Rules and Regulations

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The Mashantucket Pequot Tribal Law known as the Tribal Employee Retirement Income Security Act (TERISA), XV M.P.T.N. (accessibleat **www.mptnlaw.com**), governs certain team member benefit plans, including some of the plans described in this Plan Document and SPD. This section discusses your legal rights under TERISA, as well as some important administrative information.

TERISA Coverage

Most of the benefits described in this Plan Document and SPD are subject to TERISA, a tribal law covering certain employee benefit plans. For a listing of the TERISA plans, see “Other Plan Details” within this section.

Participating Divisions

The Mashantucket Pequot Tribal Nation (MPTN) sponsors and administers benefit plans for a number of different divisions:

- The Mashantucket Pequot Tribal Government, and all governmental entities, including:
    - The Mashantucket Pequot Museum and Research Center,
    - PRxN/Pequot Plus Health Benefit Services, and
    - The Mashantucket Pequot Gaming Enterprise (doing business as Foxwoods Resort Casino).

The benefits available to you depend on the division of MPTN for which you work. As a result, if you are employed by or transfer within MPTN to another division, your benefits may change.

The plans described in this Plan Document and SPD are available to eligible team members of MPTN, as described in each separate section of the Plan Document and SPD, for example in the *Health Care Benefits* or *401(k) Plan* sections. You may obtain a complete listing of all divisions participating in any plan by writing to the plan administrator.

Individuals Not Eligible

Although many team members of MPTN are eligible to participate in the Mashantucket Pequot Team Member Benefit Plans described in this Plan Document and SPD, some are not. Even if you otherwise meet the eligibility requirements for an MPTN Benefit Plan, you cannot participate if you are:

- employed by a division that does not participate in the applicable plan or program (see “Participating Divisions” above for more information),
- an individual employed by an outside agency that provides team members to MPTN and who has been classified by MPTN as not eligible to participate,
- an individual classified by MPTN as an independent contractor,
- an individual engaged under an agreement that states that you are not eligible to participate in the applicable plan or program,
- an individual classified by MPTN as a casual or temporary team member (please note that casual and temporary team members are eligible for the 401(k) Plan),
- any other individual who provides services to MPTN but is not an active team member of MPTN, or
- in any other defined group of individuals that is not eligible, as determined by the plan sponsor or administrator

Qualified Change in Status

After you enroll for coverage, the level and type of coverage you selected (for example, single or family medical coverage, or the amount you elected to contribute to a flexible spending account, etc.) remains the same until the following December 31. You may only change or terminate your benefit elections during the Plan Year if you experience a qualified change in status.

As long as you meet the 30-day deadline, the new elections you make will generally take effect on the first of the month following 30 days from the qualified event. Special provisions apply for medical and dental coverage when the change in qualified status is:

- Your marriage, or
- The birth of your child or a child's placement for adoption with you.

See "When Coverage Begins" in the *Health Care Benefits* section for details on these special provisions.

Change in Status

If you have a qualified change in status, you must make any eligible changes to your elections within 30 days of the event by contacting Human Resources at 1-888-287-4369. Otherwise, you must wait until the next annual enrollment period.

Generally, a qualified change in status includes:

- any event that changes your legal marital status, such as marriage, divorce, legal separation, annulment, or the death of your spouse,
- any event that changes the number of your eligible dependents, such as birth, adoption, placement for adoption, or the death of your dependent,
- any event that changes your employment status or the employment status of your spouse or dependent, such as termination or beginning of employment, beginning or end of an unpaid leave, change in worksite, or change of employment classification (for example, part-time to full-time or vice versa),
- any event that changes dependent status (for example, age), or
- a change in residence for you or your spouse or dependent (for example, if you are enrolled in a Medical Plan or Dental Plan and you move out of the network service area).

Consistency Requirements

The changes you make to your medical, vision, dental, dependent care flexible spending account and health care flexible spending account coverage must be "due to and consistent with" your qualified change in status. To satisfy the "consistency rule," your qualified change in status and corresponding change in coverage must meet **both** of the following requirements:

For the Dependent Care Flexible Spending Account (DCFSA), the qualified change in status must affect eligibility for coverage under the DCFSA or eligibility of dependent care expenses for the available tax exclusion. For example, when your child reaches age 13, dependent care expenses are no longer eligible for reimbursement.

- **Effect on eligibility:** Except for the Dependent Care Flexible Spending Account, the qualified change in status must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.
- **Corresponding election change:** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel medical coverage only for that dependent. The plan administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a qualified change in status.

You may also be able to change your benefit elections due to certain other events during the Plan Year, such as the following:

- A significant increase in the cost of similar coverage under your spouse's or dependent's employer's plan. This change does not apply to your Health Care Flexible Spending Account.
- A loss of similar coverage for your spouse or dependent under another employer's plan.
- If a benefit option is added during the year, you may be able to change your election to elect the new option.
- If a benefit option is dropped during the year, you may be able to elect another option with similar coverage.
- If there is a "significant curtailment" of your coverage, you may be able to change your election and elect another option with similar coverage. "Significant curtailment" may mean, for example, the elimination of hospital/physician networks or specialty vendors. "Significant curtailment" may also be based on plan design changes. This change does not apply to your Health Care Flexible Spending Account.
- If there is a significant change in the cost of coverage, plan design, or benefit options under your spouse's or dependent's employer's plan, you may be able to make a corresponding election change under MPTN's Plan (for example, you may drop coverage under your spouse's plan and elect coverage under MPTN's Plan if the cost of coverage under your spouse's employer's plan significantly increases). The change in cost provision applies to Dependent Care Flexible Spending Account benefits only if the cost change is imposed by a dependent care provider who is not your relative. This change in cost provision does not apply to your Health Care Flexible Spending Account.
- You may be able to drop coverage under MPTN's Plan for yourself or your spouse or dependents to elect similar coverage under your spouse's employer's plan.
- If the MPTN Team Member Benefit Plans receive a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), requiring the plan to provide accident or health coverage to your dependent child. In this instance, the plan will automatically change your benefit elections to provide coverage for the child. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. This change does not apply to the Dependent Care Flexible Spending Account.
- If you, your spouse or dependent becomes entitled to, or loses entitlement to coverage under a U.S. government institution, Medicare, Medicaid, or a state children's health program, you may make corresponding changes to your benefit elections under the MPTN Team Member Benefit Plans. This change does not apply to the Dependent Care Flexible Spending Account.

You may change your Dependent Care Flexible Spending Account elections during the Plan Year under the following circumstances:

- If another employer's Dependent Care Flexible Spending Account allows for a change in your family member's coverage (either during that plan's annual enrollment period or due to a mid-year election change permitted under the U.S. Internal Revenue Code), you may be able to make a corresponding election change under the dependent care flexible spending account.
- If there is a change by your dependent care service provider. For example: (i) if you terminate one dependent care service provider and hire a new service provider; and (ii) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.

Other Rules

Special Enrollment Events: You have special enrollment rights under certain circumstances. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents for medical, vision and dental coverage, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you miss the 30-day deadline, you will have to wait to enroll until the next annual enrollment period — or for another qualified change in status or another special enrollment right.

Qualified Medical Child Support Order (QMCSO): A QMCSO is any judgment, decree, or order (including a settlement agreement or administrative notice), issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process under tribal or state law which has the force and effect of law in that jurisdiction, and meets the requirements of TERISA.

Written Documentation

To meet Internal Revenue Service regulations and plan requirements, the plan reserves

If you are required to provide medical, vision and/or dental care coverage to your child who is your dependent as the result of a judgment, decree or order (including a QMCSO), the plan will automatically change your benefit elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date specified in the order, or if none is specified, the date of the order. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. You also may make other corresponding changes to your benefit elections under the plan, to the extent permitted by the Internal Revenue Code and the plan. If a judgment, decree, or order (including a QMCSO) requires you to provide health care coverage for a dependent, you may adjust your health care flexible spending account contributions accordingly.

the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualified change in status.

The plan administrator will determine whether a requested change is due to a qualified change in status event and is on account of and consistent with the event.

Medicare or Medicaid Entitlement

You may change an election for medical coverage mid-year if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your medical/dental coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding medical/dental coverage only for the person who loses eligibility for Medicare or Medicaid. If your spouse or dependent becomes covered by Medicare or Medicaid, your Health Care Flexible Spending Account coverage may be canceled completely.

Plan Basics

Plan Sponsor

The plan sponsor and principal employer for all plans is:

Mashantucket Pequot Tribal Nation
350 Trolley Line Boulevard
P.O. Box 3777
Mashantucket, Connecticut 06338-3777

1-888-287-4369

The plan sponsor is the party that establishes and maintains the plan.

The plan sponsor's responsibilities include:

This Plan Document and SPD supersedes all earlier descriptions of the plans, as of January 1, 2024.

Because the benefits and other programs described in this Plan Document and SPD may change, MPTN will provide updated information as necessary and as required by law.

- Deciding on the plan's design, in terms of the services it covers. (For the Medical Plan, the medical utilization company decides whether care is medically necessary on an individual beneficiary basis. Even if care is determined to be medically necessary, it may not be covered by the plan.)
- Determining the employer-employee cost sharing contributions of the plan.
- Serving on the appeals committee.
- Managing the plan with respect to actuarial integrity, utilization review, auditing of the claims process and determining which elements require review.

Plan Administrator

The Plan Administrator has the authority to control and manage the operation and administration of each plan. The Plan Administrator has the sole discretion to interpret and administer the provisions of the plan and make factual determinations related thereto. The person or entity responsible for specific operational or administrative duties (such as processing claims) may not be the official "Plan Administrator."

Unless a different party is named, the plan sponsor is the Plan Administrator.

The administrator's responsibilities include:

- Acting solely in the interest of plan participants and beneficiaries, and for the exclusive purpose of providing benefits and defraying reasonable administrative expenses.
- Managing the plan's assets to minimize the risk of large losses.
- Acting in accordance with the documents governing the plan. This includes the responsibility to construe the meaning of, to make interpretations, and to make factual determinations regarding the plans, their trust(s), this Plan Document and SPD, and any other related document, and to grant or deny benefits as part of the administrative appeals process.
- Serving on the appeals committee.
- Managing the selection and coordination of vendors necessary to operate the plan, including but not limited to the medical utilization company and benefit provider organizations.

The Plan Administrator for the MPTN Health Care and Group Benefit Plans is:

Senior Vice President – Human Resources & Administration
Foxwoods Resort Casino
350 Trolley Line Boulevard
P.O. Box 3777
Mashantucket, Connecticut 06338-3777

1-888-287-4369

The Plan Administrator for the Mashantucket Pequot Tribe 401(k) Retirement Plan is:

Senior Vice President – Human Resources & Administration
Foxwoods Resort Casino
350 Trolley Line Boulevard
P.O. Box 3777
Mashantucket, Connecticut 06338-3777

1-888-287-4369

Trustee and Record Keeper

Bank of America, N.A. is the Trustee and Record Keeper for the Mashantucket Pequot Tribe 401(k) Retirement Plan.

You can reach them at:

Bank of America, N.A.
1400 American Boulevard
Pennington, New Jersey 08534

1-800-228-4015

Legal Agent

The agent for service of legal process for all plans is:

Office of Legal Counsel
Mashantucket Pequot Tribal Nation
2 Matt's Path
P.O. Box 3060
Mashantucket, Connecticut 06338-3060

Legal process may also be served upon the Trustee or the Plan Administrator.

Administrative Details

The Mashantucket Pequot Tribal Nation employer identification number is 06-0995554.

In addition to the employer identification number, an official name and number are assigned to all benefit plans subject to TERISA. The plans listed within this section under “Other Plan Details” show the names, numbers, insurance companies or trustees, and sources of funding of the plans subject to TERISA.

Plan Year

For all plans, the Plan Year is January 1 to December 31.

Hospital Stays—Childbirth

Group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

This coverage will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Your Rights for Health Care Coverage

Tribal law adopts the substantive law of the Health Insurance Portability and Accountability Act (HIPAA), a part of TERISA. This was enacted to provide improved portability and continuity of health insurance coverage for dependents. The law restricts the ability of group health plans to exclude coverage for pre-existing conditions.

About Your Privacy

We are committed to maintaining the confidentiality of medical information about you and that can be identified with you. Tribal laws, which include the substantive law of HIPAA, also impose numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as “protected health information,” includes virtually all individually identifiable health information held by any health plan, including health care flexible spending accounts — whether received in writing, in an electronic medium, or as an oral communication. It includes demographic information and information that relates to your physical or mental health, the treatment you received or the payment for your care. Your protected health information is contained in the enrollment, payment, claims adjudication, case or medical management record systems and other documents maintained by the health plans in order to provide you with insurance coverage.

The plan has implemented policies and practices to appropriately protect the privacy of your protected health information. Protected health information that you provide will be handled in accordance with the MPTN Notice of Privacy Practices. The “Notice of Privacy Practices” (the “Notice”) describes how we may use and disclose your protected health information.

We are required to protect the confidentiality of your protected health information, to notify you of our legal obligations and your rights with respect to your protected health information, and to abide by the terms of the Notice, as currently in effect. To obtain a copy of the Notice, contact Human Resources toll-free at 1-888-287-4369.

Court Orders

In certain situations, courts may issue orders that benefits be provided for a certain individual or individuals, typically a family member of an employee. Examples of these court orders include:

- Qualified Medical Child Support Orders, also known as QMCSOs, and
- Qualified Domestic Relations Orders, also known as QDROs.

If a QMCSO ,QDRO or other court order affects you, you should notify Human Resources so that the order can be handled properly. You will be notified if MPTN receives a QMCSO, QDRO or other court order affecting you. MPTN will comply with all valid QMCSOs, QDROs and other court orders. You may receive, without charge, a copy of the procedures applicable to QMSCOs, QDROs and other court orders.

Other Plan Details

An official name and number are assigned to all benefit plans subject to TERISA. The list below provides the names, numbers, insurance companies or trustees, and sources of funding of MPTN's plans subject to TERISA. (The Dependent Care Flexible Spending Account is not a TERISA plan and is not listed below.)

For some benefits, the MPTN Plan is either an insured plan or a self-insured plan. For self-insured plans, MPTN is liable for any benefits payable. However, the claims administrator has the authority to determine first-level administrative claims and appeals for all welfare plans, subject to TERISA. For insured plans, the plan insurer listed is liable for any benefits payable and is authorized to determine claims and appeals.

To learn more about MPTN's benefit plans or to arrange to see the official plan documents, call Human Resources toll-free at 1-888-287-4369. Contact information for the plans is shown below.

Plan	Contact
For the MPTN Health Care Plan, including the Medical, Vision and Dental Plans, and the Flexible Spending Account Plans	**For post-service claims only:** Pequot Plus Health Benefit Services Mashantucket Pequot Tribal Nation 1 Annie George Drive P.O. Box 3559 Mashantucket, Connecticut 06338-3620 1-888-779-6872 **For urgent, pre-service, and concurrent care claims:** Medical utilization company See the number on your benefit card
Insurance Plans	1-855-212-7102
For the Mashantucket Pequot Tribe 401(k) Plan	Human Resources 401(k) Mashantucket Pequot Tribal Nation 350 Trolley Line Boulevard P.O. Box 3777 Mashantucket, Connecticut 06338-3777 1-888-287-4369

For the Childcare Reimbursement, Tuition Reimbursement and Wellness Plans	Mashantucket Pequot Gaming Enterprise (Foxwoods Resort Casino) 350 Trolley Line Boulevard P.O. Box 3777 Mashantucket, Connecticut 06338-3777 1-888-287-4369

Mashantucket Pequot Health Benefits Plan

This plan includes the MPTN Medical Plan, Vision Plan and Dental Plan.

- **Plan Type** — Self-insured welfare benefit plan
- **Plan Number** — 501
- **Claim Administrator** — Pequot Plus Health Benefit Services
- **Source of Contributions** — Mashantucket Pequot Tribal Nation and team members
- **Source of Benefit Payments** — Mashantucket Pequot Tribal Nation

Health Care Flexible Spending Account and Dependent Care Flexible Spending Account

- **Plan Type** — Welfare benefit plan
- **Plan Number** — 501
- **Claim Administrator** — Pequot Plus Health Benefit Services
- **Source of Contributions** — Team members
- **Source of Benefit Payments** — Mashantucket Pequot Tribal Nation

Group Short-Term Disability Plan

(“Short-Term Disability Plan”)

- **Plan Type** — Insured welfare benefit plan
- **Plan Number** — 501
- **Plan Insurer** — Life Insurance Co of North America
- **Claim Administrator** — Cigna Group Insurance
- **Source of Contributions** —Team members
- **Source of Benefit Payments** — Plan insurer

Group Long-Term Disability Plan

(“Long-Term Disability Plan”)

- **Plan Type** — Insured welfare benefit plan
- **Plan Number** — 501
- **Plan Insurer** — Life Insurance Co of North America
- **Claim Administrator** — Cigna Group Insurance
- **Source of Contributions** — Mashantucket Pequot Tribal Nation and team members
- **Source of Benefit Payments** — Plan insurer

Group Term Life and Accidental Death and Dismemberment Insurance Plan

(“Life and AD&D Insurance Plan”)

This plan includes team member Basic Life and AD&D insurance and Supplemental Life insurance coverage as well as optional Spousal and Dependent Child Life insurance.

MPTN Contributions to Other Benefit Plans

In addition to those plans listed here, MPTN contributes on your behalf to other governmental benefit plans, such as Social Security and Medicare.

- **Plan Type** — Insured welfare benefit plan
- **Plan Number** — 501
- **Plan Insurer** — Life Insurance Co of North America
- **Claim Administrator** — Cigna Group Insurance
- **Source of Contributions** — Mashantucket Pequot Tribal Nation and team members
- **Source of Benefit Payments** — Plan insurer

Mashantucket Pequot Tribe 401(k) Retirement Plan

(“The 401(k) Plan”)

This type of plan is not subject to or insured by the Pension Benefit Guaranty Corporation (PBGC).

- **Plan Type** — Defined contribution plan
- **Plan Number** — 001
- **Trustee and Record Keeper** — Bank of America, N.A.
- **Source of Contributions** — Mashantucket Pequot Tribal Nation and participants

Change or Discontinuance of Plans

MPTN intends to continue the team member benefits plans indefinitely. However, MPTN reserves the right to amend, modify, suspend, or terminate any plan, in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason. A decision to terminate, amend, or replace a plan may be due to changes in the law governing qualified retirement or welfare benefits, the requirements of the Internal Revenue Service, TERISA, or any other reason.

If a plan is terminated, you will still be paid any benefit you were entitled to receive under the terms of that plan, up to the cancellation date. Long-term disability payments will be paid to the extent funded.

For some of the plans, if MPTN terminates the plan, you may be able to convert your coverage to an individual insurance policy. Please refer to the description of the specific plan for these privileges.

If MPTN terminates the Health Care Flexible Spending Account Plans and the Dependent Flexible Spending Account Plans, no further contributions will be made to team member accounts. However, you can continue to submit and be reimbursed for claims for eligible expenses through March 31 following the year in which the plan terminates.

Claims Review and Appeals Procedures

The procedures for filing claims for benefits are summarized in the respective plan overviews.

The plan administrator has the authority to control and manage the operation and administration of the plans described in this Plan Document and SPD. The person or entity responsible for specific operational or administrative duties (such as processing claims) may not be the official "plan administrator." For some plans (such as the Short-Term Disability Plan, for example), the insurance company is the claim administrator, who has final responsibility and authority for responding to claims appeals.

For a list of the persons or entities responsible for processing claims for the plans offered by MPTN, see "Other Plan Details" within this section.

Claims Review Process

Each plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by TERISA. The period of time the plan has to evaluate and respond to a claim begins on the date the claim is first filed.

If you have any questions regarding how to file or appeal a claim, contact the appropriate claim administrator listed in "Other Plan Details" within this section.

Initial Benefit Determination

The initial benefit determination is the first time the plan considers your claim for benefits and makes a decision on your claim.

Health Plans

For health claims, the plan recognizes four categories of claims, as explained below.

- **Urgent Care Claims —** Claims for which, in the opinion of the treating physician, the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise. This type of claim generally includes those situations commonly treated as emergencies. For urgent care health claims, the medical utilization company will notify you and your provider of their initial determination, whether adverse or not, as soon as reasonably possible, taking into account medical exigencies but not later than 72 hours after receipt of the claim, unless you or your provider fail to provide sufficient information to make a determination. In the case of such a failure, the medical utilization company will notify you and your provider as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally, unless the claimant requests written notification. You and your provider will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The medical utilization company will notify you and your provider of the determination as soon as possible, but no later than 48 hours after the earlier of the medical utilization company's receipt of the specified information or the end of the period afforded you and your provider to provide the specified additional information.

Urgent Care — Who to Call

Urgent care claims should be directed to the medical utilization company by calling the number on your benefit card.

Concurrent Care — Who to Call

Concurrent care claims should be directed to the medical utilization company by calling the number on your benefit card.

Pre-Service Care — Who to Call

Pre-service care claims should be directed to the medical utilization company by calling the number on your benefit card.

Post-Service Care — Where to Write

Post-service care claims should be mailed to:

Pequot Plus Health Benefit Services

Mashantucket Pequot Tribal Nation
P.O. Box 3620
Mashantucket, Connecticut 06338-3620

- **Concurrent Care Claims**— A concurrent claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. You will be notified in advance if the plan intends to terminate or reduce concurrent care claim benefits so that you will have the opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If your concurrent care claim is an urgent claim, you must notify the medical utilization company at least 24 hours before the termination of treatment and the medical utilization company will notify you of its decision within 24 hours after receiving the claim. You will be given time to provide any additional information required to reach a decision.
- **Pre-Service Claims** — A pre-service claim is a claim for a benefit under the plan which requires pre-certification, such as a hospital stay or when there is a question as to whether or not the service is medically necessary. For pre-service claims, the medical utilization company will notify you and your provider of the determination not later than 15 days after receipt of the claim. This 15-day period may be extended by the medical utilization company for an additional 15 days, provided the extension is necessary due to matters beyond the medical utilization company's control and the medical utilization company notifies you within the initial period of the circumstances requiring the extension and the date by which the medical utilization company expects to render a decision. If such an extension is necessary due to you and your provider's failure to submit the information necessary to decide the claim (request), the notice of extension will specifically describe the required information. For example, the period may be extended because you have not submitted sufficient information, in which case you will have at least 45 days to provide the information requested of you by the medical utilization company. You will be notified of the medical utilization company's decision no later than 15 days after the end of the extended period (or after receipt of the information, if earlier).
- **Post-Service Claims** — A post-service claim for a benefit under the plan is a claim for a benefit that has already been received. If you have filed a post-service claim for benefits, you will be notified of the claims fiduciary's decision on your claim only if it is denied in whole or in part. The plan has up to 30 days to evaluate and respond to claims after the claims fiduciary receives the claim. This 30-day period may be extended by 15 days provided the extension is necessary due to matters beyond the control of the claims fiduciary and the claims fiduciary notifies you within the initial period of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide any additional information requested of you by the claims fiduciary, if the extension is due to the claim's fiduciary's need for additional information from you or your health care providers.

Disability Plans

For disability claims, the plan has up to 45 days to evaluate and respond to claims for benefits covered by TERISA. The 45-day period begins on the date the claim is first filed.

This period may be extended twice by 30 days each (105 days in total) if the claim administrator:

- determines that an extension is necessary due to matters beyond the control of the claim administrator, and
- notifies you within the initial period (and within the first 30-day extension period, if applicable) of the circumstances requiring the extension and the date by which the claim administrator expects to make a decision.

In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

Life and Accident Insurance Plans

If an application for life and accidental death and dismemberment insurance claims is denied in whole or in part, the plan will notify you or your representative in writing within 90 days of receiving the claim. This period may be extended by an additional 90 days if the claims administrator:

- determines that an extension is necessary due to matters beyond the control of the claim administrator, and
- notifies you within the initial period of the circumstances requiring the extension and the date by which the claim administrator expects to make a decision.

401(k) Plan

As a plan participant, you do not have to file a claim for benefits, and neither does your beneficiary. However, if you feel your benefit has been incorrectly determined and you wish to request a review of that determination, you may file a written notice with the plan administrator.

The plan administrator has up to 90 days to evaluate and respond to your claim covered under TERISA, unless special circumstances require an extension of time. This extension will not exceed an additional 90 days (180 days total) and you will receive notice of such extension before the end of the initial 90-day period. This extension notice will state the circumstances requiring the extension of time and the date by which a decision is expected. You will be notified within the initial period of the circumstances requiring the extension and the date by which the plan administrator expects to make a decision.

Health Care Flexible Spending Account

For claims for benefits from the Health Care Flexible Spending Account, the plan has up to 30 days to evaluate and respond to claims for benefits covered by TERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the claim administrator or its delegate:

- determines that an extension is necessary due to matters beyond the control of the plan, and
- notifies you within the initial period of the circumstances requiring the extension and the date by which the plan expects to render a decision.

In addition, the written notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be given at least 45 days from receipt of the notice within which to provide the specified information.

Adverse Benefit Determination (Applicable to All Claims)

An “adverse benefit determination” is a denial, reduction or termination of a benefit, a rescission of coverage (even if the rescission does not impact a current claim for benefits), or failure to provide or pay for (in whole or in part) a benefit. This can also include a denial of participation in the plan. For health coverage, an adverse benefit determination also means a claim denial on the grounds that the treatment is experimental or investigational or not medically necessary. This also includes concurrent care determinations.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- the specific reasons for the adverse determination,
- the specific plan provisions on which the determination is based,
- a request for any additional information needed to reconsider the claim and the reason this information is needed,
- a description of the plan’s review procedures and the time limits applicable to such procedures,
- a statement of your right to bring an action in the Mashantucket Pequot Tribal Court under TERISA following an adverse benefit determination on review,
- for disability and health claims, if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request,
- for disability and health claims, for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request, and
- for health claims involving urgent care, an expedited review may be initiated orally. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the plan by telephone,

Adverse Benefit Determination

To seek review of an adverse benefit determination for urgent care, pre-service care, and concurrent care claims, beneficiaries must contact the medical utilization company at the number on your benefits card. The medical utilization company provides a multi-level appeals process for claims denied based on medical necessity.

For post-service claims not related to medical necessity, appeals must be directed to Pequot Plus Health Benefit Services.

facsimile, or other similar method. When an appeal is expedited, the medical utilization company will respond orally with a decision within 72 hours, followed by a written notification of the decision.

Claims Appeal Process

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination. If you disagree with the initial decision, you should request a review of the claim.

- For disability or health claims, you (or an authorized representative) can appeal and request a claim review within 180 days after receiving the denial notice.
- For all other benefits, you (or an authorized representative) can appeal and request a claim review within 60 days after receiving the denial notice.

Be sure to state why the claim should not have been denied and submit any data, questions, or comments you think are appropriate. In connection with your right to appeal the initial determination regarding your claim, you also:

Claims Fiduciary

For some plans (such as the Short-Term Disability Plan, for example), the insurance company is the claim administrator and has final responsibility and authority for responding to claims appeals.

- may review pertinent documents and submit issues and comments in writing;
- will be given the opportunity to submit written comments, documents, records, or any other information relevant to your claim;
- will, at your request and free of charge, have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination; and
- are entitled to an appeal that does not provide deference to the previous decision.

To seek review of an adverse benefit determination for urgent care, pre-service care, and concurrent care claims based on medical necessity, beneficiaries must contact the medical utilization company at the number on your benefit card. The medical utilization company provides a multi-level appeals process for claims denied based on medical necessity.

For post-service claims, appeals not based on medical necessity must be directed to Pequot Plus Health Benefit Services, as instructed above.

The request must be made in writing and should be filed with the claim administrator at the address shown for each plan under “Other Plan Details” within this section.

The claim administrator will forward the appeal request to the appropriate named fiduciary for review.

For health care plans, the review will be conducted by the plan sponsor’s appeals committee, comprised of individuals who did not make the adverse benefit determination which is the subject of the review, and are not the subordinates of those who did make that determination.

401(k) Plan Claims

You will receive written or electronic notification from the plan administrator of its decision within sixty (60) days of receipt of your appeal, unless special circumstances require an extension. If special circumstances require an extension of time to process your appeal, you will receive notice prior to the end of the original period that the time for rendering a final decision has been extended — but not beyond 120 days from the receipt of your appeal. This notice will set out the circumstances requiring an extension of time and the date by which a decision is expected.

Life and Accident Insurance and Disability Claims

For Life and AD&D insurance claims, a final decision on review shall be made not later than 60 days following receipt of the written request for review, unless special circumstances require an extension. This extension will not exceed 60 days. For Disability claims, a final decision on review shall be made not later than 45 days following receipt of the written request for review, unless special circumstances require an extension. This extension will not exceed 45 days.

If special circumstances require an extension of time to process your appeal, you will receive notice prior to the end of the original period that the time for rendering a final decision has been extended. This notice will set out the circumstances requiring an extension of time and the date by which a decision is expected.

Health Plan Claims

The claims administrator or the medical utilization company (whichever is applicable) will notify you and your provider of the plan's determination on review within the following timeframes:

- For appeals of urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours for expedited appeals.
- For appeals of pre-service claims, within a reasonable period of time given the medical situation, but no later than 15 days from the receipt of you or your provider's request for appeal of a denied claim.
- For appeals of post-service claims, within a reasonable period of time, but no later than 30 days after receipt of the request for appeal of a denied claim.

In certain cases, the plan may obtain a limited extension of time if notice of the extension is provided to the claimant before the end of the initial decision making period.

In all cases the benefit determination will be rendered in a consistent and nondiscriminatory manner according to the provisions of the applicable plan. The claims administrator's decisions are conclusive and binding for first level appeals.

If you are not satisfied with the first level appeal decision of the claims administrator, you have the right to request a second level appeal. Second level appeals, for claims not related to medical necessity, are reviewed by the plan sponsor's appeals committee. Your second level appeal must be submitted to the claim administrator within 60 days from the date you or your provider received the first level appeal decision. You or your provider will receive a decision from the claim administrator or the medical utilization company (whichever is applicable) on your second level appeal within the following time frames:

- For appeals of urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours for expedited appeals.
- For second level appeals of pre-service claims, within a reasonable period of time given the medical situation, but no later than 15 days from the receipt of the request for review of the first level appeal decision.
- For second level appeals of post-service claims, within a reasonable period of time, but no later than 30 days after receipt of the request for review of the first level appeal decision. For second level appeals, the appeals committee's decisions are conclusive and binding.

Judicial Review

You must timely pursue all the administrative claim and appeal rights described in this section before you may seek any other legal recourse regarding claims for benefits. You may not bring any action at law or in equity to recover benefits or for an adverse benefit determination unless and until the administrative appeal rights described in this section have been exercised and the benefits requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). If you wish to seek judicial review of any adverse benefit determination, you must file an action in the Mashantucket Pequot Tribal Court under TERISA (Title XV, Mashantucket Pequot Tribal Law, accessible at **www.mptnlaw.com**) **within one year** after the date on which all administrative remedies are exhausted, that is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued, or you will be forever prohibited from commencing such action.

Notices

For all TERISA claims, the claim administrator will provide written notification of the plan's determination on review. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse determination on review,
- reference to the specific provisions of the plan on which the determination is based,
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits,
- a description of your right to bring an action under TERISA following an adverse determination on review,
- for health and disability claims, if any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of

such information will be made available free of charge upon request,
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request, and
- a description of your right to obtain additional information upon request about any voluntary appeals procedures under the plan.

In all cases the benefit determination will be rendered in a consistent and nondiscriminatory manner according to the provisions of the applicable plan. All decisions are final and binding unless determined otherwise by the Mashantucket Pequot Tribal Court.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

- Any eligible adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigative), as determined by the external reviewer.
- A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

- Request for external review. The plan will allow a participant to file with the plan a request for an external review if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal or Tribal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal or Tribal holiday.
- Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    - The participant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    - The adverse benefit determination or the final internal adverse benefit determination does not relate to the participant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    - The participant has exhausted the Plan's internal appeal process unless the participant is not required to exhaust the internal appeals process applicable regulations.
    - The participant has provided all the information and forms required to process an external review.
    - Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the participant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a participant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
- Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take reasonable action against potential bias and to ensure independence. Accordingly, the

Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

- Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

- Request for expedited external review. The Plan will allow a participant to make a request for an expedited external review with the Plan at the time the participant receives:
    - An adverse benefit determination if the adverse benefit determination involves a medical condition of the participant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function and the participant has filed a request for an expedited internal appeal.
    - A final internal adverse benefit determination, if the participant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the participant received emergency services, but has not been discharged from a facility.
- Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the participant of its eligibility determination.
- Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
- Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the participant and the Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the plan. As such this plan may pay benefits that are later found to be greater than the Maximum Allowable Amount. In this case, this plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the plan pays benefits exceeding the amount of benefits payable under the terms of the plan, the plan administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the participant or dependent on whose behalf such payment was made.

A participant, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the plan or on whose behalf such payment was made, shall return

or refund the amount of such erroneous payment to the plan within 30 days of discovery or demand. The plan administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The plan administrator shall have the sole discretion to choose who will repay the plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a participant or other entity does not comply with the provisions of this section, the plan administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the plan by the amount due as reimbursement to the plan. The plan administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the plan, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this plan and agree to submit claims for reimbursement in strict accordance with applicable health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the plan administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the plan must bring an action against a participant, provider or other person or entity to enforce the provisions of this section, then that participant, provider or other person or entity agrees to pay the plan's attorneys' fees and costs, regardless of the action's outcome.

Further, participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (participants) shall assign or be deemed to have assigned to the plan their right to recover said payments made by the plan, from any other party and/or recovery for which the participant(s) are entitled, for or in relation to facility- acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the plan has not already been refunded.

The plan reserves the right to deduct from any benefits properly payable under this plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a participant fails to comply with the plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the plan to pay benefits under this plan in any such instance.

The deduction may be made against any claim for benefits under this plan by a participant or by any of his covered dependents if such payment is made with respect to the participant or any person covered or asserting coverage as a dependent of the participant.

If the plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall abstain from billing the plan participant for any outstanding amount(s).

Assignments

No benefit, right or interest of any participant under the plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefit payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, the plan may choose to remit payments directly to providers with respect to covered benefits, if authorized by the participant, but only as a convenience to the participant. Providers are not, and shall not be construed as, "participants," "beneficiaries" or "claimants" under this plan and

have no rights to receive benefits from the plan or to pursue legal causes of action on behalf of (or in place of) participants under any circumstances.

Your Rights Under TERISA

As a participant in MPTN Plans, you are entitled to certain rights and protections under the Tribal Employee Retirement Income Security Act (TERISA) with regard to the plans subject to TERISA. TERISA provides that all plan participants shall be entitled to:

- examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor. (These documents are available at Human Resources or at your own work location upon written request to the Senior Vice President, Human Resources.)
- obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. (The administrator may charge you a reasonable fee for the copies.)
- continue health care coverage for yourself or your family members if there is a loss of coverage under the plan as a result of a qualifying event. (You or your family members may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your MPTN COBRA continuation coverage rights.)

For More Information …

You should contact your plan administrator at the address shown in "Other Plan Details" if you have any questions about:

- your plan,
- this statement, or
- your rights under TERISA.

In addition to creating rights for plan participants, TERISA imposes duties upon the people who are responsible for the operation of the team member benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under TERISA. If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial and have a right to obtain without charge copies of documents relating to the decision. You also have the right to have the plan review and reconsider your claim, as described under "Claims Review and Appeals Procedures" within this section.

Under TERISA, you can take steps to enforce these rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit, pursuant to Title XV, Mashantucket Pequot Tribal Law, in the Mashantucket Pequot Tribal Court. In such a case, the court may require the plan administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

You may also file suit within one year after the date on which the applicable incident described below occurred, pursuant to Title XV, Mashantucket Pequot Tribal Law, in the Mashantucket Pequot Tribal Court if you:

- have a claim for benefits that is denied or ignored, in whole or in part,
- disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order,
- believe that plan fiduciaries have misused the plan's money, or
- believe that you have been discriminated against for asserting your rights.

The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay these costs and fees. However, if your suit is unsuccessful — because, for example, the court finds your claim frivolous — the court may order you to pay these costs and fees on your own.

A TERISA plan does not give you the right to be retained as an employee. This Plan Document and SPD is not a contract for or a guarantee of present or continued employment. You should retain this summary and refer to it as questions arise concerning your participation in the plan. However, should there ever be any discrepancy between this booklet and the official text of the applicable MPTN Plan, or should there ever be any claim that involves interpretation of such documents, the applicable MPTN Plan and not this Plan Document and SPD will control.