G6 Hospitality

PRESCRIPTION DRUG BENEFITS

Summary Plan Description

The G6 Hospitality Medical Plan (the "Medical Plan") offers prescription drug benefits to eligible team members, their spouses, and eligible dependents when enrolled in the Medical Plan. This document (referred to as the "Prescription Drug Plan", the "Plan" or the "SPD") describes those prescription drug benefits. The Prescription Drug Plan is a component sub-plan under both the Medical Plan and the G6 Hospitality LLC Group Insurance Plan. This document is effective January 1, 2020.

Prescription Benefits Manager

OptumRx is the prescription benefits manager responsible for the Prescription Drug Plan's administration. You may contact OptumRX as follows:

OptumRX Customer Care Representative

1-844-775-7416

OptumRX Claims and Appeals

OptumRx c/o Appeals Coordinator
PO Box 25184
Santa Ana, CA 92799

Phone: 1-888-403-3398
Fax: 1-877-239-4565

Prior Authorization for Medications

1-800-711-4555

Eligibility for Benefits

If you (and your eligible dependents, if applicable) enroll in coverage under the Medical Plan, you will automatically be enrolled in the Prescription Drug Plan. You are neither required nor permitted to make separate enrollment elections under this Prescription Drug Plan. Coverage under the Prescription Drug Plan will be effective at the same time coverage under the Medical Plan begins. Coverage under the Prescription Drug Plan will continue until your coverage under the Medical Plan ends. If you timely elects to continue your Medical Plan coverage pursuant to COBRA or other coverage continuation provisions under the Medical Plan, then coverage under the Prescription Drug Plan will also continue.

Upon enrollment in the Plan, you will be provided with an identification ("ID") card. The ID card tells participating pharmacies the OptumRX network that you are entitled to benefits under the Plan. You must present your ID card to the participating pharmacy every time you get a prescription filled to be eligible for Plan benefits. You can also download the OptumRx app for a digital copy of your ID card. The participating pharmacy will calculate your claim online. You will pay any deductible, copayment, or coinsurance directly to the participating pharmacy. The ID card provides important information specific to your coverage including, but not limited to your subscriber identification number, your pharmacy group number, and the Customer Service number.

Prescription Drug Benefits

Copayment amounts and coinsurance amounts are shown on the Schedule of Benefits, below. The amount you pay depends on the quantity and whether the covered drug dispensed is a generic drug, preferred brand drug, or a non-preferred brand drug.

Schedule of Benefits		
	Value Plan	**Premium PPO**
Short Term Medications – 30 Day Retail		
Preventative Therapy Drug List	$10 co-pay	N/A
Generics	30% of Rx Cost after deductible	$10 co-pay
Preferred	30% of Rx Cost after deductible	20% of Rx Costs $22 min; $45 max
Non-Preferred	30% of Rx Cost after deductible	20% of Rx Cost $37 min; $75 max
Long-Term Medications		
Preventative Therapy Drug List	$25 co-pay	N/A
Generics	50% of Rx Cost after deductible	$25 co-pay
Preferred	50% of Rx Cost after deductible	20% of Rx Cost $100 min; $200 max
Non-Preferred	50% of Rx Cost after deductible	20$ of Rx Cost $176 min; $352 max
90-Day Long-Term Medications – Mail Order or Retail Pharmacy		
Preventative Therapy Drug List	$25 co-pay	N/A
Generics	30% of Rx Cost after deductible	$25 co-pay
Preferred	30% of Rx Cost after deductible	20% of Rx Cost $56 min; $113 max
Non-Preferred	30% of Rx Cost after deductible	20% of Rx Cost $94 min; $188 max
Specialty Medications		
All	30% of Rx Cost after deductible	20% of Rx Cost $60 min; $120 max

OptumRX Network. When you need a prescription order filled, you can generally elect to go to an in-network pharmacy or an out-of-network pharmacy. Obtaining your benefits through network pharmacies has many advantages. Benefits and cost sharing may vary by the type of network pharmacy where you obtain your prescription drug and whether you purchase a generic, preferred brand or non-preferred brand drug. Network pharmacies include retail, specialty and mail service

pharmacies. Cost sharing amounts and provisions are described in the Schedule of Benefits.

If you fill a prescription order at an out-of-network pharmacy, you must pay the pharmacy the full billed amount. If you are unsure whether a Pharmacy is a network Pharmacy, you may access OptumRx's website at www.optumrx.com or contact Customer Care at 844-775-7416**.**

In addition, there are special programs you must use for medications that you take for longer than 30 days, and for certain high cost specialty drugs that require special handling. Except for long term medications ("maintenance medications") filled at a participating CVS retail Pharmacy, each prescription filled at a retail pharmacy is limited to a 30-day supply.

	Retail Pharmacy	CVS 90 Saver Program	Specialty Drug Program
When to Use Your Benefit	For immediate medicine needs or short-term medicines (up to a 30-day supply).	For medicines you take on a regular, daily basis to treat a chronic or long-term condition.	For high-cost drugs used to treat complex or chronic rare medical conditions.
Where	You can use your prescription benefit at participating (in-network) retail pharmacies nationwide. To find a participating retail Pharmacy in your area, go to www.optumrx.com and use the "Find a Pharmacy" search or call OptumRx Customer care toll-free at **844-775-7416.**	Take your original prescription written for a 90-day supply to a CVS Pharmacy, or mail your original prescription with a completed mail service order form to OptumRx.	You or your physician should contact OptumRx Specialty Pharmacy at **844-775-7416.**

Cost Sharing for Network Benefits. Network pharmacies have agreed to accept as payment in full the lowest of the following:

- Billed charges, or
- The "Allowable Amount" as determined by OptumRx, or
- Other contractually determined payment amounts.

You will be responsible for the copayment amount or applicable coinsurance amount for each prescription or refill as specified in the Schedule of Benefits. If the Allowable Amount of the drug is less than the copayment amount or coinsurance amount, you will pay the lower cost.

IMPORTANT NOTE: If you buy a Brand-Name Drug when a Generic Drug is available—whether or not your doctor writes "Brand Name Only" or "Dispense As Written" (DAW) on the prescription order—you will pay the Brand-Name Drug Coinsurance Amount AND the difference in price between the Generic Drug and Brand-Name Drug.

The Copayment Amount or Coinsurance Amount is payable directly to the network Pharmacy at the time the prescription is dispensed.

When you obtain your prescription drugs through a network Pharmacy, you will not be subject to balance billing for any amount above the negotiated charge, and no claim forms are required.

If you are unsure whether a Pharmacy is a network Pharmacy, you may access OptumRx's website at www.optumrx.com or contact Customer Care at 844-775-7416.

Preventive Therapy Drug List (applies to value plan only). OptumRx's Preventive Therapy Drug List is a list of medications that help treat specific chronic conditions. It includes both generic and preferred brand-name drugs. You pay a co-pay when you use approved medications on this list. The IRS defines preventive care drugs as those taken to prevent the reoccurrence of a disease from which a person has recovered or those used as part of preventive care. You will be able to see a list of which drugs are covered and your costs on www.optumrx.com.

CVS90 Saver Program. The CVS90 Saver Program is a program that allows you to get 90-day supplies of your maintenance medications at any CVS Pharmacy location or through OptumRx home delivery. Your pharmacy benefit covers only a limited

number of 30-day refills of a maintenance medication. After the allowed refills, you must choose to fill your prescription through OptumRx home delivery or at a CVS Pharmacy, or pay the full cost of your maintenance medication.

Specialty Drugs. Specialty drugs often require special handling and extra care and must be purchased through the OptumRx Specialty Drug program. Specialty drugs include self-administered injectable drugs and certain oral medications for serious conditions such as multiple sclerosis, rheumatoid arthritis, hemophilia, cystic fibrosis, hepatitis C, growth hormone deficiency, anemia, Crohn's disease, neutropenia, pulmonary hypertension and many others. A complete list of specialty drugs that must be purchased through OptumRx specialty Pharmacy is located on www.optumrx.com. You may also call Optum Specialty Pharmacy at **877-656-9604** for more information.

The OptumRx Specialty Pharmacy provides not only your specialty medicines, but also personalized Pharmacy care management services including:

- Access to a team of clinical experts that are specially trained in your condition. Your team will be led by a pharmacist or nurse who can help you understand and manage your condition, troubleshoot side effects, and advise you on proper use and storage of your medication.
- On-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery to the address of your choice, including your doctor's office
- Medicine- and condition-specific education and counseling
- Insurance and financial coordination assistance
- Confidential and empathetic care
- Online support and resources through **www.optumrx/com/oe_premium/landing**, including condition-specific information and the specialty Pharmacy drug list

Most specialty medications are delivered by mail to your home, office or other location of your choice. The quality of your medicine is maintained during shipping with secure, temperature-controlled packaging. To protect your privacy, the outside of the shipping package is non-descriptive, and OptumRx will include the supplies you need to take your medicines, such as syringes and alcohol swabs.

Covered Drugs. Covered drugs are based on OptumRx's Premium Formulary, which is a list of medications and where they fall in the Plan's coverage. Only the medicine approved under the Premium Formulary is covered by the Plan. The Premium Formulary is available online at www.optumrx.com.

There are three categories of medications:

- Tier 1 – usually generics and have the lowest out-of-pocket costs
- Tier 2 – preferred brand drugs
- Tier 3 – brand drugs (the highest cost option that typically have a lower cost option in Tier 1 or 2).
    - If there is a Tier 3 medication that has a Tier 1 option, and you choose the higher cost Tier 3 drug, there is a penalty of the copay plus the cost difference between the Tier 3 brand and the Tier 1 generic.

There are some medications that may be excluded from the Premium Formulary. If your doctor prescribes you a medication not covered under the Premium Formulary, you will be responsible for paying the full cost of the medication. If your doctor feels you must take a specific drug that is not part of the Premium Formulary, your doctor must work with OptumRx to see if you qualify for a medical necessity exception. If you do not qualify for a medical necessity exception, you may have to pay the full cost of the medicine. If you are currently using one of the medicines that require step therapy and prior authorization, ask your doctor to consider one of the approved Premium Formulary medications.

Drugs that are covered include:

- Birth control, oral contraceptives, and contraceptive devices (IUD or diaphragm) and implants (Norplant)
- Compound medication of which at least one ingredient is a prescription legend drug (prior authorization may be required and limits may apply)
- Disposable insulin needles/syringes by prescription
- Insulin by prescription
- Glucose test strips and lancets
- Drugs that may only be dispensed upon the written prescription of a physician or other lawful qualified prescriber under the applicable state law

- Growth hormones and releasing agents, subject to Optum's guidelines
- Prenatal vitamins prescribed by a physician
- Prescription drugs and generic drugs, except those drugs listed in the exclusions
- Smoking cessation prescription drugs and over-the counter (OTC) drugs by prescription

Drugs that are not covered include:

- Charges for the administration or injection of any drug are not paid as part of the drug benefits
- Charges incurred before a person was covered
- Dental drugs
- DESI drugs (drugs determined by the FDA as lacking substantial efficacy
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the covered person (unless related to a covered clinical trial)
- Drugs newly approved by the FDA, prior to review by the applicable Pharmacy and Therapeutics Committee
- Hair replacement drugs for treatment of alopecia (hair loss) including Minoxidil (Rogaine) and Propecia are not covered unless the hair loss is result of chemotherapy
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis
- Infertility drugs
- Medication to be taken or administered, in whole or in part, while a patient is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, skilled nursing facility or similar institution that operates on its premises, a facility for dispensing pharmaceuticals
- Medication to enhance athletic performance
- Mineral supplements, except folic acid
- Obesity drugs
- Off-label drugs (pharmaceutical drugs unapproved by the FDA for indication or in an unapproved age group, unapproved dosage, or unapproved form of administration)
- Over-the-counter medicines and supplies – that do not require a physician's prescription and may be obtained over the counter, regardless of whether a physician has written a prescription for the item, are not covered except for diabetic supplies and prenatal vitamins
- Prescription and nonprescription supplies, devices and appliances other than syringes used in conjunction with injectable medications
- Prescription drugs provided free of charge from local, state or federal programs
- Prescription drugs used for cosmetic purposes such as: drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products
- Prescriptions provided without a charge under a worker's compensation program
- Prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products
- Therapeutic devices or appliances, and other nonmedical substances, regardless of intended use, are not covered unless specifically listed as a covered item.

Preventive Drugs. The Medical Plan covers preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a network pharmacy if they are prescribed by a doctor, obtained at a pharmacy and submitted to a pharmacist for processing. Coverage of preventive care drugs and supplements will be subject to any gender, age, medical condition, family history, and frequency guidelines in the recommendation of the US Preventive Services Task Force.

Medications with Clinical Requirements. Certain medications have requirements that must be met before the plan provides coverage.

Prior Authorization. Certain medications must be approved in advance before they are covered by OptumRx. If prior authorization is required, your pharmacist will instruct you to have your physician contact OptumRx Prior Authorization unit. If the prescription is approved for medical necessity, the prior authorization is valid for up to one (1) year. If the request is denied, you or your representative will receive a notice of denial, which will include the appropriate procedures for filing an appeal. You can contact Customer Care at 844-775-7416 for more information.

Step Therapy with Post-Step Prior Authorization. You must try a lower-cost alternative before a higher-cost medication will be covered. If you have a unique medical situation where the lower-cost alterative doesn't work well for you, your doctor must contact OptumRx and confirm that a specific medication is clinically necessary for your condition.

Quantity Limit. The Plan limits the amount of a specific medication that you can fill in a 30-day or 90-day period. If you have a unique medical situation that requires you to exceed the limit, your doctor can contact OptumRx and confirm that a higher quantity is clinically necessary for your condition. You can find a comprehensive list of covered drugs along with any specific criteria at www.optumrx.com.

If a requested prescription order is still denied after your physician or authorized provider has submitted clinical documentation, you have the right to appeal in accordance with the claims and appeals procedures provided in this Plan.

New Prescriptions. If your doctor gives you a new prescription for a long-term (maintenance) medication, you should ask him or her for a 30-day prescription that you can fill immediately and a 90-day prescription that you can fill for ongoing use. Take the 30-day prescription to your local in-network pharmacy to be filled. Then order a 90-day supply of your prescription at a participating retail pharmacy or through OptumRx Mail Service Pharmacy.

Filling Long-Term (Maintenance) Medications. Long-term (maintenance) medications are those medications that your physician prescribes for chronic conditions such as diabetes, high blood pressure, heart conditions, allergies, thyroid conditions, etc. You can verify with your pharmacist or OptumRx customer service whether your prescription is for a long-term medication. After the second time you fill a long-term (maintenance) medication, you are required to have your maintenance medications filled with a 90-day prescription or you will be penalized with a higher coinsurance or copay. Filling a long-term (maintenance) medication in 30-day supplies will cost you as much as a 90-day supply or more. You can get a 90-day supply at any retail CVS location or through OptumRx mail order.

Optum Mail Delivery Service. Home delivery from OptumRx is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication for delivery to your home, office or location of your choosing.

Online Enrollment. Log on to www.optumrx.com to register for home delivery. Be sure to have your prescription card with ID number available when you register for the first time. If your prescription is for a controlled drug, you may need to obtain a written prescription from your doctor.

Paper Form Enrollment. Ask your doctor for a written prescription. If you need a prescription filled right away, ask your doctor to write two prescriptions for your long-term medications. The first prescription is for a short-term supply (e.g. 30 days) to be filled right away at a participating CVS pharmacy and the second for the maximum days' supply (up to a 90-day supply) with as many as three refills to be mailed to OptumRx. Complete the mail service order form. You can fill out and print the form online at www.optumrx.com or request a blank form from customer service. Mail your order form along with the prescription(s) and payment. New envelopes are provided with each fulfillment.

Claims Procedure

OptumRx is the "Claims Administrator" and serves as a fiduciary solely for the purpose of initial claim adjudication and appeals relating to eligibility and coverage under the Plan, except for medical necessity appeals.

OptumRx has contracted with an independent external review organization for processing appeals relating to medical necessity. The independent external review organization shall act as the Plan's named fiduciary under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") solely with respect to adjudication of medical necessity appeals.

The presentation of a prescription to your pharmacist is not a "claim" subject to ERISA benefit claim procedures because your pharmacist simply determines cost by reference to the Plan's Schedule of Benefits and exercises no discretion on behalf of the Plan.

Claims Administrator Address
OptumRx c/o Appeals Coordinator
PO Box 25184
Santa Ana, CA 92799

Phone: 1-888-403-3398

Fax: 1-877-239-4565

Initial Coverage Review. You have the right to request that a medication be covered or be covered at a higher benefit – e.g., a lower copay, higher quantity, etc.

The prescriber or dispensing pharmacist may submit a request for an initial review electronically. If your situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, the patient's health may be in serious jeopardy or the patient may experience pain that cannot be adequately controlled while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone.

In order to make an initial determination for a clinical coverage review request, the pharmacist must submit specific information for review. For an administrative coverage review request, you must submit information to support the request. The initial determination and notification will be made within the specified timeframes as follows:

Type of Claim	**Decision Timeframe** **Decisions are completed as soon as possible from receipt of request, but no later than:**
Standard Pre-Service*	15 days
Standard Post-Service*	30 days
Urgent**	72 hours

*If necessary, this period may be extended one-time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan and you are notified prior to the expiration of the initial review period. If an extension is necessary because you failed to provide the necessary information needed to make a determination, you will have 45 days from receipt of the notice within which to provide the needed information. The claim will be denied in full if you fail to timely provide the information within 45 days.
**If additional information is necessary to make a determination, you will be notified within 24 hours of receipt of the initial claim and will be provided a 48 hour extension to provide the information.

Right of Appeal. When an initial coverage review has been denied (adverse benefit determination), you or your authorized representative may submit a request for appeal within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the Claims Administrator:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent appeals must be submitted by phone or fax directly to OptumRX. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

OptumRX completes appeals per business policies that are aligned with state and federal regulations. Depending on the type

of appeal, appeal decisions are made by a pharmacist, physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request, but no later than:
Standard Pre-Service	15 days
Standard Post-Service	30 days
Urgent*	72 hours

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding.

External Review Process. The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to the Claims Administrator and the request must be received within 4 months of the date of the final Internal adverse benefit determination. If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.

OptumRX will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization ("IRO") and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to OptumRX for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Prescription Drug Plan and OptumRX written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Legal Action for Recovery. If after you have exhausted the appeal and external review process, if applicable, you are still not satisfied with the outcome, you may file a legal or equitable action in federal or state court. Any such action must be filed within one (1) year from the date your original prescription was denied.

Plan Administration

Plan Administrator. G6 Hospitality LLC ("G6") is both the "Plan Sponsor" and the designated "Plan Administrator" for purpose of ERISA. Relevant information for G6 is below:

G6 Hospitality LLC
Attn: Mary Fregia, Director of Benefits
4001 International Parkway
Carrollton, TX 75007
Telephone Number: (972) 360-5716
EIN: 77-0086501

G6 may choose to delegate some or all of its administrator authority to OptumRX or another party. To the maximum extent permitted under ERISA, G6 or its authorized delegate has full discretionary power to administer the Prescription Drug Plan in all of its details. For this purpose, discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Prescription Drug Plan:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Prescription Drug Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- To interpret the Prescription Drug Plan;
- To decide all questions concerning the Prescription Drug Plan and the eligibility of any person to participate in the Prescription Drug Plan;
- To compute the amount of benefits which will be payable to any Member or other person in accordance with the provisions of the Prescription Drug Plan, and to determine the person or persons to whom such benefits will be paid;
- To authorize the payment of benefits;
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Prescription Drug Plan; and
- To delegate its responsibilities under the Prescription Drug Plan and to designate other persons to carry out any of its responsibilities under the Prescription Drug Plan, any such delegation or designation to be in writing.

Any determination by G6 or any authorized delegate, will be final and binding on all persons, in the absence of clear and convincing evidence that DFA or authorized delegate acted arbitrarily and capriciously.

Funding of Benefits. The benefits offered under the Prescription Drug Plan are provided on a self-insured basis and are paid through a combination of G6 and employee contributions.

Trust Fund and Trustees. Benefits are paid through G6's general assets and there is not a separate trust with respect to the Prescription Drug Plan.

HIPAA Privacy and Security Protections. The HIPPA protections identified in the Medical Plan will also apply to this Prescription Drug Plan.

Plan Year. The Prescription Drug Plan is administered and maintained based on each 12-month period beginning January 1 and ending on the following December 31.

ERISA Plan Number. The Prescription Drug Plan is a component sub-plan of the G6 Hospitality LLC Group Insurance Plan. The plan number assigned for purposes of ERISA is 501.

Service of Legal Process. Service of legal process may be made upon the following:

G6 Hospitality LLC
Attn: Mary Fregia, Director of Benefits
4001 International Parkway
Carrollton, TX 75007
Telephone Number: (972) 360-5716

Amendment or Termination of Plan. G6 reserves the right to amend, modify, or terminate the Prescription Drug Plan, including but not limited to terms and conditions of eligibility and benefits, in whole or in part at any time.

No Vested Rights. No employee nor any spouse or other dependent of an employee will have any vested rights to benefits under the Prescription Drug Plan at any time. Further, nothing in this document creates any right to an employee's continued employment with G6 or its affiliates.

Governing Law. The Prescription Drug Plan will be governed by the laws of the state of Texas.

Nonalienation of Benefits. No benefit, right or interest of any person will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or as required by a qualified medical child support order.

Without limiting the foregoing, a member may not assign to any party, including without limitation to a provider of healthcare services/items, such member's right to benefits under the Prescription Drug Plan, nor may the member assign any administrative, statutory, or legal rights or causes of action he or she may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights will be void and unenforceable under all circumstances.

Continuing Coverage under COBRA. If you lose your Plan coverage, including your coverage under the Prescription Drug Program, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 ("COBRA"). Additional information about continuation coverage under COBRA is available in the Medical Plan's SPD. Please refer to that document.

STATEMENT OF ERISA RIGHTS:

Eligible persons covered under the Prescription Drug Plan are entitled to certain rights and protections under ERISA. ERISA provides that all Members will be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Prescription Drug Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Prescription Drug Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Prescription Drug Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may charge a reasonable fee for the copies.
- Receive a summary of the Prescription Drug Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Prescription Drug Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries:

- In addition to creating rights for covered Eligible Employees, ERISA imposes duties upon the people who are responsible for the operation of the Prescription Drug Plan. The people who operate your Plan, called "fiduciaries" of the Prescription Drug Plan, have a duty to do so prudently and in the interest of you and other Members. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

- If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason

for the denial. You have the right to have the Prescription Drug Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Prescription Drug Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you 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.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Prescription Drug Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions:

- If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

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