

ARTICLE IX COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

This section is intended to prevent the duplicate payment of Benefits, or to prevent reimbursement, with respect to any expense, which exceeds the expense incurred. It applies when a Covered Person is also covered by any other Plan or Plans (as defined in this Section), or is entitled to payments from some other source. When benefits are payable from more than one source, one plan normally pays benefits on a primary basis (as though there were no other source) and the other plan pays a reduced benefit, or pays on a secondary basis. This Plan will always provide coverage either on a primary or secondary basis so that the Benefits it pays, when added to the benefits payable by another source, will not exceed the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

DEFINITIONS

This Article contains certain terms, which are defined in a special way. Those definitions follow below. Other defined terms are explained in the Article of this booklet titled, *Definitions*. In the case of ambiguity, terms shall be construed by the Plan Sponsor in a manner consistent with the intention of this Article.

Allowable Expense

An expense which is covered in whole or in part either by this Plan or by the other Plan. It is limited to the Usual, Customary and Reasonable expense for the medical care or treatment provided.

Person

Any individual, association, partnership, corporation or any other organization.

Plan

Includes, but is not limited to, any of the following providing payments on account of a Sickness or Injury:

- any group, blanket or franchise health insurance, or coverage similar to same;
- a group contractual prepayment or indemnity plan, or coverage similar to same;
- a Health Maintenance Organization (HMO), whether group practice or individual practice association;
- a labor-management trusted plan or a union welfare plan;
- an employer or multi-employer plan or employee welfare benefit plan;
- a governmental medical benefit program;
- insurance required or provided by statute;
- automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);
- settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Primary Plan/Secondary Plan

When this Plan is primary, its Benefits are determined before those of the other Plan. The benefits of the other Plan are not considered. When this Plan is secondary, its Benefits are determined after those of the other Plan. Its Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan may be primary as to one and may be secondary as to another.

COORDINATION OF BENEFITS

What this Plan Pays as the Secondary Plan

When this Plan is the Secondary Plan, it considers as the Covered Expense under this Plan the difference (if any) of the total expense minus the amount paid by the Primary Plan. Then, this Plan applies to this remainder any Co-payment and/or Co-insurance amounts and other amounts that would normally apply to a Covered Expense under this Plan.

Secondary Amount Rule

Where this Plan is the Secondary Plan, then notwithstanding any other provision of this Plan to the contrary, the Benefits payable by this Plan are subject to the “secondary amount rule”. The “secondary amount rule” applies where the Primary Plan (as determined under applicable coordination of benefits rules) contains a coordination of benefits (or similar type of) provision that reduces the Primary Plan’s benefits (either directly or indirectly) on account of the existence of secondary coverage to an amount less than such Primary Plan would have paid had there been no secondary coverage. For example, a Primary Plan might provide that if there is secondary coverage, the Primary Plan’s benefits are limited to \$1,000. In that event, this Plan will never pay more than the “secondary amount”. The “secondary amount” payable by this Plan is the amount this Plan would by its terms pay, as determined by this Plan in its sole discretion, had the Primary Plan paid benefits as though there were no secondary coverage (that is, had the Primary Plan not reduced its benefits on account of the existence of the secondary coverage).

Order Of Determination

This Plan determines its order of Benefits using the *first* of the following, which applies:

- a. **Other Plan Does Not Coordinate.** A Plan that does not coordinate with other Plans is always the Primary Plan.
- b. **Non-Dependent/Dependent.** The benefits of the Plan that covers the person as an Employee, laid-off Employee, former Employee, Retired Employee, member or subscriber (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan. However, if that person is a Medicare beneficiary, and if as a result of the provisions of Title XVIII of the Social Security Act and its regulations Medicare is (i) secondary to the plan covering the person as a Dependent, and (ii) primary to the plan covering the person other than as a Dependent (e.g., as a Retired Employee), then the order of benefits is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the other plan is primary.
- c. **Dependent Child/Parents Not Separated or Divorced.** Except as provided below, in the subsection titled, *Dependent Child/Parents Separated or Divorced*, when this Plan and another Plan cover the same Child as a Dependent of different parents:
 - the Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but
 - if both parents have the same birthday, the benefits of the Plan, which covered the parent the longer, is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan.
 - if the other Plan does not have the birthday rule, but has the gender rule and if, as a result the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- d. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent Child of divorced or separated parents (whether or not the parents were ever married), benefits for the Child are determined in this order:
 - first, the Plan of the parent with custody of the Child;
 - then, the Plan of the spouse of the parent with custody;
 - finally, the Plan of the parent without custody of the Child.However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the Child, then that parent’s Plan is the Primary Plan. In the case where the parents of a Dependent Child were never married to each other, these rules shall apply as though such parents were divorced or separated.
- e. **Active/Inactive Employee.** The Primary Plan is the Plan that covers the person as an Employee who is neither terminated, laid-off nor retired (or as that Employee’s Dependent). The Secondary Plan is the Plan, which covers that person as a former, laid-off or Retired Employee (or as that Employee’s Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- f. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Primary Plan is the Plan, which covered the Employee, member or subscriber longer; the Secondary Plan is the Plan, which covered that person the shorter time.

In order to prevent total payments from exceeding a Covered Person’s medical expenses, this Plan may, at its option, defer payment of Benefits until the amount of benefits payable under any other plan has been determined.

Medicare Reduction/Coordination

a. **Active Employees or Dependents of Active Employees Eligible for Medicare Due to Age.** If you are covered under this Plan due to your or someone else's current employment with the Employer, and are also eligible for Medicare due to age, you may:

- continue your coverage under this Plan (to the extent you remain eligible, of course) and defer enrollment in Medicare; or
- continue your coverage under this Plan and also enroll in Medicare; this Plan would be your primary medical coverage and Medicare your secondary medical coverage as long as your coverage under this Plan is attributable to current employment with the Employer; or
- drop your coverage under this Plan and enroll in Medicare, in which case Medicare would be your primary medical coverage.

CAUTION: If when your coverage ceases due to termination of your or someone else's current employment status with the Employer you (1) are eligible for Medicare, and (2) you elect COBRA coverage under this Plan, you should know three important facts:

- First, your COBRA coverage is not attributable to "current employment status". That means that if you were enrolled in Medicare this Plan would pay *second*, behind Medicare (except in some cases where your Medicare is due to end-stage renal disease).
- Second, under the Plan, if you're *eligible* for Medicare we'll deem you to be *enrolled* in Medicare, and only pay Benefits after calculating what Medicare *would have paid*. So if you don't enroll in Medicare after losing your coverage attributable to current employment status (that is, if you don't enroll in Medicare when you become eligible for COBRA coverage), ***you may have to pay out-of-pocket the amount Medicare would have paid had you been enrolled.***
- Third, you have a limited, eight-month special enrollment period for Medicare after your coverage under this Plan ends due to termination of the current employment status. If you wait to enroll in Medicare until after you exhaust COBRA coverage, you may not be able to enroll in Medicare immediately, and you may be required to pay an additional premium for Medicare Parts B and D.

In sum, whether or not you elect COBRA coverage you should consider enrolling in Medicare immediately after your coverage under this Plan ceases to be provided due to your or someone else's current employment status (assuming, of course, you are eligible for Medicare when the current employment status ends).

b. **Covered Persons Eligible for Medicare Due to Disability.** This Plan is primary and Medicare is secondary if you are eligible for Medicare by reason of disability (but not age), and your coverage under this Plan is on account of your (or someone else's) current employment with the Employer. If coverage under this Plan is not on account of current employment status with the Employer and you are eligible for Medicare solely by reason of disability, Medicare is primary and this Plan is secondary. Note that in this latter case, where this Plan is secondary, this Plan will deem you or the Dependent, as the case may be, to be enrolled in Medicare Parts A and B even if you or the Dependent, as the case may be, is not so enrolled. The rules in this section continue to apply for as long as the Plan has at least 100 participants as described in federal Medicare regulations. ***See the special "Caution" text box above concerning the possible effects of not enrolling in Medicare immediately where Medicare would be your primary payer because of the absence of your or someone else's current employment with the Employer.***

c. **End-Stage Renal Disease (ESRD).** If you become eligible for Medicare solely on account of end-stage-renal disease (ESRD), then this Plan will be primary to Medicare for up to 30 months (called the "coordination period"); after that, the Plan becomes the secondary payer (assuming you're still eligible for coverage), and Medicare is the primary payer. The coordination period begins on the first day of the month for which you are eligible for Medicare benefits on account of your ESRD, and ends not later than 30 months later (it might end earlier in some cases, such as when your coverage ends under this Plan). If at the time you become eligible for Medicare benefits due to ESRD you are already entitled to Medicare benefits on account of age or disability, and Medicare is the primary payer (and this Plan is secondary), then Medicare remains the primary payer, even after you become eligible for Medicare benefits due to your ESRD. Please note that for purposes of this provision, the coordination period begins in the month you are merely eligible for Medicare benefits due to ESRD, whether or not you actually enroll in Medicare then.

Medicaid and State Children's Health Insurance Program Coordination

This Plan will always be primary, and any Medicaid or State Children's Health Insurance Program will be secondary only.

Coordination With Automobile Insurance Coverage

This Plan's liability for otherwise Covered Expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by your state. Currently there are three types of state automobile laws (i) No-fault automobile laws; (ii) Financial responsibility laws; and (iii) Other automobile liability insurance laws. It is the Plan's general intent not to pay medical expenses resulting from automobile Accidents, and the Plan will be so interpreted.

a. **Coordination Under Auto No-Fault Coverage.** Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy nor does it intend to be primary in order to reduce the premiums or costs of no-fault automobile coverage. If you incur Covered Expenses as a result of an automobile Accident (either as a driver, passenger or pedestrian), the amount of Covered Expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage; and
- any Co-payment under the automobile coverage; and
- any expense properly excluded by the automobile coverage that is a Covered Expense; and
- any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he or she is either:

- an owner or principal named insured of the policy; or
- a family member of a person insured under the policy; or
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

b. **Coordination Under Financial Responsibility Law.** This Plan is secondary to automobile coverage or to any other party who may be liable for your medical expenses resulting from the automobile Accident. If your state has a "financial responsibility" law which does not allow the Plan to pay Benefits as secondary or which does not allow the Plan to pay advance payments with the intent of subrogating or recovering the payment, the Plan will not pay to you or on your behalf any Benefits related to an automobile Accident.

c. **Coordination Under Other Automobile Liability Insurance.** If your state does not have a no-fault automobile insurance law or a "financial responsibility" law, this Plan is secondary to any applicable automobile insurance coverage or to any other party who may be liable for the automobile Accident.

Coordination With Underinsured/Uninsured Motorist Coverage

If you are involved in an automobile Accident and as a result of the Accident the Plan pays Benefits, and if you receive a settlement or judgment under an uninsured or underinsured motorist policy, the Plan is entitled to receive, from the proceeds of the uninsured or underinsured motorist coverage, an amount equal to the Covered Expenses paid or payable by the Plan whether or not the proceeds are characterized as reimbursement for medical expenses, and whether or not the proceeds are sufficient to make you "whole". The amounts payable to the Plan shall not be reduced on account of your expenses, including attorneys' fees, unless the Plan specifically agrees, in writing, to such a reduction. The Plan may, in the sole discretion of the Plan Sponsor, agree to payment of Benefits prior to the receipt by you of any recovery from the uninsured or underinsured motorist policy, and you agree, as a condition of your and your eligible Dependents' coverage under this Plan, to remit to the Plan the proceeds of any recovery received from an uninsured or underinsured motorist policy up to the amounts paid or payable by the Plan.

Any Covered Expenses paid or payable by the Plan, which are in excess of the proceeds received by the uninsured or underinsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

TRICARE Coordination Rules

Notwithstanding any provision of this Plan to the contrary, the following rules shall apply:

a. This Plan shall not offer any financial or other incentives for a TRICARE-eligible Employee not to enroll (or to terminate enrollment) in this Plan in the situation where this Plan would (in the case of enrollment)

be a Primary Plan, in the same manner as the provisions of the Social Security Act apply to prohibit the offering of any financial or other incentives for an individual entitled to Medicare benefits not to enroll (or to terminate enrollment) under a group health plan or large group health plan which would (in the case of enrollment) be a Primary Plan.

- b. A TRICARE-eligible Employee shall have the opportunity to elect to participate in this Plan and receive primary coverage for health care services under the Plan in the same manner and to the same extent as similarly situated Employees who are not TRICARE-eligible Employees.

For purposes of this provision, the term "TRICARE-eligible Employee" means a covered beneficiary under 10 U.S.C. Section 1097c(f)(3) who is entitled to health care benefits under the TRICARE program.

These TRICARE coordination rules shall not apply to any employer who has fewer than 20 employees.

RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

Corrective Payments

Whenever payments which should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any other Plans, this Plan shall have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid shall be deemed to be Benefits paid under this Plan and, to the extent of such payments; this Plan shall be fully discharged from liability.

Reimbursement

Whenever this Plan makes payments which together with the payments the Covered Person has received or is entitled to receive from any other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the Benefits properly payable to the Covered Person, Plan, provider or Person to or for or with respect to whom the payments were made, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Sponsor in its sole discretion shall determine:

- the Covered Person;
- if the Covered Person is an eligible Dependent or former eligible Dependent, the eligible Employee or former eligible Employee with respect to whom the Covered Person is or was an eligible Dependent;
- any other Plan, provider or Person to or for or with respect to whom such payments were made;
- any insurance company or other Plan or person which should have made the payment; and
- any other organizations.

Alternatively, the Plan Sponsor or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, Persons, providers, insurance companies or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Sponsor or its designee later determine that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense which is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These Reimbursement provisions also apply where this Plan makes payments of Covered Expenses incurred for treatment of a Sickness or Injury for which another Plan or Person (as defined in these coordination and reimbursement/subrogation provisions) is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the Sickness or Injury. If the other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the Sickness or Injury, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person) from the payment made by the other Plan or Person, in an amount equal to (i) the lesser of the Benefits paid by this Plan for treatment of the Sickness or Injury, or (ii) the amount of the payment made by the other Plan or Person. This provision shall not apply where the other Plan is a health plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's Covered Expenses.

These reimbursement provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) from any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other Person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any Person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where another Plan or Person (as defined in this Article) pays compensation to or on behalf of a Covered Person for a Sickness or Injury for which another Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise Covered Expenses for treatment of the Sickness or Injury, a special rule applies. In such a case, such otherwise Covered Expenses which were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, shall be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the Covered Expenses which the Plan has already paid for treatment of the Sickness or Injury.

This Plan shall not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any other Plan or Person unless this Plan agrees, in writing, to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, shall not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable Covered Expenses pursuant to these provisions.

Subrogation

The Plan shall be subrogated, to the extent of Benefits paid or payable by this Plan, to any monies (i.e., "first dollar" monies) paid or payable by any other Plan or Person (as defined in this Article) by reason of the Sickness or Injury which occasioned or would occasion the payment of Benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan shall not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any other plan, unless this Plan agrees, in writing, to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, shall not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan shall also be subrogated to the extent of Benefits paid under this Plan to any claim a Covered Person may have against any other Plan or Person for the Sickness or Injury which occasioned the payment of Benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but shall not be required to) collect the claim directly from the other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan shall apply any monies collected from the other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to you as soon as administratively practical. The Plan Sponsor may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

Implementation

The Plan Sponsor shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Sponsor may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (i) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (ii) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Where this Plan is entitled to reimbursement or subrogation under the provisions of this section, the Plan shall be permitted to obtain reimbursement or satisfy its subrogation lien by reducing Benefits payable to the Covered Person and/or, in the Plan's discretion, any covered member of the Covered Person's family, for Covered Expenses then incurred but not yet paid, and for Covered Expenses incurred in the future.

Subrogation/Reimbursement Agreement

Except as otherwise provided herein (e.g., the coordination rules regarding automobile insurance), if a Covered Person incurs a Sickness or Injury under circumstances where compensation may be payable to the Covered Person by some other Plan or Person (as defined in this Article), the Plan is not required to pay Benefits for treatment of the Sickness or Injury (notwithstanding any other provision of this Plan to the contrary), but may agree to pay Benefits for that Sickness or Injury to the extent otherwise payable under the Plan. As a condition of paying such Benefits, the Plan may (but is not required to) require the Covered Person or someone legally qualified and authorized to act for the Covered Person, in writing, to:

- consent to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the Sickness or Injury;
- promise not to take any action which would prejudice the Plan's subrogation rights;
- promise to reimburse the Plan for any such Benefits payments to the extent that the Covered Person receives a recovery from another Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and
- promise to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to execute whatever assignment, form or document requested by the Plan Sponsor or its designee, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any Benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims not yet incurred and claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision shall be construed to prevent application of the provisions of the Reimbursement provisions of this Plan, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the Sickness or Injury which gave rise to the expenses.

Constructive Trust

In the event the Plan, pursuant to these Reimbursement and Subrogation provisions, is entitled under such provisions to be reimbursed for Benefits it has paid for treatment of a Covered Person's Sickness or Injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such Sickness or Injury from some other source, the Plan shall have a constructive trust on such compensation to the extent of the Benefits paid by this Plan. Such constructive trust shall be imposed upon the person or entity then in possession of such compensation.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Plan or any other plan, the Plan Sponsor may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Sponsor deems to be necessary for such purposes, with respect to any person claiming Benefits under this Plan. Any person claiming Benefits under this Plan shall furnish to the Plan Sponsor such information as may be necessary to implement this provision.