BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD., SUITE. 400 • DUBLIN, CA 94568-7756
TEL. (925) 833-7303 • TOLL FREE (800) 654-1824 • FAX (925) 833-7301

WELCOME TO BAY AREA DELIVERY DRIVERS SECURITY FUND

The Summary Plan Description (SPD) and Summary and Supplemental Information (S&SI) insert you received contains information regarding the medical, dental, alcoholism & chemical dependency, vision, prescription drug, disability, and life insurance benefits available to you and your covered dependents when you are eligible.

ELIGIBILITY: Please refer to pages 1-10 for eligibility requirements. Note your eligibility each month is based on the hours worked the prior month. See your collective bargaining agreement for the minimum number of hours necessary to be eligible. For example, if your CBA requires you to work 80 hours in a month to be eligible and you work at least 80 hours in February are eligible for benefits in March.

MEDICAL BENEFITS: If you enrolled in the Indemnity Plan all benefits are described in the SPD & S&SI. If you enrolled in the Kaiser Medical Plan you should have received a Kaiser packet with information on your medical and chemical dependency benefits through Kaiser.

DENTAL BENEFITS: Dental benefits are administered by Health Services & Benefit Administrators (HS&BA). Refer to your SPD & Dental Benefit Breakdown. For eligibility and benefit information you and/or your dentist may call customer service at 1-800-654-1824.

PRESCRIPTION DRUG BENEFITS: Prescription Drug benefits are provided through WelldyneRx. You will receive a prescription drug card with a unique identification number directly from WelldyneRx. If you or your dependents require prescriptions before you receive your card you may either; (1) call BADD customer service at 1-800-654-1824 and request your ID number which you can use at the pharmacy or, (2) purchase your prescription and mail the drug tag (with name of person drug is for, RX number, name of drug, strength, quantity and amount charged) and with Welldyne's reimbursement form to WellDyne, PO Box 90369, Lakeland, FL 33804.

VISION, DISABILITY, LIFE AND CHEMICAL DEPENDENCY BENEFITS: Refer to your Summary Plan Description and Summary and Supplemental Information insert. Note: Chemical Dependency through TAP is not available to Kaiser participants. Chemical Dependency treatment is included in your Kaiser benefit package.

COBRA: Please refer to pages 11-18 of your SPD for an extensive explanation on your COBRA rights and responsibilities. You will also receive a COBRA Election Notice with more information within 14 days after the administrator is notified of a qualifying event.

If you have any questions regarding your eligibility or benefits, please call customer service at: 1-800-654-1824.

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Greetings Prospective Retiree:

Enclosed with this letter you will find information on retiree eligibility requirements, enrollment procedures and a Retiree Enrollment application for the Retiree Plan 11A & 11B.

Participants who are not yet eligible for Medicare Part B will be enrolled in Plan 11A. Participants who are or will become eligible for Medicare Part B will be enrolled in Plan 11B.

Note: Medicare-eligible Kaiser participants must also complete a Kaiser Permanente Senior Advantage enrollment form.

Please read and complete the Retiree Enrollment application(s). Any missing information or documentation may delay the approval of your enrollment into the Retiree Plan.

When you make the decision to retire, be sure to contact the Human Resources Department at your employer for procedures to start the retirement process.

Before taking this application to the Local, be sure to call your Union Local office and verify their "in person" procedure. You must take the following items along with the completed application to be signed on the back by the Secretary Treasurer of your Union Local:

- ***Retiree application*** competed by you and to be signed by an officer of your Union Local.
- Copy of ***Pension Award Letter*** from Western Conference of Teamsters (or another Plan recognized for this purpose by the Board of Trustees) or
- Documentation showing you are eligible for (old age) Social Security Benefits (***Social Security Award Notice***) or
- Documentation showing you are eligible for Social Security Disability Benefits (***Social Security Administration; Retirement, Survivors, and Disability Insurance; Notice of Award***)

If you are under age 65 and not eligible for Medicare, you have a monthly copay (staggered rate per age group). You may mail your first month's copay to: Bay Area Delivery Drivers Security Fund; PO Box 7685; Fremont, CA 94537-7685. A return envelope is enclosed.

Submit your completed documentation (including Kaiser applications) to the Bay Area Delivery Drivers Security Fund; 4160 Dublin Blvd Ste 400; Dublin, CA 94568-7756

Sincerely,

Participant Services Department

ELIGIBILITY

Eligibility Rules

To be eligible for the Retiree plan(s), you must *satisfy all* of the following rules:

1) **First**, you are eligible to participate in the Retiree plan if you are receiving:
   - A pension from the Western Conference of Teamsters Pension Fund (or another Plan recognized for this purpose by the Board of Trustees), or
   - Social Security old age benefits, or
   - A pension from a plan sponsored by an employer that has participated in the Fund for at least ten consecutive years and has a current collective bargaining agreement and approved subscription agreement with a participating local union, or
   - Federal Social Security disability benefits for which you qualified while working in employment covered by the Fund as an active employee; **and**
2) **Second**, while an active employee you must have been eligible for benefits under a Bay Area Delivery Drivers Security Fund plan for active employees for at least 60 months, including at least 48 out of the last 60 months immediately preceding the effective date of your pension or disability; and
3) **Third**, you make the required monthly copayment, which is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated; and
4) **Fourth**, the Employer from which you retired remains a contributing employer in one or more of the Fund's Plans for active employees: If your former employer leaves the Fund, its Retirees lose eligibility in the Retiree plan effective at the end of the month in which the Employer stops contributing to the Fund.

Why does a retiree lose eligibility in the Retiree Plan if his former Employer leaves the Trust Fund?

The Retiree Plan is primarily funded through employer contributions for active employees. Note, however, that if your former Employer files for bankruptcy and/or goes out of business, your retiree coverage will still continue.

Enrollment for Newly Eligible Retirees

You will not be eligible for coverage through the Retiree Plan until you enroll in the Plan (even if you have been covered without interruption under the Active Employee Plan prior to your retirement).

To enroll in the Retiree plan, you must provide the following documentation:

- Retiree application competed by you and an officer of your Local.
- Copy of Pension Award Letter from Western Conference of Teamsters (or another Plan recognized for this purpose by the Board of Trustees) or
- Documentation showing you are eligible for (old age) Social Security Benefits or
- Documentation showing you are eligible for Social Security Disability Benefits

Dependents who were eligible under your active coverage will continue to be covered under your Retiree plan as long as they meet the Plan's definition of a Dependent.

Unlike the benefits available to Active Employees, **Retirees and their Dependents are ineligible for**:

- Dental benefits;
- Dependent Life Insurance (there is a reduced Life Benefit for the Retiree);
- AD & D and survivor income benefit; and
- Short-Term Disability Income Coverage.

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APPLICATION FOR RETIREE BENEFITS

Name: _____ S. S. #: _____

Address: _____ Phone #: _____

_____ Birth Date: _____

Employer: _____ Retirement Date: _____

Show the following information with regard to any dependents, including your spouse and unmarried dependent children less than nineteen (19) years of age or full-time students to age twenty-four (24) residing with you and wholly dependent upon you for financial support.

Full Name: _____

Sex: _____ Relationship: _____ Birth Date: _____

Full Name: _____

Sex: _____ Relationship: _____ Birth Date: _____

Full Name: _____

Sex: _____ Relationship: _____ Birth Date: _____

On what basis did you obtain your pension? AGE ☐ or DISABILITY ☐ If you checked Disability you must attach a copy of your Social Security Award letter that shows the beginning date of your disability. You will be eligible for Medicare at age 65 if NOT disabled OR 24 months after the date you are eligible to receive Social Security Disability Benefits due to disability. IMPORTANT: You MUST sign up for both Part A and Part B Medicare at the time you are eligible. If you fail to sign up for Part B Medicare, Indemnity Plan benefits will be paid as if you had signed up for Part B. As a result your benefits will be substantially reduced. If you are a Kaiser member you will be enrolled in the Indemnity Plan with reduced benefits. *This requirement also applies to your spouse or other dependents.* Are you or any dependents eligible for Medicare at this time? ☐ Yes ☐ No If Yes, attach a copy of card.

DO YOU OR ANY OF THE DEPENDENTS LISTED ABOVE HAVE OTHER GROUP COVERAGE?
IF YES, PLEASE COMPLETE BELOW:

Name of covered person (s): _____

Insurance Carrier: _____ Group # _____

Effective date of coverage: _____

Employer: _____

LIFE INSURANCE BENEFICIARY DESIGNATION:

I hereby designate _____, whose address is

_____ as my beneficiary for my life insurance provided for retired employees under the Bay Area Delivery Drivers Security Fund.

Dated this _____ day of _____ 20____ at _____

Signed: _____ Date: _____

MONTHLY CO-PAYMENT: If you retire on or after 7/1/04 the following monthly co-payment is required. Please check the applicable rate below based on the age of the retiree (not spouse). Payment is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated.

Under age 55: $150/mo _____ Age 55 through 59: $100/mo _____

Age 60 through 64: $50/mo _____ Age 65 and over (or Medicare eligible): No co-payment due _____

SEE REVERSE

Retiree Application

TO BE COMPLETED BY TEAMSTERS UNION LOCAL SECRETARY-TREASURER

Member of Union Local #_____ from _____ to _____

Pension or Social Security Award from _____
(a copy of this award must accompany this application)

Verified by: _____Secretary-Treasurer

TO BE COMPLETED BY THE ADMINISTRATION OFFICE:

Period of Eligibility: From _____*to* _____

Employed by:_____from_____to_____

Verified by:_____

SEE REVERSE

KAISER PERMANENTE®

Group Plan

Kaiser Permanente Medicare Advantage/Senior Advantage (HMO)

Group Medicare Election/Enrollment Form

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Medicare Advantage/Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call Kaiser Permanente at the phone number listed below for your region, seven days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

California Region	**1-800-443-0815**
Colorado Region	**1-800-476-2167**
Georgia Region	**1-800-232-4404**
Hawaii Region	**1-800-805-2739**
Mid-Atlantic States Region	**1-888-777-5536**
Northwest Region (NW Oregon, SW Washington, and Lane County, OR)	**1-877-221-8221**

Washington Region (Counties: Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Grays Harbor (ZIP codes: 98541, 98557, 98559, 98568), and Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592)) **1-800-581-8252** (calling this number will direct you to a licensed Medicare sales specialist)

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

   You can also FAX or EMAIL your completed form to:
   FAX: 1-855-355-5334
   EMAIL: 8553555334@fax.kp.org
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Medicare Advantage/Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus** (does not apply to Washington region).

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Employer Group Use Only
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

To Enroll in Kaiser Permanente Medicare Advantage/Senior Advantage, Please Provide the Following Information

Please indicate which Kaiser Permanente **region** you reside in and wish to enroll:

☐ **CALIFORNIA** ☐ **COLORADO** ☐ **GEORGIA** ☐ **HAWAII** ☐ **MID-ATLANTIC STATES** ☐ **NORTHWEST** ☐ **WASHINGTON**

Employer or Union Name: _____ Group #: _____

LAST Name: _____

FIRST Name: _____ Middle Initial: _____ Gender: ☐ Male ☐ Female

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number: _____

Permanent Residence Street Address (P.O. Box is not allowed): _____

City: _____

County: _____ State: _____ ZIP Code: _____

Home Phone Number: _____ Mobile Phone Number: _____ Birth Date: (mm/dd/yyyy) _____

Mailing Address (only if different from your Permanent Residence Address)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	
MEDICAL (Part B)	

You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

2. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (mm/dd/yyyy):
   If no, name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse:
   Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

Last Name _____ First Name _____

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If yes, please provide the following information:

   Name of institution: _____

   Address of institution (number and street): _____ Phone Number: _____

6. Requested effective date (subject to CMS approval): _____

For Washington region only – Selecting a primary care provider:

If you have a current primary care provider who contracts with Kaiser Foundation Health Plan of Washington (primary care providers do not include specialists) and you would like to continue seeing that physician, please include his/her name here.

_____

(If you are a current Kaiser Permanente member and are not making a primary care provider change, please leave blank.)

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese ☐ Braille ☐ Large Print ☐ Audio CD

If you need information in an accessible format or language other than what is listed above, please contact Kaiser Permanente at the phone number listed below for your region, seven days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

California	**1-800-443-0815**	**Mid-Atlantic States**	**1-888-777-5536**
Colorado	**1-800-476-2167**	**Northwest**	**1-877-221-8221**
Georgia	**1-800-232-4404**	**Washington**	**1-888-901-4600**
Hawaii	**1-800-805-2739**		

Please complete the information below

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Medicare Advantage/Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name:

_____

Employer Group/Union/Trust Fund ID #: _____ Subgroup: _____ Requested effective date (subject to CMS approval): _____

Last Name _____ First Name _____

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however most employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE** (**1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Medicare Advantage/Senior Advantage plan because I can be enrolled in only one Medicare Advantage/Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Medicare Advantage/Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Medicare Advantage/Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Medicare Advantage/Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Medicare Advantage/Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

For Northwest region only: Any services received under the Outside Service Area Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Release of Information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Last Name _____ First Name _____

FOR CALIFORNIA ENROLLEES ONLY:
KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

FOR HAWAII ENROLLEES ONLY:
KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT FOR THE HAWAII REGION

If you want to pursue a claim that is not resolved by other procedures described in this section, any and all claims, disputes, or causes of action arising out of or related to this Agreement, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Agreement. Claims subject to the Medicare appeals process are not subject to binding arbitration.

By enrolling in Kaiser Permanente Senior Advantage, you waive all rights to have these types of claims decided in a court of law. The arbitrator's decision is binding.

This includes but is not limited to any claim asserted:

1. By or against you, or a member, the heirs or the personal representative of your estate or the member's estate, or any other person entitled to bring an action for damages for harm to you or a member as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this section, all family members of you or of the member who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms.
2. On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
3. By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
   I. Kaiser Foundation Health Plan, Inc.
   II. Kaiser Foundation Hospitals
   III. Hawaii Permanente Medical Group, Inc.
   IV. The Permanente Federation, LLC
   V. Any individual or organization that contracts with an organization named in (i), (ii), (iii), (iv), or (v) above to provide to provide services to you or a patient, when such contract includes a provision requiring arbitration of the claim made.

Last Name _____ First Name _____

Claims not subject to binding arbitration
Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

1. Claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
2. Actions for appointment of a legal guardian of a person or property subject to probate laws;
3. Purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this Agreement (such as temporary restraining orders, and emergency court orders);
4. For members of private employer Groups, claims for benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA);
5. Claims subject to the Medicare appeals process.

Initiating arbitration
A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at the address set forth in Chapter 2 of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage.** The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration proceedings
Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) shall arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for:

1. Production of documents that are relevant and material,
2. Taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation), and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and
3. Independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Last Name _____ First Name _____

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties.

Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review.

The arbitration award shall be final and binding. You, the Member Parties and Kaiser Permanente Parties waive your/their rights to jury or court trial.

With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General provisions

All claims based upon the same incident, transaction or related circumstances regarding you or the same member shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding). A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple Members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.

Confidentiality

This Agreement concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special claims

1. Medical Malpractice Claims. Prior to initiating any arbitration proceedings alleging medical malpractice, you shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the termination of proceeding by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, you shall serve a demand for arbitration on Kaiser Permanente Parties as specified above.
2. ERISA Claims. If your plan is governed by ERISA, and you have a claim for benefits that is denied or ignored (in whole or in part), you may file suit in federal court under Section 502(a)(1)(B) of ERISA. If a suit is filed, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator, i.e., your employer or group sponsor.

Last Name _____ First Name _____

Although benefit-related claims subject to ERISA are not required to be resolved by binding arbitration pursuant to this section, you may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of Section 8-B of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage.** If a voluntary election to use binding arbitration is made by you, the arbitration shall be conducted pursuant to this Section 8-B of the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage.**

3. Senior Advantage Member Claims. Complaints and appeals procedures are described in the Hawaii Kaiser Permanente Senior Advantage **Evidence of Coverage** chapter 9 titled, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)". The arbitration provisions of this Agreement apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this Agreement, irrespective of the legal theory upon which the claim is asserted.

I acknowledge that I have read and understood the information in the Arbitration Agreement above and agree that I, on behalf of myself, all applicants, and all family members, hereby (i) acknowledge that I have read and understood the provisions of the KFHP Arbitration Agreement, (ii) agree to binding arbitration, and (iii) give up my constitutional right to a jury trial.

Signature: _____

Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: _____ **Relationship to Enrollee:** _____

Last Name _____ First Name _____

For CA, CO, GA, HI, NW & WA regions – Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

For MAS region – Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____

PBP#: ☐ H2172-801 ☐ H2172-803 ☐ H2172-804 ☐ H2172-805

Group Number: _____ Subgroup Number: _____

Employer Subsidy Group ☐ Yes ☐ No Part D Group ☐ Yes ☐ No

ICEP/IEP: _____ AEP: _____ SEP (type): _____