Health Care Benefits

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This section explains which MPTN team members are eligible to participate in health care benefits and discusses some aspects of your employment that can affect your participation, such as your regularly scheduled work week. You also can find details about which of your family members are eligible to participate under the benefit plans offering dependent coverage and information about how to enroll these individuals.

For More Information …

If you need more information about participating in health care coverage, including eligibility, contact Human Resources at 1-888-287-4369.

Eligibility and Enrolling

You are eligible to enroll for and participate in MPTN health care coverage if:

- you are employed by an MPTN division that participates in the applicable plan.
- you are a regular full-time team member actively at work.
- you are a regular part-time team member actively at work.
- you have been employed continuously for 60 days.

If your regularly scheduled work week or your average hours worked per week changes, your eligibility to participate in MPTN benefits may change.

The plan does not include coverage for temporary or seasonal team members, nor does it cover team members who work less than the required minimum hours per week.

If you are not eligible for benefits but later change to an eligible status — for example, if you change from a seasonal to a full-time team member — you must be employed continuously for 60 days in the new status before you become eligible for benefits. If you enroll for benefits, in most cases coverage begins on the first of the month following the day you complete 60 days of service in the new status.

Different Eligibility for Different Plans

Eligibility rules differ for the different benefits for a variety of reasons. In some cases, such as the 401(k) Plan, Internal Revenue Code requirements determine who is eligible.

The Mashantucket Pequot Tribal Nation (MPTN) offers a variety of health care benefits for team members, including:

- medical coverage,
- prescription drug coverage,
- vision coverage,
- dental coverage,
- mental health and alcohol/substance abuse coverage.

Individuals no longer eligible for health care coverage may be able to continue coverage at their own expense through MPTN COBRA.

Active Team Member

The health care benefit plan described in this Plan Document and SPD is designed primarily for active team members and their eligible family members. For benefits eligibility purposes, you are considered an active team member if you are receiving a regular paycheck to pay wages for services you are currently providing to MPTN.

Although you may be able to continue participating in some of the plans if your active employment ends (for example, if you go on an approved, unpaid leave of absence), to begin participating you must be considered an active team member.

For information on your eligibility to continue participating in the health care plan when you are not an active team member, see the separate descriptions of the plans and “Coverage in Special Situations” within this section.

Family Eligibility

If you are eligible, you may enroll your spouse and eligible dependent children for health care coverage under the MPTN Health Care Plan.

The plans that offer coverage for family members generally enable you, as an eligible team member, to cover:

- your spouse, if he or she is your legal spouse, (Common law marriages, civil unions and domestic partnerships are

not recognized under the plan.),
- your children up to their 26th birthday,
- your children of any age who are incapable of self-support because of a mental or physical handicap that existed before they reached age 26, and were covered under the plan up to age 26.

Dependent Children

Eligible dependent children include children:

- by birth,
- by adoption (effective as of the date the child is placed for adoption),
- by marriage (that is, stepchildren),
- for whom you are legally responsible, and
- children who are specified under legal guardianship documents.

Your eligible dependent children (as defined above) include your children who:

- are under age 26, and
- depend on you to pay medical expenses under a divorce decree or support order, such as a Qualified Medical Child Support Order (QMCSO) or a Qualified Domestic Relations Order (QDRO).

Coverage Levels

You can choose separate coverage levels for your medical and dental coverage. You must select from the following three coverage levels:

- Single (team member only)
- Single + 1 (team member + one family member)
- Family (team member + two or more family members)

If your child is removed from your home — for example, your child becomes a ward of the state — health care coverage ends as of the date the child is no longer legally your dependent.

If a QMCSO affects you, notify Human Resources so that the order can be handled properly. If Human Resources receives a QMCSO or a QDRO affecting you, you will be notified. Human Resources will comply with all valid QMCSOs and QDROs. For more information, see “Court Orders” in the *Rules and Regulations* section.

Disabled Dependent Children

If your child becomes totally and permanently disabled before age 26, that child is eligible for coverage as your dependent as long as the child remains disabled.

To cover disabled dependent children, you must verify in writing that the disability occurred before age 26.

Enrolling and Changing Coverage

If you are eligible, you can enroll yourself and any eligible dependents in health care coverage, which includes medical, dental vision coverage and prescription drug coverage. When you enroll, you must select a coverage level:

- Single (team member only),
- Single + 1 (team member + one family member), or
- Family (team member + two or more family members).

Please note that you may elect a different level for dental coverage than you do for medical coverage. See the *Dental Coverage* section for more information.

If both you and your spouse are eligible team members, the following rules apply:

- If there are no eligible children within the family, only one spouse may elect Single + one family member coverage.
- If there are eligible children within the family, only one spouse may elect Family coverage.
- The spouse who is not the primary carrier is required to waive coverage.

When First Eligible

If you want to enroll in MPTN health care coverage, you will need to complete an enrollment form and return it to Human Resources before your 60th day of employment. (Generally, you become eligible after you have been employed by MPTN for 60 days, and the coverage you elect begins on the first of the month after that 60-day period.) If you are absent from work due to illness or injury on the date your coverage would normally begin, your coverage will begin on the date you return to active employment.

In most cases, if you do not enroll you will not have an opportunity to change your health care coverage until the next annual enrollment period, unless:

- you have a qualified change in status, as explained below in "After Qualified Changes in Status," or
- you decline health care coverage from MPTN because you have other employer-provided coverage and you lose that other coverage, as explained in "After Losing Other Coverage" on the following page.

Benefit Cards

When you enroll for Health coverage, you receive a card that identifies you as a plan participant. Carry your card with you, as doctors and hospitals will ask to see it when you receive care.

If you lose your card, call the plan administrator at 1-888-779-6872 to get a new one. You can also request additional cards for covered family members.

During Annual Enrollment

Each year, MPTN holds an annual enrollment period. During this time, you have the opportunity to change your participation in MPTN health care coverage. Any health care coverage changes that you make during annual enrollment take effect on January 1 for the coming plan year.

After Qualified Changes in Status

The health care plan enrollment choices you make when you first become eligible or during annual enrollment are usually in effect for the entire plan year for which you enroll. However, because your needs for benefits typically change when you experience certain family events, such as getting married or having a baby, the health care plans, in accordance with Internal Revenue Service rules, allow you to make changes in some situations. The change must be made within 30 days after the event.

Generally, the qualified change in status must affect eligibility for coverage (for you or your dependents) under MPTN's or another employer's plan. Examples of qualified changes in status include:

- a change in your legal marital status, such as your marriage, divorce, or legal separation;
- a change in the number of your eligible dependents, including:
    - the birth or placement for adoption of a child, or
    - the death of your spouse or other benefit-eligible family member;
- a change in an eligible dependent's employment status (such as starting a new job, terminating employment, going on leave, etc.);
- a change in an eligible dependent's eligibility for coverage (for example, when your dependent child reaches the eligibility age limit or when your position changes from full-time to part-time status);
- your eligible dependent's loss of health care coverage from another source;
- a change in your or an eligible family member's entitlement to Medicare coverage; or
- a change in your or an eligible family member's residence, if it changes the health care options from which that person can choose.

Network Provider Changes Are Not Status Changes

The enrollment choices you make are in effect for the entire plan year for which you enroll. If the PPO Plan's network coverage changes — for example, if your physician is no longer available through the network — you cannot change your coverage until the next annual enrollment period. A network provider change is not a qualified change in status.

How to Make Changes

You have 30 days from the date of a qualified change in status to change your coverage. To make a change, you must notify Human Resources.

After Losing Other Coverage

Some eligible team members may choose not to enroll for MPTN health care coverage because they have coverage available from another source, such as from a spouse's employer's plan.

If you do not enroll for MPTN health care coverage because you have other coverage, and if that coverage ends, you may enroll for an MPTN plan within 30 days of the date your other coverage ends.

If you do not enroll within 30 days, you must wait until the next annual enrollment.

Reinstatement of Coverage (for the medical plan)

An employee who is terminated and rehired will be treated as an employee upon rehire only if the employee was not credited with an hour of service, as defined under the ACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Paying for Coverage

MPTN pays most of the cost of your health care coverage. Your share of the total cost generally depends on:

- the coverage option you choose, and
- the level of coverage you select (Single, Single + 1, or Family coverage).

For More Information …

… contact Human Resources at 1-888-287-4369.

In most cases, you pay your contributions for health care coverage through payroll deductions using pre-tax dollars.

If you are a highly tipped team member, you must have a positive paycheck (a paycheck that still has a positive balance) to be able to make contributions for health care coverage. If you have a negative paycheck, you must make arrangements to make weekly or monthly payments.

Contributions When Not on Payroll

If you are eligible to continue health care coverage when you are not an active team member (for example, while you are on an unpaid leave), or if you have a negative paycheck you must make arrangements to make weekly or monthly payments for your benefit elections directly to payroll. Non-payment may result in the loss or suspension of your benefits.

When Coverage Begins

The date when your coverage begins depends on when you make your health care choices:

If	Then

You enroll for yourself and your eligible dependents when you are first eligible (generally within 60 days of your date of hire)	• Coverage begins on the first of the month following your 60th day of work.
	  ◦ If you are not actively at work on the day when coverage would begin, the coverage will begin when you return to active work.
	  ◦ If your dependent is confined for medical care or treatment on the day when coverage would begin, that dependent's coverage will not begin until the dependent is given a final release from such confinement.
	• Payroll deductions begin with the next available pay cycle.

You enroll for yourself and your eligible dependents during the annual enrollment period	• Coverage will begin on January 1 of the following year. • Payroll deductions begin with the first pay cycle of the following year.
You enroll for yourself or a new dependent within 30 days of a qualifying event.	• You have 30 days from the qualifying event to add coverage. Coverage begins no later than the first of the month after the election.

If you do not enroll when you are first eligible, you will have no coverage unless you enroll during the next annual enrollment period or after a qualified change in status.

When Your Coverage Ends

Your coverage as a team member under the MPTN Health Care Plan ends on the last day of the month in which:

- you end your employment (whether voluntarily or involuntarily) or die,
- you no longer meet the eligibility requirements for coverage, or
- you stop making any required contributions toward the cost of coverage.

Your coverage will automatically terminate on any given day, if:

- MPTN discontinues the plan for all participants, or
- there is sufficient evidence, as determined by the plan, of an effort to defraud the plan.

When Coverage Ends for Your Family Members

Your covered family members' health care coverage ends on:

- the last day of the month following the date your employment ends or you die,
- the last day of the month in which your family member no longer meets the eligibility requirements for coverage (for example, if your family member's status changes so they are no longer eligible),
- the last day of the month in which you stop making any necessary contributions toward the cost of your family members' coverage,
- the day MPTN discontinues coverage for family members under the plan.

MPTN COBRA

If your health care coverage ends, you can continue coverage under the MPTN COBRA rules. (Your enrolled family members also may continue their coverage.) If you continue coverage under MPTN COBRA, it is at your expense and for a specific period of time.

For details, see the *COBRA Health Coverage* section.

If You Have Other Coverage (applicable to the Health Benefits Plan)

If you and your spouse work for different employers, you may each be covered by health insurance where you work. If you or an eligible family member has coverage under the MPTN health care plan *and* coverage under another health care plan, benefits from the MPTN Plan are coordinated with those of the other plan.

The coordination of benefits rules are designed to make sure that your health care expenses are fully covered under your health care plans but you do not collect more than the plan limit. The rules determine how much each plan pays when you or your family members are covered under more than one health care plan. The rules involve two steps:

- Determining which plan pays first (called the “primary coverage”), and
- Determining how much the MPTN Plan will pay.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this plan shall apply only as an excess over such other sources of coverage. The plan’s benefits will be excess to, whenever possible:

- any primary payer besides the plan;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker’s compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Which Plan Pays First

To determine the plan that provides primary coverage, use the following rules:

- For you — The MPTN Plan generally is primary. Submit your health care expenses to the MPTN Plan first, then to any other plan.
    - **If you are covered under Medicare —** If you are still working for MPTN and you have Medicare coverage, the medical coverage you have through MPTN is primary, so you should submit your medical bills to MPTN’s Plan first. Then submit any medical expenses not covered by the MPTN Plan to Medicare for payment.
    - **If you are receiving Workers’ Compensation benefits** — If you are receiving benefits from Workers’ Compensation, contact Risk Management, which will coordinate all Workers’ Compensation claims. If you are receiving payment from Workers’ Compensation, you must notify Pequot Plus Health Benefit Services at 1-888-779-6872.
- For your spouse — Your spouse’s employer-sponsored plan is generally primary, if he or she is enrolled in it. Submit your spouse’s expenses to the other plan first, then to the MPTN Plan, if your spouse is also enrolled in the MPTN Plan.
- For your dependent children — When the child is covered under both parents’ plans, the plan of the parent whose

birthday falls earlier in the calendar year pays benefits first. If you and your spouse have the same birthday, the plan covering the child the longest pays first. If the other plan has not adopted this “birthday rule,” that plan’s rules determine which plan is primary.

If you are divorced, legally separated, or remarried, or if the parents were never married, the plans generally pay benefits in this order:

- The plan of the parent with custody,
- The plan of the spouse of the parent with custody,
- The plan of the parent without custody, then
- The plan of the spouse of the parent without custody.

Sometimes a court assigns responsibility to one parent for paying a child’s health care expenses — for example, if there is a divorce. Court decrees take precedence over all other rules. Whenever a court decree specifies the parent who is financially responsible for the child’s health care expenses, the coverage of that parent is primary.

MPTN requests other insurance updates yearly or for other reasons throughout the year. You will receive an insurance update questionnaire which needs to be filled out and returned to Pequot Plus Health Benefit Services. Please provide Pequot Plus with the information requested to complete the processing of the claim(s) for the patient. In accordance with the terms of your health plan, Pequot Plus must have this information within forty five (45) days of the date on the letter.

Be advised that payment of your claims will not be released until the requested information is received. Further, failure to provide this information in a timely manner will result in the denial of your claims rendering you responsible for payment of these charges. You have one (1) year from the date of the last letter to respond to this information for your claims to be considered. After one (1) year, your claims will not be reprocessed and will be considered closed for timely filing.

If None of These Rules Apply

In any other situation, the plan that has covered the person the longest is primary. You should submit expenses to that plan first.

How Much the Plan Pays

If the MPTN Plan is primary — MPTN benefits are paid according to the regular plan provisions, and the other plan pays benefits according to its own coordination of benefits provisions.

If the other plan is primary (usually it will be secondary, unless you have coverage from more than two plans) —

- Then the primary plan pays benefits first. After the primary plan pays benefits, MPTN determines the benefits that would be payable if the MPTN Plan were primary (that is, as if there were no other coverage). All of MPTN’s rules will apply in determining the benefit that is payable — including the MPTN Plan’s deductible and maximum benefit provisions and any applicable reasonable and customary limits determining what portion of the total cost is covered. Once the amount payable if MPTN were primary is determined, MPTN will pay the lesser of:
    - the amount MPTN would pay if it were primary, or
    - the amount of the charge covered under the MPTN Plan remaining after the primary plan has paid benefits.

Third Party Recovery, Subrogation and Reimbursement (applicable to the Health Benefits Plan)

Payment Condition

The plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “participant(s)”) or a third party, where any party besides the plan may be responsible for

expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “coverage”).

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the plan or the plan’s assignee. The plan shall have an equitable lien on any funds received by the participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant(s) agrees to include the plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the participant(s) understands that any recovery obtained pursuant to this section is an asset of the plan to the extent of the amount of benefits paid by the plan and that the participant shall be a trustee over those plan assets.

In the event a participant(s) settles, recovers, or is reimbursed by any coverage, the participant(s) agrees to reimburse the plan for all benefits paid or that will be paid by the plan on behalf of the participant(s). If the participant(s) fails to reimburse the plan out of any judgment or settlement received, the participant(s) will be responsible for any and all expenses (fees and costs) associated with the plan’s attempt to recover such money.

If there is more than one party responsible for charges paid by the plan, or may be responsible for charges paid by the plan, the plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this plan, the participant(s) agrees to assign to the plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the participant(s) is entitled, regardless of how classified or characterized, at the plan’s discretion, if the participant(s) fails to so pursue said rights and/or action.

If a participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the plan to any claim, which any participant(s) may have against any coverage and/or party causing the sickness or injury to the extent of such conditional payment by the plan plus reasonable costs of collection. The participant is obligated to notify the plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The participant is also obligated to hold any and all funds so received in trust on the plan’s behalf and function as a trustee as it applies to those funds until the plan’s rights described herein are honored and the plan is reimbursed.

The plan may, at its discretion, in its own name or in the name of the participant(s) commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the plan.

If the participant(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers’ compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The participant(s) authorizes the plan to pursue, sue, compromise and/or settle any such claims in the

participant's/participants' and/or the plan's name and agrees to fully cooperate with the plan in the prosecution of any such claims. The participant(s) assigns all rights to the plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the participant(s) is fully compensated by his or her recovery from all sources. The plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the plan's equitable lien and right to reimbursement. The obligation to reimburse the plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant's/participants' recovery is less than the benefits paid, then the plan is entitled to be paid all of the recovery achieved. Any funds received by the participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the participant's obligation to reimburse the plan has been satisfied in accordance with these provisions. The participant is also obligated to hold any and all funds so received in trust on the plan's behalf and function as a trustee as it applies to those funds until the plan's rights described herein are honored and the plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the plan's recovery without the prior, express written consent of the plan.

The plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating plan's recovery will not be applicable to the plan and will not reduce the plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the plan and signed by the participant(s).

This provision shall not limit any other remedies of the plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of plan assets and is therefore deemed a trustee of the plan solely as it relates to possession of any funds which may be owed to the plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the participant understands that he or she is required to:

- Notify the plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
- Instruct his or her attorney to ensure that the plan and/or its authorized representative is included as a payee on all settlement drafts.
- In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third party from whom the participant obtains a settlement, judgment or other source of coverage to include the plan or its authorized representative as a payee on the settlement draft.
- Hold any and all funds so received in trust, on the plan's behalf, and function as a trustee as it applies to those funds, until the plan's rights described herein are honored and the plan is reimbursed.

To the extent the participant disputes this obligation to the plan under this section, the participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the plan's interests, and without reduction in consideration of attorneys fees, for which he or she exercises control, in an

account segregated from their general accounts or general assets until such time as the dispute is resolved.

No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the plan's interest on the plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the plan's Coordination of Benefits section.

The plan's benefits shall be excess to any of the following:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the plan, funds recovered by the participant(s), and funds held in trust over which the plan has an equitable lien exist separately from the property and estate of the participant(s), such that the death of the participant(s), or filing of bankruptcy by the participant(s), will not affect the plan's equitable lien, the funds over which the plan has a lien, or the plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these plan rights and terms by which benefits are paid on behalf of the participant(s) and all others that benefit from such payment.

Obligations

It is the participant's/participants' obligation at all times, both prior to and after payment of medical benefits by the plan:

- To cooperate with the plan, or any representatives of the plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the plan's rights.
- To provide the plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information.
- To take such action and execute such documents as the plan may require to facilitate enforcement of its subrogation and reimbursement rights.
- To do nothing to prejudice the plan's rights of subrogation and reimbursement.
- To promptly reimburse the plan when a recovery through settlement, judgment, award or other payment is received.
- To notify the plan or its authorized representative of any settlement prior to finalization of the settlement.
- To not settle or release, without the prior consent of the plan, any claim to the extent that the participant may have against any responsible party or coverage.
- To instruct his or her attorney to ensure that the plan and/or its authorized representative is included as a payee on any settlement draft.
- In circumstances where the participant is not represented by an attorney, instruct the insurance company or any third

party from whom the participant obtains a settlement to include the plan or its authorized representative as a payee on the settlement draft.
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the plan and participant over settlement funds is resolved.

If the participant(s) and/or his or her attorney fails to reimburse the plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the plan's attempt to recover such money from the participant(s).

The plan's rights to reimbursement and/or subrogation are in no way dependent upon the participant's/participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the participant and/or his or her attorney fails to comply with any of the requirements of the plan, the plan has the right, in addition to any other lawful means of recovery, to deduct the value of the participant's amount owed to the plan. To do this, the plan may refuse payment of any future medical benefits and any funds or payments due under this plan on behalf of the participant(s) in an amount equivalent to any outstanding amounts owed by the participant to the plan. This provision applies even if the participant has disbursed settlement funds.

Minor Status

In the event the participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The plan administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the plan's subrogation and reimbursement rights. The plan administrator may amend the plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and plan. The section shall be fully severable. The plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan.

Coverage in Special Situations

In certain instances, you may be entitled to continue your health care coverage, even if your employment with MPTN ends.

If You Take a Leave of Absence

Health care coverage continues for you and your eligible family members for the entire period of your authorized leave, provided you continue to make any required contributions. This includes MPTN Family Medical Leave (FML). The contributions for you and your family are the same as those charged for active team members. However, you will pay for coverage on an after-tax basis.

If you are on an FML, you must continue to make your contributions on a weekly basis in order to continue coverage.

For information on paying contributions when you are on an authorized leave other than an FML leave, see “Contributions When Not on Payroll” within this section.

If Your Employment Ends

If your employment with MPTN ends, and you are enrolled for MPTN health care coverage at the time you leave, you may be able to continue coverage for yourself and your covered family members through MPTN COBRA. See the *COBRA Health Care Coverage* section for details.

If You Die

If you die while an active team member, coverage for your enrolled family members will continue through the end of the month in which your death occurs. After that date, they can continue coverage under MPTN COBRA. For details, see the *COBRA Health Care Coverage* section.