility and knowledge base to enter and provide the needed service(s) with reasonable startup time or training. It is understood that any decision to insource work will require an adequate transition period for implementation. Quality, service, cost, workplace and patient safety will be considered in the study.
Staffing	The labor pool from which positions are filled is insufficient to meet demand. A business analysis illustrates the cost prohibitive nature of recruitment/ retention of staff, excluding labor rates and benefits costs.	The potential workforce is available in the labor market to allow KP to recruit for positions required by the proposed insourcing project.
Cost	A business analysis shows that retaining the services would be significantly more costly than comparable competitor operations, excluding labor rates and benefit costs, and puts the organization at a significant competitive disadvantage.	A business analysis has been completed for the insourcing option. The business analysis indicates that the insourcing option is significantly less costly than the contracted vendor, excluding labor rates and benefit costs.

Category	Subcontracting Principle	Insourcing Principle
Quality	It has been demonstrated that the organization does not have the core competencies required to provide the desired quality of service or to provide them efficiently. There has been a demonstrated inability to acquire the core competencies for success.	The insourcing solution complies with and ensures the quality standard that is acceptable and efficient to the organization.
Labor Relations	The union should receive adequate notification of the desire to subcontract services. All applicable provisions of the National Agreement will be adhered to, by the Alliance and Management.	Wages and job duties/descriptions are created, confirmed and negotiated, as necessary. Jurisdictional issues are clarified.
Contracting and Compliance	The subcontracting solution does not create or result in liability with any existing contracts or other unions/bargaining units performing the work. Compliance with requirements of JCAHO, EEOC, HCFA, Title 22 and SMWBE (Small, Minority, Women-owned Business Enterprise) are ensured.	The insourcing solution does not create or result in liability with any existing vendor contracts or other unions/ bargaining units performing the work. Compliance with requirements of JCAHO, EEOC, HCFA, Title 22 and SMWBE (Small, Minority, Women-owned Business Enterprise) are ensured.
Employer of Choice	The subcontracting solution should be in keeping with the vision of KP becoming the Employer of Choice. The subcontracting solution supports KP's involvement in community service.	The insourcing solution will support KP's involvement in community service and contribute to KP being the employer of choice.
Ongoing Review	If a decision results in keeping the function/service in KP, results will be periodically reviewed to determine if efficiencies were achieved. In the event the goals/ efficiencies are not achieved, subcontracting will become an option.	If a decision results in bringing work into KP, the service or function will be periodically reviewed to determine if efficiencies/goals were achieved. In the event the goals/ efficiencies are not achieved, subcontracting will become an option.

EXHIBIT 2.A.1.

ROC (GEORGIA, HAWAII, MID-ATLANTIC STATES, WASHINGTON) ATB INCREASES

For 2019, the Georgia, Hawaii and Mid-Atlantic States regions will receive 2% and an additional 0.75%. The 0.75% ATB will be implemented prospectively in 2020 (six weeks after finalized agreement) and the lump sum will be paid for the period between the first pay period in October 2019 and the effective date of the new rates. The lump-sum calculation will be paid before the end of June 2020, based on employees' compensated hours.

For 2019, in the Washington region, the UFCW Pro Tech Optical unit will receive an additional 0.5% ATB. The implementation time lines and lump-sum calculation methodology for this increase are the same as those outlined above.

EXHIBIT 2.A.2.

ELEMENTS OF AN EFFECTIVE PERFORMANCE IMPROVEMENT REWARD PROGRAM

In general, an effective reward program should be:

Based on a Compelling Case for Improvement

- » Be based on engaging employees in a continuum of knowledge about the business context in which KP operates
- » Be linked to a visionary and motivating reason to achieve the improvements; i.e., impact on improving members'/

patients' lives and keeping KP affordable to working families

Simple/Be Easy for All to Understand

Well Communicated

Goals Can be Cascaded "Up and Down"

- » So all understand the role their efforts play in meeting regional/national goals

Based on Line-of-Sight Improvements

- » Connected to the day-to-day work at the lowest possible (ideally unit) level
- » Be linked to day-to-day behaviors that are in the power of the employees to affect

Based on Metrics That Are:

- » tied to strategic goals and focused on the key drivers of results
- » objective
- » outcome based, or, if process measures, they should be linked to achieving outcomes
- » captured and reported at the lowest possible (ideally unit) level
- » as uniform across regions as possible so can compare and benchmark

Easy to Administer

Timely

- » In terms of when the goals are set and communicated
- » When progress is reported
- » In how payouts are linked to efforts made by employees

Stable

- » Don't change it mid-stream unless prove it can be made more effective
- » Part of overall recruitment/retention strategy
- » As a reason we are a best place to work: employees engaged in performance improvement and rewarded for their efforts

Self-Funded

EXHIBIT 2.B.1.c.

LETTER OF AGREEMENT PARENT MEDICAL COVERAGE

In accordance with Section 2.B.1.c. of the 2000 National Agreement, effective May 1, 2002, Kaiser Permanente will offer federally non-qualified group medical coverage to parents of employees represented by a National Partnership Union.

In order for an employee's parents to qualify for this coverage, the employee must be an active employee and be eligible for medical benefits, whether or not they actually enroll in Health Plan coverage.

Benefits included in Parent Medical coverage are:

- » \$5 doctor's office visits
- » \$5 prescription drug coverage
- » Uncapped prescription drug benefit
- » \$5 hearing and vision exams
- » No charge for inpatient hospital care
- » No charge for lab tests and X-rays

- » No charge for allergy testing and treatment
- » \$25 Emergency department copayment
- » No charge for approved ambulance services

Individuals who enroll in Parent Medical Coverage will be responsible for the entire amount of the premium for their coverage, as well as for any applicable copayments and any Third Party Administrative fees. Kaiser Permanente will not subsidize any portion of the premiums.

BILL ROUSE

Benefits Task Force Labor Co-Chair

UNAC/UHCP, AFSCME

ELLEN CANTER

Benefits Task Force Management Co-Chair

VP, Benefits and HR Administration

Kaiser Permanente

Intent Parent Medical Coverage

In accordance with the 2000 National Agreement, effective May 1, 2002, Kaiser Permanente will offer federally non-qualified group medical coverage to parents of employees represented by a National Partnership Union.

Eligibility

Eligible Employees

In order for an employee's parents to qualify for this coverage, the employee must be an active employee represented by a Kaiser Permanente National Partnership Union and be eligible for

medical benefits, whether or not they actually enroll in Health Plan coverage. An employee is also considered eligible if they retired from Kaiser Permanente as a member of a National Partnership Union between October 1, 2000, and March 1, 2002, in accordance with the provisions of their retirement plan.

Eligible Parents

The following are considered eligible parents and may enroll in Parent Medical Coverage as long as the employee through whom they claim coverage meets the eligibility requirements above:

- » Employee's natural parents.
- » Employee's stepparents, if still married to or widowed from employee's natural parent. Widowed stepparents who remarry will not be eligible for coverage.
- » A domestic partner of employee's parent. The domestic partner will be required to complete an Affidavit of Domestic Partnership.
- » Employee's spouse's or domestic partner's natural parents.
- » Employee's spouse's or domestic partner's stepparents, if still married to or widowed from spouse's or domestic partner's natural parent. Widowed stepparents who remarry will not be eligible for coverage.
- » A domestic partner of spouse's parent. The domestic partner will be required to complete an Affidavit of Domestic Partnership.

To be eligible, parents and parents-in-law must reside in the same region as the

Partnership Union employee through whom coverage is being offered.

For the purposes of this plan, Northern California and Southern California will be considered separate regions.

Dependents of parents are not eligible for this coverage.

Enrollment in Parent Medical Coverage

Enrollment for Parent Medical Coverage will only be allowed only during designated enrollment periods.

There will be an annual open enrollment period.

- » New employees will have 31 days from their date of hire to enroll their eligible parents. Coverage will be effective on the 1st of the month following enrollment.
- » Employees who have a change in eligibility status (e.g., change from a non-benefited to a benefited status, or a marriage or divorce) will have 31 days to enroll or disenroll parents from coverage. Coverage will be effective on the 1st of the month following enrollment.
- » Employees and their eligible parents are required to fill out and return all necessary forms and provide any requested documentation prior to enrollment.
- » Each eligible parent must enroll separately. In addition, enrollees who are eligible for Medicare Parts A and B must submit a Senior Advantage enrollment form.

- » Parents may enroll outside of the open enrollment period if they move into the region, or become newly eligible for Medicare, within 31 days of the qualifying event.
- » Parents who disenroll from this coverage for any reason must wait until the next open enrollment period to re-enroll.

Coverage Premiums

- » Coverage premiums are age-rated for all non-Medicare eligible parents. Premiums are subject to change annually.
- » Age-rated premiums will be charged based on subscriber's age on the date of enrollment. After the initial enrollment, age-related premium increases for subsequent years will be determined based on subscriber's age as of January 1 of that year.
- » Medicare-eligible enrollees in this plan will be pooled with other Medicare-eligible members in their region to determine premium rates.
- » Individuals who enroll in Parent Medical Coverage will be responsible for the entire amount of the premium for their coverage, as well as for any applicable copayments and any Third Party Administrative fees.
- » Kaiser Permanente will not subsidize any portion of the premiums for this coverage.
- » Premium payments for coverage are made directly through the Third Party Administrator of the plan, currently WageWorks.

Coverage

Parent Medical Coverage is essentially the same in all regions in which Kaiser Foundation Health Plan medical services are available. However, there will be certain regional differences in how the Health Plan is administered, including differences in some copayments, exclusions and limitations. Benefits included in Parent Medical Coverage are:

- » \$5 doctor's office visits
- » \$5 prescription drug coverage
- » Uncapped prescription drug benefit
- » \$5 hearing and vision exams
- » No charge for inpatient hospital care
- » No charge for lab tests and X-rays
- » No charge for allergy testing and treatment
- » \$25 Emergency department copayment
- » No charge for approved ambulance services

There will be no exclusions for pre-existing conditions, and no medical review will be required.

Copayments in the plan will be maintained at the current level to the extent that such copayments are available in each region, as long as the plan maintains its "large group" status.

Medicare-eligible parents who are enrolled in Medicare Parts A and B and assign their benefits to Kaiser Permanente will be offered Senior Advantage or a similar Medicare Risk plan where available. In regions where there is no Medicare Risk plan, a Medicare Cost plan will be substituted.

Parents who are enrolled in Medicare Part A only will receive the non-Medicare benefits, but may be eligible for reduced premiums.

In areas where Kaiser Permanente does not offer any Medicare plan, eligible parents may still enroll in the non-Medicare plan, and will pay the non-Medicare premiums, regardless of their participation in Medicare.

Coverage will be available in all regions in which Kaiser Foundation Health Plan medical services are offered and in which there are active National Partnership Union employees, including the Northern California and Southern California, Colorado and Mid-Atlantic States Regions. The Northwest Region will continue to offer its existing parent coverage plan, under the rules already established for that plan. National Partnership Union employees in Texas will not be eligible to enroll their parents in this plan, as there is no Kaiser Foundation Health Plan coverage available in that region.

When Parents Lose Coverage

Coverage will end at the end of the month in which:

- » The employee through whom a parent claims benefits terminates prior to retirement, is no longer represented by a National Partnership Union, or is no longer eligible per the eligibility requirements above.
- » The parent no longer meets the eligibility requirements as stated in the “Eligible Parents” section above.

- » The employee and covered parent no longer reside in the same region. For the purposes of this plan, Northern California and Southern California are considered two separate regions.
- » Premiums for medical coverage are not paid.

Parents who are disenrolled from Parent Medical Coverage will be offered conversion to an individual plan.

May 22, 2003

(Relevant section only)

Sponsored Parent/ Parent-In-Law Group

Applicable to parents and parents-in-law of all classifications.

Effective January 1, 2003, parents and parents-in-law of Regular employees will be offered the opportunity to purchase the enhanced Senior Advantage health plan coverage at their own expense provided they are enrolled in Parts A and B of Medicare and meet the eligibility rules of the Senior Advantage health plan. For those regions without a Senior Advantage product, the Medicare product available in that Region will be offered.

The enrollment rules, eligibility and plan design (benefits and copays) will be consistent although not identical, (regional variation may apply) and will be reviewed by the Benefits Task Force (regional variation may apply). The Employer shall not be required to bargain over such changes. However, the Employer shall provide the unions with 45 days’ notice of the nature and date of such changes.

Participants enrolled prior to January 1, 2003, will be Legacy under their current eligibility rules.

In the Northwest, the parties will resolve the issue as follows:

(1) No new non-Medicare eligible will be admitted.

(2) Rates for Legacy group will be raised by the same percent the market increases annually plus an additional 25% annually toward closing the gap to market, with intent to reach market rates at year four.

(3) New enrollees will be charged market rates.

EXHIBIT 2.B.1.g.

**SUPPLEMENTAL MEDICAL —
CHIROPRACTIC AND ACUPUNCTURE BENEFITS**

REGION	EE GROUP	
NCAL	UNAC Therapists (mid/High plan only)	
SCAL	UNAC SCNSC	UNAC Pharmacists
	KPMWON-CNM	KPASCO*
	KPMWON-WOCN	UNAC*
	UTSC	KPNAA*
Colorado	UFCW Local 7 IUOE Local 1 UFCW Local 7MH	
Northwest	OFNHP Professionals OFNHP Lab Professionals ILWU Local 28	
Georgia	UFCW Local 1996 Clerical/Technical UFCW Local 1996 Professionals Union Eligible	
Hawaii	UNAC PT/OT UNAC Pharmacists	

* eligibility for supplemental medical is different than eligibility for active medical.

EXHIBIT 2.B.2.b.**LIST OF LMP DEFINED-BENEFIT PLANS SPONSORED BY KAISER PERMANENTE****Plan Name**

- » Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP
- » Kaiser Permanente Fontana Pension Plan Supplement to KPRP
- » Kaiser Permanente Northwest Pension Plan Supplement to KPRP
- » Kaiser Permanente Colorado Professional Employees Pension Plan Supplement to KPRP
- » Kaiser Permanente Mid-Atlantic Employees Pension Plan Supplement to KPRP
- » Kaiser Permanente Physicians and Employees Retirement Plan Supplement to KPRP
- » Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP
- » Kaiser Permanente Fontana Pension Plan Supplement to KPRP for SCPMG
- » Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP for SCPMG
- » Kaiser Permanente Nurse Anesthetists Pension Plan Supplement to the KPRP for SCPMG
- » Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP for SCPMG

- » Kaiser Permanente Hawaii Employees Pension Plan Supplement to KPRP

Letter of Agreement

In accordance with the Common Retirement Plan provisions of the 2000 National Agreement, the undersigned constituted a Labor Management Partnership Committee to consider moving to a common minimum pension multiplier. The committee met on January 7, 2002, and after consideration, agreed to a common minimum pension multiplier of 1.4% for National Agreement signatory unions. The new minimum multiplier is effective January 7, 2002, and will be retroactively applied to participants who terminate on or after October 1, 2000. This agreement applies to all sponsoring employers of Kaiser Permanente pension plans covering members of Partnership unions listed in the attachment, Section A. Plans will be amended to reflect the new minimum multiplier.

In addition, the Committee agrees that employees covered by these plans and members of the signatory unions to the National Agreement, who are plan participants but whose benefits have been grandfathered at a lower pension multiplier, will also have their multiplier moved to the new minimum multiplier.

Finally, the Committee agrees that employees covered by the National Agreement who are reflected in the attachment, Section B, and as such are currently in a pension plan that provides a pension multiplier equal to or higher than the new minimum, shall maintain the current multiplier.

PETER DICICCO	BILL ROUSE
Executive Director	Benefits Task Force Labor Co-Chair
Coalition of Kaiser Permanente Unions	UNAC/UHCP, AFSCME
LESLIE MARGOLIN	ELLEN CANTER
Senior VP, Workforce Development	Benefits Task Force Management Co-Chair
Kaiser Permanente	VP, Benefits and HR Administration
	Kaiser Permanente

RELEVANT SECTIONS OF ATTACHMENT TO LETTER OF AGREEMENT CONCERNING: 1.45 PERCENT MULTIPLIER

PLAN	UNION
MID-ATLANTIC STATES	
Kaiser Permanente Mid-Atlantic Employees Pension Plan Supplement to KPRP	United Food and Commercial Workers, Local 27, Health Professionals United Food and Commercial Workers, Local 400, Health Professionals
GEORGIA	
Kaiser Permanente Physicians and Employees Retirement Plan Supplement to KPRP	United Food and Commercial Workers, Local 1996
NORTHWEST	
Kaiser Permanente Northwest Pension Plan Supplement to KPRP	Oregon Federation of Nurses and Health Professionals, Local 5017, Registered Dental Hygienists Oregon Federation of Nurses and Health Professionals, Local 5017, Technical Employees Oregon Federation of Nurses and Health Professionals, Local 5017, Registered Nurses International Longshoremen’s and Warehousemen’s Union, Local 28 Oregon Nurses Association, AFT

1.45 PERCENT MULTIPLIER continued

PLAN	UNION
SOUTHERN CALIFORNIA	
Kaiser Permanente Fontana Pension Plan Supplement to KPRP (and KPRP for SCPMG)	United Steel Workers of America, Local 7600
Kaiser Permanente Nurse Anesthetists Pension Plan Supplement to the KPRP for SCPMG	Kaiser Permanente Nurse Anesthetists Association
Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP	United Nurses Association of California/Union of Health Care Professionals United Food and Commercial Workers, Local 770, Bakersfield/Kern County, Healthcare Workers United Food and Commercial Workers, Local 770, Kern County Administrative/Clerical Unit United Nurses Association of California/Union of Health Care Professionals, United Therapists of Southern California
Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP for SCPMG	United Food and Commercial Workers, Locals 135, 324, 770 and 1428, Clinical Laboratory Scientists and Medical Laboratory Technicians United Nurses Association of California/Union of Health Care Professionals United Food and Commercial Workers, Local 770, Bakersfield/Kern County, Healthcare Workers United Food and Commercial Workers, Local 770, Kern County Administrative/Clerical Unit International Brotherhood of Teamsters, Local 166 United Nurses Association of California/Union of Health Care Professionals, United Therapists of Southern California
HAWAII	
Kaiser Permanente Hawaii Employees Pension Plan Supplement to KPRP	UNITE HERE Local 5

1.5 PERCENT MULTIPLIER

PLAN	UNION
MULTIPLE REGIONS	
Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP	NORTHWEST Oregon Federation of Nurses and Health Professionals, Local 5017, Laboratory Professionals Oregon Federation of Nurses and Health Professionals, Local 5017, Professional Employees
	SOUTHERN CALIFORNIA United Nurses Association of California/Union of Health Care Professionals, Specialty Care Nurses of Southern California United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Midwives and Wound Ostomy Nurses
	NORTHERN CALIFORNIA United Nurses Association of California/Union of Health Care Professionals, United Therapists of Northern California (UTNC)
	HAWAII United Nurses Association of California/Union of Health Care Professionals, United Pharmacists of Hawaii (UPHI) United Nurses Association of California/Union of Health Care Professionals, United Therapists of Hawaii (UTH)
	SOUTHERN CALIFORNIA
Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP for SCPMG	United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Association of Southern California Optometrists United Nurses Association of California/Union of Health Care Professionals, Specialty Care Nurses of Southern California United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Midwives and Wound Ostomy Nurses

1.5 PERCENT MULTIPLIER *continued*

PLAN	UNION
COLORADO	
Kaiser Permanente Colorado Professional Employees Pension Plan Supplement to KPRP	United Food and Commercial Workers, Local 7, Professional and Health Care Division United Food and Commercial Workers, Local 7, Mental Health Workers International Union of Operating Engineers, Local 1

NOTE: The term “supplement” in this exhibit refers to the fact that individual retirement plans, for example Kaiser Permanente Retirement Plan (KPRP), are filed with the federal government for each corporate entity (Kaiser Foundation Health Plan, Southern California Permanente Medical Group, etc.). These retirement plans are comprised of separate pieces of a larger pie. The separate pieces are the *supplements* to the overall retirement plans we file with the government under ERISA.



May 22, 2003

(Relevant section only)

Pension

Effective March 1, 2003, for pension plans of employees covered by agreements of Partner unions that currently provide for a defined-benefit plan with a multiplier of 1.4% FAP, the FAP multiplier will increase to 1.45%. This multiplier will apply to all years of service. In addition, 1,800 hours will be considered a year of Credited Service under these plans for pension calculation purposes. This new Credited Service hours definition will be effective beginning with the 2003 calendar year.

In the Northwest, effective March 1, 2003, for OFN/ONA RNs, OFN-Hygienists and Technical employees who have a defined-contribution plan only, the improvement described above will apply prospectively only.

In the Northwest, effective March 1, 2003, the employer contribution to the defined-contribution plan will be changed as follows: 1% for OFN-Hygienists and Technical employees and 1.5% for OFN/ONA RNs.

It is understood that where pension plans are moving from a defined-contribution plan to a defined-benefit plan, such is subject to ratification of the bargaining unit.

Letter of Agreement Early Reduction Factors

In accordance with the Common Retirement Plan provisions of the 2000 National Agreement (Section 2.B.2.b.),

the undersigned constituted a Labor Management Partnership Committee to consider changes in the early reduction factors for the defined-benefit pension plans. After consideration, the committee agreed to change early reduction factors used in calculating pension benefits from an actuarial reduction based on age to a standard 5% reduction per year for National Agreement signatory unions.

The new early reduction factors are effective immediately, and will be retroactively applied to participants who take either Early Retirement or Disability Retirement on or after January 1, 2002. This agreement applies to all sponsoring employers of Kaiser Permanente pension plans covering members of Partnership unions listed in the attachment, Section A. Plans will be amended to reflect the new early reduction factors.

In addition, the Committee agrees that employees covered by the National Agreement who are reflected in the attachment, Section B, who as such are currently in a pension plan that provides early reduction factors equal to or higher than the new minimum, shall maintain their current early reduction factors.

Finally, the Committee agrees that pension benefits will be recalculated, and corrective payments made to National Partnership Union members who have taken Early Retirement or Disability Retirement and have received a distribution from their Kaiser Permanente defined-benefit pension plan between the effective date of the change and the present.

RELEVANT SECTIONS OF ATTACHMENT TO LETTER OF AGREEMENT CONCERNING EARLY REDUCTION FACTORS

PLAN EARLY RETIREMENT FACTORS			
Age	5% Method	Age	5% Method
55	50	60	75
56	55	61	80
57	60	62	85
58	65	63	90
59	70	64	95

PLAN	UNION
NORTHWEST	
Kaiser Permanente Northwest Pension Plan Supplement to KPRP	Oregon Federation of Nurses and Health Professionals, Local 5017, Registered Dental Hygienists Oregon Federation of Nurses and Health Professionals, Local 5017, Technical Employees Oregon Federation of Nurses and Health Professionals, Local 5017, Registered Nurses International Longshoremen's and Warehousemen's Union, Local 28 Oregon Nurses Association, AFT
SOUTHERN CALIFORNIA	
Kaiser Permanente Fontana Pension Plan Supplement to KPRP (and KPRP for SCPMG)	United Steelworkers of America, Local 7600
Kaiser Permanente Nurse Anesthetists Pension Plan Supplement to the KPRP for SCPMG	Kaiser Permanente Nurse Anesthetists Association
Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP	United Nurses Association of California/Union of Health Care Professionals United Food and Commercial Workers, Local 770, Bakersfield/Kern County, Health Care Workers United Food and Commercial Workers, Local 770, Kern County Administrative/Clerical Unit United Nurses Association of California/Union of Health Care Professionals, United Therapists of Southern California

RELEVANT SECTIONS OF ATTACHMENT TO LETTER OF AGREEMENT CONCERNING EARLY REDUCTION FACTORS continued

PLAN	UNION
SOUTHERN CALIFORNIA (CONTINUED)	
Kaiser Permanente Southern California Employees Pension Plan Supplement to KPRP for SCPMG	United Food and Commercial Workers, Locals 135, 324, 770, and 1428, Clinical Laboratory Scientists and Medical Laboratory Technicians
	United Nurses Associations of California/Union of Health Care Professionals
	United Food and Commercial Workers, Local 770, Bakersfield/Kern County, Health Care Workers
	United Food and Commercial Workers, Local 770, Kern County Administrative/Clerical Unit
	International Brotherhood of Teamsters, Local 166
	United Nurses Association of California/Union of Health Care Professionals, United Therapists of Southern California
MID-ATLANTIC STATES	
Kaiser Permanente Mid-Atlantic Employees Pension Plan Supplement to KPRP	United Food and Commercial Workers, Local 27, Health Professionals
	United Food and Commercial Workers, Local 400, Health Professionals
GEORGIA	
Kaiser Permanente Physicians and Employees Retirement Plan Supplement to KPRP	United Food and Commercial Workers, Local 1996

NOTE: The term “supplement” in this exhibit refers to the fact that individual retirement plans, for example Kaiser Permanente Retirement Plan (KPRP), are filed with the federal government for each corporate entity (Kaiser Foundation Health Plan, Southern California Permanente Medical Group, etc.). These retirement plans are comprised of separate pieces of a larger pie. The separate pieces are the supplements to the overall retirement plans we file with the government under ERISA.

PLAN EARLY RETIREMENT FACTORS			
Age	3 and 5% Method	Age	3 and 5% Method
55	60	60	85
56	65	61	88
57	70	62	91
58	75	63	94
59	80	64	97

RELEVANT SECTIONS OF ATTACHMENT TO LETTER OF AGREEMENT CONCERNING EARLY REDUCTION FACTORS continued

PLAN	UNION
MULTIPLE REGIONS	
Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP	NORTHWEST Oregon Federation of Nurses and Health Professionals, Local 5017, Laboratory Professionals Oregon Federation of Nurses and Health Professionals, Local 5017, Professional Employees
	SOUTHERN CALIFORNIA United Nurses Association of California/Union of Health Care Professionals, Specialty Care Nurses of Southern California United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Midwives and Wound Ostomy Nurses
SOUTHERN CALIFORNIA	
Kaiser Permanente Represented Employees Pension Plan Supplement to KPRP for SCPMG	United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Association of Southern California Optometrists
	United Nurses Association of California/Union of Health Care Professionals, Specialty Care Nurses of Southern California
	United Nurses Association of California/Union of Health Care Professionals, Kaiser Permanente Midwives and Wound Ostomy Nurses
COLORADO	
Kaiser Permanente Colorado Professional Employees Pension Plan Supplement to KPRP	United Food and Commercial Workers, Local 7, Professional and Health Care Division
	United Food and Commercial Workers, Local 7, Mental Health Workers
	International Union of Operating Engineers, Local 1

PLAN EARLY RETIREMENT FACTORS			
Age	6% Method	Age	6% Method
55	42.39	60	63.82
56	45.88	61	69.57
57	49.73	62	75.96
58	53.96	63	83.09
59	58.64	64	91.06

RELEVANT SECTIONS OF ATTACHMENT TO LETTER OF AGREEMENT CONCERNING EARLY REDUCTION FACTORS continued

PLAN	UNION
HAWAII	
Kaiser Permanente Hawaii Employees Pension Plan Supplement to KPRP	UNITE HERE Local 5

EXHIBIT 2.B.2.i.

RETIREE MEDICAL BENEFITS – BASE ELIGIBILITY

LOCAL UNION/BARGAINING GROUP	BASE ELIGIBILITY PRM	BASE PRM BENEFIT
NORTHERN CALIFORNIA		
UNAC/UHCP Kaiser Permanente, United Therapists of Northern California (UTNC) (effective January 1, 2023)	55 & 15 or Disability & 10 YOS Eligible for active med on term date	KPSA Mid-level group plan w/ Supplemental Medical
SOUTHERN CALIFORNIA		
UNAC/UHCP Kaiser Permanente Midwives and Wound Ostomy Nurses; UNAC/UHCP Specialty Care Nurses of Southern California	55 & 15 or age & svc = 75 with 15 YOS Eligible for active med on term date	KPSA Mid-level group plan w/ Supplemental Medical
UNAC/UHCP UTSC – Therapists UNAC/UHCP Pharmacists	55 & 15 or Disability & 10 YOS Eligible for active med on term date	KPSA Mid-level group plan w/ Supplemental Medical
UFCW Local 770 Bakersfield and Kern Co. and CLS	55 & 15 or Disability & 10 YOS	KPSA group plan
UNAC/UHCP (L.A. and San Diego)	55 & 15 or Disability & 10 YOS	KPSA group plan

RETIREE MEDICAL BENEFITS – BASE ELIGIBILITY continued

LOCAL UNION/BARGAINING GROUP	BASE ELIGIBILITY PRM	BASE PRM BENEFIT
SOUTHERN CALIFORNIA (CONTINUED)		
Teamsters Local 166, USW Local 7600	55 & 15 or Disability & 10 YOS Eligible for active med on term date	KPSA group plan
KPNAA Nurse Anesthetists	55 & 15 or age & svc = 75 with 15 YOS or Disability & 10 YOS	KPSA group plan (with Supp Med if enrolled and ER paid at retirement)
KPASCO Optometrists	55 & 15 or age & svc = 75 with 15 YOS Eligible for active med on term date	KPSA group plan (with Supp Med if enrolled and ER paid at retirement)
IUOE Local 501	55 & 15 or Disability & 10 YOS Eligible for active med on term date	KPSA group plan OR Alternate Medical
COLORADO		
IUOE Local 1 Operating Engineers	55 & 15 or age & svc = 75 with 15 YOS Eligible for active med on term date	KPSA/HRA and Subsidy
UFCW Local 7 Mental Health Workers; and Professional UFCW Local 7 Professional and Health Care Division	55 & 15 or age & svc = 75 with 15 YOS Eligible for active med on term date	KPSA/HRA and Subsidy
GEORGIA		
UFCW Local 1996	55 & 15	KPSA/HRA and Subsidy
MID-ATLANTIC STATES		
UFCW Local 27 and UFCW Local 400	55 & 15 Eligible for active med on term date	KPSA/HRA and Subsidy

RETIREE MEDICAL BENEFITS – BASE ELIGIBILITY continued

LOCAL UNION/BARGAINING GROUP	BASE ELIGIBILITY PRM	BASE PRM BENEFIT
NORTHWEST		
ILWU Local 28; OFNHP Local 5017 Dental Hygienists, RNs, Technical; Oregon Nurses Association	55 & 15 or age & svc = 75 with 15 YOS or Disability & 15 YOS Enrolled in medical on term date	KPSA/HRA and Subsidy
OFNHP Local 5017 Lab Professionals, Professionals	55 & 15 or age & svc = 75 with 15 YOS or Disability & 15 YOS Enrolled in medical on term date	KPSA/HRA and Subsidy
HAWAII		
UNAC/UHCP Pharmacists (UPHI); UNAC/UHCP Therapists (UTH)	55 & 15 or Disability & 10 YOS Eligible for active med on term date	KPSA/HRA and Subsidy
WASHINGTON		
UFCW Local 3000 Pharmacy, ProTech/Optical (Eastern WA Pharmacy Tech effective January 1, 2023)	55 & 15 Eligible for active med on term date	HRA only

DEPENDENT ELIGIBILITY NOTE: All groups are “same as active.” However, dependents of the following groups must be enrolled on term date in order to be eligible for retiree medical coverage: ILWU Local 28; OFNHP Local 5017 Dental Hygienists, Lab Professionals, Professionals, RNs and Technical; Oregon Nurses Association; UFCW Local 3000.

EXHIBIT 2.B.2.i.6.**REHIRED RETIREES**

As a result of a dispute between the Parties, KP and the CKPU held a dispute resolution panel under Section 2.C. of the 2015-2018 National Agreement on September 29–30, 2016, to resolve retiree medical eligibility post-retirement and re-retirement as it relates to Section 2.B.2.h [now Section 2.B.2.i], Retiree Medical Benefits of the National Agreement, in circumstances where employees return to work after retiring with eligibility for retiree medical benefits. Section 2.B.2.h. [now Section 2.B.2.i] of the National Agreement is clarified as follows:

California Retirees**PRE-2017**

As provided in the National Agreement, for California employees who retire before January 1, 2017, with eligibility for retiree medical benefits, the existing retiree medical plans, including Employer contribution rates or cost share, shall remain the same. Retiree medical benefits, including copayments and out-of-pocket maximums, for retirees in a KP service area shall be the same as the active medical benefits and cost-sharing features at the time the retiree initially enrolls in the KP retiree medical plan.

If an employee is rehired in a non-benefited position after retiring with eligibility for retiree medical benefits **but before** commencing their retiree medical benefit, the employee will maintain their eligibility to enroll in the retiree medical benefit for which they were first eligible to enroll.

If an employee is rehired after they retire with eligibility for retiree medical benefits **and after** commencing their retiree medical benefit, the employee's ability to maintain retiree medical benefit coverage will depend on the position status, benefited or non-benefited, in which they are rehired.

Benefited position: If an employee is rehired into a benefited position, their retiree medical benefit will be replaced by active medical benefits while working. Once the employee re-retires from their benefited position, the retiree medical benefits the employee is offered will be the retiree medical benefits in effect on the date they re-retire and for the employee group from which they re-retire.

Non-benefited position: If an employee is rehired into a non-benefited position, the employee will maintain coverage under their retiree medical benefit, and when the employee re-retires they shall also maintain coverage under the same retiree medical benefit.

POST-2016

As provided in the National Agreement, for California employees who retire on or after January 1, 2017, the employees shall be covered by the Medical Premium Subsidy/HRA Plan effective in 2028 or, if later, when the net cost in either region exceeds the Fixed Amount defined in Section 2.B.2.h.5. [now Section 2.B.2.i.5] of the National Agreement. Before the Medical Premium Subsidy/HRA Plan becomes effective, retiree medical benefits, including copayments and out-of-pocket maximums, for retirees in a KP service area shall be the same as the

active medical benefits and cost-sharing features at the time the retiree initially enrolls in the KP retiree medical plan.

If an employee is rehired in a non-benefited position after retiring with eligibility for retiree medical benefits **but before** commencing their retiree medical benefit, the employee will maintain their eligibility to enroll in the retiree medical benefit for which they were first eligible to enroll.

If an employee is rehired after they retire with eligibility for retiree medical benefits **and after** commencing their retiree medical benefit, the employee's ability to maintain retiree medical benefit coverage will depend on the position status, benefited or non-benefited, in which they are rehired.

Benefited position: If an employee is rehired into a benefited position, their retiree medical benefit will be replaced by active medical benefits while working. Once the employee re-retires from their benefited position, the retiree medical benefits the employee is offered will be the retiree medical benefits in effect on the date the employee re-retires and for the employee group from which they re-retire.

Non-benefited position: If an employee is rehired into a non-benefited position, they will maintain coverage under their retiree medical benefit up until the date the Medical Premium Subsidy/HRA Plan becomes effective. On the date the Medical Premium Subsidy/HRA Plan becomes effective, in 2028 or later as provided for in the National Agreement, the employee's retiree medical benefit

will be suspended if and to the extent required by regulation/law. If regulations/laws change and no longer require suspension of the retiree medical benefit or when the employee re-retires, the employee's benefit will be reinstated.

Regions Outside of California (ROC), including Northwest, Colorado, Hawaii, Mid-Atlantic States and Georgia

PRE-2017

As provided in the National Agreement, for ROC employees who retire before January 1, 2017, with eligibility for retiree medical benefits, the existing retiree medical plans, including Employer contribution rates or cost share, shall remain the same. Retiree medical benefits, including copayments and out-of-pocket maximums, for retirees in a KP service area shall be the same as the active medical benefits and cost-sharing features at the time the retiree initially enrolls in the KP retiree medical plan.

If an employee is rehired in a non-benefited position after retiring with eligibility for retiree medical benefits **but before** commencing their retiree medical benefit, the employee will maintain their eligibility to enroll in the retiree medical benefit for which they were first eligible to enroll.

If an employee is rehired after they retire with eligibility for retiree medical benefits **and after** commencing their retiree medical benefit, the employee's ability to maintain retiree medical benefit coverage will depend on the position status, benefited or non-benefited, in which they are rehired.

Benefited position: If an employee is rehired into a benefited position, their retiree medical benefit will be replaced by active medical benefits while working. Once the employee re-retires from their benefited position, the retiree medical benefits the employee is offered will be the retiree medical benefits in effect on the date they re-retire and for the employee group from which they re-retire.

Non-benefited position: If an employee is rehired into a non-benefited position, the employee will maintain coverage under their retiree medical benefit, and when the employee re-retires they shall also maintain coverage under the same retiree medical benefit.

POST-2016

As provided in the National Agreement, ROC employees who retire on or after January 1, 2017, shall be covered by the Medical Premium Subsidy/HRA Plan (see Section 2.B.2.h.1. [now Section 2.B.2.i.1] of the National Agreement).

If an employee is rehired in a non-benefited position after retiring with eligibility for retiree medical benefits **but before** commencing their retiree medical benefit, the employee will maintain their eligibility to enroll in the retiree medical benefit for which they were first eligible to enroll.

If an employee is rehired after they retire with eligibility for retiree medical benefits **and after** commencing their retiree medical benefit, the employee's ability to maintain their retiree medical benefit coverage will depend on the position status, benefited or non-benefited, in

which they are rehired.

Benefited position: If an employee is rehired into a benefited position, their retiree medical benefit will be replaced by active medical benefits while working. Once the employee re-retires from their benefited position, the retiree medical benefits the employee is offered will be the retiree medical benefits in effect on the date the employee re-retires and for the employee group from which they re-retire.

Non-benefited position: If an employee is rehired into a non-benefited position, the employee's retiree medical benefit will be suspended if and to the extent required by regulation/law. If regulations/laws change and no longer require suspension of the retiree medical benefit or when the employee re-retires, the employee's benefit will be reinstated.

EXHIBIT 2.B.4.d.

GENERAL DESCRIPTION OF DISABILITY PLAN BENEFIT LEVELS

SECTION 26 — INCOME PROTECTION/ EXTENDED INCOME PROTECTION

980: Employees scheduled to work twenty (20) or more hours per week will be provided with an Income Protection or Extended Income Protection Plan. The benefit amount will be equal to either 50% of base wages, 60 % if integrated with a statutory plan (i.e., State Disability Insurance, Workers' Compensation, etc.), or 70% if the employee is on an approved rehabilitation program. If the employee is part time, the benefits will

be prorated according to the employee's scheduled hours. The minimum integrated benefit (prorated for part-time employees) provided by the program during the first (1st) year of disability will not be less than one-thousand (\$1,000.00) dollars per month.

981: Section 27 — Eligibility for Income Protection or Extended Income Protection

982: Eligibility for Income Protection or Extended Income Protection is based on length of service.

983: Section 28 — Income Protection Benefit

984: This benefit is provided to employees with less than two (2) years of service. Employees will receive a benefit commencing at the latter of exhaustion of Sick Leave or according to SDI guidelines (i.e., the first (1st) day of

hospitalization, eighth (8th) day of illness/injury), and will continue for up to one (1) year from the date of disability with continued medical certification.

985: Section 29 — Extended Income Protection Benefit

986: This benefit is provided to employees with two (2) or more years of service. Employees will receive a benefit commencing at the latter of exhaustion of Sick Leave or three (3) months from the date of disability, and will continue for up to five (5) years from the date of disability with continued medical certification. Benefits due to psychological-related disabilities and alcohol/drug abuse are limited to a maximum of three (3) years from the date of disability. The Duration of Benefits Schedule will apply to employees age sixty (60) or over who become disabled while eligible for this program.



EXHIBIT 2.B.4.f.

REVISED DENTAL BENEFIT

		SCAL PPO Plan CO GA MAS	NW Dental
PLAN DESIGN			
Plan Pays	Diagnostic and Preventive	100%	\$5
	Basic	90%	\$5
	Crowns and Cast Restorations	90%	OV + \$45
	Prostodontics	70%	OV + \$25 to \$95
	Child Orthodontics	50%	50%
	Adult Orthodontics	Not covered	Not covered
Deductibles	Per patient per calendar year	\$0	\$0
	Per family per calendar year	\$0	\$0
	D&P exempt from deductible and calendar year max?	N/A	N/A
Maximums	Per patient per calendar year	\$1,500	None
	Orthodontic lifetime maximum	\$1,500	\$1,500



EXHIBIT 3.D.1

PROCEDURE FOR DISPUTE RESOLUTION

Dispute filers will:

- » use the approved form when bringing the dispute;
- » submit the dispute within 60 days or the dispute will be barred;
- » submit all relevant documents before the completion of the factfinding 60-day timeline; AND
- » actively collaborate with fact finders in framing the dispute, collecting all relevant documents and identifying witnesses.

Fact finders:

- » must provide an accurate report with all relevant facts to be considered to the Tri-Chairs (facts and documents not provided or submitted late will not be considered in resolving the dispute, except to respond to issues that arise in the hearing);
- » in collaboration with the dispute filers and responders, fact finders should identify all witnesses and attach all documents that bear on the dispute in their report;
- » may take an active role in asking questions to develop a more comprehensive record;
- » should attempt to mediate the issue; and

- » should try to agree on facts — if they cannot, each side can state its understanding of the facts separately; however, this should be avoided whenever possible.

Panelists:

- » must receive all documents at least 10 days prior to a panel;
- » must have witnesses identified at least 10 days prior to a panel;
- » may take an active role in asking questions to develop a more comprehensive record and possibly settle the dispute;
- » will seek to expedite the presentation of information from relevant parties;
- » should be active in trying to settle disputes prior to the decision; and
- » may share preliminary findings in order to encourage settlement before issuance of a binding decision.

The parties may consider establishing panels to hear all disputes within a time frame (e.g., 1 year) to facilitate settlement and promote consistency of decisions.

Advocates:

- » shall meet at least 10 days prior to a panel to: (1) exchange documents; (2) identify witnesses; (3) stipulate to facts and exhibits in an effort to limit the need for testimony; and (4) attempt a potential settlement of the subject dispute; and
- » will cooperate and seek to resolve the dispute in the spirit of partnership.

Third-Party Neutral:

- » may take an active role in asking questions to develop a more comprehensive record in an effort to resolve the dispute;
- » shall seek to settle the dispute in discussions with the parties' advocates and with the panels;
- » shall provide a concise written determination within 30 days following the completion of the panel dispute if no settlement can be achieved; and
- » may request more documents and information than has been provided through the fact-finding process.

There will be not transcripts or briefs unless agreed upon by the parties or requested by the Third-Party Neutral. Annually, the parties will schedule quarterly panels.

EXHIBIT 3.D.2.

GUIDE FOR DISPUTE RESOLUTION

The work of developing the Dispute Resolution Guide should begin no more than 120 days after ratification and be finished within 9 months. The Tri-Chairs will approve the guide prior to publication and distribution.

The guide should include the path from initiation through escalation, the types of issues the dispute process is designed to address, the contact information for those responsible for the escalation process and other relevant information. The guide will be put on the LMP website and may be included in the annual refresher.

A cascading communication plan will be developed and start with a presentation to the regional and local LMP councils.

The guide should be reviewed annually and updated as needed for accuracy, and might be included in the annual refresher and other training modules.



EXHIBIT 3.E

LOCAL UNION AGREEMENTS

International Union	Local Union	Group	Region	Bargaining Unit	Current Expiration Date	Extended Expiration Date
AFT	ONA	1	Northwest	RN	9/30/21	9/30/25
AFT	OFNHP L5017	1	Northwest	RN	9/30/21	9/30/25
AFT	OFNHP L5017	1	Northwest	Professional	9/30/21	9/30/25
AFT	OFNHP L5017	1	Northwest	Lab Professional	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Southern California	Pharmacists	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Southern California	RN	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Southern California	Midwives and Wound Ostomy Nurses	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Southern California	United Therapists of Southern California	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Southern California	Specialty Care Nurses of Southern California	9/30/21	9/30/25
AFSCME	UNAC/UHCP	1	Hawaii	United Pharmacists of Hawaii	N/A	9/30/25
AFSCME	UNAC/UHCP	1	Hawaii	United Therapists of Hawaii (UTH)	N/A	9/30/25
AFSCME	UNAC/UHCP	1	Northern California	United Therapists of Northern California	N/A	9/30/25
UFCW	UFCW L1996	1	Georgia	Clerical/ Technical	9/30/21	9/30/25
UFCW	UFCW L1996	1	Georgia	Professional	9/30/21	9/30/25
UNITE HERE	UNITE HERE L5	1	Hawaii	Health Care	9/30/21	9/30/25
USW	USW L7600	2	Southern California	Health Care Workers	10/1/21	10/1/25

LOCAL UNION AGREEMENTS continued

International Union	Local Union	Group	Region	Bargaining Unit	Current Expiration Date	Extended Expiration Date
UFCW	UFCW L3000	2	Washington	Pro-Tech Optical	10/31/21	10/1/25
UFCW	UFCW Locals: 135, 324, 770, 1167, 1428, 1442	2	Southern California	Pharmacy Non-Prof	11/1/21	11/1/25
IBT	IBT L166	2	Southern California	Technical	12/31/21	12/31/25
UFCW	UFCW Locals: 135, 324, 770, and 1428	2	Southern California	Clinical Lab Scientist	2/1/22	2/1/26
AFSCME	KPASCO/ UNAC/UHCP	2	Southern California	Optometrist	2/28/22	2/28/26
IUOE	IUOE L1	2	Colorado	Operating Engineers	4/2/22	4/2/26
UFCW	UFCW L7	2	Colorado	Professional	4/2/22	4/2/26
ILWU	ILWU L28	2	Northwest	Security Officers	4/17/22	4/17/26
UFCW	UFCW L7	2	Colorado	Mental Health	5/31/22	5/31/26
IUOE	IUOE L501	2	Southern California	Operating Engineers	6/30/22	6/30/26
KPNAA	KPNAA	2	Southern California	Anesthetist	6/30/22	6/30/26
UFCW	UFCW L3000	2	Washington	Pharmacy	7/31/22	7/31/2026
UFCW	UFCW L770	2	Southern California	Kern County, Main	8/19/22	8/19/26
UFCW	UFCW L770	2	Southern California	Kern County Admin-Tech	8/19/22	8/19/26
UFCW	UFCW L27	2	Mid-Atlantic States	Health Professional	9/11/22	9/11/26
UFCW	UFCW L400	2	Mid-Atlantic States	Health Professional	9/11/22	9/11/26
AFT	OFNHP L5017	2	Northwest	Technical	10/1/22	10/1/26
AFT	OFNHP L5017	2	Northwest	Hygienist	10/15/22	10/15/26

INDEX

A

Access to Care, 3, 21, 36, 81, E.19
Accretion, 53
Acupuncture, 66, E.38
Affordability and Competitiveness Task Force, 9, 20
Affordability Goal, 21, 62
Affordable Care Act, 76
AHCU, 57, 70, 71
AHCU Growth, 23
Alliance, 1, 3, 4, 5, 7, 8, 9, 10, 11, 14, 16, 20, 22, 23, 24, 26, 27, 28, 32, 34, 37, 38, 39, 40, 41, 42, 43, 45, 46, 49, 51, 53, 54, 56, 57, 59, 60, 62, 63, 64, 65, 67, 68, 70, 71, 78, 79, 80, 82, 83, 85, 86
Alliance Performance Sharing Program (APSP), 21, 59, 60, 61, 62, 67
Annual Refresher, 55, 56
Attendance, 1, 10, 11, 16, 20, 21, 30, 32, 33, 53, 59, 60, 61, 62, 65, 71
Attendance Intervention Model. *See Attendance*

B

Backfill, 1, 6, 11, 20, 32, 34, 35, 37
Belong@KP, 40
Ben Hudnall Memorial Trust, 23, 24, 35, 40
Benefits, 1, 16, 17, 19, 22, 23, 24, 25, 28, 30, 33, 35, 37, 38, 40, 41, 44, 50, 58, 62, 63, 65, 66, 67, 78, 79, 80, 81, 85
Bloodborne Pathogens, 48
Board of Trustees, 9, 10
Budgeting, 6, 20, 32, 33, 34, 37
Build Capacity, 56

C

Capacity Building, 1, 20, 32
Career Development, 26, 27, 28, 30
Charter, 14, 23, 34, 37, 38, 42, 45
Chiropractic, 66
Citizenship Fee Assistance, 80
Code of Conduct, 4
Co-lead, 8, 9, 24, 25, 41
Collaborative, 8, 21, 29, 42, 43, 48, 55
Communication, 6, 10, 20, 21, 23, 24, 27, 28, 39, 41, 42, 43, 46, 47, 49, 50, 51, 65
Community Engagement, 43
Compensation, 1, 21, 25, 58, 84
Continuing Education. *See Education*
Contract Specialists, 37, 38
Corrective Action, 45, 46, 54, 55, 56
Cost Structure Reduction, 10, 11
Cross-Regional Functions, 5
Cultural Diversity, 10, 12

D

Decision Making, 1, 4, 5, 12, 14, 15, 22, 34, 45, 55
Defined-Benefit Retirement Plan, 67, 68, 78
Defined-Contribution Plan, 66, 67, 70
Dental, 6, 14, 16, 19, 47, 50, 64, 65, 70, 79, 80
Department Meetings, 5
Dependent Care Spending Account, 78
Disability, 48, 64, 78
Dispute Resolution Process, 1, 3, 4, 8, 14, 54, 56, 83, 84, 85

Disputes, 4, 55, 83, 85
Domestic Partner Benefits, 71
Donating Days, 44

E

Early Reduction Factors, 68
Education, 1, 2, 3, 6, 9, 11, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 37, 39, 40, 42, 43, 46, 49, 51, 57, 65, 81
Employee Health Care Management Program, 79
Employment Income Security Agreement, 24
Engagement, 1, 5, 6, 36, 41, 43, 47, 51, 58
Equity, Inclusion and Diversity (EID), 38, 39, 40
Ergonomics, 49
Executive Committee, 8, 9, 14, 26, 29, 32, 38, 52, 53, 70
Executive Committee of the Strategy Group. *See Executive Committee*

F

Flexibility, 3, 11, 12, 13, 14, 30, 34, 52
Flexible Personal Days, 16
Flu Prevention, 46
Funding, 9, 11, 15, 22, 23, 24, 25, 28, 30, 68

G

Gate, 61
Governance, 1, 3, 4, 9, 24
Governing Bodies, 9
Grievance Arbitrability, 85
Growth, 3, 4, 21, 22, 23, 29

INDEX continued

- H**
- Healing/Restorative Circles, 39
 - Health and Well-Being, 40, 42, 43, 44
 - Health Care Spending Account, 65
 - Healthcare Reimbursement Account, 19, 65
 - Huddles, 6, 47
- I**
- IBPS/CDM Training, 55
 - Innovation, 21, 25, 28
 - Integrated Disability Management, 48
 - Integration, 4, 5, 9, 14, 21, 23, 26, 33
 - Issue Resolution, 22, 45, 46, 50, 52, 54, 55, 56
- J**
- Jobs of the Future, 25
 - Joint Accountability, 8
 - Joint Committee, 68, 81
 - Joint Marketing, 22, 23
 - Just Culture, 1, 42, 45
- K**
- KFHP/H National Leadership Team, 9
 - KP Learn, 55, 56
 - KP Promise, 3, 11, 29
- L**
- Labor Management Partnership, 1, 2, 4, 5, 9, 11, 12, 14, 21, 22, 23, 25, 26, 29, 30, 33, 37, 38, 42, 48, 51, 52, 53, 54, 56, 57, 58, 59, 60, 82, 83
 - Labor-Management Staffing Committee, 34, 35, 36, 37
 - Leaves of Absence, 32, 50, 78
 - Legal Assistance, 80
 - Legal Assistance Fund, 80
 - Liaisons, 37, 38
 - Life Insurance, 50, 64, 79
 - Line of Sight, 6, 8, 59
 - Listening Sessions, 39
 - LMP Councils, 5, 23, 24, 32, 41, 55
 - LMP Executive Committee.
See Executive Committee
- M**
- Mahalogram, 47
 - Maintenance of Benefits, 80
 - Mandatory Overtime, 45
 - Medical Benefits, 62, 63, 71, 72, 74, 75, 78
 - Medical Centers, 7, 11, 15
 - Medical Facilities, 7
 - Membership, 1, 4, 10, 12, 21, 22, 37, 53, 54
 - Mental Health, 39, 40, 43, 44, 63, 64, 80
 - Multiplier, 67, 68, 69
- N**
- National Attendance Committee.
See Attendance
 - National Functions, 4, 5, 6, 7, 19, 20, 42
 - National Health, Safety and Well-Being Committee (NHSWBC), 42
 - National LMP Learning Group, 32, 41
 - National LMP Tri-Chairs, 8, 9, 26, 31, 49
 - New Employee Orientation (NEO), 40, 53
 - New Positions, 51
 - Non-Spouse Survivor Qualified Dependent, 71
- O**
- Obligations, 1, 2, 3, 13, 20, 58
 - Office of Labor Management Partnership (OLMP), 9, 11, 19, 52, 53, 55
 - Organizational Performance, 2, 5, 10, 11, 12, 13, 16, 20, 59
 - Outcomes, 8, 9, 12, 23, 31, 54
 - Overtime, 45
- P**
- Parallel Structures, 5, 10
 - Partnership, 1, 2, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 19, 20, 21, 22, 23, 25, 26, 29, 30, 31, 32, 33, 37, 39, 41, 42, 44, 45, 46, 47, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 82, 83, 85
 - Partnership Trust, 9, 10, 23, 28
 - Part-time, 17, 18, 34, 54, 56, 68
 - Path to Performance (PSP), 7, 8
 - Pathway to Partnership Performance, 8
 - Patient Access, 3, 21, 36
 - Patient Safety, 1, 10, 11, 45, 46
 - Patient Satisfaction, 36
 - Pension Protection Act (PPA), 69, 70
 - Performance Improvement, 3, 10, 11, 12, 13
 - Performance Sharing, 3, 30, 58, 59, 60, 61, 85
 - Performance-Based Pay, 10, 11
 - Permanente Federation, 9, 20
 - Permanente Medical Groups, 9, 23
 - Personal Days, 16, 17
 - Planning Committees, 5
 - Point of Service (POS) Plans, 63, 66
 - Position Control, 35

Posting and Filling of Vacancies, 26, 27, 34, 35, 36, 48

Preferred Provider Option (PPO), 66

Pre-Retirement Survivor Benefits.
See Survivor Benefits

Prevention of Workplace Violence, 49

Privileges, 1, 3, 5, 57

Problem-Solving Processes, 1, 8, 48, 54

Project Teams, 5

Psychologically Safe, 42, 43, 47

Q

Quality and Care Delivery, 39

Quality of Service and Attendance.
See Attendance

R

Racial Justice, 1, 38, 40

Racial Justice Task Force, 38, 39

Recognition, 15, 44, 47, 53, 57, 82

Recruitment, 15, 21, 25, 26, 29, 35

Redeployment, 24, 26, 27, 29

Regional Presidents, 9, 16

Retention, 21, 23, 26, 29, 41

Retiree Medical Benefits.

See Medical Benefits

Retirement Benefits, 66, 70, 78

S

Scope of Practice, 1, 10, 11, 13, 21, 22, 30

Seasonal, 13, 36, 46

Service Quality, 3, 14, 15

Shared Services, 4, 5, 6, 7, 11, 28, 32

Sick Leave, 16, 17, 18, 19

Southern California Wage Equity, 59

Sponsors, 6, 7, 8, 20

Sponsorship, 5, 8, 9, 16, 20, 22, 32, 47

Staffing, 1, 6, 13, 16, 20, 24, 32, 33, 34, 35, 36, 37, 79

Stakeholders, 4, 6, 20, 54, 84

Stewards, 5, 6, 7, 10, 30, 37

Strategy Group, 10, 22, 23, 25, 26, 41, 42, 44, 52, 53, 54, 59, 70, 81, 83

Subcontracting, 51

Successful Practices, 3, 10, 11, 14, 19, 24, 26, 43, 79

Supervisors, 5, 6, 7, 10, 31, 47

Survivor Assistance Benefit, 78

Survivor Benefits, 71

T

Taft-Hartley Trusts, 19, 22, 23, 24, 25, 68, 69, 71, 79

Technology, 10, 12, 21, 23, 30, 34, 80

Total Health, 40, 41, 43

Total Health Agreement.

See Total Health

Total Health Incentive Plan.

See Total Health

Training, 1, 2, 3, 6, 9, 12, 13, 15, 19, 22, 23, 24, 25, 26, 28, 29, 30, 31, 32, 35, 39, 40, 41, 42, 43, 44, 46, 47, 49, 55, 56, 58

Tuition, 28

U

UBT Consultants, 7, 55, 56

UBT Health and Safety Champion, 41

UBT Tracker, 11, 39

UFCW Variable Annuity Pension Plan (Sound VAP), 69

Union Capacity, 5, 8, 9, 37

Union Organizing, 53

Union Security, 1, 3, 50

Unit-Based Team Assessment, 7

Unit-Based Team Targets, 7

Unit-Based Teams, 5, 6, 7, 8, 10, 14, 24, 26, 30, 39, 44, 55

V

Value Compass, 3, 5, 8, 14, 36

W

Well-Being, 36, 40, 42, 43, 44, 45

Workers' Compensation, 17, 78

Workforce Development, 1, 3, 10, 11, 24, 25, 27, 38, 40

Workforce Equity, 24, 38, 40

Workforce Equity and Inclusion, 24

Workforce Planning and Development, 23, 24, 25, 26, 27, 28, 29

Workforce Wellness, 30, 38, 39, 42

Work-Life Balance (WLB), 10, 40, 44

Workplace Safety, 1, 10, 11, 46, 47, 59, 60, 61, 62

