ARTICLE 1- RECOGNITION

1.1 Christiana Care Health System, Inc. (hereinafter "Employer" or ChristianaCare" or "Health System") recognizes Doctors Council, SEIU Local 10MD (hereinafter "Doctors Council" or "Union") as the sole and exclusive collective bargaining representative of all full-time and regular part-time acute care physicians who:

(a) are employed in a position identified in Exhibit A; and

(b) provide 0.2 clinical FTE or greater of acute care, which is defined as care for patients who are in inpatient, observation or emergency department status, while the physician and the acute care patient are both physically located at one of the following locations: Christiana Hospital, 4755 Ogletown-Stanton Rd., Newark, DE; Wilmington Hospital, 501 West 14th St. Wilmington, DE; Union Hospital of Cecil County Inc., (Affinity Health Alliance Inc.) 106 Bow St., Elkton, MD; and Middletown Free-standing Emergency Department, 621 Middletown Odessa Rd., Middletown, DE (collectively the "Hospital(s)"); and

(c) whose position is not otherwise excluded from the bargaining unit.

Notwithstanding the foregoing, but subject to the exclusions below, any physician listed on the voter list and not identified as voting subject to challenge in case numbers 04-RC-342224, 04-RC-342229, and 04-RC-342252 (Attached as Exhibit B) shall be and remain a bargaining unit member (hereinafter "legacy bargaining unit member") unless and until the legacy bargaining unit member is no longer in the position they were in as listed on the voter list. If a legacy bargaining unit member's position changes from the position identified in the voter list, their inclusion in the bargaining unit shall be controlled by the unit definition contained in this Section 1.1.

1.2 **Excluded:** All other physicians (including expressly Breast Imagers, CT Surgeons and Urologists), Podiatrists, all other professional employees, contracted physicians (physicians employed by an organization other than Christiana Care Health Services to provide services at the Hospitals), Chiefs, Section Chiefs, Program Directors, Clinical Directors, Clinical Leaders, Service Line Leaders, Department Chairs, Department Vice Chairs, Union Hospital Associate Medical Director, residents, fellows, confidential employees, guards, supervisors as defined by the Act, and all other employees.

1.3 Where an employee works both as an acute care physician and holds a position outside the bargaining unit, the employee's work as an acute care physician is bargaining-unit work and the employee's work in the other position is non-bargaining-unit work.

1.4 **Academic Work.** A physician's academic position (to the extent a physician has an academic position) and all academic work, is excluded from coverage under this Agreement, except for benefits. Notwithstanding the foregoing, a physician's academic position will count toward their FTE status with regard to eligibility for the benefits contained in Article ___ of this Agreement.

1.5 **Definition of Physician**. Whenever the word "physician(s)" is used in this Agreement, it shall be deemed to mean the physicians included in the bargaining unit as defined by Section 1.1 above.

Appendix A
List of Positions in the Doctors Council Bargaining Unit,
Subject to Satisfaction of The Rest of the Acute Care Test in Article __

Cardiologist
Advanced Heart Failure Cardiologist
Cardiac Hospitalist
Cardiac Surgery Critical Care Intensivist
Cardiac Critical Care Intensivist
Electrophysiology Cardiologist
Invasive / Interventional Cardiologist
Vascular Interventional Radiologist

Gynecologic Oncologist
Hematologist
Inpatient Oncologist
Surgical Oncologist

Laborist
Neonatologist
OB/GYN Physician
Uro Gynecologist
Minimally Invasive Gynecologic Surgeon (MIGS)

Emergency Medicine Physician
Pediatric Emergency Medicine Physician
General Pediatrician in Emergency Medicine (GPEM)
Pediatric Center Physician

Pediatric Hospitalist
Hospitalist
Family Medicine Academic Hospitalist

Medical Critical Care Intensivist
Pulmonary Intensivist

Bariatric Surgeon
Breast Surgeon
Colorectal Surgeon
General Surgeon

Reconstructive Plastic Surgeon
Kidney Transplant Surgeon
Trauma Surgeon
Vascular Surgeon

Diagnostic Radiologist
Neuroradiologist
Nuclear Medicine Physician

Epileptologist
Neuro Interventional Surgery
Neurocritical Care Physician
Neurohospitalist
Vascular Neurologist

Endocrinologist
Otorhinolaryngologist/ENT
Gastroenterologist
Ophthalmologist
Palliative Care Physician
Pathologist
Physiatrist
Consult Liaison Psychiatrist
Inpatient Psychiatrist
Pulmonologist
Interventional Pulmonologist
Rheumatologist
Inpatient Addiction Medicine Physician

Thoracic Surgeon

ARTICLE 2 – MANAGEMENT RIGHTS

2.1 The Health System retains all rights, powers, authority, prerogatives, privileges, responsibilities, and obligations which are customarily and/or inherently performed by an employer and which are not expressly abrogated, surrendered, modified, or amended by a specific term of this Agreement. Any right of the Health System to act with respect to the management and operation of all facilities, and functions, including the direction of the work force, is retained, and reserved to the judgment of the Health System, unless such right is specifically abrogated, restricted, surrendered, amended, modified and/or abridged by a term of this Agreement. The exercise of the Health System's rights includes, solely by way of illustration, and not in any manner by way of limitation, the following rights:

To hire, assign, reassign, appoint, direct, discipline or discharge for just cause, transfer, promote, demote, reward, evaluate, lay-off, recall, compensate, and supervise the actions of employees, investigate any matter in advance of exercise such rights, or to refrain from taking any such actions; and

To set initial compensation, even if such compensation is above the applicable wage scale, the right to offer a signing bonus and/or retention bonus (and set any repayment obligations for such bonus), or any other inducements, incentives, or supplemental pay; and

To determine the nature and type of duties, tasks, functions, programs and/or services to be performed by physicians, as well as to which physicians it will assign such functions, and the schedules by which such functions will or will not be performed; and

To contract or subcontract, including but not limited to the manner described in Article 17, the performance of such duties, tasks, services, programs, etc., as the Health System deems necessary, including to hire or use temporary, seasonal, and/or casual employees, including use of locum doctors; and

To determine which equipment, including safety equipment such staff duress badges, technology, and/or supplies will be utilized by physicians in the performance of functions, programs, services, tasks, duties, etc.; and

To bill for, or have a third-party bill for, all professional medical services rendered by a physician, in the physician's name; and

To require physicians to timely complete such work as necessary to facilitate the Health System accurate preparation of bills for professional medical services; and

To collect deposits of all revenue generated by a physician's professional medical services and to retain the proceeds from such billing; and

To install, remove, modify, maintain, replace, or substitute equipment and supplies; and

To determine and/or set all standards of clinical care; and

To determine the location and type of operations and to introduce new and/or improved methods of operations, including the right to discontinue any department, practice, line, service, section or portion thereof; and

To determine the number of hours to be worked by physicians and to determine to what extent any department, practice, line, service, section, unit, or group within the Health System will utilize moonlighting; and

To establish, increase and/or decrease the number of work shifts and their starting and/or ending times; and

To transfer or relocate any or all the operations of the Hospitals to any location or to discontinue such operation, including to organize, reorganize, combine, or discontinue units or departments, or sell any or all of the Health System's entities and properties, including its parent corporation, subsidiary corporations, related corporations, assets (whether stock or real property), operations, and joint ventures to a third-party; and

To modify positions and determine wage levels for any newly established or modified position; and

To establish, post, and enforce work rules, procedures, standards, and/or regulations governing the conduct or performance of assigned functions, and other acts of physicians, including concerning use of drugs and/or alcohol and smoking; recognizing that any discipline shall be subject to just cause and

To select, train, assign and/or reassign managerial and/or supervisory employees to perform whatever tasks the Health System deems necessary without regard to whether such work is customarily performed by the bargaining unit; and

To train and retrain physicians as necessary; and

To establish, change and/or determine job content/duties and individual employment qualifications, including required credentials, licenses, and certifications; and

To require the preparation, distribution and maintenance of documentation and records pertinent to the business of the Health System, as well as to alter such requirements as the needs of the business may dictate; and

To determine the physical requirements of employment and continued employment, including the right to require physicians to submit to physical examinations, alcohol and/or drug testing as part of the new hire process, as required by government regulation and/or for reasonable suspicion, and any other type of examination that the Health System deems relevant to determine the physician's ability to perform their job; and

To establish quality standards, performance standards, and procedures applicable to the bargaining unit; and

To carry out all ordinary, extraordinary, routine, and/or customary functions of management whether or not the performance of such function has been contemplated by the parties to this Agreement prior to or since its execution.

2.2 The decision itself to exercise or not exercise any of the rights as provided herein shall be that of the Health System.

2.3 The Health System will continue, in its sole discretion, to select professional liability insurance options and any other insurance coverage. The Health System maintains the sole right and obligation to defend against and settle claims on behalf of any and all physicians under such plans, as well as any other claims against the Health System or its physicians acting within the scope of their employment. Additionally, the Health System has the sole right to choose legal counsel in these matters. Decisions regarding professional liability insurance will not be a proper subject for the grievance procedure contained in this Agreement.

ARTICLE 3 - UNION RIGHTS

3.1 Doctors Council may appoint (through a method of its choosing) up to twenty-one (21) Union Delegates. Doctors Council shall provide the Health System with a list of such Delegates. These Delegates shall receive physician complaints and process grievances through the grievance procedure and when deemed necessary by the employee or Delegate, bring these complaints to the attention of the management. These duties also include 15 minutes with bargaining unit members at new clinician orientation, and other labor-management activities. Delegates shall be permitted reasonable amounts of time during the Delegates' workday to handle and process grievances. No Delegate work shall interfere with patient care.

3.2 Duly authorized representatives of Doctors Council shall be permitted to enter the Hospitals (excluding direct patient care areas) for purposes of transacting Union business, provided that the representatives request such access in writing with at least 24 hours' notice by email to an HR inbox (which the Health System will identify), receive approval from Human Resources prior to arrival and comply with all Health System property access requirements. Such approval shall not be unreasonably denied. The email must provide the location, anticipated timeframe, and purpose of the visit.

(a) No representative of Doctors Council will speak with patients or patients' family members or friends, or other visitors while at a Hospital, including adjacent spaces such as parking lots. The representative shall in no way interfere with the Health System's work or operations while at a Hospital.

(b) The Health System will notify appropriate management on site at the Hospital in advance of Doctors Council's visit that the representative shall be allowed access to the Hospital consistent with the terms of this agreement. Access will be limited to areas of the Hospital that are related to the purpose of the Union's visit.

(c) While at a Hospital, representatives of Doctors Council will comply with all policies applicable to visitors.

3.3 The Health System will permit Doctors Council use of one bulletin board per physician lounge. Any physical notice posted shall be initialed in advance by the Vice President of Employee and Labor Relations or designee. Permission to post physical notices will not be unreasonably denied. The Health System shall also furnish to the Union a process to post Union notices on the Intranet for members of the Bargaining Unit only.

ARTICLE 4
UNION SECURITY

1. All employees on the active payroll as of _____ who are members of the Union shall maintain their membership in the Union in good standing as a condition of continued employment.

2. All employees on the active payroll as of _____who are not members of the Union shall become members of the Union thirty (30) days after the effective date of this Agreement and shall thereafter maintain their membership in the Union in good standing as a condition of continued employment.

3. All employees hired after _____shall become members of the Union on the thirtieth (30th) day following the beginning of such employment and shall thereafter maintain their membership in the Union in good standing as a condition of continued employment.

4. An employee who has failed to maintain membership in good standing as required by this article, shall within one-hundred and twenty (120) calendar days following receipt of a written demand from the Union requesting his/her discharge, be discharged if, during such period, the required dues and initiation fee have not been tendered. Notwithstanding the foregoing, any physician who provides a statement to the Union and the Health System that the physician has a bona fide religious objection to Union membership may elect to not be a Union member and in lieu of Union dues to pay a non-member fee to the Union. Further, the Health System shall have no obligation to discharge the employee for noncompliance with Sections 1 through 3 of this Article.

5. The Union agrees that it will indemnify and hold the Employer harmless from any recovery of damages sustained by reason of any action taken under this Article.

6. At least 14 days prior to the start date of any new bargaining unit employee, the Health System will provide Doctors Council the new employee's name, Employee ID number, full-time equivalent status, job title, department, date of hire, salary, home email and phone number.

ARTICLE 5 - UNION DUES

5.1 Upon written or electronic authorization, the Employer agrees that the dues and initiation fees of the members of the Union, according to the schedule which the Union will furnish to the Employer, including such assessments which the Union shall levy and give notice thereof, in writing, to the Employer, shall be deducted from the salaries of said members of the Union on the first payroll date of each month.

5.2 Aggregate deductions from all physicians shall be remitted by wire transfer to Doctors Council's bank account, and an itemized statement, including employee ID number, employee first and last name, amount of individual dues, and total dues remitted to the union that month, shall be sent to Doctors Council's treasurer within twenty-five (25) days after such deductions.

5.3 It is specifically agreed that the Employer assumes no obligation, financial or otherwise, arising out of the provisions of this Article, and the Union hereby agrees that it will indemnify and hold the Employer harmless from any claims, actions, or proceedings by any member arising from deductions made by the Union hereunder. Once the funds are remitted to the Union, their disposition thereafter shall be the sole and exclusive obligation and responsibility of the Union.

5.4 The Health System shall provide Doctors Council a monthly report identifying all employees in the bargaining unit. The report will contain the following information and be in alphabetical order by employee last name: employee's name, Employee ID number, full-time equivalent status, job title, department, date of hire, and salary.

ARTICLE 6 – NON-DISCRIMINATION

6.1 The Health System and Doctors Council agree that the operation and/or application of any provision of this Agreement shall in no way serve to discriminate against or in favor of any physician with respect to compensation, terms and conditions of employment or otherwise affect the physician's status as an employee on account of race, color, religion, age, sex, national origin or ancestry, sexual orientation, gender identity, marital status, status as a disabled or Vietnam veteran or status as a qualified disabled individual, or any other basis prohibited by applicable local, state and/or federal law, or on the basis of a physician's Union membership, lawful Union activity, or exercise of a right protected by Section 7 of the National Labor Relations Act. Further, the Health System shall have the right to take steps which it deems necessary for it to comply with federal and/or state law, including but not limited to the Americans with Disabilities Act ("ADA") and/or Title VII of the Civil Rights Act of 1964 ("Title VII"), and the Pregnant Workers Fairness Act ("PWFA")without violating this Agreement; provided, however, that the Health System uses its best efforts to comply with its obligations under federal and/or state law in a manner that does not conflict with this Agreement.

6.2 Reasonable efforts will be made to provide lactation rooms that will be a private space, which is protected from interruption by coworkers or patients, which is shielded from view and that has access to an electrical outlet and a lock, where available. The Health System will also provide refrigerators for breast milk in the lactation rooms. Eligible physicians who take lactation breaks will be provided credit toward their annual productivity standards for up to two 20-minute breaks per shift of eight hours or more or one 20-minute break per shift of less than eight hours. Proxy wRVUs with value [to be determined in economic proposal] will be available per eligible break. For physicians with hours-based productivity measures, time spent on eligible lactation breaks will count as time worked. Where possible, physicians will try to avoid peak work volume hours when taking lactation breaks.

ARTICLE 7 - GRIEVANCE & ARBITRATION PROCEDURE

7.1 Any grievance or dispute which may arise between the parties concerning the application, interpretation, performance, or alleged breach of this Agreement shall be subject to the procedures of this Article and shall be settled in the following manner. Notwithstanding the foregoing, the Health System's removal of a physician from a Medical Director, Assistant or Associate Medical Director position is not subject to the just cause provision of this grievance and arbitration procedure.

7.2 Step 1: Informal Resolution

(a) Within fourteen (14) calendar days of a physician's knowledge of the occurrence, to the extent that physician's rights under this agreement are personally affected, and in all other cases within fourteen (14) calendar days of the occurrence of the issue that gives rise to the complaint a physician shall promptly email their immediate clinical supervisor regarding the occurrence, with the subject line "pre-grievance for informal resolution." The employee's immediate clinical supervisor must acknowledge receipt of the pre-grievance in writing within seven (7) calendar days of the complaint, so long as the pre-grievance is received via email. The immediate clinical supervisor and the physician will attempt to informally resolve the issue. For the avoidance of any doubt, any pre-grievance submitted in any form other than email is invalid.

(b) In instances where the complaint involves the immediate clinical supervisor, the physician may informally discuss the complaint with the Service Line Leader or its designee or may advance the grievance directly to Step 2.

(c) If a physician does not comply with the requirements of Step 1 or the Union does not file a grievance under Step 2 (as described below) within fourteen (14) calendar days of the occurrence of the issue that gave rise to the grievance or within fourteen (14) calendar days of the physician's knowledge of the occurrence, the matter is considered closed, and may not be further grieved, appealed, or arbitrated.

(d) Neither any pre-grievance and nor any informal resolution thereof may be used in arbitration proceedings.

7.3 Step 2: Formal Procedure

(a) Within fourteen (14) calendar days of the Step 1 acknowledgment, or from the date the immediate clinical supervisor should have acknowledged if no response was provided, the Union may file a written grievance with the physician's Service Line Leader or its designee, by emailing the grievance to an HR inbox (which the Health System will identify). Failure to file a timely Step 2 grievance means the matter is considered closed, and may not be further grieved, appealed, or arbitrated. No individual physician shall have the right to file a grievance under Step 2.

(b) A written grievance shall include the Article and Section of the contract allegedly violated and the desired remedy or correction; it also shall be signed and dated by a Union Delegate and/or Representative.

(c) The Union and the Service Line Leader, or his/her designee, shall schedule a meeting to discuss the grievance within twenty (20) calendar days of the filing of the Step 2 grievance.

(d) The Service Line Leader, or his/her designee, shall provide a written response within seven (7) calendar days of the Step 2 meeting. If the Service Line Leader does not respond within the specified time limit, the grievance is considered denied at Step 2.

7.4 Step 3: Higher Level Review

(a) Within seven (7) calendar days of the Service Line Leader's or designee's Step 2 response, or within seven (7) calendar days of the date the Service Line Leader's response was due, the Doctors Council may appeal the grievance to the President of the Medical Group by having a Union Delegate or Representative email an appeal to HR inbox (which the Health System will identify). If the Union does not file a timely appeal consistent with the terms of this Section 7.4, the matter is closed and may not be further grieved, appealed, or arbitrated.

(b) The Union and the President of the Medical Group, or his/her designee, shall schedule a meeting to discuss the grievance within (20) calendar days of the filing of the Step 3 appeal.

(c) The President of the Medical Group, or his/her designee, shall provide a written response within seven (7) calendar days of the Step 3 meeting.

7.5 Step 4: Appeal to Arbitration

(a) If Doctors Council or the Health System wants to advance a grievance to arbitration, within twenty (20) calendar days of the President of the Medical Group's or designee's Step 3 response, or of Doctors Council's business agent's response in the event of a grievance filed by the Health System, the party advancing the grievance must notify the other party of the party's intent to take the grievance to arbitration. Notice to the Health System must be made by email to an HR inbox (which the Health System will identify). Notice to the Union must be made by email to Doctors Council's business agent. If neither the Health System nor Doctors Council provides such notice of intent to advance the grievance to arbitration in the time allotted, the Step 3 response is deemed accepted, and the matter is closed and may not be further grieved, appealed, or arbitrated. No individual physician shall have the right to invoke this arbitration procedure.

(b) Within thirty (30) calendar days of a party's notice of intent to take a grievance to arbitration, the party advancing the grievance must request a panel of at least seven (7) impartial arbitrators, all of whom must be experienced in labor law and a member of the National Academy of Arbitrators, from the American Arbitration Association (AAA), with

copy sent to the HR inbox (which the Health System will identify) or, in the event of a grievance advanced by the Health System, to Doctors Council's business agent.

(c) The parties shall select a single arbitrator to hear the grievance by alternately deleting one name until six (6) names have been eliminated and the one person whose name remains shall be selected to arbitrate the grievance. The party who advances the grievance to arbitration shall strike first.

(d) The parties will schedule an arbitration hearing within ninety (90) calendar days of the selection of an arbitrator, unless the selected arbitrator does not have any availability within that 90-calendar day period, in which case an arbitration shall be scheduled as soon as practicable.

7.6 Precedential Value

All grievances resolved prior to arbitration will be without precedential value.

7.7 Filing at an Advanced Step

(a) For grievances that affect all or a significant portion of the bargaining unit such that the immediate clinical supervisor or Service Line Leader cannot provide effective relief, the Union may file a grievance directly at Step 2, if the Service Line Leader can provide effective relief, or Step 3, if only the President of the Medical Group can provide effective relief, within fourteen (14) calendar days of the occurrence giving rise to the grievance. The Health System may return any grievance inappropriately filed at an advance step to the lowest Step where the manager can grant effective relief. If the Union does not file a timely grievance consistent with the terms of this Section 7.7(a), the matter is closed and may not be further grieved, appealed, or arbitrated.

(b) For grievances regarding the termination of a physician's employment, the Union shall file the grievance in the first instance at Step 3 within fourteen (14) calendar days after the Union receives notice of the physician's termination of employment. If the Union does not file a timely grievance consistent with the terms of this Section 7.7(b), the matter is closed and may not be further grieved, appealed, or arbitrated.

(c) For grievances initiated by the Health System, the Health System shall file the grievance in the first instance at Step 3 within fourteen (14) calendar days of a Service Line Leader, Vice President of Human Resources, Vice President of Labor and Employee Relations, or higher-level official's knowledge of the Union conduct which the Health System believes violates the Agreement and such grievance shall be served on the applicable Doctors Council business agent. If the Health System does not file a timely grievance consistent with the terms of this Section 7.7(c), the matter is closed and may not be further grieved, appealed, or arbitrated.

7.8 Extensions of Time

(a) The parties may extend any of the deadlines in this Article through mutual agreement in writing.

(b) Both parties will cooperate to ensure that grievance processing does not interfere with patient care, including agreeing to reasonable extensions of time for both parties' deadlines in the grievance procedure to ensure that patient care is not impacted. Notwithstanding the foregoing, the deadline for initial notice of a grievance shall not be extended.

7.9 Arbitrator's Authority

(a) The jurisdiction and authority of the arbitrator and his/her award shall be confined exclusively to the specific provision(s) of this Agreement at issue between the Union and the Health System in the grievance before the arbitrator.

(b) The arbitrator shall have no authority to add to, alter, amend, or modify any provision of this Agreement, and shall have no authority to consider any matter specifically excluded from the grievance procedure.

(c) The arbitrator shall not hear or decide more than one grievance at a time without the mutual consent of the Health System and the Union.

(d) The arbitrator's award must be in writing and, so long as the award is within the arbitrator's jurisdiction and authority as specified in this Agreement, shall be final and binding on the grievant, the Union, and the Health System.

7.10 Patient Care Evidence

(a) Neither the Union, the physician, nor the Health System will seek to call any patient, patient's family member, patient's friend, acquaintance or associate or patient's guardian, health care agent, or surrogate decision maker, as a witness during any hearing, and neither the Union nor the physician may contact any patient, patient's family member, or patient's guardian, health care agent, or surrogate decision maker regarding any grievance. For purposes of this Article, "patient" includes individuals receiving treatment as well as those seeking treatment.

(b) Copies of patient records relied on by the Health System in a decision that is later grieved ("Patient Records") may only be obtained by the Union through a valid subpoena issued by the arbitrator with the jurisdiction and authority over the matter. The Union, physician, Health System, and arbitrator all shall maintain Patient Records as confidential and destroy all copies of Patient Records upon final resolution of the arbitration. The Health System may redact all Protected Health Information (as defined by HIPAA) prior to producing Patient Records in response to a duly issued subpoena. The Health System may challenge a subpoena under any basis it would otherwise have in arbitration, including to carry out the Health System's obligations under HIPAA and any other relevant privacy law.

(c) This grievance procedure is not a replacement for a physician's responsibility and obligation to report patient care issues in accordance with the patient care and safety reporting system established by the Health System, and/or State or Federal governing authority.

(d) The arbitrator shall not issue subpoenas for Medical Staff personnel's testimony, or any records maintained by the Health System that are covered by peer review privilege as established by state and/or federal law or otherwise protected by the Patient Safety and Quality Improvement Act of 2005 and its regulations.

7.11 Remedies

(a) The arbitrator shall have no authority to issue a back pay remedy with an effective date prior to the date of the filing of the grievance unless the grievance involves a wage and hour or benefits allegation, in which case the arbitrator may award back pay with an effective date no earlier than the date of the alleged wage and hour or benefits violation.

(b) The arbitrator shall only have the authority to issue a back pay award and shall not issue an award for consequential or punitive damages, or attorney's fees.

(c) In the event a back pay award is issued, for the purpose of compliance with Stark Law and/or Anti-Kickback statute only, to effectuate that back pay award, the parties will execute a release agreement (example attached) reflecting that the back pay award resolves the physician's outstanding grievance against the Health System and that each party is releasing any and all claims against each other related to the subject matter of the grievance.

7.12 Costs

(a) Each party shall bear its own costs and fees, including attorneys' fees.

(b) The expenses of the Arbitrator and any transcript service shall be shared equally by the Health System and Doctors Council.

(c) All hearings shall be held at the Health System's offices at Avenue North, or similar location specified by the Health System, unless mutually agreed to by the parties.

ARTICLE 8 LABOR MANAGEMENT COMMITTEE

8.1 **Labor-Management-Committee:** In the interest of sound labor relations, Doctors Council and the Health System will form a Labor-Management Committee made up of physicians, Doctors Council representatives, and representatives from the Health System, including Human Resources and Clinical Leadership. The Labor-Management Committee shall meet in person every other month to discuss and address issues and concerns and recommend solutions to those issues, with the Health System having final discretion and authority as to whether a recommended solution is adopted and implemented. In the event that the Labor-Management Committee reaches consensus (which is defined as all members of the Health System's representatives agree with the recommendation and all members of Doctors Council's representatives agree with the recommendation) and the Health System refuses to adopt and/or implement the recommendation, then Doctors Council may file a grievance requesting an explanation of the Health System's decision. Such a grievance may not proceed to arbitration.

(a) The Labor-Management Committee will discuss, and problem solve matters that impact both the Health System and the bargaining unit. This includes discussing questions, concerns or discrepancies related to the counting and tracking and assignment of wRVUs.

(b) The Labor-Management Committee's regular membership will be twelve (12) bargaining unit physicians and Doctors Council representatives and no more than eight (8) Health System representatives. Members will generally serve at least a one-year term, and membership in the committee shall generally remain constant from meeting to meeting, except that a member on extended leave may have a temporary substitute.

(c) By mutual agreement of the Labor-Management Committee members, additional members may be added on an ad hoc basis. Ad hoc committee service will be limited in number and duration.

8.2 By mutual agreement of Health System representatives (as a whole) and Doctor's Council representatives (as a whole) of the Labor-Management Committee, the Labor-Management Committee may utilize an issue resolution process, such as Interest Based Problem Solving (IBPS), which the Labor Management-Committee determines in its sole discretion is most appropriate to facilitate discussion of issues of mutual concern.

8.3 The Parties shall not utilize this Agreement's Grievance and Arbitration procedure to resolve any issues brought before the Labor Management Committee. Additionally, neither the discussions of the Labor-Management Committee nor the statements of the individual Committee members at the Committee meetings are subject to this Agreement's Grievance and Arbitration procedure. However, the procedures of the Labor-Management Committee (contained in Sections 2(b), 2(c), 3 and 4) are subject to the Grievance and Arbitration procedure.

8.4 The Committee members will work cooperatively to schedule meetings so that these meetings will not impact patient care. The decision of when, where and how to meet will be determined by mutual agreement of Health System representatives (as a whole) and Doctor's

Council representatives (as a whole) of the Labor-Management Committee. Meetings shall not be recorded, and formal minutes are not required, but this shall not restrict the taking of hand-written or typed notes.

APPENDIX 1 – RVU & QUALITY COMPENSATION SPECIALTIES

Advanced Heart Failure Cardiologist
Bariatric Surgeon
Breast Surgeon
Cardiology: General
Colorectal Surgeon
Diagnostic Radiologist
Electrophysiology Cardiologist
Endocrinologist
Epileptologist
Gastroenterology
General Surgery
Gynecologic Oncologist

Hematologist
Hematologist Oncologist
Interventional Pulmonologist
Invasive / Interventional Cardiologist
Minimally Invasive Gynecologic Surgeon (MIGS)
Neuroradiologist
Nuclear Medicine
OB/GYN
Ophthalmologist
Otorhinolaryngologist/ENT
Palliative Care
Physiatrist / Physical Medicine & Rehabilitation
Pulmonologist
Reconstructive Plastic Surgeon
Rheumatologist
Surgical Oncologist
Thoracic Surgery
Transplant Surgery
Urogynecology
Vascular Surgery

APPENDIX 3 – SHIFT & QUALITY COMPENSATION SPECIALTIES

Cardiac Hospitalist
Cardiac Surgery Critical Care Intensivist
Cardiac Critical Care Intensivist
Consult Liaison Psychiatrist
Emergency Medicine
General Pediatrician in Emergency Medicine (GPEM)
Hospitalist
Inpatient Addiction Medicine
Inpatient Oncologist
Inpatient Psychiatrist
Laborist
Medical Critical Care Intensivist
Neonatologist
Neuro Critical Care
Neuro Interventional Surgery
Neurohospitalist

Palliative Care
Pediatric Hospitalists
Pediatric Emergency Medicine
Pulmonary Intensivist
Trauma Surgery
Vascular Interventional Radiology
Vascular Neurologist

REPAYMENT AGREEMENT

This Repayment Agreement ("Agreement") is made by and between [Physician Full Name], Employee Badge No. 801XXXXXX ("Employee") and Christiana Care Health Services, Inc. (“Company”) as of the date signed below.

WHEREAS, Employee erroneously received [overpayment description] on [date(s) of overpayment] in the amount of the Repayment Obligation as defined herein and agrees to the terms herein for repayment of the Repayment Obligation;

NOW THEREFORE, in consideration of the foregoing premises and the mutual promises contained herein and intending to be legally bound hereby, Company and Employee agree as follows.

1. **RECITALS**. All Recitals are incorporated into this Agreement by reference.

2. **REPAYMENT OBLIGATION.** Employee and ChristianaCare acknowledge and agree that Employee was overpaid [describe overpayment], in the gross amount of [NUMBER] (the “Repayment Obligation”).

3. **REPAYMENT TERMS**. Employee will repay to Company the Repayment Obligation in the following manner: [edit as appropriate based on tax years, Employee preference, and any requirements from Payroll]

   a. Employee desires and authorizes Company to make payroll deductions as follows: [specify number of hours to be deducted per pay period and number of pay periods, not to exceed a maximum payroll deduction of 15% of Employee’s gross weekly wages for applicable pay period until the Repayment Amount is repaid].

   b. Employee will issue a personal check payable to “Christiana Care Health Services, Inc.” in the amount of [NUMBER]. The check shall be delivered by mail or courier to the address below:

[insert address and contact person]

4. **REPRESENTATION**. By signing below, Employee acknowledges and agrees that Employee owes Company the Repayment Obligation. Employee acknowledges and agrees that if Employee defaults on the Repayment Obligation, then Company may exercise all available rights and remedies available in law and equity. In the event Employee default of the Repayment Obligation, then Employee confesses judgment to the Repayment Obligation herein and will reimburse Company for all expenses incurred for enforcement of this obligation.

5. **COUNTERPARTS**. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original as against any party whose signature appears thereon, and all of which shall together constitute one instrument, and may be delivered via facsimile or electronic transmission.

EMPLOYEE NAME, Employee Badge No. 801xxxxxx ("Employee")

Signature: _____ Date: _____

Name: _____

COMPANY Christiana Care Health Services**:**

Signature: _____ Date:_____

Name:_____

Copies to: Employee, HR/Employment File, Legal, Meditract

Original to: Provider Compensation

ARTICLE 8 LABOR MANAGEMENT COMMITTEE

8.1 **Labor-Management-Committee:** In the interest of sound labor relations, Doctors Council and the Health System will form a Labor-Management Committee made up of physicians, Doctors Council representatives, and representatives from the Health System, including Human Resources and Clinical Leadership. The Labor-Management Committee shall meet in person every other month to discuss and address issues and concerns and recommend solutions to those issues, with the Health System having final discretion and authority as to whether a recommended solution is adopted and implemented. In the event that the Labor-Management Committee reaches consensus **(**which is defined as all members of the Health System's representatives agree with the recommendation and all members of Doctors Council's representatives agree with the recommendation**)** and the Health System refuses to adopt and/or implement the recommendation, then Doctors Council may file a grievance requesting an explanation of the Health System's decision. Such a grievance may not proceed to arbitration.

(a) The Labor-Management Committee will discuss, and problem solve matters that impact both the Health System and the bargaining unit.

(b) The Labor-Management Committee's regular membership will be twelve (12) bargaining unit physicians and Doctors Council representatives and no more than eight (8) Health System representatives. Members will generally serve at least a one-year term, and membership in the committee shall generally remain constant from meeting to meeting, except that a member on extended leave may have a temporary substitute.

(c) By mutual agreement of the Labor-Management Committee members, additional members may be added on an ad hoc basis. Ad hoc committee service will be limited in number and duration.

8.2 By mutual agreement of Health System representatives (as a whole) and Doctor's Council representatives (as a whole) of the Labor-Management Committee, the Labor-Management Committee may utilize an issue resolution process, such as Interest Based Problem Solving (IBPS), which the Labor Management-Committee determines in its sole discretion is most appropriate to facilitate discussion of issues of mutual concern.

8.3 The Parties shall not utilize this Agreement's Grievance and Arbitration procedure to resolve any issues brought before the Labor Management Committee. Additionally, neither the discussions of the Labor-Management Committee nor the statements of the individual Committee members at the Committee meetings are subject to this Agreement's Grievance and Arbitration procedure. However, the procedures of the Labor-Management Committee (contained in Sections 2(b), 2(c), 3 and 4) are subject to the Grievance and Arbitration procedure.

8.4 The Committee members will work cooperatively to schedule meetings so that these meetings will not impact patient care. The decision of when, where and how to meet will be determined by mutual agreement of Health System representatives (as a whole) and Doctor's Council representatives (as a whole) of the Labor-Management Committee. Meetings shall not be recorded, and formal minutes are not required, but this shall not restrict the taking of hand-written or typed notes.

ARTICLE 9
COMMITTEE ON POLITICAL EDUCATION

9.1 The Employer agrees to deduct and transmit to Doctors Council payments to the Union COPE fund, in the amount designated by the union member per pay period from the wages of those employees who voluntarily authorized such contributions on the forms provided for that purpose by Doctors Council. These transmittals shall be accompanied by a list of the names of those employees for whom such deductions have been made and the amount deducted for each such employee.

9.2 Doctors Council further agrees that it will pay the Health System a 4% fee to cover the Health System's costs for making the aforementioned deductions and transmittals. The transmittals will be made on a quarterly basis.

9.3 The Employer assumes no obligation, financial or otherwise, arising from the provisions of this Article. The Union agrees it will indemnify and hold the Employer harmless from any claims, actions, or proceedings by an employee arising from deductions made by the Employer. Once the funds are remitted to the Union, their disposition shall be the sole responsibility of the Union.

9.4 Physicians must make an election in writing and such election must be signed. Physicians may only elect to have the Health System make deductions and transmissions to Doctors Councils' COPE Fund on their behalf once a year, which shall be during the first pay period of the Health System's fiscal year.

ARTICLE 10 - DISCIPLINE

10.1 The Health System shall not take any disciplinary action against a physician without just cause. The Health System will promptly notify Doctors Council in writing of any disciplinary actions against the physician.

10.2 The Health System may place a physician on paid administrative leave when, in its judgment, such action is necessary because of the nature of the misconduct under investigation.

10.3 Written corrective actions or disciplinary notes can only impact compensation or bonuses in the same fiscal year in which the discipline occurred.

10.4 A physician shall be provided with reasonable advanced notice of an investigatory meeting with the Health System which could lead to discipline so that the Physician may arrange for a Delegate or Union Representative to attend the meeting.

ARTICLE 11 – PROBATIONARY PERIOD

11.1 The Health System may terminate a physician's employment in the physician's initial one (1) year of employment with the Health System at any time and for any reason, including with or without just cause. If the Health System elects to discharge a probationary physician, the Health System shall have no more than one-hundred and twenty (120) days from the date it notified the probationary physician of the Health System's intent to discharge to effectuate the discharge. The discipline or discharge of a probationary physician is excluded from and not subject to the grievance and arbitration procedure contained in this Agreement. In the Health System's sole discretion, the probationary period may be shortened or eliminated.

11.2 If a physician leaves the bargaining unit for a period of less than one year and subsequently returns to the same position they held at the time of their separation from the bargaining unit, they shall not be required to restart the probationary period.

11.3. Upon successful completion of the probationary period, the physician's seniority date shall be retroactively applied to their original date of hire into the bargaining unit position.

ARTICLE 12 - PHYSICIAN OBLIGATIONS AND PROFESSIONAL AUTHORITY

12.1 Physicians are engaged to practice medicine. Physicians are responsible for the care of each patient assigned to their service with respect to all medical and psychiatric problems during the course of a patient's hospitalization, including care in an Emergency Department or observation units. Physicians shall have the right to practice medicine consistent with the physician's licensure, applicable federal, state, and local laws, professional medical standards, and other professional standards such as the Medical Dental Staff Bylaws.

12.2 In cases of time sensitive patient care or practice needs, physicians shall comply with assignments made by the Health System. After doing so, physicians may utilize the grievance procedure as described in Article 7, if the physician believes the Health System violated a term of this Agreement. Where the assignment is not time sensitive, and the physician believes the assignment violates this Agreement, the physician shall file a grievance within the time limits contained in Article [__], and in all cases, shall file the grievance prior to the commencement of the assignment. Filing a grievance does not relieve the physician of the obligation to comply with the assignment. The Health System will use its best efforts to provide Doctors Council with 30 days of notice of any non-time sensitive assignment change which will last longer than 30 days.

12.3 In accordance with generally accepted medical practice, Health System policies, Medical-Staff Bylaws, Health System rules and policies, and such direction as the Health System from time-to-time provides, physicians shall prepare records of all examinations, procedures and other professional services rendered by the physician. The ownership and right of control of any and all medical records, reports, and supporting documents prepared by the physicians, medical or otherwise, generated as a result of services rendered pursuant to this Agreement, are and shall remain the exclusive property of the Health System, provided, however, that the physicians shall have the right of access to such medical records, reports, and supporting documentation as

permitted under the Health System's policies within the scope of their employment and for the fulfillment of their job-related responsibilities.

12.4 Physicians shall at all times adhere to all of the Health System's policies and procedures, unless such policy and/or procedure is directly contradicted by a term of this Agreement, in which case this Agreement shall control.

12.5 Physicians shall at all times adhere to the security and privacy requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), their respective regulations as adopted from time to time, and Health System policies and procedures related to security and privacy.

12.6 All medical records generated by physicians shall remain in the possession of the Health System after the expiration of this Agreement, except that, upon written request of any patient for the purpose of transferring or coordinating their medical care, a copy of the patient's records shall be delivered to a physician in accordance with the Health System's policies and procedures then in effect with regard to such transfer of records. Physicians shall not remove or copy any record without the written approval of the Health System.

12.7 Physicians acknowledge that, in the best interests of the patient, to provide high quality coordinated care, enhance patient experience and in order to advance the legitimate business purposes of the Health System, Physicians are required to refer to and utilize providers and practitioners employed by or affiliated with the Health System, as well as services provided directly by the Health System within the scope of their employment. This requirement is subject to patient preference, insurer determinations, and Physician's exercise of reasonable professional judgment as to the best medical interests of the patient.

ARTICLE 13 - REQUIRED CERTIFICATIONS & LICENSES

13.1 The Health System, in consultation with the newly hired physician, will set the amount of financial and other assistance offered to the newly hired physician to obtain required certifications, licenses, or credentials where the newly hired physician is required to obtain a certification, license, or credential by the Health System.

13.2 The Health System will reimburse physicians for the cost of obtaining and renewing licenses and certifications which are required by the Health System as an express written term of employment. The Health System will also reimburse specific medical education which is required by the Health System as part of your job duties (this does include any CME requirements for the acquisition and/or maintenance of any license, etc.). The Health System will not require physicians to utilize CME as a reimbursement for the cost of the items in this Section 13.2.

13.3. Whenever possible, the Health System will provide a physician advance notice of the need to obtain an additional certification or license.

(a) For interstate compact applications, the Health System will provide the physician with two (2) weeks to submit the necessary application to the appropriate licensing board, and for all other applications one (1) month to submit the necessary application to the appropriate licensing board.

(b) The Health System acknowledges that the timing of the issuance of the required certification and/or license depends on factors beyond the physician's control, but the physician must cooperate in a timely manner in the process and follow-up within 72 hours when the physician is scheduled to work for any request for additional information or clarification as needed to ensure the application is timely processed.

(c) The Health System may require a physician to submit an application sooner than the timing set forth in Section 13.3(a) where additional coverage is needed to ensure patient access to care.

13.5 Notice of Change

Physicians shall advise the Health System within 72 hours of:

(a) Any changes in the status of the physician's medical licensing, certification, or registration, including state or federal certification to dispense controlled substances;

(b) The commencement of any action or proceeding by a medical staff involving the suspension, termination or other disciplinary action or review of the physician's Medical Staff membership or clinical privileges at any health care facility;

(c) The commencement of any disciplinary action or proceeding by a medical staff (including medical staffs not affiliated with the Health System), licensing board, or payor relating to the physician's fitness to practice or professional conduct (including but not limited to behavior);

(d) Notification of any claims from a medical staff (including those medical staff not affiliated with the Health System), licensing board, or payor, involving or arising from the physician's professional services;

(e) Notification of any investigation, action, or proceeding involving potential sanctions, suspension or exclusion from Medicare, Medicaid or other federal or state health benefit program; or

(f) Any other event or circumstance that may have a materially adverse effect on the ability of the physician to perform services for the Health System.

ARTICLE 14 – MEDICAL STAFF BYLAWS

14.1 The Union and the Health System agree that all issues regarding credentialing, privileging, and appointment to a Medical Staff to practice medicine at the Health System and peer review by a Medical Staff shall be exclusively governed by the applicable Medical Staff Bylaws, e.g., ChristianaCare Medical-Dental Staff Bylaws, Union Hospital Medical Staff Bylaws, and the bylaws of any medical staff that operates in the Hospitals, and inclusive of all Medical Staff governing documents, including Rules and Policies (collectively, "Medical Staff Bylaws").

14.2 Any disagreement arising from the application of the applicable Medical Staff Bylaws will be resolved exclusively through the procedures outlined in the applicable Medical Staff Bylaws and not through the grievance and arbitration procedure of this Agreement.

14.3 Disputes regarding the application of the Medical Staff Bylaws are subject to the terms of Article [__] "No Strike No Lockout".

14.4 All aspects of credentialing, privileging, appointment, and peer review, including the assessment of the professional medical competence of a physician, which are governed by the applicable Medical Staff Bylaws are not covered by this Agreement, and will not be a proper subject for the grievance and arbitration procedure contained in this Agreement, but are subject to the terms of Article [__] "No Strike No Lockout".

14.5 Any bargaining unit physician elected as President of a Medical Staff shall resign the physician's membership in Doctors Council for the duration of the physician's term as President and Immediate Past President.

ARTICLE 15 – PROFESSIONAL LIABILITY INSURANCE

15.1 The Health System procures and maintains professional liability insurance coverage for physicians while they are acting within the scope of their employment. This coverage applies solely to work performed during the course of their duties at the Health System and does not extend to any medical practice or activities outside their employment. The Health System will provide written notice to the Doctors Council and physicians regarding any reduction or cancellation of coverage. Such reduction or cancellation may not result in professional liability insurance coverage below the minimum established in 15.2.

15.2 The Health System shall maintain, at no cost to physicians, professional liability insurance on a claims-made basis in a minimum amount of Two Million and 00/100 Dollars ($2,000,000) per claim and Four Million and 00/100 Dollars ($4,000,000) annual aggregate, or such other terms as determined by the Health System from time to time. Physicians are also covered by the Health System's professional liability insurance for administrative duties. The Health System agrees to maintain appropriate tail coverage for claims reported in future years for acts and omissions regarding administrative and clinical services provided during the term of the applicable engagement letter. If a physician is defended by the Health System, then the Health System will select counsel and unless the Health System in its sole discretion determines otherwise, a physician's defense will be joint with the Health System. Physician will cooperate in the joint defense and will waive any conflict associated with such joint defense. If a physician desires separate defense counsel, then physician will be responsible for his or her own defense costs, unless the Health System determines that joint representation is not appropriate.

ARTICLE 16- SCHEDULING

16.1 Physician schedules will be set pursuant to department policy, subject to the Health System's rights under Article 2, Management Rights. The Health System will instruct department chairs to use their best efforts to make scheduling decisions through engagement with the physicians in their department. The Health System may change or add to a schedule when it is necessary to ensure adequate coverage for patient care or in cases of emergencies.

16.2 Physicians may only request a change to a posted schedules in accordance with department policy or established practices.

ARTICLE 17 - SUBCONTRACTING

17.1 The Health System will utilize its physicians to perform work they are qualified to perform.

17.2 Where the Health System determines subcontracting is in the interest of patient care and no physician would be laid off because of the subcontracting, the Health System must provide Doctors Council with 30 days of advanced notice of an intent to subcontract (measured from the effective date of the anticipated subcontracting). Such notice shall include all material patient care rationales for the need to subcontract.

(a) Upon providing notice of an intent to subcontract, Doctors Council, in its sole discretion, may request a meeting with the Health System to discuss the notice of intent to subcontract. Doctors Council must make this request as soon as possible, but no later than 7 days after receipt of the notice of an intent to subcontract. In the event that Doctors Council requests a meeting with the Health System, the meeting shall be held within 14 days of Doctors Council's request and shall be for the purpose of (i) discussing the Health System's patient care rationales as detailed in the notice of intent to subcontract; (ii) the nature and scope of the proposed subcontracting; and (iii) whether Doctors Council believes there is a way other than through subcontracting to address the Health System's patient care rationales.

(b) The Health System shall consider whether patient care will be better served by subcontracting or the Doctors Council proposed subcontracting alternative. The Health System at all times retains the final authority to determine whether to implement the subcontracting proposal or the subcontracting alternative.

(c) The Health System will offer qualified bargaining unit physicians the opportunity to perform additional moonlighting/extra call to meet patient care needs prior to subcontracting that bargaining unit work pursuant to this Section 17.2.

17.3 Where the Health System determines subcontracting is in the interest of patient care and a physician would be laid off as a result of the subcontracting, the Health System must provide Doctors Council with 120 days of advanced notice of an intent to subcontract (measured from the effective date of the anticipated subcontracting). Such notice shall include all material patient care rationales for the need to subcontract.

(a) Upon providing notice of an intent to subcontract, Doctors Council, in its sole discretion, may request a meeting with the Health System to discuss the notice of intent to subcontract. Doctors Council must make this request as soon as possible, but no later than 7 days after receipt of the notice of an intent to subcontract.

(b) In the event that Doctors Council requests a meeting with the Health System, the meeting shall be held within 7 days of Doctors Council's request and shall be for the purpose of (i) discussing the Health System's patient care rationales as detailed in the notice of intent to subcontract; (ii) the nature and scope of the proposed subcontracting; (iii) the potential impact on those physicians performing the work which is the subject of the proposed subcontracting; and (iv) whether Doctors Council believes there is a way other than

through subcontracting to address the Health System's patient care rationales. Doctors Council must identify and provide in writing to the Health System any alternative proposals to subcontracting no later than 21 days after the meeting between the Health System and Doctors Council

(c) If Doctors Council proposes a way other than through subcontracting to address the Health System's patient care rationales, and the Health System agrees that the Doctors Council proposal could address those patient care rationales (and such agreement will not be unreasonably withheld), then within 7 days of the Health System's response, the parties will form a sub-committee which shall be limited to 2 members of management and 2 members of the union (all of whom shall be members of the Labor Management Committee, however the union members of the subcommittee may invite up to two additional individuals to participate in the sub-committee's work who are members of the impacted department and the management members of the committee may likewise invite up to two individuals to participate in the subcommittee's work who are knowledgeable about the impacted department) to analyze the subcontracting alternative and provide a written report detailing the results of the analysis. The subcommittee may consider the following list of non-exhaustive factors in conducting its analysis:

i. Whether the Health System has the expertise, or can readily and in a commercially reasonable manner acquire the expertise, to provide the requisite patient care;
ii. Whether physician staffing concerns are present and whether such concerns are the result of market conditions;
iii. Whether the proposed subcontractor has specialized skill and/or knowledge in the work to be subcontracted.

The subcommittee may consider utilizing interest-based problem solving in conducting their review.

(d) The committee will meet promptly and as needed to complete and submit its report to the Labor Management committee (which shall convene a special meeting for the purpose of reviewing this report) within 30 days of the date the committee was formed. The Labor Management committee will consider the report and make a recommendation to the Health System as to whether patient care will be better served by subcontracting or the Doctors Council proposed subcontracting alternative. The Health System at all times retains the final authority to determine whether to implement the subcontracting proposal, the subcontracting alternative proposed by Doctors Council , or any other alternative proposed by the Labor Management Committee.

(e) The Health System's compliance with the 120 day notice provision of Section 17.3, the Health System's or Doctors Council's compliance with the time deadlines in 17.3 (a), (b), (c) and (d) or the Health System's and/or Doctors Council's compliance with any information request related to the Health System's proffered patient care rationale and/or Doctors Council's proposed subcontracting alternative, shall be subject to expedited arbitration. Expedited arbitration shall require the party claiming noncompliance with the 120-day notice provision of Section 17.3, the Health System or Doctors Council's compliance with the time deadlines in 17.3 (a), (b), (c) and (d) or the Health System and/or Doctors Council's compliance with any information request related to the Health System's proffered patient care rationale and/or Doctors Council's proposed

subcontracting to file expedited arbitration within 14 days of the date of claimed non-compliance. The arbitration must be held within 10 business days of the filing for arbitration and the arbitrator must render a decision within 7 business days of the conclusion of the hearing. The three exclusive remedies of the arbitrator are, in the event that the Health System failed to provide the appropriate 120 day notice, an order that the Health System provide the appropriate notice or, in the event that the Health System and/or Doctors Council fails to comply with time deadlines in 17.3(a), (b) and (c), or (d) an order that the non-prevailing party engage in effects bargaining, or, in the event of a dispute regarding the production of information, an order requiring the non-prevailing party to produce the disputed documents.

(f) With regard to the production of information, the Parties agree that the following information is not subject to production pursuant to any information request:

i. Documents that are in the custody of a 3rd party and/or 3rd party documents shared with the Health System pursuant to a confidentiality and/or non-disclosure provision;
ii. Peer review information; and
iii. Individualized patient care data or other Protected Health Information as defined by HIPPA.

(g) In no circumstances whatsoever may the arbitrator issue any remedy other than the three identified in the final sentence of 17.3(e).

(h) In no circumstances is the Health System's final decision concerning whether to utilize subcontracting subject to the expedited grievance provision contained in this Article, and/or the grievance and arbitration provision of this agreement.

(i) In no circumstances, including by the arbitrator's award, shall the 120-day notice period be modified and/or extend.

(j) In the event that any physician is laid off as a result of a subcontracting decision made pursuant to this Section 17.3, that physician shall be entitled to 5 months of severance, which shall be paid at the physician's base salary rate, and, if the physician timely and properly elects health care continuation coverage under COBRA, for such period of 5 months following the physician's separation date, the Health System shall pay the full COBRA premium. In order to be eligible for the severance benefits contained in this Section 17.3(j), a physician must:

i. Work through the implementation date of the subcontracting;
ii. Not remain on the Medical Staff as a private practice physician with clinical privileges at the Hospital(s) for a period of twice the duration of the severance; and
iii. Execute a release agreement which shall include a restriction that the physician may not work for the subcontractor at the site of the subcontracting identified in the notice for a period of twice the duration of the severance.

An eligible physician will be paid the severance amount in one-lump sum thirty (30) days after their separation date.

17.4 The Health System may offer physicians the opportunity to become physician-owners in practices or facilities affiliated with ChristianaCare but where work is performed outside of the Hospitals. Doctors Council and the Health System agree that the Health System is permitted to negotiate the matter of physician ownership in practices or facilities performing work outside the Hospitals directly with physicians. If a physician becomes a physician-owner in a practice or facility affiliated with ChristianaCare and where work is performed outside of the Hospitals, the parties acknowledge that the physician's practice performed outside of the Hospitals is not considered bargaining unit work and that physician is no longer part of the bargaining unit (unless the physician holds a separate position which is in the bargaining unit).

17.5 The parties agree that the Health System may transfer existing bargaining unit work to ChristianaCare practices and/or facilities affiliated with ChristianaCare but located outside of the Hospitals based on a patient care rationale and in accordance with the process detailed in Section 17.2 above. Any work performed outside the Hospitals, including work at practices or facilities affiliated with ChristianaCare, is not bargaining unit work, but may be performed by bargaining unit personnel if the Health System determines that is in the best interest of patient care. If a current bargaining unit physician performs transferred bargaining unit work at a location outside of the Hospitals and continues to work .2 acute care or greater, they shall remain in the bargaining unit. If the physician performs transferred bargaining unit work at a location outside of the Hospitals to such an extent that they no longer satisfy the recognition clause's 0.2 acute care threshold, that physician shall remain in the bargaining unit as a legacy bargaining unit member so long as that bargaining unit physician's position does not change. If the bargaining unit physician's position changes, the bargaining unit physician is no longer a legacy bargaining unit member and that physician's inclusion in the bargaining unit will be subject to the requirements of the recognition clause.

17.6 Consistent with current practice, the Health System has the right to meet immediate day-to-day operational needs through the use of locums. Prior to the use of locums to meet coverage needs, the Health System will offer internal moonlighting to physicians who are qualified to perform the work.

Article 18- Right of First Refusal for Moonlighting Shifts

18.1 After a department's clinical coverage schedule is created for specialties listed in Appendix 3 ("shift and quality-based specialties"), the department will provide bargaining unit physicians in those specialties an opportunity to volunteer for any open/unfilled shifts as moonlighting, consistent with continuity requirements, before those shifts are offered to non-bargaining unit physicians. This provision will not interfere with the department's ability to schedule employed ChristianaCare Physicians without first offering those shifts to bargaining unit members. Non-Legacy Casuals shall not be placed on the coverage schedule until bargaining unit physicians have had an opportunity to volunteer for any open/unfilled shifts as moonlighting.

18.2 In non-emergent situations, for any subsequent open unfilled shifts that become available for moonlighting after the schedule is released, bargaining unit physicians in those specialties shall be notified of those shifts via department-specific communication methods prior to non-bargaining unit physicians, and the qualified bargaining unit physician who signs up first for the entire shift via the same communication method shall fill the shift. The Health System will use its best efforts to provide at least twenty-four hours of advance notice to bargaining unit physicians regarding the availability of open unfilled shifts which become available after the schedule is released prior to soliciting non-bargaining unit employees to fill those shifts.

ARTICLE 19 - CONTINUING MEDICAL EDUCATION (CME)

19.1 The Health System will reimburse physicians up to $7,500 per year for qualified CME expenses under the Physician and Advanced Practice Clinician (APC) Professional Allowance Guidelines (CME) policy (the "CME Policy"). Qualified CME expenses shall include the cost of program registration and materials, travel, including international travel , and lodging expenses consistent with Health System expense reimbursement policies, as well as Board Certification. The Health System may make changes to these policies and the CME Policy at any time provided such change is on the same basis as a change to benefits offered to non-bargaining unit physicians and no less than the amount of CME and terms stated in this Agreement. All CME must comply with and be consistent with the Health System's Conflict of Interest policy.

19.2 The Health System in its sole discretion may reimburse physicians who exhaust their $7,500 per year reimbursement on qualifying CME expenses for travel, including international travel necessary for an oral presentation, accommodations, and other costs of attending a conference when a physician has scholarly work accepted for presentation at the conference. Such reimbursements shall not be unreasonably denied.

19.3 Physicians may receive up to $5,250 in tuition reimbursement under the Health System's Tuition Reimbursement Policy on the same terms as non-bargaining unit employees. The Health System may make changes to this policy at any time provided such change is on the same basis as a change to benefits offered to non-bargaining unit physicians, except that no change may result in a reduction in the tuition reimbursement to an amount less than $5,250 unless such reduction is required by law (including IRS regulations).

ARTICLE 20

VACANCIES AND FILLING POSITIONS

20.1 Bargaining Unit Vacancies: Vacancies in bargaining unit positions to be filled by a full time or part time hire shall be posted in the manner the Health System ordinarily posts job openings at least 5 business days in advance of publicly posting the position to afford bargaining unit members first consideration of the position. Notwithstanding the foregoing, the Health System may post a job vacancy externally without satisfying the 5-business day posting requirement described in this Article if (1) no actively employed bargaining unit member is qualified for the position or (2) the Health System determines in its sole discretion there is a critical need to fill the position.

20.2 Interviews: Departments shall endeavor to engage with physicians, as appropriate, about the interview process and candidates. Nothing in this Article shall be construed to limit in any way the Health System's rights in Article 2 ("Management Rights").

20.3 All Physicians who apply for a bargaining unit position will be notified as to the outcome of their application.

20.4 When there is a vacancy in the bargaining unit, preference shall be given to the most qualified candidate.

ARTICLE 21

LAYOFF

21.1 The Parties agree that the Health System and Doctors Council shall engage in effects bargaining concerning the effects of any layoff impacting bargaining unit members.

21.2 If a physician timely applies for a vacant position, and that physician has been laid off from the physician's prior bargaining unit position within the last six months, and the physician provides notice to the Health System that they were previously employed at the Health System, then the Health System shall give preference to the physician where the physician is equally qualified in all material ways, as determined by the Health System in its sole discretion, to the external candidate. The Health System's determination as to whether the physician is equally qualified in all material ways to the external candidate is not subject to the Grievance and Arbitration Procedure (Article 7).

ARTICLE 26 – INDIVIDUAL ENGAGEMENT LETTER

26.1 Each physician must execute an individual engagement letter for employment (see attached Sample Engagement Letter) with the Health System and be subject to the terms of an applicable collective bargaining agreement.

(a) Individual engagement letters will be for a term three (3) years. When the CBA expires, the individual engagement letters will remain in full force and effect during the status quo period. When a new collective bargaining agreement is ratified, new individual engagement letters will be issued which shall be for the term of that CBA.

(b) The Health System will provide a physician 120 days' notice of its intent not to offer a physician a new engagement letter at the expiration of the physician's current engagement letter's term. The Health System's decision not to renew a physician's engagement letter is subject to

just cause and the grievance and arbitration procedure. The reason for the non-renewal will be provided in the grievance procedure.

(c) Distribution of Engagement Letters.

(i) New hire physicians must sign their initial engagement letter within 60 days of receipt thereof.

(ii) Once the applicable collective bargaining agreement is ratified, the Health System will send engagement letters to the physicians. The physicians will have 60 days to review the engagement letter for accuracy and either sign or file a grievance. If at the end of the 60-day time period, a physician has not signed the engagement letter or filed a grievance, the Health System may terminate the physician's employment. Any deadline contained in this Section 26.1(c)(ii) may be extended by mutual agreement of the Parties. Upon conclusion of the grievance process, a physician shall have 7 days to sign the perfected engagement letter.

(iii) This process shall not apply to mid-term modifications to the engagement letter. Under such circumstances, a physician shall have 14 days to sign the new engagement letter or file a grievance. If a physician has not signed the engagement letter or filed a grievance, the Health System may terminate the physician's employment. Upon conclusion of the grievance process, a physician shall have 7 days to sign the perfected engagement letter.

26.2 The terms of an individual engagement letter will include:

(a) The physician's compensation consistent with the terms of this Agreement;

(b) The physician's job description, which shall be current as of the date of the ratification date of the applicable collective bargaining agreement;

(c) Representations and warranties required for compliance with federal, state, local law, and regulation, including Anti-Kickback laws, Stark, and similar provisions;

(d) An acknowledgement that, in the best interests of the patient, to provide high quality coordinated care, enhance patient experience and in order to advance the legitimate business interest of the Health System, physicians are required to refer to and utilize providers and practitioners employed or affiliated with the Health System, as well as services provided directly by the Health System within the scope of his or her employment. This requirement is subject to patient preference, insurer determinations, and physicians' exercise of reasonable professional medical judgment as to the best medical interest of the patient;

(e) A requirement that the physician remain in good standing with the applicable Medical Staff and maintain credentials at the Hospital(s) where they practice;

(f) The requirement that the physician provide the Health System 120-days' notice to terminate an engagement letter before expiration of its term;

(g) A requirement that the physician devote the physician's full professional time and attention to their duties as an employee of the Health System, and may not render administrative, teaching, or other professional medical services to another institution without express written permission of the Health System and in accordance with Health System's applicable policy. The Health System's permission shall not be withheld unless the Health System determines: (1) the administrative, teaching or other professional medical services are not consistent with physician's employment with the Health System, the Medical-Dental Staff Bylaws and/or the Code of Conduct (including but not limited to an improper referrals, anti-kickback and conflict of interest); (2) the administrative, teaching or other professional medical services interfere with the performance of scheduled or reasonably anticipated to be scheduled Health System work; (3) the physician is on an active intervention plan (i.e. performance improvement plan); (4) the physician is not in good standing (i.e. failing to meet any and all quality and/or productivity metrics); (5) the compensation for the administrative, teaching or other professional medical services is not fair market value and/or is not commercially reasonable; (6) the physician does not have appropriate malpractice insurance; or (7) there are internal moonlighting opportunities that exist within the physician's subspeciality (taking into account the physician's availability to perform the moonlighting, the internal shifts that are available at the time the request is made (including the availability of essential unfilled department shifts), the amount of moonlighting the physician wants to perform, and whether the outside employment moonlighting involves the same job duties as the physician's Health System employment).

A physician's self-reporting of outside activity earnings shall be controlled by the Health System's Outside Activity Policy (last review date May 2025), except that the below (i) and (ii) are negotiated exemptions to the existing policy:

i. The appropriate immediate clinical leadership may approve up to $30,000 per fiscal year (July 1 – June 30) of Outside Activity earnings. The $30,000 limit does not include associated reimbursement for travel and expenses.

ii. Requests that would result in additional income above $30,000 per fiscal year must be approved by the clinical executive leadership or designee.

If permission is denied, Doctors Council may file a grievance challenging the denial and such a grievance shall proceed immediately to Step 3 of the parties' grievance procedure. The Step 3 resolution shall be final and binding on the parties and in no event may a grievance challenging the denial of permission to render administrative, teaching, or other professional medical services to another institution be subject to arbitration.

The Health System's approval is good for one year, and the physician must seek reapproval prior to the expiration of the one-year period. The Health System may deny reapproval based on any of the criteria identified above. Such a denial of reapproval is subject to the expedited grievance process detailed above but shall not be subject to arbitration.

But this provision will not prohibit a physician from moonlighting for the Health System pursuant to other provisions of this agreement, or from lecturing at or participating in education conferences and drug representative surveys and receiving and retaining honoraria or other compensation associated with such service, provided the physician receive prior written permission as required by the Health System's Conflict of Interest Policy;

(h) A non-solicitation restriction which will prohibit the physician from soliciting any co-workers or patients of the Health System during the course of the physician's employment and for one year after the physician's employment with the Health System terminates; and which allows the Health System to seek injunctive relief in a federal and/or state court of appropriate jurisdiction. The employee non-solicitation restriction shall only restrict solicitation of current employees of the Health System. .

(i) Any other provisions relevant to an individual physician, such as visa and permanent residency sponsorship, loan repayment program participation, and or any other type of compensation or loan unique to a physician (i.e. sign on bonuses, student loan repayment, etc.).

(j) No physician subject to this Agreement shall be subject to a non-compete during the pendency of this Agreement.

(k) The employer will maintain electronic or papers documentation of the physician's employment history

26.3 Physicians may voluntarily resign from the Medical Staff by submitting written notice at least thirty (30) calendar days prior to their resignation date to the Medical Executive Committee, with a copy to the Department Chair. The physician must satisfy all responsibilities outlined in the Medical Staff Bylaws before the resignation date. In the event that the physician does not voluntarily resign, or in the event of the termination of the physician's employment by the Health System, or by expiration of the individual engagement letter, the Health System shall administratively terminate all of the physician's clinical privileges, including the physician's membership in the Department and the physician's Medical Staff membership. Notwithstanding any provisions of the applicable Medical Staff Bylaws, in the event of an administrative termination of privileges pursuant to this provision, all rights relating to notice, hearing, appellate review, and/or other rights generally provided to members of the Medical Staff prior to adverse action with respect to appointment and clinical privileges, shall be expressly waived.

26.4 A true and correct copy of a model individual engagement letter is attached hereto as Exhibit ____.

ARTICLE 27 - BENEFITS

27.1 Physicians will be offered employee benefits by the Health System, such as Health, Dental, and Vision insurance, short- and long-term disability coverage, childcare assistance, and other benefits which the Health System may choose to offer, on the same basis as non-bargaining unit physicians.

27.2 The Health System will determine the cost to physicians. The Health System will provide at least fifteen (15) calendar days' notice to physicians and Doctors Council of material changes to coverage or cost of benefits before such changes take effect outside of the Open Enrollment Period. The Health System may alter, amend, add to, subtract from, or discontinue any benefit offered now or in the future provided such change is on the same basis as a change to benefits offered to non-bargaining unit physicians.

27.3 All employee benefits will be subject to the terms and conditions of the applicable plan documents. All insured benefits will also be subject to the terms and conditions of the applicable contract of insurance.

27.4 Physicians may choose to make changes to their benefit selection during the designated Open Enrollment Period. The Health System will provide thirty (30) calendar days advance notice of such Open Enrollment Period to Doctors Council and Physicians and will provide Doctors Council and Physicians a copy of the updated benefits guide and rate sheet before the Open Enrollment Period begins.

27.5 Parking. The Employer will provide free parking at the Hospitals. Parking lots at the Hospitals will be regularly monitored by security 24/7.

27.6 Break Rooms: Each Hospital will have a break room furnished, at minimum, with coffee, a functioning refrigerator, microwave, sink, and a table and chair.

ARTICLE 28 - SAFETY

28.1 The Health System will maintain healthy and safe working conditions necessary to protect and preserve the health and safety of physicians and their patients, employees and visitors. The Health System shall continue to maintain safety and security policies for all Hospitals and will provide Doctors Council notice of material changes to these policies.

28.2 Personal protective equipment, including masks, gloves, gowns, goggles, safe needles, and other appropriate equipment, as needed, shall continue to be available at appropriate locations at the Hospitals. Physicians shall follow all Health System safety rules, regulations, policies, and procedures.

28.3 Health and safety issues, including issues concerning workplace violence and workplace safety, as well as disputes concerning the equipment and supplies provided by the Health System to perform bargaining unit work, shall be raised with the Labor Management Committee, consistent with Article [__]. By mutual agreement of the Health System's representatives (as a whole) on the Labor Management Committee and Doctor's Council's representatives (as whole) on the Labor Management Committee, the Labor Management Committee may create a "workplace safety" subcommittee which may meet monthly to address workplace safety concerns, including disputes concerning the equipment and supplies provided by the Health System to perform bargaining unit work. The processes and protocols of this subcommittee shall be determined by the Labor Management Committee as a whole.

ARTICLE 29 - SEVERABILITY

If any provision of this Agreement is found to be in contravention of the laws or regulations of the United States or any State where physicians' employment is governed by the terms of this agreement or found by a court of competent jurisdiction to be invalid, such invalidity shall not impair the validity and enforceability of the remaining provisions of this Agreement. The parties shall promptly commence collective bargaining negotiations for the limited purpose of arriving at an agreement on the replacement provision for an invalidated provision.

ARTICLE 30 - COMPREHENSIVE AGREEMENT

30.1 This is a complete Agreement regarding the terms and conditions of the physicians' employment. Any existing compensation practices not specifically enumerated in this Agreement are void, including any policies, written or unwritten, or past practices regarding physician compensation that existed prior to this Agreement, except that the Physician Compensation Guidebook issued by the Health System, and the policies contained therein, shall remain in full force and effect at all times and, under no circumstances, shall be void to the extent they do not conflict with a provision of this Agreement. In the event of a conflict, this Agreement shall prevail.

30.2 This Agreement may not be amended, modified, or supplemented at any time, except by mutual consent of the Health System and the Union, in writing and signed by the President of the Medical Group or their designee and the Union. Such modifications shall be limited to the specific provision(s) involved and will not affect any other provision of this Agreement.

ARTICLE 31 - NO STRIKES AND NO LOCKOUTS

31.1 During the term of this Agreement and any extension thereof, there shall be no strikes, sit-ins, work stoppages, slowdowns, sympathy strikes, unfair labor practice strikes, boycott, picketing or other interference with or interruption, curtailment, or restriction of work by the Union, its members or other bargaining unit employees, individually or collectively, for any reason whether or not it be arbitrable under this Agreement. Physicians shall not be entitled to any benefits, wages, or privileges to practice medicine at the Hospitals while they are engaged in any activity in violation of this Section. The parties also recognize the right of the Health System to take disciplinary action, including discharge, against any physician who participates in an action in violation of this section.

31.2 In the event any physician or group of physicians covered by this Agreement violate this provision, the Union, and its officers and organizers shall immediately:

(a) Instruct by letter and/or email such employee or group of employees to resume work immediately; and

(b) Take all reasonable steps to bring about observance of provisions of this section, including any sanctions available under Doctors Council's constitution and bylaws.

31.3 The Union shall indemnify the Health System for any losses that the Health System incurs as a result of a violation of this Article by any physician, officer or agent. The Health System's entitlement to damages is not a subject of the grievance or arbitration procedure, and the Health System shall be entitled to pursue a remedy for violation of this Article 31 in court.

31.4 During the term of this Agreement, the Health System will not engage in a lock-out of physicians.

APPENDIX B- SETTLEMENT AGREEMENT AND RELEASE

This Settlement Agreement and Release ("**Agreement**") is entered into by and between _____ ("**Physician**") and Christiana Care Health Services, Inc. ("**ChristianaCare**") as of the last date indicated below.

RECITALS

WHEREAS, Physician and ChristianaCare are parties to that certain [_____] dated [_____] (the "**Collective Bargaining Agreement**") under which Physician provided services to ChristianaCare.

WHEREAS, effective [_____], ChristianaCare [terminated/suspended] the Physician.

WHEREAS, a dispute has arisen between Physician and ChristianaCare arising out of the Physician's [termination/suspension] related to the Collective Bargaining Agreement, resulting in the filing of a grievance (the "**Grievance**") by Physician which has been formally resolved through adjudication [_____] (the "**Dispute**").

WHEREAS, ChristianaCare and Physician desire to resolve all matters arising out of and related to the Dispute, as set forth in this Agreement.

NOW, THEREFORE, the parties, each in consideration of the representations, warranties, covenants, and agreements contained herein, the sufficiency of which are hereby acknowledged, and as full payment and settlement of any and all amounts owed to Physician related to the Dispute, do hereby agree as follows.

1. **Settlement Terms and Fee.** Subject to the terms set forth below, ChristianaCare agrees to pay to the Physician an amount equal to [_____] (the "**Settlement Fee**"). The Settlement Fee shall be paid by ChristianaCare in exchange for the release and fulfillment of other covenants by Physician as set forth in this Agreement. This amount is commercially reasonable and consistent with fair market value and has not been determined in any manner that takes into account the volume or value of referrals by the Physician or other business generated between the parties. Physician agrees to be wholly responsible for payment of all federal, state, and local taxes with regard to the Settlement Fee.

2. **Physician's Release.** Physician releases and forever discharges ChristianaCare and its officers, directors, affiliates, subsidiaries, successors, agents, and assigns, of and from any and all claims whether now known or unknown to the parties, which could have been brought as part of the Grievance, subject only to the agreements and covenants contained in this Agreement.

3. **ChristianaCare's Release.** ChristianaCare, for itself and its officers, directors, affiliates, subsidiaries, successors, agents, and assigns, releases and forever discharges Physician of and from any and all claims whether now known or unknown to the parties, which could have been brought as part of the Grievance, subject only to the agreements and covenants contained in this Agreement.

4. **Limited Agreement.** The parties agree and acknowledge that this Agreement is limited solely to any claim or cause of action the parties have, may have or may learn of in the future which could have been brought as part of the Grievance and should not be construed in any way to affect any other agreement, arrangement, or understanding between Physician and ChristianaCare which may now exist or may exist in the future.

5. **Entire Agreement.** This Agreement contains and states the entire agreement of the parties with regard to its subject matter. All prior understandings and agreements between the parties with regard to the subject matter of this Agreement, if any, are merged into and with this Agreement, which fully, completely and accurately states and expresses their entire understanding and agreement with regard to the subject matter of this Agreement.

6. **No Inducement.** The parties acknowledge that, except as expressly set forth in this Agreement, no representations or promises, whether express, implied or otherwise, of any kind, nature or description whatsoever have been made to them, as an inducement to entering into this Agreement or otherwise, by the other party or any partner, director, officer, employee, agent, or attorney of the other party.

7. **Execution in Counterparts.** This Agreement may be executed in one or more counterparts, any one of which need not contain the signature of more than one party and all of which taken together shall constitute one and the same agreement. This Agreement shall become effective when fully executed and delivered by both parties, whether in one or more counterparts. This Agreement shall be governed by Delaware law.

Christiana Care Health Services, Inc.	[PHYSICIAN]
By: _____	By: _____
Its: _____	Date: _____
Date: _____	

DEFINITIONS

The following terms and abbreviations used throughout this agreement shall have the meanings below unless explicitly stated otherwise in the Agreement.

FMV: Fair Market Value as determined from third-party data or expert opinion or appraisal on physician compensation.

FTE: Full Time Employee

cFTE: Clinical Full Time Employee, or an employee whose employment compensation with the Health System is based solely on time devoted to clinical work.

Hourly Rate (Shift Model): Hourly rate is defined as the fixed portion of total cash compensation attributed to clinical work divided by clinical annual work hour expectation for the physician's applicable FTE status.

Medical Staff: This term refers to the applicable Medical Staff based on the Hospital where the physician works and will include either the ChristianaCare Medical-Dental Staff, the Union Hospital Medical Staff, or both as appropriate.

TCC: Total Cash Compensation is the total annual compensation of the individual provider, including base, variable, administrative, and teaching compensation plus all voluntary salary reductions. Examples of TCC would include, but are not limited to, the following: compensation paid as salary or production-based compensation plans, any type of additional bonuses or incentives, clinically related medical directorships, administrative stipends, research or teaching stipends, call coverage, ancillary or APC supervision stipends, moonlighting stipends and other unidentified compensation. The compensation reported should generally equal reporting W2 wages.

RVU: Relative Value Unit

wRVU: Work Relative Value Unit

ARTICLE 19 - wRVU & QUALITY BASED COMPENSATION

19.1 Specialties paid according to this framework are listed in Appendix 1. The Health System has the right to designate whether any new department or, specialty line , or physician will be paid according to this framework.

(a) Sections 19.2 through 19.4 apply to physicians in their second year or greater of employment with the Health System.

19.2 Base Compensation

Physicians will receive a salary that is equal to 950% of the market position for TCC for the physician's appropriate productivity percentile related to their clinical work and based upon their cFTE. The appropriate productivity percentile is determined by adding three percentiles to the physician's productivity percentile as measured from the preceding April 1st through the following March 31st. for the prior fiscal year. The three percentiles added to the physician's productivity percentile are provided in lieu of, and void, the non-billable clinical incentive. No bargaining unit physician is eligible for the non-billable clinical incentive.

19.3 Quality Based Incentive

(a) Physicians are eligible for a quality-based incentive that is equal to 510% of the market position for TCC for the physician's appropriate productivity percentile as described in Section 19.2.

(b) The Health System, in its sole discretion, will set the criteria for the quality-based incentive with notice to Doctors Council. Prior to setting the criteria, which will occur at the specialty level, the Health System shall provide an opportunity for physicians in each specialty to furnish to their specialty leadership a list of up to ten metrics that the Health System shall consider when determining the quality-based incentive. The Health System is not obligated to select the metrics furnished by the physicians. Prior to finalizing the quality-based incentive criteria, specialty leadership will provide the proposed criteria to the physicians at a meeting for feedback. Physicians must fully satisfy the criteria during the fiscal year to receive the quality-based incentive payment.

19.4 Additional Compensation for wRVUs

(a) Physicians must personally perform a threshold number of wRVUs before the physician is eligible for additional compensation as described in this subsection. Physicians will receive additional wRVU compensation when the physician personally performs wRVUs above the physician's appropriate productivity percentile individual threshold. The physician will receive compensation equal to the 35th percentile compensation per wRVU for each wRVU generated once the physician exceeds the physician's individual thresholdappropriate productivity percentile. The individual threshold is the physician's wRVU expectation for the current fiscal year. appropriate productivity percentile as set forth in Section 19.2.

(b) The Health System will conduct a semi-annual a single half yearly reconciliation of each physician's wRVUs. Any physician's whose productivity level is more than 10% below the physician's assigned percentile for base compensation will may receive a downward adjustment to base and incentive compensation and, in the event of a downward adjustment, will be eligible for additional wRVU based on the new percentile from the effective date of the base compensation adjustment at the time of the semi-

annual reconciliation. Factors the Health System will consider in determining whether a downward adjustment is appropriate include market fluctuations and whether the physician utilized a protected leave of absence. The Health System's reconciliation decision will be grievable but not subject to arbitration.

The Health System will not make a downward adjustment as described in Section 19.4(b) during the first year of the first collective bargaining agreement, consistent with the provisions of Article 25.

(c) Compensation Above the 75th Percentile: A bargaining unit physician's base compensation, as set forth in article 19.2, is capped at the TCC market position of the 75th percentile for that bargaining unit physician's specialty. A bargaining unit physician who hits the 75th percentile cap (inclusive of the three percentiles identified in Section 19.2) will earn compensation equal to the 35th percentile per wRVU for each wRVU generated in excess of the 75th percentile cap. Additionally, a physician whose base compensation is at the 75th percentile may be subject to the reconciliation described in 19.4(b) on a quarterly basis.

19.5 New to Practice

Physicians with less than two years of experience after residency and fellowship programs will receive 100% of their compensation for the first and second first years of employment with the Health System as salary equivalent to the TCC for the physician's subspecialty between the 2525th and 5040th percentiles. Thereafter, their compensation shall be established on a going forward basis in accordance with Sections 19.2 through 19.4.

Notwithstanding the foregoing, a new to practice physician may elect to convert their Section 19.5 salary to the compensation outlined in Section 19.2 to 19.4 so long as the following conditions are satisfied:

(a) The physician has 12 continuous months of wRVU data;
(b) The physician provides thirty days' written notice of the intent to make the change; and
(c) The applicable Service Line Leader approves the change.

Assuming these conditions are satisfied, the measurement period to determine the physician's base compensation in accord with Section 19.2 shall be the most recent available twelve months of data before the date of the written notice. The physician's base salary will be set as detailed in Section 19.2.

19.6 Experienced Practitioners

Physicians with two or more years of prior work experience beyond residency and fellowship programs will receive 100% of their compensation for the first year of employment with the Health System as salary equivalent to the TCC for the physician's subspecialty between the 40th and 55th percentiles. Thereafter, their compensation shall be established on a going forward basis in accordance with Sections 19.2 through 19.4.

19.7 Upward Adjustment

The Health System, in its sole discretion, has the authority to set compensation for new physicians covered by Sections 19.5 or 19.6 above the percentiles listed in Section 19.5 and 19.6 when circumstances require.

ARTICLE 20 - wRVU & QUALITY BASED SPECIALTIES DEFINITION OF FULL-TIME EMPLOYMENT

20.1 Work Hours

A 1.0 cFTE for a physician in the RVU & Quality framework will be 2080 hours per year.

A 1.0 cFTE physician will include:

(a) 304240 hours of Time Away from Practice ("TAP") per year, which physicians may use for any purpose.

(b) 40 hours of leave per year to attend CME programs ("CME Leave").

(c) Physicians must follow applicable departmental policy on requesting and scheduling TAP and CME Leave. The System will use its best efforts to ensure that physicians are able to use their requested TAP and CME leave.

(d) TAP and CME Leave not used within the fiscal year it is granted may not be rolled over or cashed out.

(e) Physicians may not receive any other type of pay during the time that the physician is on CME Leave.

20.2 wRVU Threshold

The Health System will track the number of wRVUs generated per physician per fiscal year. A physician must generate a threshold number of wRVUs (on an individual basis unless otherwise specified by the Health System in its sole discretion) that is equal to the number of wRVUs the physician generated in the prior fiscal year before the physician is eligible for additional compensation pursuant to Section 19.4.

(a) The Health System will provide physicians with access to an electronic dashboard or equivalent which will provide the physician's individual year-to-date wRVU totals, which the Health System will update on a regular basis.

(b) The Health System will conduct a semi-annual reconciliation of each physician's wRVUs. Any physician's whose productivity level is more than 10% below the physician's assigned percentile for based compensation will receive a downward adjustment to base compensation and will be eligible for additional wRVU based the new percentile from the effective date of the base compensation adjustment.

(c) The Health System will prorate a physician's annual wRVU threshold, including for the semi-annual reconciliation, if the physician is on an approved leave of absence greater than four (4) weeks..

ARTICLE 21 - wRVU & QUALITY BASED SPECIALTIES EXCESS CALL

21.1 The requirements and obligations for Excess Call shall be controlled by the terms of the Compensation Guidebook. All physicians in these specialties are eligible for additional compensation if the physician meets the below criteria:

(a) The physician is a 1.0 FTE (clinical and administrative combined) or the physician has already performed the equivalent work of a 1.0 FTE;

(b) The physician takes call more frequent than a 1:3 rotation; and

(c) Excess Call does not count towards full-time status.

21.2 Where possible the Health System will solicit volunteers for excess call. If there are insufficient volunteers for excess call, the Health System may mandate excess call.

21.3 Excess call will be assigned pursuant to department policy and at the discretion of the Health System on an as needed basis.

ARTICLE 22 – SHIFT & QUALITY-BASED SPECIALTIES COMPENSATION

22.1 Base Compensation

For physicians employed in the specialties listed in Appendix 3, and provided that the physician carries a full-time schedule for the physician's subspecialty, as defined in Article 23, physicians will receive the following base compensation, or prorated amount if the physician is less than a 1.0 cFTE:

(a) New to practice Shift & Quality-Based Specialty physicians and physicians with less than three 3.99(3) full years of practice after residency and fellowship programs will receive 950% of their compensation as salary at the 3735th percentile of the TCC for the market position for the physician's subspecialty. Thereafter, their compensation shall be established on a going forward basis in accordance with Section 22.1(b).

(b) All other Shift & Quality Based-Specialty physicians with between 4 and 9.99 years of practice will will receive 950% of their compensation as salary at the 51st 50th percentile of the TCC for the market position for the physician's subspecialty. Shift & Quality Based-Specialty physicians with between 10 and 23.99 years of practice will receive 95% of their compensation as salary at the 56th percentile of the TCC for the market position of the physician's subspecialty. Shift and Quality Based-Specialty physicians with 24 or more years of practice will receive 95% of their compensation as salary at the 60th percentile of the TCC for the market position of the physician's subspecialty.

(c) For the purposes of increases to base compensation under 22.1(a) and (b), years of practice are measured at the start of the Health System's fiscal year. Years of practice are measured from the date the physician completed the graduate medical education required for the position in which the physician is employed assuming continued practice within the specialty. In the event that a physician holds more than one position with the Health System, years of practice will be measured for each position from the date the physician completed the graduate medical education required for each position.

(dc) A Shift & Quality-Based Specialty physician who works exclusively on a swing shift or a weekend shift will receive a 105% reduction in the hours or shift which define full-time employment, and a 105% increase in salary over a 1.0 cFTE described in 22.1(a) and (b).

(ed) A Shift & Quality-Based Specialty physician who works exclusively on an overnight shift will receive a 150% reduction in the hours or shift which define full-time employment, and a 150% increase in salary over a 1.0 cFTE described in 22.1(a) and (b).

(f) A Partial Swing or Partial Nocturnist (defined as working greater than 50% of their shifts in a fiscal year swing or nocturnist) will receive an overall 5% reduction in the hours or shifts which define full-time employment ~~or shifts~~, and a 5% increase in salary over 1.0 cFTE.

22.2 Quality-Based Incentive

(ab) New to practice physicians are eligible for a quality-based incentive equivalent to 510% of the 35th percentile of TCC for the market position for the physician's subspecialty at the market position percentile for the physician's experience tier identified in Article 22.1. Thereafter, their compensation shall be established on a going forward basis in accordance with Section 22.2(1).

(b) Shift & Quality Based-Specialty physicians are eligible for a quality-based incentive equivalent to 5% of the TCC for the market position for the physician's subspecialty at the market position percentile for the physician's experience tier identified in Article 22.1.

(c) The Health System, in its sole discretion, will set the criteria for the quality-based incentive with notice to Doctors Council. Prior to setting the criteria, which will occur at the specialty level, the Health System shall provide an opportunity for physicians in each specialty to furnish to their specialty leadership a list of up to ten metrics that the Health System shall consider when determining the quality-based incentive. The Health System is not obligated to select the metrics furnished by the physicians. Prior to finalizing the quality-based incentive criteria, specialty leadership will provide the proposed criteria to the physicians at a meeting for feedback. Physicians must fully satisfy the criteria during the fiscal year to receive the quality-based incentive payment.

22.3 The Health System has the right to designate whether any new department or, specialty line, or physician will be paid according to the framework in this Article 22.

22.4 Remote CCHP work shall be paid at a rate which is 15% below the applicable in-person hospitalist work rate.

ARTICLE 23 – SHIFT & QUALITY-BASED SPECIALTIES DEFINITION OF FULL-TIME EMPLOYMENT

23.1 Full Time Employment.

The Health System will set the number of work hours or work shifts per fiscal year on a department-by-department basis that constitutes a the minimum work expectation 1.0 cFTE for all Shift & Quality-Based Specialties. Unless the Union is notified otherwise, the number of work hours or work shifts per fiscal year which constitute the minimum work expectation will be determined by the standard market shifts and/or hours on a per specialty basis. To the extent the Health System increases the number of work hours or work shifts based on standard market shifts and/or hours, or modifies, amends, or revises the methodology by which it determines market hours, the Health System will provide the Union, in advance, with the factual basis underlying the Health System's determination, modification, amendment or revision (including any underlying source or methodological data), subject to the limitations and restrictions contained in Article 25.1, including confidentiality restrictions. If a change in methodology results in an increase to the number of shifts associated with the minimum work expectation, or if the Health System increases the number of shifts for any other reason, the System will engage in effects bargaining with the Union upon request by the Union, which both parties will use their best efforts to commence prior to the implementation of the change, including the opportunity in effects bargaining to discuss the ability of individual physicians to modify their FTE. The Health System's number of work hours or work shifts for any department may not deviate more than 6% from the number of work hours or work shifts from the prior fiscal year. AAll such specialties are listed in Appendix 3.

23.2 A 1.0 FTE physician will include:

(a) The minimum work expectation for that physician's specialty as determined in by Section 23.1; plus

(b) 80 hours of Time Away from Practice ("TAP") per year, which the physician may use for any purpose; plus

(c) 40 hours of leave per year to attend CME programs ("CME Leave"), except that 20 of the 40 hours of leave per year to attend CME may count toward the physicians minimum work expectation where the following conditions are met: (1) the physician is participating in a conference where the physician will receive CME, (2) the physician's participation in that conference is approved by their Service Line Leader, and (3) the physician, upon returning to work, provides their Servicer Line Leader with proof of participation in the conference and receipt of CME for that participation. If a physician fails to meet their minimum work expectations by the last day of the fiscal year because of utilizing CME toward their minimum work standards in accordance with this Section 23.2(c), the physician must provide to the Health System the Service Line Leader approval of their use of CME toward their minimum work expectation.

(d) Physicians must follow applicable departmental policy on requesting and scheduling TAP and CME Leave.

(e) TAP and CME Leave not used within the fiscal year it is granted may not be rolled over or cashed out.

Under this Section 23.2, a physician must actually work, in all cases, the minimum work expectation. Compensation, as detailed in Article 22, is linked to the minimum work expectation. The Health System has no obligation to guarantee shifts and/or work hours above the minimum work expectation. If a physician fails to meet their minimum work expectations by the last day of the fiscal year because of a documented medical emergency which occurred within the last two months of the fiscal year (May and June), the System and the Union will use their best efforts to resolve the issue before the System assesses a financial penalty against the Physician. In all cases, the parties shall discharge their best-efforts obligations within the first month of the fiscal year (July).

This definition of full-time status will include 40 hours of CME Leave per physician per fiscal year to attend approved CME programs. If CME Leave is not used in the year it is granted, it may not be rolled over to the next year or exchanged for cash.

23.2 Requesting Time Off.

Physicians shall submit requests for specific hours or day(s) off pursuant to existing departmental policy or practice. The Health System will make reasonable efforts to accommodate such requests and such requests may not be unreasonably denied..

23.3 The Health System will prorate the hours or shift expectations for a physician in the hospital-based specialties listed in Appendix 3 if the physician is on an approved leave of absence greater than four (4) weeks.

23.4 Overnight Shifts

(a) Individual departments on the shift-based model may implement a process for physicians to request to opt out of overnight shifts (defined as any clinical shift that starts after 7p) based on criteria determined by the Individual department. Requests will be granted subject to departmental and patient care needs. Approval may be rescinded by department leadership temporarily in the event of a staffing need during which other bargaining unit members are unable to fully staff the department.

(b) No bargaining unit physician will be required to opt out of overnight shifts based on pregnancy, age, or any other classification protected by law.

(c) If a bargaining unit physician qualifies for increased pay and reduction in hours based on working overnight shifts (e.g., nocturnists) and is approved to opt out of overnight

shifts, the physician's individual engagement letter will be amended to remove the premium rate and reduced hours for the duration of the physician's opt out.

ARTICLE 24 – SHIFT & QUALITY-BASED SPECIALTIES MOONLIGHTING

24.1 Physicians who are a 1.0 FTE (clinical and administrative combined), or doing equivalent work, may take additional shifts beyond the required coverage expected by the physician's subspecialty. Consistent with Article 18 of this Agreement, tThe Health System prefers to fill additional coverage needs through volunteers, but the Health System shall have the right to assign moonlighting shifts in an emergent situation where the event there are insufficient volunteers to meet patient care needs. Mandatory moonlighting as the result of an emergent situation ("Emergent Mandatory Moonlighting"), as detailed in this Section 24.1, shall be paid at the premium moonlighting rate where such Emergent Mandatory Moonlighting is required with less than 48 hours' notice to the physician, however, such mandatory moonlighting hours shall not count toward the physician's minimum work expectation. No premium pay for Emergent Mandatory Moonlighting shall be paid where the emergent situation is the result of physicians in the applicable specialty failing to sign up for moonlighting shifts and/or failing to work their scheduled moonlighting shifts.

24.2 A department may elect to establish and/or continue a backup system for call coverage. If a physician is called into the Hospital to work back up, the physician will receive the premium moonlighting rate for their specialty or sub-specialty, however, such back up hours shall not count toward the physician's minimum work expectation. If a department materially increases its overnight shift burden for non-nocturnists or its backup call burden, the Health System and the Union will engage in effects bargaining regarding the impact of the decision to increase the backup call or overnight shift burden.

24.32 Moonlighting will be assigned pursuant to department policy and at the discretion of the Health System on an as needed basis.

24.43 Eligibility for premium pay for moonlighting:

(a) Shift & Quality-Based Specialty physicians will be compensated at the premium FMV moonlighting rates, which are listed in Appendix 4, for each shift and/or hour they work above their minimum work expectation as determined in accordance with Article 23, or, in the event of Emergent Mandatory Moonlighting as described in Section 24.1. the expected number of shifts for a full-time physician in that subspecialty per the FMV moonlighting rates, which are listed in Appendix 4.

(b) If RVU & Quality-Based Specialty physicians take moonlighting shifts to cover Shift & Quality-Based Specialty practices, the RVU & Quality-Based Specialty physician will receive a base pay rate as identified in Appendix [__]of one-hundred dollars ($100) and will also receive credit for all wRVUs personally generated during the shift for purposes of calculating compensation pursuant to Section 19.4.

(c) Moonlighting shifts or hours will not count towards the required number of annual hours or shifts for purposes of meeting the physician's minimum work expectation. Any

physicians that have less than a 1.0 FTE and work additional shifts or hours above their FTE status will receive pay at the standard, not premium, rate for those shifts, until that physician works above the minimum work expectation for a 1.0 FTE.

24.54 The Health System will set the moonlighting rates consistent with FMV for each subspecialty and will provide notice to Doctors Council of any adjustment to such rates.

24.5 Moonlighting shifts will not count towards the required number of annual hours or shifts for purposes of assessing full-time status. Any physicians that have less than a 1.0 cFTE and work additional shifts or hours above their cFTE status will receive pay at the standard, not premium, rate for those shifts.

24.66 The Health System, in its sole discretion, may temporarily permit physicians that are less than a 1.0 cFTE to work moonlighting shifts and receive premium pay during periods of reduced coverage in a subspecialty because of leaves of absence, attrition, increased patient load or similar circumstances.

24.7. Bargaining unit physicians are no longer eligible for the Excess Hours premium contained in the Physician Compensation Guidebook.

24.8. Where a department through local practice maintains a work expectation based on quantity of assignments or considers patient volume and/or number of physician callouts as guidelines for additional coverage, the Health System may modify the local practice for a patient care, patient safety and/or physician wellness reason upon notice to Doctors Council. In the event that such local practice is modified, the Health System and the Union will engage in effects bargaining regarding the impact of the decision to modify local practice.

ARTICLE 25 - FAIR MARKET VALUE

25.1 The Health System will, as necessary, obtain third-party survey data and opinions for use in assessing the FMV for physician compensation, including salaries, wRVU, excess call, and moonlighting rates. For new specialties where insufficient market data exists, the Health System shall, in its sole discretion, determine the analogous specialties to use for purposes of assessing the FMV of TCC, wRVUs, excess call, and moonlight rates. Upon the request of Doctors Council, and provided that Doctors Council executes a confidentiality and/or common interest agreement as requested by the Health System, the Health System may provide to Doctors Council opinions and/or analysis utilized by the Health System in making a FMV assessment. Such a request by Doctors Council shall not be unreasonably denied.

25.2 The Health System shall set, and adjust at its discretion, the rate schedule for purposes of determining the productivity associated with each TCC percentile, determining the wRVUs assigned to new and existing procedures and treatments, temporary procedures and treatments, unlisted codes and initial determinations on new moonlighting work, with notice to Doctors Council before implementation. excess call, and moonlighting rates, with notice to Doctors Council before implementation.

25.3 The parties agree that the Health System may adjust, up or down, the rates of any physician compensation with notice to the Union, where the Health System's compensation rates are found to be potentially inconsistent with FMV.

25.4 The Health System shall utilize the prior calendar year CMS physician fee schedule jin its sole discretion select the CMS physician fee schedule year that the Health System will use for assigning wRVU values in the following fiscal year unless the Health System believes that utilizing an updated CMS physician fee schedule will be detrimental to bargaining unit physicians. In such a circumstance, the Health System and Doctors Council shall meet, discuss, and reach agreement on whether the new fee schedule shall be utilized. .

25.5 wRVU Transparency. Upon request by a physician whose compensation is in the RVU Model. but no more than quarterly, physicians may access their report of their wRVU totals that will include each patient encounter with the listed CPT code, wRVU value, and/or EMR code or each encounter down to the patient level for accurate record keeping. All wRVUs will be paid based on calculated totals from the department's reporting programs to ensure accuracy.

ARTICLE 28 - LEAVE OF ABSENCE

28.1 Physicians in the bargaining unit may take job-protected leave such as FMLA, on the same basis as non-bargaining unit physicians. The Health System will maintain written policies regarding all leaves of absence available to physicians, the basis on which they will be granted, and the method for requesting such leave. The Health System may update such policies with thirty (30) noticedays' notice to Doctors Council.

28.2 The Health System may alter, amend, add to, subtract from, or discontinue any leave of absence policy offered now or in the future, provided that the leave of absence benefit is offered on the same basis to physicians as to non-bargaining unit physicians.

28.3 In the event that the Health System recognizes a new holiday, physicians will be credited 8 hours additional TAP per new holiday recognized.

ARTICLE XX – COMPENSATION FOR RESIDENT SUPERVISION

XX.1- As of the date of ratification of this Agreement, eRVUs shall no longer be assigned to bargaining unit physicians.

XX.2- Because the Parties recognize the importance of resident/fellow supervision as a key component of high-quality patient care and to further the resident's and/or fellow's educational development at the Health System, the Health System will compensate any bargaining unit physician who meets the following criteria with a flat yearly stipend of $15,000: (1) is employed as a 1.0 FTE in a specialty identified in Appendix [ ] ("RVU Model") and (2) whose Service Line Leader certifies that the bargaining unit physician spends 40% or more of their work time supervising residents/fellows.

XX.3- A resident for the purposes of this article is defined as a resident in a Health System ACGME program. A fellow for the purposes of this article is defined as a physician who has completed an accredited residency program and is enrolled in an ACGME-accredited fellowship program for advanced subspecialty training.

ARTICLE ## - ADMINISTRATION OF PAY

##.1 Underpayment Correction

The Health System will audit all physician compensation actually paid pursuant to this Agreement on at least an annual basis and will promptly correct any underpayments.

##.2 Overpayment Correction

(a) All physicians are responsible for repaying any overpayments of compensation pursuant to this Agreement consistent with the terms of the attached overpayment correction form.

(b) All physicians are responsible for repaying any bonus payments that were contingent on service in a particular role, e.g. sign-on or retention bonuses.

##.3 Timekeeping

(a) The Health System may require physicians to complete timekeeping duties, including entering and/or verifying timekeeping data on digital applications and/or programs or with other digital tools. The Health System will use its best efforts to ensure that such timekeeping application shall be accessible via cellular phone and computer. Additionally, the Health System will use its best efforts to minimize the time or effort required for physicians to complete timekeeping duties and will engage with effects bargaining with Doctors Council upon request following implementation of any new timekeeping application.

.4 FTE Changes.

On a onetime basis, physicians who are not employed as partial/full nocturnists, partial/full swing, or weekendists may, within 1 week of ratification of the contract, request an FTE change to be effective no later than January 3 of the following year, or 120 days after the effective date of the contract, whichever is later, and such a request will not be unreasonably denied.

Physicians who are employed as partial/full nocturnists, partial/full swing or weekendists may, within 1 week of ratification of the contract, request an FTE change to be effective no later than 180 days after the effective date of the contract, and such a request will not be unreasonably denied.

ARTICLE XX –– MISCELLANEOUS LIVING AGREEMENT

1. The Parties agree that operational and/or administrative changes, modifications and/or adaptations to enhance quality, patient safety, patient experience, and/or financial stability are permitted during the life of this Agreement.

2. Such changes and adaptations may improve bargaining unit members' conditions of employment, or in some cases may diminish or erode bargaining unit members' conditions of employment.

3. To the extent the Health System alters, modifies, or amends existing post-call practice, round and go practice, or work from home practice, the Health System will use its best efforts to provide Doctor's Council with 120 days' notice prior to implementing any such change, and in all cases will provide no less than 60 days' notice prior to implementing any such change,, unless such a change is required by law and/or regulation, in which case such notice will be provided prior to the change.

4. To the extent that the Health System alters, modifies, or amends the Physician Compensation Handbook, the Health System will provide Doctors Council with 60 days' notice prior to implementing any such change, unless such a change is required by law and/or regulation, in which case such notice will be provided prior to the change.

ARTICLE XX - CRITICAL STAFFING

A. Hospital-Based Model

Qualifying physicians will be paid a 10% premium on their current moonlighting rates.

B. Eligibility

20% reduction of working physician clinical FTEs compared to the budgeted number of physicians who are qualified to perform the applicable clinical work based on their title in the Individual Engagement Letter, including unfilled FTEs based on vacancies or leave; OR

Significant increase in total hours worked across the practice above scheduled hours standards.

1. For large practices (>20 physicians in coverage pool) = 10% or more hours above standard.
2. For small practices (<20 physicians in coverage pool) = 5% or more hours above standard.

ARTICLE 32 - DURATION OF AGREEMENT

This Agreement shall be effective one-hundred and twenty days from the Ratification Date until June 30, 2029. as of through the third anniversary date of ratification (the "Term"). This Agreement shall automatically be renewed from year to year thereafter unless either party shall notify the other in writing not less than one-hundred eighty (180) days prior to the end of the Term, or any subsequent one-year renewal Term, of its desire to modify or terminate this Agreement.

Except for the first year of this Agreement, which shall run from the effective date until the end of that fiscal year, each subsequent year of this Agreement shall run from the first day of the fiscal year (July 1) until the last day of the fiscal year (June 30).

Side Letter A

The parties agree that acute care provided by a physician as part of the Acute Hospital Care at Home (AHCAH) program, enacted by the Centers for Medicare and Medicaid Services (CMS) as a Public Health Emergency Waiver pursuant to Section 1135 of the Social Security Act (AHCAH Waiver), and as approved by CMS with respect to ChristianaCare on June 14, 2021, is bargaining unit work for the duration of the AHCAH Waiver or ChristianaCare's participation in the AHCAH Waiver, whichever is terminated first, and that such physicians performing such work are members of the bargaining unit. For the avoidance of any doubt, and consistent with Article 1 of the Parties' CBA, all other hospital level care provided in the home, including hospital level care provided in the home that is provided pursuant to another or different CMS waiver(s) or other
CMS program(s), is not bargaining unit work. Upon the expiration of the AHCAH Waiver or ChristianaCare's withdrawal, non-renewal, or termination from participation in the AHCAH Waiver, any work previously performed pursuant to the AHCAH Waiver shall no longer be bargaining unit work and the physicians who previously performed such work shall no longer be members of the bargaining unit. **These physicians covered by Side Letter A will continue to receive the same terms and conditions of employment as determined by their waiver.**

Side Letter B

The parties agree that casual physicians are excluded from the bargaining unit under the recognition clause contained in Article 1 of the parties Collective Bargaining Agreement ("CBA").

Notwithstanding the foregoing, the parties further agree that "Legacy Casuals," i.e. casuals who had an opportunity to vote in the election in case numbers 04-RC-342224, 04-RC-342229, and 04-RC-342252, are included in the bargaining unit so long as they remain in their current

position and/or their employment with the Health System is not terminated, cancelled or non-renewed.

The list of Legacy Casual physicians is attached hereto as Exhibit ___.

So long as any Legacy Casual remains in the bargaining unit, each Legacy Casual's employment shall be governed by the following terms and conditions:

(a) Legacy Casual physicians will not be entitled to any benefits offered to other part-time or full-time employees of the Health System.

(a) Legacy Casual physicians are not guaranteed a minimum number of shifts, hours, or days of call, nor are they guaranteed any specific shift times or dates.

A. All Legacy Casuals must sign a written casual employment agreement provided by the Health System and any amendments or renewals to that agreement that the Health System may provide in its sole discretion.

a. The Health System shall have sole discretion in determining whether to renew a Legacy Casual's contract.

a. The Legacy Casual or the Health System may terminate the Legacy Casual's agreement during the term of the agreement for a material breach of the agreement that is not cured by the breaching party within thirty (30) days, or without cause or penalty with one hundred twenty (120) days' written notice by the terminating party to the other party.

a. The Health System may terminate the Legacy Casual's contract immediately upon written notice if:

i. the Legacy Casual fails to maintain a required medical license;

i. the Legacy Causal's DEA registration is suspended, denied or revoked;

i. the Legacy Casual's privileges on the ChristianaCare Medical-Dental Staff or Union Hospital Medical Staff are suspended, denied, terminated, or revoked;

a. the Legacy Casual fails to provide medical services required by the Written Agreement;

(1) the Legacy Casual renders medical care that jeopardizes the safety, health or well-being of patients;

i. the Legacy Casual engages in repeated or egregious unprofessional or disruptive conduct;

i. the Legacy Casual becomes a "Sanctioned Provider." A Sanctioned Provider is one who (1) is currently under indictment or prosecution for, or has been convicted of: (a) any offense related to the delivery of an item or service under the Medicare or Medicaid programs or any program funded under Title V or Title XX of the Social Security Act (The Maternal Child Health Services Program or the Block Grants to States for Social Services programs, respectively); (b) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or

service; (c) fraud, theft, embezzlement, or other financial misconduct in connection with the delivery of a health care item or service; (d) obstructing an investigation of any crime referred to in (a) through (c) above; or (e) unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (2) has been required to pay any civil monetary penalty under 42 U.S.C. §1320a-7a, regarding false, fraudulent, or impermissible claims under, or payments to induce a reduction or limitation of health care services to beneficiaries of, any state or Federal health care program, or is currently the subject of any investigation or proceeding which may result in such payment; or (3) has been excluded from participation in the Medicare, Medicaid, or Maternal and Child Health Services (Title V) program, or any program funded under the Block Grants to States for Social Services (Title XX) Program; or

i. the Legacy Casual is not eligible to participate in Medicare, Medicaid, or any other major third-party payor of the Health System.

a. The Health System's decision to non-renew a Legacy Casual's written agreement is not subject to the CBA's Grievance & Arbitration procedures.

a. The Health System shall compensate Legacy Casuals at no less than an hourly rate and/or wRVU rate commensurate with the full and/or part time bargaining unit physician premium hourly rate and/or wRVU rate for similar work. Full and part time bargaining unit physician hourly rate and/or wRVU rate is identified in Articles [to be inserted]. This section (C)(v) shall not apply to benefits, which is controlled by section (A) above.

Doctors Council

By : _____

Date:_____

Christiana Care Health Services, Inc.

By:_____

Date: _____

Exhibit to Side Letter B: List of Legacy Casual Physicians in the Bargaining Unit, Subject to the Terms and Conditions of Side Letter B

Last Name	First Name	Job Title
Vora	Vaishali	Physician- Physiatry

Fields	Jessica	Physician- Ob/Gyn
Ayyagari	Aravinda	Physician- Pediatric Hospitalist
Hamwi	Haytham	Physician- Pediatric Hospitalist
Khan	Mohammad	Physician- Pediatric Hospitalist
Tabrizi	Maryam	Physician- Pediatric Hospitalist
Memon	Raafia	Physician- Endocrinology
Amico	Frank	Physician- Cardiology
Anderson	Paul	Physician- Emergency Medicine
Dillen	Jonathan	Physician- Emergency Medicine
Gill	Rhonda	Physician- Emergency Medicine
Godovchik	Joseph	Physician- Emergency Medicine
Lefrak	Karen	Physician- Emergency Medicine
Liou	Jesse	Physician- Emergency Medicine
Mink	Jennifer	Physician- Emergency Medicine
Osborne	Arayel	Physician- Emergency Medicine
Squadrito	Francis	Physician- Emergency Medicine
Watson	Erin	Physician- Emergency Medicine
Afridi	Fatima	Physician- Hospitalist
Clayton	Elizabeth	Physician- Hospitalist
Conteh	Salima	Physician- Hospitalist
Davitt	Jack	Physician- Hospitalist
Dhamija	Avnish	Physician- Hospitalist
Dillon	Allie	Physician- Hospitalist
Fucci	Pasquale	Physician- Hospitalist
Harper	Maritza	Physician- Hospitalist
Johnykutty	Rene	Physician- Hospitalist
Kalli	Venkata Shilpa Reddy	Physician- Hospitalist

Kehagias	Ioannis	Physician- Hospitalist
Khanal	Prakash	Physician- Hospitalist
Lee	Harvey	Physician- Hospitalist
Mathew	Thomas	Physician- Hospitalist
Mehta	Paavan	Physician- Hospitalist
Mufti	Shayasta	Physician- Hospitalist
Nazim	Syeda Aisha	Physician- Hospitalist
Ogunwande	Clement	Physician- Hospitalist
Olufemi	Olalekan	Physician- Hospitalist
Park	Hyeon Jeong	Physician- Hospitalist
Pataparla	Sravanthy	Physician- Hospitalist
Pattani	Needhi	Physician- Hospitalist
Provenzano	Noelle	Physician- Hospitalist
Rachan	Srilatha	Physician- Hospitalist
Ruether	James	Physician- Hospitalist
Seigo	Michaela	Physician- Hospitalist
Suri	Krithika	Physician- Hospitalist
Szeto	Irene	Physician- Hospitalist
Tirado Navales	Andres	Physician- Hospitalist
Venkata	Sandhya	Physician- Hospitalist
White	William	Physician- Hospitalist
Valentino	Dominic	Physician- Pulmonary Intensivist
Hasan	Rabia	Physician- Radiology- Diagnostic
Hopkins	James	Physician- Cardiology - Invasive - Interventional
Chou	Margaret	Physician- Obstetrics/Gynecology- Laborist
Khandker	Maya	Physician- Hospitalist (Adult/Peds)

Last Name	First Name	Job Title
Ali	Tabassum	Physician- Ophthalmology
Boyd	Jeffrey	Physician- Ophthalmology
Kaplan	Jason	Physician- Ophthalmology
Minkovitz	Jeffrey	Physician- Ophthalmology
Suh	Erwin	Physician- Ophthalmology
Kofahi	Raid	Physician- Neurology

Side Letter C

The parties agree that Article 18 ("Right of First Refusal for Moonlighting Shifts) and Article 24 ("Shift and Quality Based Specialties Moonlighting") shall apply to bargaining unit physicians employed in the Radiology specialty (Diagnostic Radiology, Neuroradiologist, and Nuclear Medicine Physician). For the avoidance of doubt, Radiology local practice shall control the manner in which Radiology leadership assigns moonlighting. The moonlighting rate applicable to any moonlighting shifts worked by bargaining unit physicians employed in the Radiology specialty shall be paid in accordance with Article 24.3(b) plus a flat rate of $10 per hour, except that the first sixty-two (62) hours of moonlighting any Radiologist performs (on an annual basis per fiscal year) shall be paid at a flat rate of $335 per hour.

The parties further agree that legacy bargaining unit mid-shift and overnight physicians in the Radiology specialty shall be paid as follows:

(1) Their fixed based compensation shall be $500,000;
(2) Their productivity incentive threshold shall be 9,500 RVUs;
(3) Their productivity incentive conversion factor shall be $50.00; and
(4) Their value-based incentive shall be $25,000.

Additionally, legacy bargaining unit mid-shift physicians in the Radiology specialty shall work a schedule of "7 on and 7 off." Legacy bargaining unit overnight physicians in the Radiology specialty shall work a schedule of "7 on and 14 off."

For the avoidance of doubt, the parties further agree that the mid-shift and overnight positions in the Radiology specialty are non-bargaining unit positions because they are virtual. As such, the terms of this side letter apply to the legacy physicians employed in the mid-shift and overnight positions only (the "legacy" concept is defined in Article 1).

Finally, the parties agree that the Health System shall purchase an online STATdx subscription and an IMAIOS e-anatomy subscription as reference and educational material for physicians in the Radiology specialty with individual credentials.

Memorandum of Understanding

The parties agree that bargaining unit work for physicians employed in the Radiology Department shall be defined as:

Any work performed by ChristianaCare physicians employed in the Radiology Department as of the date of the union election (June 27, 2024). If physicians employed in the Radiology Department did work as of that date, that is their work moving forward (unless they are unable to perform the work in which case the Health System can use non-bargaining unit physicians to perform the work). Any work that was not performed as of June 27, 2024, is new work, and new work is not bargaining unit work.

New positions are subject to the CBA's recognition test. A virtual radiology position is non-bargaining unit because it does not meet the 0.2 acute care definition.

The Radiology Department is comprised of the following positions: diagnostic radiologist, neuroradiologist, and nuclear medicine physician.

Side Letter D

(1) The parties agree that a 1.0 FTE Emergency Medicine physician, for the purpose of determining compensation pursuant to Article 22 and Minimum Work Hours pursuant to Article 23, shall be 1600 annual hours.

(2) The parties further agree that an Emergency Medicine physician shall not be eligible for premium moonlighting rates until the physician works 1656 annual hours. Any moonlighting shifts worked by an Emergency Medicine physician who has not worked their 1656 annual hours will be paid at that physician's regular rate. Any shifts worked above the 1656 annual hours will be paid at the Emergency Medicine premium moonlighting rate.

(3) The parties further agree to modify Article 22.1(d), (e), and (f) as follows:

(a) An Emergency Medicine physician who works exclusively on an overnight shift will receive an 8% reduction in the hours or shift which define full-time employment, and an 8% increase in salary over a 1.0 cFTE described in 22.1(a) and (b).

(b) An Emergency Medicine physician who works as a Partial Nocturnist (defined as working greater than 50% of their shifts in a fiscal year as a nocturnist) will receive an overall 4% reduction in the hours or shifts which define full-time

employment, and a 4% increase in salary over 1.0 cFTE described in 22.1(a) and (b).

(c) An Emergency Medicine physician who works as a Full or Partial Swing (a Partial Swing is defined as working greater than 50% of their shifts in a fiscal year as a swing) will receive no reduction in the hours or shifts which define full-time employment and no increase in salary over 1.0 cFTE.

(4) This Side Letter D shall expire on June 30, 2029.

Side Letter E

The parties agree to the following work standards for Vascular Interventional Radiologist physicians:

(b) Vascular Interventional Radiologist physicians shall not be eligible for any proration of compensation based on a difference between their Minimum Work Hours and the Health System determined Market Hours. For the avoidance of doubt, this prohibition includes within its ambit a proration resulting in an increase in compensation based on a Vascular Interventional Radiologist Minimum Work Standard that is greater than the specialty's Market Hours.

(c) Scheduling, coverage and time off shall be determined by the Section Chief, in accordance with Health System policies and procedures and clinical and coverage needs as identified by the Service Line Leader.

This Side Letter E shall expire on June 30, 2029.