JEFFERSON COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA REQUEST

TO: **Board of County Commissioners**

FROM: **Mark McCauley, County Administrator**
Sarah Melancon, HR Director

DATE: **November 21, 2022**

SUBJECT: **Memorandum of Agreement between Jefferson County and Teamsters Local No. 589 – Employee "Opt-Out" of Medical Coverage**

STATEMENT OF ISSUE:

Jefferson County Public Works Department and Teamsters Local No. 589 are Parties to a Collective Bargaining Agreement (CBA) that will expire on December 31, 2023. The current CBA does not allow an employee to "opt-out" of medical coverage. Recently, the Parties learned there is a procedure within the Teamsters Welfare Medical Trust to allow for employees to "opt-out" of medical coverage.

ANALYSIS:

The CBA signed in December, 2021, requires all employees to pay the 15% share of medical coverage, while the County pays 85 % of medical coverage. Under the current CBA, employees are not able to "opt-out" of coverage. It was recently learned by the County and Teamsters that there is a procedure within the Medical Trust that allows for employees to "opt-out". To "opt-out", an employee must complete an Employee Waiver of Benefits Form and return it to the Teamsters Medical Trust for approval.

RECOMMENDATION:

Approve and sign the Memorandum of Agreement between Jefferson County and Teamsters Local No. 589.

REVIEWED BY:

Mark McCauley, County Administrator — 11/15/22 Date

MEMORANDUM OF AGREEMENT (2022-1)
BY AND BETWEEN
JEFFERSON COUNTY WA (Employer)
AND
TEAMSTERS LOCAL 589 (Union)
Covering the Jefferson County Public Works Department

A. The Employer and Union are Parties to a Collective Bargaining Agreement (CBA) which will expire on December 31, 2023, and;

B. Recently the Parties learned there is a procedure within the Medical Trust to allow for employee "Opt-Out", and;

C. The Parties having discussed the opt-out process in a subsequent bargaining agreement wish to include the opt-out provisions in this PW Agreement.

NOW THEREFORE IT IS AGREED:

1. The CBA will remain as adopted with the herein additions.

2. Article 16 shall have the existing Section 16.1 removed and replaced in its entirety as follows:

   16.1 The County shall be responsible for 85% of the required contribution for the benefits provided in Article 15. with employees' responsible for 15% of the required contribution. Provided, however, any employee who properly executes Appendix B "NOTICE THAT EMPLOYEE DEDUCTION NOT AUTHORIZED" shall for the period of time that the appropriate Trust only requires the County to pay 85% of the total contribution and the Trust does not require the employee 15% to be remitted to the Trust, such employee, who has properly executed Appendix B, shall not be obligated for the 15% employee responsibility notwithstanding the County contribution of 85%. Provided further, IF and only IF, the Trust fund requires the County to pay the full 100% of the contribution rate it is then agreed that all employee responsibilities under this section are "wage rate reductions" to provide for Bargaining Unit medical coverage.

3. Attached hereto as Attachment 1 shall be Appendix D to be the companion for the revised Article 16, Section 16.1.

4. All other terms and conditions of the unexpired CBA shall remain as written.

This MOA-2022-1 shall be effective as of November 1, 2022.

//Signatures on following page//

Jefferson County Commissioners
JEFFERSON COUNTY WASHINGTON

Heidi Eisenhour, Chair

Greg Brotherton

Kate Dean

TEAMSTERS LOCAL 589

Robert A. Driskell

Robert Driskell, Secretary/Treasurer
Date: November 4, 2022

Approved as to Form

Chief Civil Deputy Prosecutor

P. C. Hunsucker November 8, 2022

Philip C. Hunsucker

Clerk of the Board:

Carolyn Gallaway, CMC

MOA 2022-1; ATTACHMENT I
APPENDIX D – Employee Waiver of Benefits Form

NORTHWEST ADMINISTRATORS, INC.

2323 Eastlake Avenue E
Seattle, WA 98102-3393
(206) 329-4900
(206) 726-3209 fax

WASHINGTON TEAMSTERS WELFARE TRUST
NOTICE THAT EMPLOYEE PAYROLL DEDUCTION NOT AUTHORIZED

Employer Name: Jefferson County WA -Public Works **Account No.:** 1060000

Employee Name:_____ **Social Security #:** xxx-xx-_____

Effective Date:_____ **Worked Hours (Month/Year)**

_____ **Coverage Month (Month/Year)**

Section II E of the Trust Operating Guidelines states:

> If, under the maintenance of benefits provisions of a collective bargaining agreement, employee wages are impacted, the agreement may provide either that wages are to be reduced to provide for the funding of contributions to the Trust or that contributions may be deducted from employee wages for this purpose. Where the collective bargaining agreement provides for deduction from wages, any employee in the bargaining unit who objects to the required deduction shall be treated as declining coverage beginning with the month for which the deduction for full maintenance of benefits is required. The employer shall remain obligated to continue its monthly contributions to the Trust on behalf of the employee, without regard to employee's deduction decision. Such employee shall not be permitted to be covered for benefits under the Trust from such date of interrupted coverage until the earlier of (a) twelve (12) months after such first month of required contributions or (b) the date provided under ERISA Section 701(f) (Internal Revenue Code Section 9801(f)) for return to coverage through special enrollment in the event of such employee's loss of other group health plan coverage or acquisition of a dependent through marriage, birth, adoption, or placement for adoption.

The current collective bargaining agreement indicates that the required contributions to the Trust being made by the employer are broken down as follows:

	Medical	Dental	Vision	Life	Time Loss		
Contribution	Per subscription agreement					Employer	85%
						Employee	15%
						Total	100%

Contributions include Life and Accidental & Dismemberment insurance, Time Loss benefits, disability waivers, extensions, and benefits, etc.

The named employee declines a wage deduction for the above employee contribution by his or her signature on page 2 of this form.

The named employer and employee understand and agree:

- That the employee's declination of the employee contribution(s) as indicated on the first page of this form shall be treated as declining coverage beginning with the month for which the total contribution to provide for full maintenance of benefits is not made.

- Declination of employee contributions includes declination of all benefits of the declined plan(s) for the employee and all eligible family members, including but not limited to healthcare benefits (medical, dental, vision, prescription drug), Life insurance, Accidental Death & Dismemberment insurance, disability extensions, Time Loss benefits (including Long Term Disability benefits, if any), COBRA continuation coverage, and self-pay options.

- The employer remains obligated to continue its employer portion of the monthly contributions to the Trust on behalf of the employee, without regard to employee's deduction decision.

- Such employee shall not be permitted to be covered for benefits under the Trust from such date of interrupted coverage until the earlier of (a) twelve (12) months after such first month of required contributions or (b) the date provided under ERISA Section 701(f) (Internal Revenue Code Section 9801(f)) for return to coverage through special enrollment in the event of such employee's loss of other group health plan coverage or acquisition of a dependent through marriage, birth, adoption, or placement for adoption.

- In the event of a special enrollment event within twelve (12) months after coverage has been declined, the employer must begin making the proper employee payroll deduction and remit the full required contribution. The employer and employee must also notify the Trust of the special enrollment event by completing and returning the proper form available from the Trust Office before coverage will be reinstated.

For Jefferson County WA
Employer Signature _____ **Date** _____

Print Name _____

Employee Signature _____ **Date** _____
Employee Declining Coverage

Print Name _____

Mail completed form to: **Washington Teamsters Welfare Trust**
Attn: Accounting & Eligibility
2323 Eastlake Avenue E.
Seattle, WA 98102