ARTICLE XVI

HEALTH AND WELFARE

Note: *Sections 1.0 and 2.0 of Article XVI, Health and Welfare have been revised in accordance with the 2017-2020 Health Benefits agreement dated January 18, 2018 contained in Appendix K.*

1.0 District Contribution Obligations (as to all eligible District personnel): The parties agree increases for benefited employees' health benefits costs represent an increase in employee compensation, and that such increased expenditure is an essential component of the 2006-2007 total compensation increase. The parties further agree:

a. The projected cost of District contributions for all District employees for the 2007 calendar year is $803.4 million.

b. This cost represents up to a $29.3 million increase over the maximum amount the parties agreed the District would budget for calendar year 2006 ($774.1 million) for health and welfare benefits and a $58.2 million increase over the estimated actual cost of benefits for calendar year 2006.

c. Currently, a one percent (1%) compensation increase is approximately $40 million for all District employees.

d. It is jointly acknowledged and agreed that cost containment and related potential Plan changes must continue to be a high priority for the coming years.

1.1 The District shall fully fund the employee health and welfare benefits for calendar year 2007 by increasing its contractual contribution to cover the actual costs of the current plans, up to but not to exceed $803.4 million, subject to fluctuation in participants as set forth herein. This $803.4 million maximum contribution will not be increased in the future absent agreement by all parties reached through the negotiations process set forth in this Agreement, including but not limited to section 2.1 of this Article. All negotiated agreements between the District and all unions/associations shall be modified to establish the negotiations process, as set forth herein, as the exclusive forum in which the subject of health and welfare costs are discussed, following Health Benefits Committee (hereafter "HBC") discussion and recommendations regarding plan design.

a. The parties understand and agree that the projected $803.4 million cost is based upon an analysis by HBC consultants and further is based upon the number of anticipated participants, utilizing established eligibility/coverage criteria, at the time of the projection.

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b. Therefore it is understood and agreed by the parties that the actual cost for calendar year 2007 may be higher or lower than the $803.4 million amount as a result of an increase in the number of participants (based on current eligibility/coverage criteria) or a decrease in the number of participants (based on current eligibility/coverage criteria) compared to the number of participants on which the $803.4 million projection was based.

c. In light of the foregoing, the parties agree that if the number of participants (based on current eligibility/coverage criteria) increases above the number used to project the $803.4 million cost, the District shall fully fund any costs associated with the increase in the number of participants in an amount above the $803.4 million initially projected.

d. Conversely, if the actual costs of providing benefits is below the $803.4 million amount due to (a) lower participation than projected; (b) plan design changes that lower overall costs; or (c) other savings such as Medicare Part D reimbursement, the parties agree that any unspent monies (the difference between $803.4 million and actual costs) shall be placed in a reserve fund to defray the future costs of health benefits. Such reserve shall be subject to the management and control of the HBC through its regular "recommendation process" and the negotiations process set forth herein.

e. At such time as any state or national legislation is enacted into law that appears to impact the reserve set forth in section 2(d) above, the impact and implementation thereof, if any, shall be subject to the management and control of the HBC through its regular "recommendation process" and the negotiations process set forth herein.

2.0 Plan Revisions Through the District-wide Health Benefits Committee: A District-wide Health Benefits Committee shall be formed.

a. Composition -- Each union shall be entitled to one (1) Committee member for every 5,000 unit members represented or fraction thereof. The District shall be an official member of the HBC; the District and each union shall have one vote apiece. The District shall provide resource staff as determined by the Committee, and shall provide adequate paid release time for those Committee members who are employees of the District.

b. Decision Making -- Consensus shall be used in all Committee deliberations. If a consensus decision cannot be reached, then in the alternative, each union and the District shall have one (1) vote apiece. Any recommended changes to the existing kinds and levels of benefits shall require a 2/3 vote of the members present and voting.

c. Authority - - Subject to the terms of subsection g. below, the Committee shall have the sole and exclusive right, and duty, to design the Health and Welfare programs of the District, within the cost parameters of the District budget established for that purpose and in effect at the time. That budget figure is the product of the negotiations process set forth in section 2.1 below. (See section**s** 1.0 and 1.1 above for the current budget cost parameters).

d. Proposed changes in the existing kinds and levels of benefits shall be submitted as recommendations to the Board of Education**,** which shall thereafter be subject to the provisions set forth in section 2.1 below.

e. The Committee may investigate the creation during the term of this Agreement of a joint Employer Health and Welfare Trust. Such Trust might include other public or private sector employees as determined by the Committee. The Committee shall review all existing contracts prior to expiration. No contract shall be for more than one (1) year, or awarded without open bid, except upon Committee approval.

f. Benefit Eligibility -- During the term of this Agreement there shall be no changes in the eligibility requirements for District Benefits (see Section 3.0 below).

g. Effective no later than January 1 of any Plan year, the Union shall have the option of informing (in writing) the District and the other unions participating in the Committee of the Union's intent to remove its pro-rata share of District Health and Welfare Plan expenditures and separately negotiate with the District regarding a replacement plan to become implemented the following January 1 for this unit. Such replacement plan must be designed to fit within the District's budget established for this purpose, as described in sections 1.0, 1.1 and 2.0c and d above.

h. The District and the unions/associations will develop plans to address unfunded liability GASB 45 issues through the HBC.

2.1 <u>HBC Recommendations/Coordinated Negotiations/Dispute Resolution Process</u> The up to $803.4 million maximum District contribution set forth above will not be increased absent agreement by all parties (the District and all unions/associations) reached through the negotiations process set forth herein. The following procedure and timeline shall apply annually:

a. By May 1 - HBC recommendation(s) to School Board (“Board”).

1. Current contracts between the District and all unions/associations require consensus or 2/3 vote of HBC to recommend changes in plan design.

2. If there is HBC consensus, such recommendations shall be submitted to the Board. If the Board approves HBC's recommendations, the "new" plan shall be implemented in accordance with the established health plan year. The increased cost of benefits shall be an increase in employee total compensation and shall be accounted for in negotiations with each union in the manner described in sections 1.0 and 1.1 above.

3. If the HBC does not reach consensus, (i.e., even if 2/3 of HBC members endorse a plan,), both a majority plan recommendation (the plan that garnered at least a 2/3 HBC vote) and minority plan recommendation(s) (i.e., from any organization that did not vote for the 2/3 majority plan recommendation) shall be presented to Board.

4. Following presentation of majority and minority plans to the Board for consideration, the Board shall take action to adopt one of the following three options:

   a. Accept the "majority plan" recommendation. If this occurs, the new plan shall be implemented in accordance with section 2.1 (a) (2) above; or

   b. Endorse the "minority plan" recommendation; or

   c. Reject both recommendations.

5. If the Board chooses 4 (b) or (c) above, the issue of plan design shall be referred back to the HBC. The Board shall give guidance to the HBC as to what actions it believes should be taken.

   a. The HBC shall reconsider and potentially revise its plan design recommendation based on the above.

   b. If the HBC reaches consensus on a revised plan recommendation (i.e., there are no "minority plans"), this recommendation shall be forwarded to the Board for adoption. If the Board accepts the revised recommendation, section 2.1(a) (2) shall then apply.

6. If the Board rejects the revised consensus HBC recommendation or if the HBC is unable to arrive at a revised consensus recommendation by June 1, the following procedure shall apply:

a. Within ten days of the Board's action, or the HBC's inability to arrive at a revised consensus recommendation, the parties shall commence coordinated negotiations (the District and all unions/associations) over the subject of plan design and benefit costs for the applicable calendar year. Any agreements reached shall reduced to writing and subject to normal ratification procedures. The increased cost of any agreed upon plan shall be an increase in employee total compensation and shall be accounted for in negotiations with each union in the manner described in sections 1.0 and 1.1above.

b. If the parties have not reached a tentative agreement by October 1st, the parties shall jointly declare the existence of an impasse pursuant to Government Code section 3548 and shall immediately proceed with statutory impasse procedures (mediation, factfinding).

c. Notwithstanding the provisions of any negotiated contract between the parties (the District and all unions/associations), or the status of negotiations between the District and each individual union/association, if the statutory impasse process is exhausted, and agreement is not reached over the subject of health and welfare benefits, and if the District imposes its last best offer, all parties to this agreement shall have the right to engage in and respond to lawful concerted activities. Accordingly, the "no strike/no lockout" provisions of the respective collective bargaining agreements shall be suspended.

7. Open enrollment shall not occur until a new plan design is adopted by the parties (the District and all unions and associations) pursuant to completion of the procedures described above, (or exhaustion of the impasse process, if applicable).

a. Pending the completion of procedures/negotiations/impasse for new plan adoption, employees shall remain in their current plans.

b. Pending completion of procedures/negotiations/impasse for new plan adoption, the District shall temporarily assume

the costs attributable to the written plan design.
However, any increased costs of health and welfare benefits shall be recovered retroactively to the applicable January 1st as part of negotiations over total compensation, in the manner described in sections 1.0 and 1.1 above.

3.0 Eligibility for Plans: Eligibility requirements for employees and dependents shall be as provided in the applicable plan and also as follows:

a. Every employee who is assigned half-time or more of a full-time assignment in one class, in a status other than substitute, temporary, extra, exchange or relief, shall be eligible to enroll in a plan. The percentage of assignment shall be determined pursuant to Article XIV, Section 1.1. For employees attaining eligibility under this paragraph the enrollment year shall be January through December.

b. Employees who do not qualify under the preceding paragraph, but who in the previous school year were in paid status for the equivalent of 91 ~~100~~ or more full days as a result of any one assignment or any combination of assignments in certificated service shall be eligible to enroll in a plan. For employees attaining eligibility under this paragraph, the enrollment year shall be September through August.

c. Part-time contract employees described in Article XIII, Section 1.3 and new employees hired effective July 1, 1993 or later working one half-time with the other one-half time covered by a leave under Article XII, Section 21.1 may be eligible to receive a District contribution to the health and welfare benefits package that is prorated to the hours of contract service (e.g., a half-time teacher receives 3/6ths or 50 percent of the contribution cost for the full health and welfare benefits package); however, in order to receive the benefit of the prorated contribution, the employee must contribute the balance of the full cost.

d. Adult Education personnel (except those mentioned below) are eligible to enroll in the full health and welfare program if assigned for one hundred and twenty (120) hours per pay period in one class code other than substitute or temporary, or have been in paid status in one or more class codes for 1200 hours during the previous school year. Those who do not meet such requirement will qualify for a part-time health plan (hospital and medical only, for employee plus one dependent), provided they are assigned for at least seventy-two (72) hours per pay period in one or more class codes other than substitute or temporary or have been in paid status in one or more class codes for seven hundred and twenty (720) hours during the previous school year. For those employees obtaining eligibility under the previous school year hours, the enrollment year shall be from September through August. Exempted from this change in requirements are those Adult Education employees who qualified during the 1979-80

school year based upon the previous rules and those Adult Education employees who qualified during the 2000-2001 school year based upon previous rules, and who have thereafter continuously maintained eligibility under the previous rules. With respect to employees whose hours are reduced below the coverage level, see Section 9.0 below.

e. In order to remain eligible, the employee must be in paid status within the assignment basis. However, an employee in an unpaid status who later receives compensation from the District for the unpaid period shall be entitled to reimbursement of direct premium payments made which correspond to the period for which such compensation is allowed. To obtain such reimbursement, the employee shall file application therefore with the District's Health Insurance Section.

f. In situations where employees are married to one another and are covered by the same plan with one listed as a dependent, the dependent shall not, upon divorce or upon the retirement or death of the spouse, lose any rights the employee would otherwise have had as an eligible employee or retired employee.

g. Substitute employees who satisfy the requirement in section (b) above and are in paid status for the month of May shall maintain their healthcare benefits through August without the requirement of being in paid status during the months of June, July and August. Substitute employees who are eligible for the subsequent plan year (September through August) shall not be required to be in paid status for the month of August.

4.0 Retirement Benefit Coverage: Qualified employees who retire from the District receiving an STRS/PERS allowance for either age or disability shall be eligible to continue District-paid hospital/medical, dental and vision coverage in which the employee was enrolled at the time of retirement. For the purposes of this section, qualifying years consist of school years in which the employee was in paid status for at least 100 full-time days and was eligible for District-paid insurance coverage. The following shall not count toward, but shall not constitute a break in the service requirement: (a) time spent on authorized leave of absence and, (b) any time intervening between resignation and reinstatement with full benefits within thirty nine (39) months of the last day of paid service. The employee must meet the following requirements:

a. For employees hired prior to March 11, 1984, five (5) consecutive years of qualifying service immediately prior to retirement shall be required in order to qualify for retiree health benefits for the life of the retiree.

b. For employees hired on or after March 11, 1984, but prior to July 1, 1987, ten (10) consecutive years of qualifying service immediately prior to retirement shall be required in order to qualify for retiree health benefits for the life of the retiree.

c. For employees hired on or after July 1, 1987, but prior to June 1, 1992, fifteen (15) consecutive years of qualifying service immediately prior to retirement shall be required, or ten (10) consecutive years immediately prior to retirement plus an additional ten (10) years which are not consecutive.

d. For employees hired on or after June 1, 1992 but prior to March 1, 2007, years of qualifying service and age must total at least eighty (80) in order to qualify for retiree health benefits. For employees who have a break in service, this must include at least ten (10) consecutive years immediately prior to retirement.

e. For employees hired on or after March 1, 2007, but prior to April 1, 2009, shall be required to have a minimum of fifteen (15) consecutive years of service with the District immediately prior to retirement, in concert with the “Rule of 80” eligibility requirement (section 4.0 (d) above) to receive employee and dependents’ health and welfare benefits (medical dental and vision) upon retirement as provided for in this agreement.

f. For New Employees hired on or after April 1, 2009, years of qualifying service and age must total at least eighty-five (85) in order to qualify for retiree health benefits. This must include a minimum of twenty-five (25) consecutive years of service with the District immediately prior to retirement.

g. In order to maintain coverage, the retiree must continue to receive an STRS/PERS allowance and must enroll in those parts of Medicare for which eligible.

h. Employees on "Continuation of Enrollment" pursuant to Section 6.0 below shall, if otherwise qualifying under this section, be eligible for coverage under the District paid insurance plans upon receiving an STRS/PERS retirement allowance.

5.0 <u>Enrollment</u>: For the hospital-medical, dental and vision care plans, an unenrolled employee eligible for enrollment may submit application for enrollment in a plan at any time. However, an employee who has previously been enrolled in a plan during the current enrollment year must, upon re-enrollment in that same enrollment year, select the same plan. Such an employee must wait until the next open enrollment period to effect a change of plans. The District shall process applications so as to make coverage effective on the earliest practicable date consistent with the plan provisions, and in no case shall this be later than the first day of the calendar month following the receipt of the completed application.

5.1 Eligible dependents may be enrolled by the employee in the hospital-medical, dental, and vision care plans at any time provided. The eligible employee submits a “dependent add form” and proof of eligible status as described below.

Newborn children of the employee are automatically covered for the first thirty days following birth, provided that an application for dependent coverage is received by

the Health Insurance Section before the end of the 30 day period.

Dependents	Documents Required (copy)
Legal Spouse	State or County Issued Marriage Certificate
Domestic Partner	Notarized “Declaration of Domestic Partnership” (LAUSD Form DP 1.0) At least two of the documents listed in Section 5.1 (9) below
Child, to age 19	Birth Certificate (in case of newborn, evidence of birth until birth certificate is available)
Stepchild, to age 19	Birth Certificate and income tax return showing dependent status
Adopted Child, to age 19	Adoption papers
Child to age 19 who is a Legal Ward,	Court order establishing legal guardianship
Child over 19, to age 25	In addition to the appropriate documents listed above, proof of full-time student status is required at least annually

Note: The children of a domestic partner are not eligible for coverage unless they have been adopted by the employee or the employee is the legal guardian. In such cases, the required documentation for adoption or legal guardianship must be provided.

a. A domestic partner of the same or opposite sex of an eligible employee may be covered as a dependent if all of the following criteria are met. The employee and his/her partner:

(1) have shared a regular and permanent residence for the past twelve (12) months immediately preceding the application for coverage with the LAUSD;

(2) are engaged in an exclusive, committed relationship for mutual support and benefit to the same extent as married persons and intend to stay together indefinitely;

(3) are jointly responsible to each other for basic living expenses; basic living expenses are defined as the

expenses supporting daily living, i.e., shelter, food, clothing (contributions need not be equal);

(4) are not currently married to another person;

(5) have not signed a declaration of a domestic partnership with another individual in the previous twelve (12) month period;

(6) are at least eighteen (18) years of age;

(7) are not blood relatives any closer than would prohibit legal marriage in the state of residence;

(8) are mentally competent to consent to a contract;

(9) are financially interdependent as proven by providing at least two of the following documents: common ownership of real property or a common leasehold interest in real property; common ownership of a motor vehicle; joint bank account or joint credit account; designation as a beneficiary for life insurance or retirement benefits.

b. No other dependents or family members are eligible for coverage, except that disabled children who meet the disability standards of the plan(s) and who have been enrolled prior to age nineteen (19) or, who were first enrolled as eligible full-time students prior to the disabling condition, may continue to be covered beyond age nineteen (19).

c. Eliminate dual coverage for spouses or qualifying domestic partners in the District on a voluntary basis. If both spouses are District employees and each is covered both as an employee and as a dependent, the District will pay $1000 to them if they agree to accept coverage under the same plan (one as an employee and the other as a dependent). If the District employee agrees to waive coverage under the District plan and accepts coverage solely under a plan of the spouse's employer (not the District), the District will pay $1000 to the employee.

5.2 It is the responsibility of the employee to notify the Health Insurance Section immediately regarding the termination of his/her domestic partner relationship. The employee must submit LAUSD Form DP2.0, "Statement of Disenrollment or Termination of Domestic Partnership." The coverage for a domestic partner shall end on the last day of the month in which the relationship and/or living arrangement terminates and/or for which either party is no longer eligible for coverage.

5.3 For the District-paid life insurance plan, all eligible employees are automatically covered. No application is necessary to obtain this benefit.

5.4 Eligible employees may enroll in the employee-paid life insurance plan without evidence of insurability provided that a completed

application is received by the District's Health Insurance Section no later than sixty (60) days from the date the employee is first eligible. Employees not submitting applications during the period specified above may enroll by providing evidence of good health acceptable to the plan. Application for the employee-paid life insurance shall be processed to provide coverage at the earliest date consistent with the plan provided and payroll deduction schedules.

Employees participating in the employee-paid life insurance plan may also purchase spouse, domestic partner and/or dependent children coverage. Dependents eligible pursuant to 5.1 above may be enrolled without evidence of insurability in the following circumstances:

- An application for such coverage is made simultaneously with the employee's initial enrollment.
- The eligible dependents are acquired after the point of initial enrollment by the employee. The application for such enrollment, however, must be received by the Health Insurance Section within thirty (30) days of the acquisition of such dependent(s).
- Newborn children of the employee are automatically covered for the first thirty days following birth, provided that an application for dependent coverage is received by the health Insurance Section before the end of the thirty (30) day period.

5.5 For an employee whose spouse/domestic partner has other insurance coverage, reimbursement will be limited to the maximum percentage allowed by the higher individual policy. An employee whose spouse/domestic partner is also a District employee may mutually agree to be covered as both an employee and as a dependent within the same plan. A married couple who both work for the District or domestic partners who both work for the District may include their qualifying children on their individual policies, and such children may also be covered more than once within the same plan.

5.6 Once each year there shall be an open enrollment period during which an enrolled employee may change hospital-medical benefits plans, dental plans and/or vision care plans. The District's Health Insurance Section shall establish an announce the date of said open enrollment period.

6.0 Continuation of Enrollment: With respect to the hospital-medical, dental and vision care plans, if an employee is in an unpaid status and not eligible for District contribution, the employee may arrange for continuance of enrollment under COBRA (see 9.0 - 9.3 below.)

6.1 With respect to the District-paid life insurance plan, coverage for an employee on an unpaid leave of absence other than for illness or industrial injury/illness shall not be provided until such time as the employee returns to active service in an eligible assignment. Coverage for an employee on an unpaid leave of absence for illness or industrial injury/illness shall continue for one year after which termination of coverage shall be processed and a conversion plan offered.

Coverage for substitute employees who are unavailable for work for any reason shall not be provided.

6.2 With respect to the employee-paid life insurance plan, employees who receive no salary or who receive insufficient salary to permit deduction of the required premium after all other deductions are made may continue coverage for a period not to exceed one (1) year by making direct payments of the appropriate premiums by check or money order payable to the plan and sent to the Health Insurance Section.

6.3 With respect to employees who decline to make the above continuation payments, coverage shall be terminated and they shall not be eligible to re-enroll in a plan until returning to active service in an eligible assignment and, with respect to the employee-paid life insurance plan, submitting evidence of good health acceptable to the plan. An officer of UTLA on leave pursuant to Article IV, Section 3.0 shall not be subject to the maximum eighteen (18) month period for direct payments but may continue enrollment by making proper payment(s) to the plan in which enrolled for the period of the leave.

7.0 Termination of Enrollment: The enrollment of an employee shall terminate:

a. For failure of the employee to make direct payment as provided under Sections 8.0 and 9.0, in which case coverage shall terminate at the close of the month for which the last premium was paid;

b. At the request of an employee, in which case coverage shall terminate at the close of the month in which the request was submitted;

c. Upon termination of employment, in which case coverage shall terminate at the close of the month in which the employment termination was effective, except for District paid life-insurance in which case coverage shall terminate on the date the employee ceases to be employed;

d. In the event of the employee's loss of eligibility, in which case coverage shall terminate at the close of the enrollment year, except for the District-paid life insurance plan, which shall terminate coverage on the date of loss of eligibility; and

e. For District-paid life insurance, upon the employee's loss of eligibility or termination of employment, in which case coverage shall terminate on the date the employee ceases to be eligible or employed.

7.1 With respect to hospital-medical plan coverage, if the employee's participation is terminated at the plan's request for other than non-payment of premium, the employee may enroll in another of the District's hospital and medical plans by making proper application to the District's Health Insurance Section.

8.0 Conversion of Enrollment: With respect to the hospital-medical plans, an employee who is enrolled in a plan for at least two (2)

consecutive calendar months and whose enrollment terminates because of (a) failure to make direct payment when required, (b) loss of eligibility, or (c) termination of employment, shall be given the opportunity to exercise the right of conversion of such individual coverage as provided by the plan, at the employee's expense. With respect to the life insurance plan, an employee whose enrollment terminates because of (a) failure to make direct payments when required, (b) termination of employment, or (c) loss of eligibility, shall be given the opportunity to convert, at the employee's expense, to a permanent form of insurance (other than term insurance) pursuant to the provisions of the plan.

9.0 COBRA: Pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) and comparable State law, eligible employees or dependents may have continuation of coverage for a given period of time at their own expense under the District's health, dental and vision care plans in the event of termination of coverage due to one of the following causes: Death of covered employee, termination of covered employee (under certain conditions) or reduction in covered employee's hours of employment, divorce or legal separation of the covered employee, or a dependent child ceasing to be eligible for coverage as a dependent child under the District's health and welfare plans.

9.1 The monthly premium for continued coverage shall be determined at the time of eligibility and shall be subject to change; however, the premium charged to employees will not exceed 102 percent of the premium paid by the District for active employees and/or dependents in a comparable status. The continuation coverage shall be the same as the coverage available to continuing employees, regardless of the employee's health at the time.

9.2 It shall be the responsibility of the employee or the dependent to notify the Health Insurance Section of a divorce, legal separation or loss of eligibility of a dependent child at the time of such an event. At the time of eligibility for continuation coverage, and upon such notification, an election form shall be provided by the District.

9.3 COBRA shall be administered pursuant to federal law, and all decisions and rules with respect to eligibility, premium costs, qualification for benefits, and level of benefits shall be in accordance with published federal government guidelines. Accordingly, it is expressly understood that all such matters, as well as any other questions or issues relating to COBRA, are excluded from the grievance and arbitration provisions of Article V (Grievance Procedures).

10.0 Miscellaneous Provisions:

10.1 If any premium is refunded by a Plan carrier/administrator, it shall be retained by the District, unless it is the result of a direct payment made by an employee in which case it shall be refunded to the employee. If any injury or illness is caused or alleged to be caused by any act or omission of a third party, payments will be made according to the terms of the Plan for the services of physicians, hospitals and other providers; however, the Plan Member must reimburse the Plan for any amount paid by the Plan, up to the amount of any settlement or judgment the Member, the Member's estate, parent or legal guardian receives from or on behalf of the third party on account of such injury or illness.

The Plan may, in its discretion, condition payment upon execution by the Member, the Member's estate, parent or legal guardian of an agreement (1) to reimburse the Plan accordingly, and (2) to direct the Member's attorney to make payments directly to the Plan.

10.2 The controlling documents regarding all health plans are the applicable contracts between the District and the carriers/plan administrators. All disputes regarding coverage and benefits are to be resolved under the plan's own grievance procedures rather than under Article V of this Agreement.

10.3 UTLA shall be furnished with a copy of the current Plans and Plan summaries; the District shall notify UTLA of any proposed Plan changes promptly upon receiving notification of same from the carriers.

10.4 [Reserved]

10.5 <u>Extended Medical Leave:</u> Employees shall receive an extension of the "Continuation of Enrollment" (see 6.0) by qualifying for an Extended Special Medical Leave under the following conditions:

a. The employee must have accumulated a minimum of 20 years of qualifying service;

b. The employee must suffer from a physical condition of a permanent debilitating, irreversible nature so as to make continuation of employment an extreme hardship (e.g., certain forms and advanced stages of multiple sclerosis, cancer, sickle cell disease, diabetes, cerebral palsy and muscular dystrophy, etc.);

c. The procedures of Article XI governing "Medical Appeals" shall govern determinations to be made under this section.

d. The Extended Special Medical Leave may be renewed annually and, if continued until retirement under STRS/PERS, will permit the employee to qualify for District-paid insurance plans upon receipt of retirement allowances.

10.6 <u>STRS Counseling</u>: The District intends to renew its agreement to provide District office space to STRS representatives who will be available for retirement counseling and workshops. The District and UTLA shall cooperatively discuss with STRS the nature of those services.

10.7 <u>Section 12.5 Plan:</u> The District will continue the IRS Section 125 Plan at no expense to the District.