SECTION FIFTEEN: Coordination of Benefits and Subrogation

Members of a family are often covered under more than one plan of group benefits. Because of this, there are many instances of duplication of coverage — two plans paying benefits for the same hospital and medical expenses. For this reason, the Plan will take into account any coverage an eligible person has under other benefit programs, including Medicare. UnitedHealthcare determines which insurance pays first according to the rules summarized below. After that, benefits are provided only up to the amount which, when added to the benefits paid by the other group plan, may equal but not exceed 100% of reasonable charges for eligible health care expenses.

A. Coordination of Benefits: Who Pays First?

1. General Rule

When duplicate coverage arises, and both plans contain a Coordination of Benefits provision, the plan that insures the person incurring the claim as an employee is the primary plan and the plan that insures the person as an active employee will pay before a plan that insures the person as a laid off or retired employee. If an individual is insured under two plans through two jobs, the plan that has insured the person for the longer time pays first. If a claim is filed for a child, the group plan that insures the parent whose birth date — month and day (not year) — occurs earliest in the calendar year is primary. When another plan does not contain a Coordination of Benefits provision, it will always be considered the primary plan. Payment under the secondary plan is made after the amount payable under the primary plan has been determined.

2. Exceptions to the General Rule

a. When parents are separated or divorced and the parent with custody of a child is not remarried, the benefits of a plan that covered the child as a dependent of the parent with custody will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.

b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan that covers the child as a dependent of the parent with custody will be determined before the benefits of a plan that covers that child as a dependent of the step-parent, and the benefits of a plan that covers that child as a dependent of the step-parent will be determined before the benefits of a plan that covers that child as a dependent of the parent without custody.

c. If there is a court decree that would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan that covers the child as a dependent of the parent with such financial responsibility shall

be determined before the benefits of any other plan that covers the child as a dependent.

B. Coverage Under Two or More UnitedHealthcare Contracts

If a member or dependent is covered under more than one UnitedHealthcare contracts, he/she will be entitled to receive credit for the benefits of both contracts, up to but not exceeding the cost for hospital or physicians charges for covered services.

1. Coordination with Medicare

If you (or your covered spouse) become eligible for Social Security Retirement Benefits at age 65, you (or your spouse) are also eligible for Medicare. If you are covered by this Plan and by Medicare, then as long as you remain actively employed, this Plan pays first and Medicare pays second. This means that after the Plan pays benefits for your eligible expenses, you may submit a claim to Medicare for any unpaid balances for consideration. These rules also apply to your covered spouse who is age 65 or older whether or not you are also age 65 or older.

However, if you are under the age of 65 and become entitled to Medicare because of disability, you will no longer be considered actively employed and Medicare pays first and this Plan pays second with respect to all family members.

If any family member becomes entitled to Medicare because of end-stage renal disease (ESRD) and this Plan was primary at that time, this Plan pays first and Medicare pays second for a limited period of time.

Medicare imposes a three-month waiting period at the onset of end-stage renal disease before Medicare becomes effective. Medicare waives this waiting period if the patient enrolls in a self-dialysis training program within the first three months of the diagnosis of end-stage renal disease or receives a kidney transplant within the first three months of being hospitalized for the transplant. If there is a waiting period, this Plan continues to be the primary plan for the three-month waiting period. This Plan will then be the primary plan for the next 30 months. Medicare is the primary payor after the 30-month period.

C. Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first and the plan providing continuation coverage to that same person pays second.

D. Reimbursement and Subrogation

1. General Information

If you suffer an illness or injury as a result of an act or omission of another (including a legal entity), you must notify the Fund and execute a subrogation agreement.

The Fund shall pay benefits for covered expenses related to such illness and injury only after the Participant or Eligible Dependent (and his or her attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund. In addition, as set forth more fully below, to the extent of such recovery, the Participant and/or Eligible Dependent (and any agents and representatives) agree to act as a constructive trustee and the Fund maintains an equitable lien by agreement in such amounts.

By accepting benefits related to such illness or injury, the Participant and/or Eligible Dependent (collectively "you") agree:

a. that the Fund has established an equitable lien on any recovery received by you (or your dependent, legal representative or agent);

b. to notify any third party responsible for your illness or injury of the Fund's right to reimbursement for any claims related to your illness or injury;

c. to hold any reimbursement or recovery received by you (or your dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury, and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss;

d. that the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the participant or dependent is made whole) and that the Fund's claim has first priority over all other claims and rights;

e. to reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund (and prior to turnover held in constructive trust) as reimbursement up to the full amount of the benefits paid;

f. that the Fund's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise;

g. that, in the event that you elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;

h. to assign, upon the Fund's request, any right or cause of action you may have to the Fund;

i. not to take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate with the Fund in doing what is reasonably necessary, in the sole discretion of the Fund, to assist the Fund in obtaining reimbursement;

j. to cooperate in doing what is necessary, in the sole discretion of the Fund, to assist the Fund in recovering the benefits paid or in pursuing any recovery;

k. to forward any recovery to the Fund or to notify the Fund as to why you are unable to do so within ten days of disbursement by the third party; and

l. to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf, with respect to the illness or injury and to the extent that any recovery or proceeds that were not turned over as required, and for the Fund's cost of collection, including but not limited to the Fund's attorneys' fees and costs.

m. No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan. The Fund may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from a Participant's or an Eligible Dependent's future benefit payments (regardless of whether benefits have been assigned by a participant or Eligible Dependent to a doctor, hospital or other provider), or any other remedy available to the Fund.

n. By accepting benefits (whether the payment of such benefits is made to you, your covered dependent or on your or your covered dependent's behalf to any provider) from the Fund, you and your covered dependents agree that a court proceeding with respect to these provisions may be brought in such court of competent jurisdiction as the Fund may elect. By accepting such benefits, you and your covered dependents (and your or your covered

dependent's representatives, agents, assigns, guardians, estates, heirs or beneficiaries) hereby submit to each such jurisdiction, waiving whatever rights may correspond to you or your covered dependents (or your or your covered dependent's representative, agent, assign, guardian, estate, heir or beneficiary) by reason of you or your covered dependents' (or their) present or future domicile.

o. The Fund may need additional facts or information to properly apply the coordination of benefits, subrogation or right of recovery provisions. By filing a claim for benefits under the Fund, you and your covered dependents authorize the Fund to obtain such information as the Fund deems necessary for the enforcement or administration of the Fund's coordination of benefits, subrogation or right of recovery provisions.

p. The Fund may permit you to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Fund’s claim is subject to prior written approval by the Board of Trustees.