
Prescription Drug Program Summary Plan Description

This summary plan description (SPD) describes the prescription drug benefits available to associates who are currently enrolled in a Crestline Hotels & Resorts, LLC (Crestline) medical plan option. Enrollment in the Express Scripts Prescription Drug Program (the Plan) is automatic based upon an associate's election of medical coverage.

The Plan provides coverage for a variety of generic and brand-name prescription medications that members may purchase from any retail network pharmacy or through Express Scripts' mail order program.

Eligibility

The Plan's eligibility requirements and terms of coverage are governed by Crestline's medical plan provisions, which are detailed in your medical summary plan description. You may obtain a copy of your medical summary plan description by contacting your local HR representative.

Eligible associates are:

- employed by Crestline on a full-time, year-round (not seasonal or temporary) basis, regularly scheduled to work at least 30 hours per week for field associates or 32 hours per week if classified as a corporate associate.
- eligible for the provisions of the Family and Medical Leave Act (FMLA) of 1993, as Stated therein.
- compensated by Crestline for work/services performed in accordance with applicable federal and state wage hour laws for which compensation is reported to the Internal Revenue Service by Form W-2.

Eligible dependents include a covered associate's:

- legal spouse
- dependent child up to age 26, including a covered associate's:
 - natural child;
 - legally adopted child or grandchild;
 - child (including grandchild) for whom the covered associate is the legally recognized proposed adoptive parent, and for whom the child is dependent upon and living with during the waiting period before the adoption becomes final;
 - stepchild who permanently resides in the covered associate's household and who is dependent upon the covered associate for more than half of his or her support;
 - grandchild who is in the court ordered custody of and is dependent upon and residing with the covered associate;
 - child for whom the covered associate has been court ordered or administratively ordered to provide coverage;
- dependent child (no age limit) if:
 - the child is incapable of supporting him or herself because of mental or physical disability; and

- the child's disability occurred before the age limit of 26 while covered as the covered associate's dependent; and
- the child is primarily dependent upon the covered associate or the covered associate's spouse for support and maintenance; and
- the covered associate submits all required supporting documentation to the medical carrier as detailed in Crestline's group medical summary plan description.

Application for extended coverage and proof of incapacity must be furnished to the *Plan Administrator* within 31 calendar days after the dependent reaches age 26 or, in the case of a *covered associate* who first becomes eligible after a handicapped dependent reached age 26, within 31 calendar days after the date he or she first becomes eligible. After this initial proof, the *Plan Administrator* may request proof again two years later, and each year after.

A handicapped *covered dependent* will be eligible for coverage as long as he or she continues to be handicapped and dependent on the *covered associate*, unless coverage otherwise terminates under this *Plan*.

- domestic partner if the *covered associate* and his or her partner are:
 - the same gender;
 - at least 18 years old;
 - share a common residence;
 - are jointly responsible for each other's basic living expenses;
 - capable of consenting to the partnership; and
 - are not related by blood in a way that would prevent them from being married under applicable state law.

Please refer to Crestline Hotels & Resorts, LLC, *Domestic Partner Benefits Guide* for more information and details concerning policies and procedures for domestic partner coverage.

Who is Not Eligible

An individual is ineligible to participate in this Plan during any period in which he/she:

- is classified by the Employer as an independent contractor, regardless of his/her current legal status,
- is covered by a contract or other written agreement that provides that the individual is not *eligible* for welfare benefits or benefits under this *Plan*.
- is a Director, Trustee, corporate officer, outside counsel, consultant, owner, partner, temporary or seasonal associate unless actually employed by Crestline and meet the criteria for coverage applicable to other Crestline associates.

The following people are not eligible dependents:

- a former spouse whose marriage with the covered associate has ended in legal divorce or annulment,
- dependents in extended military service,
- stepchildren and foster children who do not live with the associate per the IRS definition of tax dependent,
- parents or grandparents (even if they are "dependents" for tax purposes),

- grandchildren (unless legal guardian is covered associate)
- significant others who do not meet all definitions and requirements established by Crestline Hotels & Resorts, LLC, *Domestic Partner Benefits Guide*.

Enrollment

Enrollment in the Plan is automatic when you enroll in a Crestline medical plan. The coverage effective date and termination date of each member's prescription drug coverage is in accordance to the coverage terms established by Crestline's medical plan(s) provisions.

How the Program Works

The Prescription Drug Program uses a three-tier copay design. The three-tier design maintains a broad choice of covered drugs for patients and their doctors, while providing an incentive to use medications that are safe, effective and less costly. Frequently there is more than one prescription drug that your physician could prescribe for a particular illness or condition. Talk with your doctor about your options to determine the best choice for you.

The program copays vary by type of drug and whether you fill your prescription at a retail pharmacy or through mail order. Here are the copays for most prescriptions:

<i>Type of drug</i>	<i>Retail pharmacy copay (34-day supply)</i>	<i>Mail order copay (90-day supply)</i>
Generic	\$15	\$30
Preferred brand-name	\$30	\$60
Non-preferred brand-name	\$45	\$90

As added incentive for diabetics to remain compliant with their medication, lower copayments apply to diabetic medications:

<i>Type of drug</i>	<i>Retail pharmacy copay (34-day supply)</i>	<i>Mail order copay (90-day supply)</i>
Generic	\$5	\$10
Preferred brand-name	\$10	\$20
Non-preferred brand-name	\$25	\$50

Brand-Name and Generic Drugs

A brand-name drug features a trade name under which it is advertised and sold, and is protected by a patent. Generic drugs are drugs for which the brand-name patent has expired, allowing other manufacturers to produce and distribute the product. A generic drug has the same active ingredients as its brand-name counterpart, and manufacturers of generic drugs must follow stringent Food and Drug Administration (FDA) regulations for safety.

When you fill a prescription, the pharmacy will check if a generic is available.

- If a generic is available and you choose it, you pay the standard copayment for a generic drug, which is less than the cost for a brand-name drug.

- If a generic is available and you choose the brand-name medication rather than choose the generic, (even if your physician prescribes a brand-name drug to be dispensed as written (“DAW”)), you’ll pay your copayment plus the difference in cost between the generic and the brand-name drug.

Preferred Drug List

A brand-name drug that is on Express Scripts’ preferred drug list will save you money compared to a brand-name drug that is not on the preferred list. The preferred list, or formulary, is a list of recommended prescription medications that is created, reviewed and regularly updated by a team of physicians and pharmacists. The list contains a wide range of generic and brand-name preferred products that have been approved by the FDA.

Use of a preferred drug is voluntary; however, your prescription cost will be higher if your doctor does not prescribe a drug on the preferred list. Sometimes your doctor may prescribe a medication for which either a preferred brand-name or generic alternative drug is available. In such cases, your doctor may specify that a prescription be “DAW”.

The pharmacist may ask your doctor whether an alternative preferred drug might be appropriate for you. If your doctor agrees, your prescription will be filled with the alternative drug. A confirmation will be sent to you and your doctor explaining the change. Ask your doctor if you have questions about the change in prescription. Your doctor always makes the final decision on your medication, and you can always choose to keep the original prescription. Pharmacies will dispense only the medication authorized by the doctor. Note that the mail-order pharmacy will automatically dispense a generic if available, unless you request the brand-name medication and are willing to pay the cost difference between the generic and brand-name medication.

Newly Approved Drugs

The Express Scripts Therapeutics Assessment Committee reviews all drugs that are newly approved by the FDA. The committee evaluates drugs for therapeutic treatment and safety. Findings are then made available to Express Scripts Value Assessment Committee, which reviews the information and develops a formulary placement recommendation that is forwarded to the Express Scripts National Pharmacy and Therapeutics Committee for final approval. The three-step process is designed to ensure a clinically sound formulary while providing cost-effective care for plan sponsors and their members.

Even after a drug is included on the preferred drug list, this evaluation process continues at least quarterly or as new information becomes available.

Retail Pharmacy Purchases

There are more than 65,000+ participating retail pharmacies available through Express Scripts’ nationwide network. To locate a participating pharmacy in your home ZIP code area, call Express Scripts at 1-877-486-5984 or visit Express Scripts’ website at www.express-scripts.com to access the pharmacy directory.

When you have your prescription filled at a participating retail pharmacy, remember to present your prescription drug ID card. This card is separate from your medical ID card and provides your pharmacist the required information to accurately process your claim and collect the appropriate copay amount. Presenting your prescription drug ID card at the time of purchase should also alleviate the need for you to complete and submit a claim form directly to Express Scripts.

You can initially purchase up to a 34-day supply of prescription medication from any participating retail pharmacy. Once your prescription medication is reduced to ¼ of the original amount, you may purchase a refill if needed. However, please note that retail copayments for maintenance medications will double after two refills at any participating retail pharmacy. As an alternative, you have the option of ordering your maintenance medications through Express Scripts' Mail Order (Home Delivery) Program, which typically offers a better value for a 90-day supply of the same maintenance medications. Please refer to the following section labeled "Mail Order Purchases" for additional details.

Mail-Order Purchases

Through Express Script's Mail Order (Home Delivery) program, you can order up to a 90-day supply of a prescription maintenance medication as prescribed by your doctor. Prescription maintenance medications are those drugs taken regularly for treating long-term chronic conditions such as asthma, diabetes, high cholesterol, hypertension or arthritis.

Typically, a pharmacist at Express Scripts will fill your prescription with a generic drug (if available) unless you specify otherwise. In addition, the pharmacist may contact your doctor if your prescription is unclear or incomplete, or to ask whether a substitution or change may be made to the prescription he/she has written.

To order a prescription from the mail-order program, you may use one of two easy ways:

1. After obtaining a Home Delivery order form from your plan administrator or directly from Express Scripts, simply complete and mail your order form directly to Express Scripts. You must include your 90-day written prescription (with up to one year of refills, if appropriate) and applicable copayment amount.
2. Request that Express Scripts contact your doctor directly to get a new prescription for Home Delivery. Just visit: www.express-scripts.com/mail/start.

For new prescription orders, you'll receive your medication within 10-14 days from the date Express Scripts receives your order. If you need your medication sooner, ask your doctor to write two prescriptions:

- one for up to a 34-day supply to be filled immediately at a retail pharmacy and paid at the retail copay; and
- another that you can send to the mail-order program for an additional 90-day supply at the mail-order copay.

Once your medication is down to a 34-day supply, you may order a refill. You'll normally receive your refill within 2-5 business days.

What's Covered

Generally, Express Scripts covers drugs that require a prescription for dispensing, are medically necessary and aren't experimental in nature. This may include:

- Agents used to suppress appetite and control fat absorption (Xenical, Meridia)
- Compounded products
- Contraception:
 - Non-injectable monthly (oral, patch, ring)
 - Injectable (e.g., Depo Provera)

- Emergency contraception (Plan B, Preven)
- Diaphragms
- Implants/IUDs
- Over-the-counter contraceptive methods (e.g., contraceptive sponge, female condom)
- Diabetic supplies, including lancets, urine tests, blood glucose calibration solutions, blood test strips (Glucose or Ketone), swabs, syringes, needles devices, and pump supplies; also includes blood monitors and kits (Glucose or Ketone) limited to 1 per year
- Diflucan (excluding 150mg tablets)
- Impotence – injectable (Caverject, Edex) and non-injectable (Viagra, Muse)
- Injectable drugs (other than insulin) included on the Express Scripts Selected List and available through the CuraScript injectable pharmacy program
- Injectable Rhogam
- Non-Insulin Syringes
- Respiratory Therapy Supplies (Aerochamber, Spacers)
- Legend smoking cessation products – up to \$550 per member per year
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin-A) – up to age 25 (after age 25, prior authorization is required)
- Travel vaccines
- Vaginal estrogen (Estring) – 3 copays for 90-day supply
- Vitamins (oral only):
 - Therapeutic agents used for specific deficiencies and conditions
 - Hemopoetic agents used to treat anemia
 - Prenatal agents used in pregnancy
 - Fluoride products – pediatric and dental

Prior Authorization Required

Some drugs are covered only if they are prescribed for a specific use. For this reason, these medications must receive prior authorization before they can be covered under the program. If the prescribed medication must be pre-authorized, your pharmacist will inform you.

The pharmacist may initiate the review process, or you may ask your doctor to call a special toll-free phone number that will be supplied by your pharmacist. It typically takes two business days. The patient and/or doctor will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

Here is a partial list of drugs that require prior authorization (contact Express Scripts for the most current complete list):

- Aranesp injectables
- Botox injectables (non-cosmetic purposes only)
- Epogen/Procrit injectables
- Enbrel

- Forteo injectables
- Growth Hormones injectables
- Humira
- Kineret
- Prolastin injectables
- Provigil
- Remodulin
- Regranex
- Remicade injectables
- Revatio
- Simponi
- Tazorac
- Xeomin
- Xolair injectables

Step Therapy Program

Crestline has implemented step therapy programs for certain categories of medications.

- Proton Pump Inhibitors – PPIs (acid reflux/ulcers)
- Selective Serotonin Reuptake Inhibitors – SSRIs (depression)
- Statins – Enhanced (high cholesterol)

In Step Therapy, drugs are grouped in categories, based on cost:

- Front-line drugs – the first step – are generic drugs proven safe, effective and affordable. These drugs should be tried first because they can provide the same health benefits as more expensive drugs, at a lower cost.
- Back-up drugs – Step 2 and Step 3 drugs – are brand-name drugs such as those you see advertised on TV. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs always cost more than front-line drugs.

The next time your doctor writes a prescription for a medication in any of the above mentioned categories:

- Ask your doctor if a generic medication – listed as a front-line drug – is right for you.
- If you have already tried a front-line drug, or your doctor decides one of these drugs isn't appropriate for you, then your doctor can prescribe a back-up drug. Ask your doctor if one of the lower-cost brands (Step 2 drugs) is appropriate.
- You can always get a higher-cost brand-name drug at a higher copayment if the front-line or Step 2 back-up drugs are not right for you.

If your doctor gives you a prescription for a drug that is not on the front-line list, you can do one of two things:

- Ask your pharmacist to call your doctor to request a new prescription for a front-line drug.
- Talk with your doctor and ask whether a front-line drug could be right for you. If your doctor approves the change, ask for a new prescription.

If the prescription was submitted to mail-order, an Express Scripts pharmacist will contact you and call your doctor to request a new prescription for a front-line drug.

If there will be a delay in getting a new prescription from your doctor and you need the medication immediately, you can ask the pharmacist for a partial fill of the original prescription. Although you may have to pay full price for this quantity of drug, you will be able to start your treatment right away.

What's Not Covered

The following prescription drugs and services aren't covered under the Express Scripts Prescription Drug Program:

- Allergens
- Depigmentation products used for skin conditions requiring a bleaching agent
- Fertility agents including injectable (Profasi, HCG) and oral/vaginal (Clomid, Crinone)
- FluMist
- Hair Growth Agents (Propecia, Vaniqa)
- Injectable cosmetics (e.g. injections for wrinkles)
- Legend homeopathic medications
- Legend Multivitamins (usually have OTC counterparts)
- Ostomy supplies
- Over-the-counter drugs that are obtainable without a prescription (except when considered preventive under the Affordable Care Act)
- Peak flow meters
- Photo-aged skin products (Renova)
- Serums, toxoids, vaccines (except travel vaccines)
- Supplemental agents (usually have OTC counterparts)
- Yohimbine for impotence (not FDA approved for this indication)

This is not intended to be an exhaustive list and is subject to change without notice. If you have any questions, call Express Scripts at 1-877-486-5984.

Claims Review and Appeals Procedures

The Prescription Drug Program has a specific amount of time, by law, to evaluate and respond to benefit claims. These time limits apply to plans subject to ERISA. The period of time Express Scripts has to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

How to File Claims

Network participating pharmacies typically file claims for you. In rare cases, you'll need to pay for the care you receive up-front, then file a claim for reimbursement.

To file a claim, you need to complete the Express Scripts' claim form and submit it, together with any other information the form requires, to Express Scripts at the following address:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

You can request claim forms from Express Scripts or download them from Express Scripts website at express-scripts.com.

If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Claims Appeal Process

If you receive notice of an adverse benefit determination and you disagree with the decision, you're entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an authorized representative) will have at least 60 days after receiving the denial notice to file an appeal.

You may be able to resolve the denied claim without a formal appeal by calling Express Scripts to discuss the situation.

Appeals are handled by MCMC, an independent, third-party utilization management company. An appeal request must be made in writing and include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant to your appeal. You should file the request with MCMC, through Express Scripts, at the following address:

Express Scripts, Inc.
Attn: Pharmacy Appeals
6625 West 78th Street
Mail Route BL0390
Bloomington, MN 55439

MCMC will follow the guidelines set forth below with respect to the review function:

- Express Scripts will forward to MCMC the applicable medical records. Express Scripts shall be responsible for submitting the specific applicable Plan Language with each case review.
- Documentation regarding any previous appeal, specific Plan language, and specific criteria will also be forwarded to MCMC by Express Scripts.

- MCMC will notify you in writing within one business day of receipt of case; inform you of your right to submit additional records for review; and provide the name and telephone number of a contact person to answer questions related to the appeal process.
- The independent specialist(s) selected by MCMC to conduct the review will review documentation within three business days from when MCMC received the case.
- Should additional information be needed, MCMC may contact your provider to request the additional information where MCMC considers such information necessary or potentially useful in MCMC's review.
- The independent specialist(s) selected by MCMC to conduct the review (1) will review available medical records, (2) will review any additional information obtained from you provider, and (3) will write an independent rationale in support of his/her final decision. The final decision of the independent specialist(s) may affirm Express Scripts' determination in full (Deny), may reverse Express Scripts' determination in full (Approve), or may affirm Express Scripts' determination in part and reverse it in part (Modify).
- A letter will be sent by MCMC to you with a copy to Express Scripts within five (5) business days of having received all information from Express Scripts, the patient, and/or the attending physician. The letter will include the final decision, the reasons for the final decision, references to the Plan provisions on which the decision is based, and a statement indicating that this is the final and binding decision. In addition to the letter, Express Scripts will receive a copy of the actual case review done by the independent specialist(s). All documentation received with the case will be kept on file at MCMC.

About COBRA

In some circumstances, federal law requires that persons who lose group health plan coverage, which includes prescription drug benefits, be given the chance to continue that coverage for a period of time.

The federal law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA. It requires that employers like Crestline Hotels & Resorts, LLC allow covered associates and their covered dependents (called "qualified beneficiaries") to temporarily extend coverage (called "COBRA coverage") at group rates. That means you may be eligible to extend your prescription drug benefits by electing COBRA continuation coverage.

COBRA coverage is available to you and your covered eligible dependents in certain instances where coverage would otherwise end (called "qualifying events"). For example, COBRA coverage is available to active associates and their covered eligible dependents if they are terminated, or if their hours are reduced to the extent that they no longer qualify for Crestline's group coverage.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Keep in mind that the coverage described below may change as permitted or required by changes in any applicable law. In some states, state law provisions may also apply to the insurers offering benefits under the Crestline Hotels & Resorts Employee Benefit Plan.

For more information, contact your COBRA administrator, Conexis. You can contact them by writing to:

COBRA Administrator
Conexis
PO Box 22610
Dallas, TX 75222

You also can contact the COBRA administrator by calling (877) 722-2667, ext. 3360.

You don't have to show that you're insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. Crestline reserves the right to terminate you and your dependents' coverage retroactively if it's determined that you and/or your dependents are ineligible for COBRA coverage under the terms of the Crestline's group Plan.

COBRA continues for up to 18, 29 or 36 months, depending on why you or your dependent became eligible.

Individuals who elect continued coverage under COBRA generally have to pay the entire cost of that coverage for themselves and their covered dependents. You will pay your share and Crestline's share—plus a 2% administrative fee.

Through COBRA, you may continue the same health care coverage you had before the event that qualified you for COBRA. If coverage for non-COBRA beneficiaries is modified, coverage made available to you through COBRA will be similarly modified.

COBRA-at-a-Glance

The following table provides an overview of available COBRA coverage for most types of healthcare coverage that can be continued under COBRA if you lose coverage under a Plan based on a qualifying event. See the following sections of this summary for more details.

Who Is Affected	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage*
You	Terminate employment	You and your covered dependents	Up to 18 months
	Have a reduction in hours below the level required for benefit eligibility	You and your covered dependents	Up to 18 months
	Are disabled at the time you become eligible for COBRA or you are determined to be disabled within the first 60 days of COBRA continuation coverage You must notify the COBRA administrator of the Social Security Administration's determination of disability as instructed in Length of COBRA Coverage."	You and your covered dependents	Up to 29 months**

* Duration of COBRA coverage is measured from the last day of the month in which the qualifying event occurs and is not available for more than a total of 36 months.

** You're required to provide proof of eligibility for Social Security disability benefits during the first 18 months of COBRA continuation coverage in order to be eligible for the additional 11 months of COBRA coverage.

Who Is Affected	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage*
Your Spouse or Dependent Child	You die	Your covered dependents	Up to 36 months
	You and your enrolled spouse become divorced or legally separated	Your covered dependents, including your former spouse	Up to 36 months
	Your spouse and/or dependent child is disabled at the time he or she becomes eligible for COBRA—or becomes disabled within the first 60 days of COBRA continuation coverage. You must notify the COBRA administrator of the Social Security Administration’s determination as instructed in “Length of COBRA Coverage.”	You and your covered dependents	29 months**
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to reaching a plan’s age limit)	Your covered dependent child	36 months

* Duration of COBRA coverage is measured from the last day of the month in which the qualifying event occurs and is not available for more than a total of 36 months.

** You’re required to provide proof of eligibility for Social Security disability benefits during the first 18 months of COBRA continuation coverage in order to be eligible for the additional 11 months of COBRA coverage.

Who Is Eligible

As an Associate

If you’re covered by Crestline Hotels & Resorts Employee Benefit Plan on the day before a qualifying event, you have the right to choose COBRA coverage:

- if you lose coverage because your hours are reduced to the extent that you no longer qualify for Crestline’s group coverage or
- because your employment terminates

Note: In some cases, you may have options to continue coverage directly under the Crestline Hotels & Resorts Employee Benefit Plan (e.g., layoff, leave of absence or illness). In these cases, you must choose either the Company-sponsored continuation of coverage or the COBRA continuation of coverage.

As a Covered Spouse

If you’re the legal spouse of an associate and you’re covered by the Crestline Hotel & Resorts Employee Benefit Plan on the day before the qualifying event, you’re considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

- your spouse dies,
- your spouse’s employment is terminated or your spouse’s hours of employment are reduced or
- you divorce or legally separate from your spouse.

As an Eligible Dependent Child

If you're a dependent child of an associate and you're covered under the Crestline Hotels & Resorts Employee Benefit Plan on the day before the qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if your coverage under the Plan is lost for any of the following reasons:

- the associate dies,
- the associate's employment is terminated or the associate's hours of employment are reduced,
- the associate divorces or legally separates or
- you cease to be a dependent child under the terms of the Plan.

Newly Acquired Dependent Children

If you are a qualified beneficiary and have a newborn child, you adopt a child or a child is placed for adoption with you while you are covered under COBRA, that child can also receive COBRA for the duration of your COBRA continuation coverage. You must notify the COBRA administrator in writing within 31 days of the birth, adoption or placement for adoption for the child to be covered as of the date of the birth, adoption or placement for adoption. In this case, the child will have the same rights as any dependent covered immediately prior to your COBRA eligibility. (A child is considered "placed for adoption" with you when you have assumed and retained a legal obligation for total or partial support of the child in anticipation of adoption.)

Written notice about a new dependent must include information about the qualified beneficiary receiving COBRA coverage as well as the new child who will be receiving COBRA coverage. The COBRA administrator also may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If you don't notify the COBRA administrator within 31 days of the qualifying event, you won't be offered the option to elect COBRA coverage for the new child.

Note: Other newly acquired dependents (such as a new spouse) won't be considered qualified beneficiaries but may be added to your COBRA coverage as dependents, according to plan rules that apply to active associates.

If a Qualifying Event Occurs

What You Need to Do

Under COBRA, you, your spouse or your other eligible dependents have the responsibility to inform the HR Representative of a divorce, legal separation or child's loss of dependent status under the Crestline Hotels & Resorts Employee Benefit Plan. Written notice must be provided, in accordance with the procedures described below, by the latest of the following to occur:

- within 60 days from the date of the divorce, legal separation or loss of dependent status; or if later
- the date coverage would normally be lost because of the event; or if later
- the date on which the qualified beneficiary is informed through the Summary Plan Description or the COBRA General Notice of his or her obligation to provide notice and the procedures for such notice.

You also must provide information about the associate or qualified beneficiary requesting COBRA coverage and any required documentation about the qualifying event that gave rise to the individual's right to COBRA coverage.

If you or the qualified beneficiary fails to notify the HR Representative in accordance with these procedures or to provide supporting documentation within the timeframes listed above, COBRA rights will be forfeited.

Documentation Required

When you provide notice of the qualifying event, you or the qualified beneficiary must also submit documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

Divorce—a copy of the divorce decree,

Legal Separation—a copy of the separation agreement and

When you inform the HR Representative that one of these events has happened (and the required documentation has been received), you will be notified as to whether or not you have the right to elect COBRA coverage.

Remember, all initial notification about one of these qualifying events and other communications regarding COBRA coverage and Crestline Hotels & Resorts Employee Benefit Plan should be directed to the HR Representative.

What Crestline Does

Qualified dependents will be notified of the right to elect COBRA coverage automatically (without any action required by you or a family member) if any of the following events that will result in a loss of coverage occurs:

- you, the active associate, die or
- your employment is terminated or your hours of employment are reduced.

Electing COBRA

Generally, when you become eligible for continuation coverage and have been notified of the right to elect COBRA—or if applicable, you have notified the HR Representative about a qualifying event in a timely manner—the COBRA administrator will provide you with the appropriate election forms and more information about COBRA.

Note: Remember, in the case of divorce, legal separation or ineligibility of a dependent child, you are responsible for notifying the HR Representative in accordance with Plan procedures within the timeframes listed above. If you do not provide notice and all required documentation, you may lose your right to elect COBRA coverage.

You must elect COBRA coverage within 60 days of the loss of coverage caused by the qualifying event, or if later, within 60 days of the date the COBRA notice is sent.

Simply fill out the COBRA election form and return it to the COBRA administrator. You will have an additional 45-day period from the date you send your election form to pay the premium necessary (retroactive to the date benefits terminated) to avoid any gap in coverage. After that, you must pay the premium by a certain date each month. Please check with the COBRA administrator for this date.

Failure to pay premiums on a timely basis may result in permanent termination of COBRA coverage.

If You Don't Make an Election Within the 60-Day Time Period

An associate or family member who doesn't choose COBRA coverage within the time period described above will lose the right to elect COBRA coverage. You and your eligible family members also will be required to reimburse the Crestline Hotels & Resorts Employee Benefit Plan for any claims mistakenly paid after the date coverage would normally have been lost.

How to Apply for COBRA

If you want to apply for COBRA, contact the HR Representative. You should be ready to provide information about the associate or qualified beneficiary requesting COBRA coverage and the qualifying event that may entitle you to COBRA continuation of coverage. Once the HR Representative has received all required information and documentation, you will be informed whether or not you have the right to choose COBRA coverage and will receive instructions and additional information about COBRA.

If you have questions about COBRA coverage once you've received the election forms or you've elected COBRA, please contact the COBRA administrator at:

COBRA Administrator
Conexis
PO Box 22610
Dallas, TX 75222
(877) 722-2667, ext. 3360

Coverage Options

If you choose COBRA coverage, Crestline is required to give you coverage that, as of the time coverage is elected, is the same coverage you and your eligible dependent(s) had on the day before the qualifying event. After your initial election, you'll have the same opportunity to change coverage as active associates have, either during annual open enrollment or when you experience a qualifying event. This also means that if the coverage for "similarly situated" associates or family members is modified, your coverage will be modified in the same way.

"Similarly situated" refers to a current associate or dependent who has not had a qualifying event.

Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has a separate right to elect COBRA coverage. This means that a spouse or dependent child is entitled to elect COBRA coverage even if you don't make an election. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage for yourself and your dependents. You will generally pay for your coverage on an after-tax basis.

If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period:

- if the Crestline Hotels & Resorts Employee Benefit Plan has been charging less than the maximum permissible amount,
- if the qualified beneficiary changes his or her coverage level, or
- in the case of a disability extension.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

COBRA Premium Payment Deadlines

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days for the payment of the regularly scheduled premium.

You are responsible for making sure that the amount of your payment is correct. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your coverage as an active associate ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends (e.g., the last day of the month in which the dependent loses eligibility).

However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If you lose group health coverage because of a termination of employment or reduction in hours, COBRA coverage may continue for you and your covered dependents for up to 18 months.

COBRA coverage for your covered dependents may continue for up to 36 months if coverage would otherwise end because:

- you die,
- you divorce or legally separate or
- your dependent child loses eligibility for coverage.

Extension of COBRA Coverage for Additional Qualifying Events

Additional qualifying events (such as a death, divorce or legal separation) may occur while COBRA coverage is in effect. These events may extend an 18-month continuation period to 36 months for your covered dependents, but in no event will coverage last beyond 36 months from the date the qualified dependent first became eligible to elect continuation coverage. These events can be second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

If an additional qualifying event occurs within the first 18 months of coverage, you must notify the Plan within 60 days of the second qualifying event in accordance with the procedures described in “Electing COBRA” or your coverage cannot be extended.

If termination of employment or reduction of hours follows Medicare enrollment, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

Extension of COBRA Coverage for Disability

The 18 months of COBRA coverage may be extended to 29 months if you or your covered family member is determined to be disabled by the Social Security Administration at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. This applies even to family members who aren’t disabled.

To benefit from the extension, the qualified beneficiary must send, and the COBRA administrator must receive, a copy of the Social Security Administration’s determination of disability before the end of the initial 18-month COBRA continuation coverage period—and within 60 days after the latest of:

- the date the disabled qualified beneficiary receives his or her determination of disability,
- the date your employment ends,
- the date your hours are reduced or
- the date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

If a child is born to you or is placed for adoption with you while you’re continuing coverage and the child is determined to be disabled within the first 60 days of COBRA coverage, the child and all family members with COBRA coverage arising from the same qualifying event may be eligible for a total of up to 29 months of COBRA coverage.

If, during COBRA coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform the COBRA administrator of this re-determination within 30 days of the date it is made, at which time continuation coverage will end.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and another qualifying event occurs within the 29-month continuation period, then the dependent(s’) COBRA coverage period is extended to 36 months from the initial termination of employment or reduction in hours. The qualified beneficiary must provide the appropriate notice to the COBRA administrator as described under “Electing COBRA”.

Social Security Administration Determination of Disability

Notice by the Social Security Administration of a determination of disability or a determination that an associate or covered family member is no longer disabled must be provided to the COBRA administrator in writing. The notice must include a copy of the Social Security Administration Award Determination Notice and information about the associate or covered family member requesting a disability COBRA coverage extension or notifying the COBRA administrator that he or she is no longer disabled.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18, 29 or 36-month period for any of the following reasons:

- Crestline no longer provides group health coverage to any of its associates,
- the full premium for COBRA coverage isn't paid on time (within the applicable grace period),
- the qualified beneficiary becomes covered—after COBRA coverage is elected—under another group health plan
- you first become entitled to Medicare after the date COBRA coverage is elected or
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

Coverage Certificates

When your COBRA coverage ends, you will automatically receive a certificate of coverage that:

- confirms that you had medical coverage and
- states how long you were covered.

In addition to the certificate you receive automatically, you also may request a certificate from the COBRA administrator within 24 months after coverage ends.

Continuing Coverage in Special Cases

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- you or your dependent is covered by the Crestline Hotels & Resorts Employee Benefit Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave) and
- you don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- when you inform the COBRA administrator that you're not returning to work or
- the end of the FMLA leave, if you don't return to work.

COBRA and USERRA

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, also referred to as a “military leave”), and COBRA continuation coverage rights are available to you, an election for continuation coverage will be an election to take concurrent COBRA/USERRA medical coverage.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid for medical coverage before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost of coverage for active associates (i.e., the associate share plus Crestline’s share).

For additional information on military leaves, such as how to request a leave and other rights and obligations, as well as their impact on benefits, please contact the HR Representative.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for workers displaced by the impact of foreign trade who, as determined by the U.S. Secretary of Labor, are eligible for a “trade readjustment allowance” or “alternative trade adjustment assistance” (“eligible TAA individuals”).

Under this tax credit, if you’re an eligible TAA individual, you’re eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including COBRA coverage. If you’re in this situation, you’ll be notified.

The Trade Act of 2002 also created a special COBRA right applicable to TAA individuals. TAA individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they didn’t already elect COBRA coverage).

This election must be made within the 60-day period that begins on the first day of the month in which the TAA individual becomes eligible for assistance under the Trade Act of 2002. Nonetheless, this election may not be made more than six months after the date the TAA individual’s group health plan coverage ends.

If you have questions about this new tax credit or your extended ability to elect COBRA coverage, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available by logging on to www.doleta.gov/tradeact/.

Converting Coverage

Your prescription drug and dental coverages cannot be converted to individual health insurance policies when your COBRA coverage ends.

COBRA Questions

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator. You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Associate Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA’s website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Also, you must notify the COBRA administrator in writing immediately if:

- your marital status has changed,

- you, your spouse or a dependent has a change in address or
- a dependent loses eligibility for dependent coverage under the terms of the Crestline Hotels & Resorts Employee Benefit Plan (i.e. age)

All initial notification about qualifying events and questions about Crestline group healthcare plans should be directed to the HR Representative. Other communications regarding COBRA coverage and enrollment should be directed to the COBRA administrator at:

COBRA Administrator
Conexis
PO Box 22610
Dallas, TX 75222
(877) 722-2667, ext. 3360

Additional Rights

Family and Medical Leave Act (FMLA)

If you are absent from work due to an approved family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), coverage may be continued for the duration of the approved leave of absence as if there was no interruption in employment. Such coverage will continue until the earlier of the expiration of such leave or the date you notify the Employer that you do not intend to return to work. You are responsible for all required Contributions.

If you do not return after an approved leave of absence, coverage may be continued under the "About COBRA" section, provided you elect to continue under that provision.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA restricts how a group health requires plans to provide documentation of coverage under this plan for associates and Dependents to use in applying for another group coverage, permits special enrollment periods and prohibits discrimination based on health status.

HIPAA also requires the plan to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice will describe how the plan may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the plan's privacy notice for more information. You can obtain a copy of the notice by contacting Crestline directly.

Military Leave of Absence

If you are absent from work due to military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue the type of coverage in effect on the day immediately prior to the start of such leave. Such coverage will continue until the earlier of the following occurs: the date you fail to return to active employment as required under USERRA or 24 months. To continue coverage, you must continue to pay the required contribution under the Plan during the first 30 days of leave. Thereafter, you may pay a premium in the same amount as is required for COBRA continuation coverage under the Plan (see the "About COBRA section").

If you decide to waive coverage under the Plan during a military leave qualifying under USERRA and return to employment following the leave (within the time period specified by USERRA), you will be reinstated in the Plan. Once you resume coverage, the Plan does not cover any expenses you incur relating to any illness or injury incurred in, or aggravated during, the performance of military service.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a court or administrative order requiring child support for medical coverage of a Plan member's child, or requiring Plan coverage for the child. A typical reason courts or certain administrative agencies issue a qualified medical child support order is to protect the benefit coverage of children in cases of divorce.

You will be notified if the Company receives a QMCSO that affects you. If you receive a qualified medical child support order, please contact your human resources representative. Your human resources representative will then follow the necessary administrative procedures. This will ensure compliance in determining the status of the QMCSO.

Plan participants (and beneficiaries) may obtain, without charge, copies of the Plan's procedures governing QMCSOs and a sample QMCSO by contacting Crestline.

Other Program Details

Program Name

Express Scripts Prescription Drug Program

Program Year

The plan year runs from January 1 through December 31.

Plan Number

The plan number for the Express Scripts Prescription Drug Program is 501.

Employer Number

Crestline Hotels & Resorts, Inc. employer identification number is 52-2214429.

Plan Sponsor

The plan sponsor for the Express Scripts Prescription Drug Program is:

Crestline Hotels & Resorts, LL
3950 University Drive, Suite 301
Fairfax, VA 22030

Plan Administrator

The plan administrator has the authority to control and manage the operation and administration of the Express Scripts Prescription Drug Program, and to designate others to be responsible for specific responsibilities or duties, such as processing and deciding claims. The plan administrator is:

Crestline Hotels & Resorts, LLC
3950 University Drive, Suite 301
Fairfax, VA 22030

Claims Administrator

The claims administrator is:

Express Scripts, Inc.
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Legal Agent

The agent for service of legal process for the Express Scripts Prescription Drug Program is:

Crestline Hotels & Resorts, Inc.
3950 University Drive, Suite 301
Fairfax, VA 22030

Legal process may also be served upon the trustee or the plan administrator.

Other Rules and Regulations

Plan Documents

Every effort has been made to ensure that the information in this summary is complete and accurate. However, if there's an inconsistency between any of the terms of the official plan documents or this SPD with respect to the legal compliance requirements under ERISA or any other federal law, the plan will be enforced consistent with the terms of applicable current law.

Copies of all plan documents are available for review upon written request to the plan administrator. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request.

Your Rights Under ERISA

As a participant in the Express Scripts Prescription Drug Program, you're entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified Crestline locations, such as worksites, all documents governing the plan, including insurance and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the 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 make a reasonable charge for the copies.

Receive a summary of the 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, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. See your medical plan summary plan description and the documents governing the plan on the rules governing your COBRA coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and don't 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 administrator's control. 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you're 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're 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, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits 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 Benefits Security Administration.