

2003 – 2005

COLLECTIVE BARGAINING
AGREEMENT

Between

HOME CARE COMMISSION

And

SERVICE EMPLOYEES INTERNATIONAL UNION,
LOCAL 503, OPEU

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ARTICLE 1 – PARTIES TO THE AGREEMENT

This Agreement is entered into between Service Employees International Union, Local 503, OPEU, AFL-CIO (Union) and the Home Care Commission (Employer) acting through the Department of Administrative Services (DAS).

ARTICLE 2 – RECOGNITION

Section 1. The Employer recognizes the Union as the exclusive bargaining representative for all Home Care Workers (Employees) represented by the Union as listed in Section 2.

Section 2. The Employer and the Union have established a single bargaining unit that consists of:

All full-time, part-time, hourly, and live-in publicly funded Home Care Workers employed through the Employer, who are Client Employed Providers (CEPs), Spousal Pay Providers, and providers in the Oregon Project Independence (OPI) Program, and compensation is paid by Department of Human Services (DHS) or other public agency that receives money from DHS.

All other Home Care Workers, including those employed by other employers, and supervisors are excluded.

Section 3. When there has been a determination of the Employment Relations Board to modify the bargaining unit listed in Section 2 above or when the Parties reach mutual agreement to modify, negotiations will be entered into as needed or as required by law.

ARTICLE 3 – TERM OF AGREEMENT

Section 1.

- (a) This Agreement shall become effective on the date of the last signature by representatives of DAS and the Union on the complete agreement after full acceptance by the Parties, and expires on June 30, 2005.
- (b) Either party may give written notice during the one hundred eighty (180)-day period preceding the expiration of the Agreement.
- (c) Negotiations shall commence at a mutually agreeable date after receipt of such notice.

Section 2. This Agreement shall not be opened during its term except by mutual agreement of the Parties, by proper use of Article 6 - Separability, or as otherwise specified in the Agreement.

ARTICLE 4 – COMPLETE AGREEMENT

Section 1. Pursuant to their statutory obligations to bargain in good faith, the Employer and the Union have met in full and free discussion concerning matters in “employment relations” as defined by ORS 243.650(7). This Agreement incorporates the sole and complete agreement between the Employer and the Union resulting from these negotiations. The Union agrees that the Employer has no further obligation during the term of this Agreement to bargain wages, hours, or working conditions except as specified below.

Section 2. The Parties recognize the full right of the Employer to issue rules, regulations and procedures and that these rights are diminished only by the law and this Agreement, including interpretative decisions which may evolve pursuant to the proper exercise of authority given by the law or this Agreement.

Section 3. The Employer agrees to bargain over any change(s) it proposes to make to mandatory subjects of bargaining not covered by the Agreement pursuant to the Public Employee Collective Bargaining Act (PECBA). Changes to any of the terms and conditions contained in the Agreement may be made by mutual agreement or as otherwise allowed by ORS 243.702.

ARTICLE 6 – SEPARABILITY

In the event that any provision of this Agreement is at any time declared invalid by any court of competent jurisdiction, declared invalid by final Employment Relations Board (ERB) order, made illegal through enactment of federal or state law or through government regulations having the full force and effect of law, such action shall not invalidate the entire Agreement, it being the express intent of the Parties hereto that all other provisions not invalidated shall remain in full force and effect. The invalidated provision shall be subject to re-negotiation by the Parties within a reasonable period of time from either party's request.

ARTICLE 7 – NO STRIKE/NO LOCKOUT

Section 1. During the term of this Agreement, the Union, its members and representatives agree not to engage in, authorize, sanction or support any strike, slowdown or other acts of curtailment or work stoppage.

Section 2. The Employer agrees that, during the term of this Agreement, it shall not cause or initiate any lockout of Employees.

Section 3. This Article does not apply to the consumers' sole and undisputed rights provided in the law, including the selection and termination of employment of the Employee.

ARTICLE 9 – UNION RIGHTS

Section 1. Bulletin Boards. The Union shall be allowed to provide and maintain a bulletin board or share space on an existing bulletin board in an area regularly accessible by represented Employees where space is deemed available by Management of the facility. Such space shall not be denied for arbitrary or capricious reasons.

Section 2. New Member Orientation. When an orientation is scheduled for representable Employee's, the Union shall be invited to make a presentation at a mutually agreeable time about the organization, representational status, and union benefits and to distribute and collect membership applications.

Section 3. List and Information. By the 10th calendar day of each month, the Union shall receive a list of all current Employees' name, address, telephone number, social security number or identification number, provider number, hours worked, gross pay, union dues, fair share payments and other deductions for the previous month's activity. The list will be provided in an agreed-upon format and transmitted electronically.

Section 4. The Union agrees to pay reasonable costs associated with fair share and dues deduction administration and/or system changes to accommodate fair share and/or dues deduction.

Section 5. The Union shall indemnify and hold the Employer or designee harmless against claims, demands, suits, or other forms of liability which may arise out of action

taken by the Employer or designee for the purpose of complying with the provisions of this Article.

Section 6. Dues Deduction.

- (a) Upon written request from the Employee, monthly Union dues plus any additional voluntary Union deductions shall be deducted from the Employee's salary and remitted to the Union. Additionally, upon written notice from the Union, authorized increases in dues in the form of special assessments, shall be deducted from the Employee's salary and remitted to the Union according to this Section. Such notice shall include the amount and duration of the authorized special assessment(s). Monthly Union dues will cease, upon written notice from the Employee. All applications for Union membership or dues cancellation, which the Employer receives, shall be promptly forwarded to the Union. Employee applications for Union membership or dues cancellation, which the Union receives, shall be promptly forwarded to the Employer.
- (b) Dues deduction shall continue until such time that the Employee requests cancellation of the dues deduction in writing.
- (c) Upon return from any break in service of not more than twelve (12) months, reinstatement of the dues deduction shall occur for those workers who were having dues deducted immediately prior to said break in service.
- (d) Dues deduction shall only occur after all mandatory and priority deductions are made in any pay period.

Section 7. Fair Share. All Employees in the bargaining unit who are not members of the Union shall make fair share payments in-lieu-of dues to the Union.

- (a) Fair share deductions shall be made in the first full month of Employee service but shall not be made for any month in which the Employee works less than thirty-two (32) hours.
- (b) Bargaining unit members who exercise their right of non-association, for example, when based on a bona fide religious tenet or teaching of a church or religious body of which such Employee is a member, shall pay an amount of money equivalent to regular monthly Union fair share dues to a non-religious charity or to another charitable organization mutually agreed upon by the Employee and the Union and such payment shall be remitted to that charity by the Employee in accordance with ORS 243.666. At time of payment, the Employee shall simultaneously send verifiable notice of such payment to the Employer and the Union.
- (c) Upon return from any break in service of not more than twelve (12) months, reinstatement of fair share deduction shall occur for those workers who were having fair share deduction immediately prior to said break in service.
- (d) Fair share deductions shall only occur after all mandatory and legal deductions are made in any pay period.
- (e) Fair Share Adjustment Summaries for SEIU Local 503, OPEU Home Care Members. The payroll summaries will be forwarded to the Union by the 10th calendar day of the following month. The Fair Share Adjustment Summary will reconcile the previous month's remittance with the current month's remittance. The Fair Share Adjustment Summary will be an alphabetical listing and shall show the following:

Name (last name first, full first name, middle initial);
Formatted Social Security Number (000-00-0000) or identification number;
Provider number;
Prior month deduction;
Current month deduction;
Variance (difference between prior month deduction and current month).

- (f) Any additional information requested under this Section may be made available electronically to the Union.

Section 8. List of Representatives. The Union shall provide the Employer with a list of the names of authorized Union staff representatives and elected officers, and shall update those lists as necessary.

Section 9. Other Deductions. Voluntary payroll deductions made to the Union for Employee benefits shall be submitted at the same time as regular dues deductions.

No later than the 10th calendar day of each month, the Union shall receive a benefit register for each benefit listing each Employee, the amount deducted, and the purpose of the deduction.

ARTICLE 10 – PAYROLL/TAX WITHHOLDING

Section 1. Paychecks shall be issued and postmarked within three (3) working days (excluding Oregon and Federal holidays) of the proper submission of a completed time voucher by the Employee.

Section 2. Vouchers shall be issued no later than seven (7) calendar days from proper submission and processing of the prior pay period's voucher.

Section 3. Pending the outcome of the Letter of Agreement on Committee review of payroll systems, Sections 1 and 2 may require modifications.

ARTICLE 12 – NO DISCRIMINATION

Section 1. The Union and the Employer agree not to engage in unlawful discrimination against any Employee because of sex, race, creed, color, national origin, sexual orientation, age, physical or mental disability or Union activities.

Section 2. This article does not apply to the consumers' sole and undisputed rights provided in the law, including the selection and termination of employment of the Home Care Workers.

ARTICLE 13 - REMOVAL FROM THE REGISTRY

Section 1. Removal from the Registry for Inactivity. If an Employee has not worked for any client for the previous twelve (12) months, they will automatically be removed from the registry. If an Employee requests removal from the registry, or reports not available for work, the Employee will be inactivated for further referrals. At any time thereafter, should a previous Employee request to re-enter the home care workforce and is deemed qualified by the Employer, the Employee shall be added back to the registry.

Section 2. An active Employee will be provided written notification in the event the Employer intends to remove the Employee from the registry.

Section 3. Removal from the Registry of Active Employees. An active Employee may be removed from the registry when the facts support the Employer's claim of misconduct, poor performance or other violations of the rule(s) adopted by the Employer

and removal from the registry is a reasonable penalty for a proven offense. An investigation shall be conducted prior to removal.

Section 4. The Employer's removal from the Registry of an actively employed Home Care Worker resulting from the loss of a provider number pursuant to the DHS Administrative Review Process (ARP) is not subject to the grievance procedure. Should an ARP appeal result in the restoration of the provider number, DHS shall promptly notify the Employer of such determination. The Employer shall reactivate the Employee on the registry where such removal was based solely on facts related to the provider number termination. Failure to reactivate the Employee on the Registry is subject to the grievance procedure.

Section 5. Employer removals from the Registry, other than described in Section 4, are subject to the grievance procedure and the ERB's decision will be based on whether the facts support the Employer's written claim and removal from the registry is a reasonable penalty.

ARTICLE 14 – GRIEVANCE PROCEDURE

Section 1. Grievances are defined as acts, omissions, applications, or interpretations alleged to be violations of the terms or conditions of this Collective Bargaining Agreement.

Section 2. The Employer encourages, whenever possible, an informal resolution approach between the Employee and local DHS/Area Agencies on Aging (AAA) or Area Agencies on Aging and Disabilities (AAAD) representative(s) over the application of the terms and conditions of the Collective Bargaining Agreement that are within their authority to administer.

Section 3. Grievances shall be filed within thirty (30) calendar days of the date the grievant or the Union knows or by reasonable diligence should have known of the alleged grievance. Once filed, the Union shall not expand upon the original elements and substance of the written grievance.

Grievances shall be reduced to writing, stating the specific Article(s) alleged to have been violated, a clear explanation of the alleged violation, and the requested remedy. Grievances shall be processed in the following manner:

Step 1. The Union on the grievant's behalf may submit the grievance in writing within thirty (30) calendar days to the Home Care Commission Executive Director or designee. The grievant and Union representative (designated by the Union) or the Union representative will attempt to meet with the Home Care Commission Executive Director or designee within thirty (30) calendar days following the Commission's receipt of the grievance. Such meeting, if held, may be face-to-face or via teleconference. Failure to meet will not invalidate the grievance.

The Commission designee shall respond to the grievance in writing within fifteen (15) calendar days following the Step 1 meeting or the date when the Parties agreed that such a meeting would not be necessary.

Step 2. No grievance may be processed under this Step which has not first been filed and investigated in accordance with Step 1 above. When the response at Step 1 does not resolve the grievance, the grievance must be filed within thirty (30) calendar days after the Step 1 response is due or received. The grievance may be filed at Step 2 thirty (30) calendar days after submission of the grievance to the Home Care Commission

Executive Director or designee whether or not a Step 1 response has been received. A grievance appeal shall be filed in writing to the ERB for hearing unless the Parties mutually agree to seek alternative dispute resolution assistance. The filing shall include the formal written grievance and any related information. The ERB shall have no authority to rule contrary to, to amend, add to, subtract from, change or eliminate any of the terms of this Agreement. The Parties waive any right to appeal ERB decisions at Step 2. The decision of ERB shall be final and binding except for decisions made outside the scope of their authority as defined in this paragraph.

Section 4. Time Limits. The time limits specified in this Article shall be strictly observed, unless either Party requests a specific extension of time, which, if agreed to, must be stipulated in writing and shall become part of the grievance record. "Filed" for purposes of all steps shall mean date of receipt by mail, hand delivery, by facsimile (fax), or as otherwise agreed to by the Home Care Commission Executive Director, or designee, and the Union. If the Employer fails to issue a response within the time limits, the Union may advance the grievance by written notice to the next step unless withdrawn by the Union. If the Union fails to meet the specified time limits, the grievance shall be considered withdrawn and cannot be resubmitted.

Section 5. The Employer is not responsible for any compensation of Employees or their representative for time spent investigating or processing grievances nor any travel or subsistence expenses incurred by a grievant or Union Steward in the investigation or processing of grievances.

Section 6. Each party shall bear the cost of its own presentation at Step 2, including preparation and post-hearing briefs, if any.

Section 7. At the conclusion of the ERB proceeding, the Parties shall share cost of filing and answer fees. Neither party will request representation costs or civil penalties under ERB rules.

ARTICLE 15 – HEALTH PLAN

Section 1. Employer Contribution. Effective April 1, 2004, the Employer shall provide health insurance for eligible participating Employees as follows:

- (a) For each eligible participating Employee who lives in the Kaiser Permanente service delivery area, the Employer shall pay four hundred three dollars and eighty-six cents (\$403.86) for the medical insurance plan described in Appendix A.
- (b) For each eligible participating Employee who lives outside the Kaiser Permanente service delivery area, the Employer shall pay four hundred sixty-three dollars and seventy-four cents (\$463.74) for the Oregon Dental Service (ODS) medical insurance plan described in Appendix B.

Section 2. Effective April 1, 2005, the Employer's contribution will be adjusted to reflect Kaiser and ODS rate increases. The increase shall not exceed fifteen percent (15%) in the composite rate. Such increase shall be based on the actual plan participation for the month prior to notice by the carriers of the new rates.

Section 3. If the April 1, 2005 increase in Employer contributions described in Section 2 above is insufficient to pay for Employees' health insurance, the Union will have the option of moving any remaining Workers' Compensation set-aside funds if available under the health insurance eligibility letter of agreement (after the health insurance

eligibility threshold has been reduced, but to no less than eighty (80) hours a month). If additional funds are necessary, the Union may notify the Employer of its intent to postpone wage increases scheduled to take effect in the second year of the contract or adjust other economic provisions resulting in necessary cost savings, and apply the resulting savings toward the health insurance premiums. The Union must notify the Employer of its desire to modify any economic provision in the contract thirty (30) days before the effective date of the proposed modification.

Section 4. Eligibility. Initial eligibility shall begin thirty (30) days after the second month when an Employee has worked a minimum of eighty-eight (88) authorized and paid hours in each of the two (2) immediately preceding months. An Employee will lose eligibility for the Employer contribution thirty (30) days after he/she fails to work a minimum of eighty-eight (88) authorized and paid hours in each of the two (2) immediately preceding months.

Section 5. Employees shall not be eligible to receive the Employer contribution for health care benefits under this Article if the worker is receiving other health care benefits, except for Medicare, until such time prescriptions drugs are covered, and Veteran's benefits. For purposes of eligibility determination by the health plan administrator, the Employee must declare when receiving other health care benefits.

Section 6. Implementation. A thirty (30)-day open enrollment period will occur sixty (60) days prior to the beginning of each plan year. Employees who are not eligible for coverage at time of open enrollment, but who subsequently meet eligibility criteria, shall become eligible for health insurance enrollment consistent with Section 4. If eligibility occurs subsequent to the open enrollment period, it is the responsibility of the Employee to request the enrollment forms from the Union.

Section 7. The Union agrees to administer the health plan in accordance with this Article and the National Association of Insurance Commissioners (NAIC) acts and regulations. The Employer will pay the Union for the cost of health plan administration in accordance with the Letter of Agreement on health insurance administration that will be executed by the Parties.

ARTICLE 16 – WORKERS' COMPENSATION

Section 1. Effective April 1, 2004, upon receipt of client request and authorization, the Employer shall provide workers' compensation insurance coverage to actively employed Home Care Workers by an appropriate insurer. The Employer will ask the Department of Human Services to facilitate the distribution and collection of such authorization forms.

In the event that a federal waiver is necessary before implementing this provision, such coverage will not begin until after obtaining the federal waiver under the Medicaid program. If a waiver is necessary, the Employer will request that such a waiver request occur no later than thirty (30) calendar days following the execution of the Agreement. In the event that the waiver is not authorized, the Parties agree to reopen this Article for renegotiation pursuant to the PECBA.

Section 2. The Employer acting through DAS agrees to meet quarterly, or as otherwise mutually agreed, with representatives from the Union and the designated carrier to review available data concerning claims, claims costs, and projected premium expenditures.

Section 3. In the event that 2003-05 claims costs and/or premium costs are projected by the designated insurance carrier to exceed three million, sixty-eight thousand, five hundred sixty-five dollars (\$3,068,565) General Fund, the Employer through the DAS will notify the Union that it intends to reopen Article 15-Health Insurance, Article 16-Workers' Compensation, Article 17-Wages, and Article 19-Time Off for renegotiation pursuant to ORS 243.746, except as modified below, on or before November 1, 2004.

If the contract is reopened under this provision, the Parties will schedule an arbitration hearing to be held on December 1, 2004. The Parties will meet to try to resolve the problem prior to the arbitration date. If agreement is reached, the hearing will be cancelled. If no agreement is reached, the hearing will be held.

To prepare for a possible arbitration, the Parties will select a mutually agreeable arbitrator within ninety (90) days of the signing of the contract. The arbitrator must agree to hold the arbitration hearing on December 1, 2004. Seven (7) days prior to the hearing, the Parties shall submit their last best offers. The arbitrator shall render an award within fifteen (15) days of the hearing and submit a full written decision no later than December 31, 2004. The Parties agree to split the costs of the arbitrator, including a reasonable retainer, if that is necessary to secure his or her agreement to adhere to the timelines above, which shall apply, notwithstanding the timelines in the PECBA.

The Parties hereby stipulate pursuant to ORS 243.746 (4)(g) that the arbitrator shall select the last best offer and issue an award that reduces the combined General Fund costs to the Employer of Articles 15, 16, 17 and 19 in a manner that will resolve the disparity between the projected 2003-05 General Fund costs of Workers' Compensation and three million, sixty-eight thousand, five hundred sixty-five dollars (\$3,068,565).

The Parties hereby stipulate pursuant to ORS 243.746 (4)(g) that the arbitrator is prohibited from issuing an award that provides for 2003-05 Workers' Compensation General Funds costs in excess of three million, sixty-eight thousand, five hundred sixty-five dollars (\$3,068,565) unless the General Fund costs of other benefits or wages provided by the contract are reduced commensurately. Additionally, the Parties stipulate that the arbitrator may not receive or consider information that challenges the workers' compensation insurance carrier's projected claims and/or premium costs. Arbitrator authority limitations as outlined in Article 14, Section 3 also apply.

Section 4. To assure continued affordable health and workers' compensation insurance is available to its members, the Union agrees to provide the best, good faith efforts to work with and support the designated insurance carrier in the areas of loss control, return to work, timely claims management and to provide and promote mandatory and/or voluntary training opportunities to its members.

ARTICLE 17 – WAGES

The rate schedule for compensation of eligible Employees will be as outlined below:

Assistance Hours	Wage Rate		
	Current	\$.40 Effective 7/1/03	\$.30 Effective 1/1/05
Full assistance	8.56	8.96	9.26
Minimal or substantial assistance	8.33	8.73	9.03
24-hour availability/self-management	2.85	3.25	3.55

The Employee's average hourly rate of pay will depend on the number of qualifying hours for each type of assistance provided.

ARTICLE 18 – MILEAGE AND PUBLIC TRANSPORTATION RIMBURSEMENT

Employees shall be reimbursed for eligible personal vehicle miles authorized for task list related transportation at a rate of twenty-six cents (\$.26) per mile for the term of this Agreement.

Travel preauthorized by DHS/AAA or AAAD for public transportation for the purpose of accompanying a client will be reimbursed for actual cost incurred.

ARTICLE 19 – TIME OFF

Section 1. Live-In Providers. Live-in providers shall accrue one (1) paid day (defined as twenty-four (24) hours) for every month of work up to a maximum of one hundred forty-four (144) hours.

Such time off may be taken in one (1) hour increments subject to client or designee authorization and available relief. Payment for time taken shall be based on the average daily-authorized wage rate for the Employee.

Live-in providers who separate from service and return and provide services within one (1) year from the last date live-in services were provided to a consumer shall have all unused leave credits restored.

Section 2. Non Live-In Providers. Effective July 1 of each year, active Employees who worked eighty (80) authorized and paid hours in any one (1) of the three (3) previous months of active employment shall be credited with eight (8) hours of paid time off to use during the current fiscal year (July 1 through June 30). Such leave shall not be cumulative from year to year.

Such time off must be utilized in one (1) eight (8)-hour block subject to client or designee authorization and available relief. If the Employee's normal workday is less than eight (8) hours, such time off may be utilized in blocks equivalent to the normal workday. Any remaining hours that are less than the normally scheduled workday may be taken as a single block. Payment for time taken shall be based on the average

authorized hourly wage rate for the Employee. If the accrued hours are not used within the fiscal year, the balance shall be reduced to zero (0). Employee's will not be compensated for paid time off unless the time is actually taken.

Section 3. Time taken off will be reflected on the time sheet. The accumulated paid time hours off will be posted on each wage statement balance.

ARTICLE 20 – TASK LIST

Section 1. Case managers will request that the consumer provide a copy of approved services and maximum hours to their Home Care Worker(s). If Employee(s) do not receive a copy of approved services and maximum authorized hours from their consumer, they may request a written copy from the case manager, which shall be provided to the Employee within fifteen (15) calendar days from the date of request.

Section 2. If changes in hours and/or services occur other than as a result of client illness requiring alternative care or death, notice of the change shall be provided to the Employee in writing on or before the effective date of the change.

Section 3. The consumer retains the right to reduce the number of hours and/or services at any time.

ARTICLE 22 – TEMPORARY CONSUMER ABSENCES

A live-in provider shall continue to receive the rate of pay immediately preceding the consumer's absence from his/her home due to illness or medical treatment for up to a maximum of thirty (30) calendar days. This provision is predicated on the expectation that the consumer will be returning home within that thirty (30)-day period.

ARTICLE 25 – WAGE OVERPAYMENTS

Section 1. Overpayments in wages resulting from client or provider error shall be repaid at no more than five percent (5%) of the Employee's pay that is based on hours paid until repaid in full. If the Employee leaves his/her employment as a Home Care Worker before the overpayment has been fully recovered, the remaining maximum amount may be deducted from the Employee's final check(s).

Section 2. An Employee who disagrees with the determination that an overpayment has been made may grieve the determination through the grievance procedure.

ARTICLE 26 – HEALTH AND SAFETY

Section 1. When gloves and masks are not available at the consumer residence, the Employee may request and receive such items from the local DHS/AAA or AAAD location. Requests by the Employees for safety equipment other than the gloves and masks that are routinely provided shall be in writing and shall be provided subject to local DHS/AAA or AAAD management approval. All such requests will be responded to within twenty (20) calendar days from the receipt of the written request.

Section 2. Employee's shall have access to information on communicable diseases, blood borne pathogens, and universal precautions through the local DHS/AAA or AAAD office.

LETTER OF AGREEMENT - HCW REFERRALS

In developing the HCC Registry Program, it is the Employer's intent that referral lists of qualified Employee names be provided to consumers in random order. Should unanticipated technical problems prevent the Employer from fulfilling this statement of intent, the Employer will review the circumstances, seek guidance from all its constituencies about how to most fairly display referral lists, and revise its approach.

LETTER OF AGREEMENT - PAYROLL/TAX WITHHOLDING

The Parties agree to the immediate implementation of a committee to address the following:

To explore and identify alternate payroll systems that will enable payroll tax withholding and direct deposit for Employees. Such exploration will include reviewing the capabilities of DHS's pay system, DAS's payroll system, or outside payroll companies and any associated costs to provide such services for Employees.

The Committee will be made up of one (1) representative each from the Department of Human Services, the DAS State Controller's Division and the DAS Human Resource Services Division and three (3) Union representatives. Either party may invite other experts to meetings as necessary to provide information to the Committee.

The Committee will establish the timeline for providing its report to DAS and the Union.

DAS will analyze the Committee's findings and choose a payroll system with the intent to implement no later than June 30, 2005. In the event of unforeseen circumstances, e.g., technological problems, the Union will be timely notified of the need for delay and expected timeline for completion.

This Agreement will sunset upon implementation of the new payroll system.

LETTER OF AGREEMENT - HEALTH INSURANCE ELIGIBILITY

If, as of January 2005, the 2003-05 General Fund costs for Workers' Compensation are projected by the designated insurance carrier to be lower than three million, sixty-eight thousand, five hundred sixty-five dollars (\$3,068,565), then, effective April 1, 2005, the eligibility hours to qualify for Employer insurance shall be reduced in hourly increments.

The reduction in hourly increments shall be proportional to the amount by which the projected 2003-05 General Fund Workers' Compensation costs are lower than three million, sixty-eight thousand, five hundred sixty-five dollars (\$3,068,565), but in no case shall the reduction be greater than the Workers' Compensation General Fund set-aside amount of one million, four hundred seventy-two thousand, five hundred sixty-six dollars (\$1,472,566).

In no instance shall the number of eligibility hours be adjusted to less than eighty (80) per month for the qualifying periods pursuant to Article 15, Section 3.

After reducing the eligibility hours to qualify for health insurance, pursuant to Article 15, Section 3, any dollars remaining of the additional Workers' Compensation General Fund set-aside amount of one million, four hundred seventy-two thousand, five hundred sixty-six dollars (\$1,472,566) may be used to subsidize insurance premium increases in excess of fifteen percent (15%) for the plan year beginning April 1, 2005.

Signed this 1st day of August, 2003, at Salem, Oregon.

FOR THE HOME CARE COMMISSION:

Eva M. Corbin
Eva Corbin, Deputy Administrator
DAS Labor Relations Unit

Dan Barker
Dan Barker, Executive Director
Home Care Commission

Cathy Schuh
Cathy Schuh
State LR Manager

FOR THE SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 503, OPEU,
AFL-CIO, CLC

Leslie Frane
Leslie Frane, Executive Director
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Karen Thompson, Chairperson

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Kimberly Powell
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Patsy White

BG Gray
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Sunny Rucker
Sunny Rucker

Patricia Mueller
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Karla Spence, Chief Negotiator
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Joye Willman
Joye Willman, Co-Chairperson

Sally Cumberworth
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Vicki Gourley Neer
Vicki Gourley Neer

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Angie Hazelton
Angie Hazelton

Marlane Morton
Marlane Morton

Jeanie Breedlove
Jeanie Breedlove

Lee Meyers
Lee Meyers

Kathie Best
Kathie Best, President
President

KAISER PERMANENTE

Summary of Medical Benefits

APPENDIX A

ANNUAL DEDUCTIBLE	None
ANNUAL LIMIT TO COPAYMENTS	\$600 per member
Not all copayments apply to this limit	
LIFETIME BENEFIT MAXIMUM	None
Benefit (When provided, prescribed, or authorized by a Kaiser Permanente Plan physician)	
	You Pay
OFFICE VISITS FOR	/
Preventive care – adult physical exams – well-child care	Primary care copayment; no charge for age 0-2
Primary care – including urgent care	\$20
Specialty care	\$20
Prenatal and postnatal care	No charge
Routine eye exams	\$20
Allergy shots and other injections	\$5
Routine immunizations	No charge
Short-term rehabilitative therapies	Specialty care office visit copay
Outpatient surgery	Primary care office visit copay
LABORATORY TESTS	No charge
X-RAYS AND SPECIAL DIAGNOSTIC PROCEDURES	No charge
OUTPATIENT PRESCRIPTION DRUGS at Kaiser Permanente Pharmacies	\$10 generic
Drugs must be prescribed in accordance with the formulary process; we cover non-formulary drugs only when you meet exception criteria. You get up to a 30-day supply. When you use free home delivery, you get up to a 90-day supply of maintenance drugs for two copayments.	\$20 brand
HOSPITAL INPATIENT CARE	No Charge
HOSPITAL MATERNITY CARE FOR MOTHER AND NEWBORN	Hospital care copayment
EMERGENCY SERVICES AT KAISER PERMANENTE EMERGENCY FACILITIES	
At the Emergicenter at Interstate Medical Office South	\$20 plus any other copayments that normally apply
At owned and affiliated hospital emergency departments	\$75 plus any other co-payments that normally apply
EMERGENCY AND URGENT CARE AT NON-KAISER PERMANENTE FACILITIES	In-plan emergency copayment plus any other copayments that normally apply
See exclusions and limitations for details on qualifying care in and out of the service areas. Your primary care copay applies for qualifying urgent care.	

Benefit (When provided, prescribed, or authorized by a Kaiser Permanente Plan physician)		You Pay
AUBULANCE SERVICE (Medically necessary transportation only)		\$75
MENTAL HEALTH SERVICES		Two-year benefit period ends December 31, 2003
Inpatient psychiatric care		\$100 per day up to \$500 per admission; you are covered for up to 16 days
Residential/day treatment		\$50 per day up to \$250 per admission; you are covered up to 26 days
Outpatient therapy with mental health professionals		\$15 per visit for up to 40 visits
CHEMICAL DEPENDENCY SERVICES (Care for Alcoholism and Drug Abuse)		Two-year benefit period ends December 31, 2003
Inpatient medical treatment		20% copayment; Kaiser Permanente pays 80% up to \$5,625 for adults/\$5,000 for children under 18; you pay 100% thereafter
Residential/day treatment		20% copayment; Kaiser Permanente pays 80% up to \$4,375 for adults/\$3,750 for children under 18; you pay 100% thereafter
Outpatient treatment		Primary care office visit charge for each visit up to 40 visits
SKILLED NURSING FACILITY CARE (Up to 100 days per year)		No charge
HOME HEALTH CARE		No charge within service area
PRESCRIPTION EYEGLASSES AND CONTACT LENSES		Balance after \$ allowance is applied
Your benefit renews every 24 months.		
SELF-REFERRED CHIROPRACTIC CARE		
Care must be provided by network chiropractors.		
INFERTILITY SERVICES		50% of charges for diagnosis and treatment
DURABLE MEDICAL EQUIPMENT (Standard Benefit-Restrictions apply)		20% of charges
INTERRUPTED PREGNANCY SERVICES		Outpatient surgery copayment applies
QUESTIONS? CALL MEMBERSHIP SERVICES (Monday – Friday 8AM-6PM)		
Portland area . . . (503)813-2000 All other areas . . . (800)813-2000		
<i>This is not a contract. This benefit summary does not fully describe your benefit coverage. For more details on your benefit coverage, claims reviews, and adjudication procedures, please see A Guide to Your Benefits (or EOC) or call Membership Services. Your group's service agreement is the binding document between Kaiser Foundation Health Plan of the Northwest and its members. In the case of conflict between this summary and the service agreement, the service agreement will prevail.</i>		



APPENDIX B

Oregon Home Care Workers Medical Benefits Summary

HOW TO USE THIS MANAGED CARE PLAN

Members select a Primary Care Physician (PCP) from the ODS Health Plans Provider Directory or website at www.odshealthplans.com. The PCP coordinates all health care needs including referrals and specialty care authorization, hospitalization authorization and severe health care problems. Each family member may choose a different PCP. Benefits under this plan will not be available to you if you receive care from a participating provider without a referral from your PCP or from any other physician.

SERVICE	MANAGED CARE NETWORK YOU PAY
Calendar Year deductible per Member	\$500
Calendar Year Maximum Out of Pocket Per Member	NO MAXIMUM
Lifetime Maximum (\$5,000 Annual Restoration)	\$1,000,000
OFFICE VISITS/PREVENTIVE CARE	DEDUCTIBLE WAIVED
Office Visits (Does not include x-ray & lab charges)	\$20 copay/visit
Urgent Care Centers	\$20 copay/visit
Mental health/chemical dependency (outpatient)	\$20 copay/visit**
Outpatient Rehabilitation	\$20 copay/visit
Routine Physical exams (does not include x-ray & lab charges)	\$20 copay/visit
Routine Immunizations (all ages)	No Copay
Women's Routine Mammograms	\$20 copay/visit
Women's Annual Exams	\$20 copay/visit
PHYSICIAN/PROVIDER SERVICES	AFTER DEDUCTIBLE
Physician Visits While Hospitalized	30%
HOSPITAL SERVICES	AFTER DEDUCTIBLE
Inpatient Care	30%
Outpatient Surgery	30%
EMERGENCY SERVICES	AFTER DEDUCTIBLE
Emergency Room (\$100 per visit waived if admitted)	\$100 per visit, then 30%*
Ambulance (up to 300 surface miles per calendar year)	30%
OTHER SERVICES	AFTER DEDUCTIBLE
X-ray & Lab Services	30%
Allergy Shots & Other Therapeutic Injections	30%
Medical Equipment & Supplies	30%
Hospice Care (Subject to limitations)	30%
Mental Health/chemical dependency (inpatient)	30%**
PRESCRIPTION DRUG (ODS Pharmacy Network)	See Attached Benefit Summary*

* Emergency room copays, prescription drug copays, expenses for transplants performed at non-contracting facilities and disallowed charges do not apply to the annual deductible

** Subject to state mandated limits

SERVICE AREA

Illustrated in the ODS Health Plans Provider Directory. You must work or reside in the service area to be eligible for the above benefits.

DEPENDENT ELIGIBILITY

Dependents are lawful spouse and unmarried dependent children to age 23, including children an employee is required to enroll due to a court or administrative order.

OUT OF AREA DEPENDENT CHILDREN COVERAGE

If your enrolled dependent child/children reside outside the service area, we will extend benefits for treatment of an illness or injury, and preventative health care and maternity services, as if care were rendered by a participating physician or provider. Out-of-area dependents must access benefits within a 30 mile radius of their residence, in order for benefits to apply.

LIMITATIONS

- * Pre-existing conditions even if they worsen or reoccur.
Note: Your plan's six month pre-existing exclusion period will be shortened one month for each month you had "creditable coverage" under another health plan, provided you do not have a 63 day lapse (or longer) in coverage immediately prior to your enrollment date in your plan, or, if earlier, the first day of the waiting period for such enrollment.
- * All medical and surgical admissions must be authorized by ODS Health Plans.
- * Mental illness/chemical dependency (including alcoholism) paid up to state mandated limits.
- * When a member has more than one group plan, combined benefits for both group plans will be provided up to, but not exceeding, the maximum plan allowance for all covered services.
- * Inpatient rehabilitation benefits are limited to 30 days per calendar year (60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 60 sessions per calendar year (60 for head and spinal cord injuries).
- * Transplant benefits are limited to an aggregate lifetime maximum benefit of \$500,000.
- * There is an additional \$500 Individual Responsibility copay on certain accidents. See member handbook for details.
- * Hospice benefits are limited to \$8,000 for home care; 12 days of inpatient care; 120 hours/3 months respite care.

EXCLUSIONS

- * Services provided by a member of the patient's immediate family.
- * Services or supplies that are not medically necessary.
- * Services and supplies for reversal of sterilization or infertility.
- * Services and supplies for obesity, including complications arising out of such treatment.
- * Surgery to alter the refractive character of the eye.
- * Dental examinations and treatment, except as specifically listed.
- * Acupuncture.
- * Massage or massage therapy.
- * Services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.
- * Treatment of personality disorders.
- * Experimental or investigational treatment.
- * Chiropractic services.
- * Naturopathic services.
- * Services or supplies available in whole, or in part under any city, county, state, or federal law.
- * Charges above those considered the maximum plan allowance.
- * Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits.
- * Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan.
- * Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education.
- * Cosmetic/reconstructive services and supplies.
- * Services and supplies to add to or reduce the upper or lower jaw.

Visit our website at www.odshealthplans.com

This is a benefit summary only. For a complete description of benefits, limitations and exclusions refer to your member handbook.

ODS Health Plans' products provided by ODS Health Plan, Inc.

