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PURPOSES

Summary Plan Description

SUMMARY PLAN DESCRIPTION
OCCUPATIONAL INJURY BENEFIT PLAN
FOR THE EMPLOYEES OF
HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC

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State of Texas Effective **12/31/2013**

PARA LOS EMPLEADOS QUE HABLAN ESPANOL

ESTE RESUMEN DE LA DESCRIPCION DEL PLAN CONTIENE UN RESUMEN EN INGLES DE LOS DERECHOS Y BENEFICIOS DE SU PLAN DE BENEFICIOS EN CASO DE LESIONES DE EMPLEADOS DEL PATROCINADOR. SI TIENE ALGUNA DIFICULTAD PARA ENTENDER ALGUNA PARTE DE ESTE RESUMEN DE DESCRIPCION DEL PLAN, USTED DEBE COMUNICARSE CON SU SUPERVISOR DURANTE LAS HORAS NORMALES DE TRABAJO. TAMBIEN PUEDE COMUNICARSE CON EL ADMINISTRADOR DEL PLAN. 0 LLAMANDO AL NUMERO DE TELEFONO QUE APARECE EN EL DIRECTORIO DEL PLAN QUE SE INCLUYE EN EL RESUMEN DE LA DESCRIPCION DEL PLAN. SE ATIENDE DE LUNES A VIERNES DESDE LAS 8:00 A.M. HASTA LAS 5:00 P.M.

Answers to Common Questions About the Occupational Injury Benefit Plan

What is an Occupational Injury Benefit Plan?

HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC (the "Company") has adopted an Occupational Injury Benefit Plan to provide benefits to its employees who are injured on the job. This program is not part of the workers' compensation system. For numerous reasons, including high costs and inefficiency in that system, **HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC** has chosen to provide benefits to injured employees under the Plan. We want to be able to provide the best health care providers possible. We feel that the plan provides a better option for employees.

What can I expect if I have an on-the-job injury?

If you are injured in the scope of your employment with the Company, you automatically become eligible for benefits under the Plan. The Plan pays medical expenses, wages for time lost from work and even a death and dismemberment benefit. The cost of these benefits is paid by the Company; there is no expense to you.

What should I do if I am injured on the job?

All accidents at work –whether you think you are injured or not-- must be reported **immediately**. Your supervisor will then complete an incident report and you may be asked to complete a report as well. If you do not report the incident immediately, and at the very latest by the end of your shift, you will not be eligible for benefits under the plan. So, whether you think you are hurt or not, report all accidents and incidents.

If medical treatment is necessary, you will be directed to go to an approved medical provider for treatment. The Plan only provides medical benefits for medical providers that have been approved in advance. Thus, be sure that you are getting treatment from a doctor that has been approved or you may be responsible for those costs yourself. Your supervisor or the human resources department can direct you. And of course, if it is an emergency, call 911.

Is this the same as my health insurance?

No. Health insurance benefits generally apply to non-work related matters. This Plan applies only to injuries to employees of the Company who are injured while working for the Company.

When does this Plan take effect?

The plan takes effect on **12/31/2013**.

What do I have to do in order to make a Claim?

The steps are simple and you will be assisted in the process. The most important thing is to report all incidents and accidents immediately, regardless of whether you think you are hurt and regardless if you think your condition is minor or will improve. Often people just want to "sleep on it," but he condition worsens. Not only can failing to immediately seek treatment cause a condition to get worse, but the delay in reporting the incident will result in benefits being denied by the Plan. That is why we say: Report all incidents and accidents regardless of whether you think you are hurt.

1. Report the incident immediately to your manager or the manager on duty. This must be done no later than the end of your shift. Failure to report may result in your claim being denied.

2. Follow claims procedures. You may be asked to complete an accident report or assist a manager in completing a report. All incidents are taken seriously and the Company wants to prevent future incidents. Benefits are paid on a no-fault basis and we want to prevent future incidents.

3. Seek treatment by a medical provider that has been approved by the Plan. Your supervisor or human resources department will give you the name of a approved provider that can assist you. Do not just assume that any doctor will be satisfactory; the plan will not pay for medical treatment for non-approved medical providers. There is an exception for emergency treatment. For emergencies, dial 911.

4. If you are injured on the job, you may be required to submit to a drug and alcohol test.

5. You must follow the approved healthcare provider's instructions. Failure to follow the approved healthcare provider's orders may lead to suspension of benefits under the Plan. If a Provider releases you to return to work, either full duty or light duty, you must report to work at the Company.

6. You must keep your medical appointments. If you cannot make an appointment, you must contact the provider and let them know you cannot make the appointment. If you fail to keep appointments or fail to follow the provider's recommendations or directions, your benefits under the Plan may be denied.

7. You must keep in contact with the Company for benefits to continue. We want to know how you are doing, when you will return to work and what your limitations might be. You are required under the plan to report to the Company regarding your treatment status. We want you to get well and get you back to work. If you do not keep us informed of your status, benefits can be denied.

The Company has adopted the Plan because we care about our employees and want to provide you with quality benefits at a time of need. This document only briefly touches on the benefits and Plan requirements. You are being given a Summary Plan Description for the Plan that sets forth its terms and conditions. Please review the document carefully and feel free to ask any questions that you might have.

SUMMARY PLAN DESCRIPTION OF THE
OCCUPATIONAL INJURY BENEFIT PLAN

The Company, identified in item No. 1 of the benefits schedule (and any Affiliated Employers which have adopted this Plan) is pleased to announce the adoption of the Occupational Injury Employee Benefit Plan ("Plan") for the exclusive benefit of employees of the Company whose principal place of employment is in the State of Texas. This Plan provides certain specified benefits for injuries solely arising from workplace accidents taking place on or after the effective date stated in item No. 6 of the benefits schedule. The benefits set forth below are "excepted benefits" under the terms of certain statutes, including without limitation, the Public Health Service Act (42 U.S.C. § 300gg-91) and the Health Insurance Portability and Accountability Act of 1996 (sec. 706(c)). Participants and Plan beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

The following Summary Plan Description is intended to generally explain and give an overview of the various benefits offered by the Plan and the terms and conditions under which benefits will be payable. A more detailed description of benefits, exclusions, and requirements is contained in the Occupational Injury Employee Benefit Plan. If there is a discrepancy between the Plan and the Summary, the Plan controls.

WHAT THE PLAN COVERS

Plan benefits shall consist of the provision of Accidental Medical Benefits for eligible medical treatment rendered by a Provider, Accident Disability Benefits for periods of disability resulting from accidental work related on-the-job injuries, and applicable Death and Accidental Death, Dismemberment and Paralysis Benefits.

The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Accident Disability Benefits, Accidental Death, Dismemberment and Paralysis Benefits) payable to a Participant or on his behalf shall not exceed the amount stated in item No. 9(a) of the benefits schedule. The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Accident Disability Benefits, Accidental Death, Dismemberment and Loss of Use Benefits) payable because of an Occurrence, regardless of the number of Participants, shall not exceed the amount stated in item No. 9(b) of the benefits schedule. The combined aggregate of all possible benefits under this Plan (including, but not limited to, Accidental Medical Expense Benefits, Accident Disability Benefits, Accidental Death and Dismemberment Benefits) payable regardless of the number of Occurrences or the number of Participants shall not exceed the Annual Aggregate amount stated in item No. 9(c) of the benefits schedule. All benefits must be for Occurrences after the Effective Date as stated in item No. 6 of the benefits schedule. The maximum duration of any benefit for any Occurrence is stated in item No. 7 of the benefits schedule.

Accidental Death and Dismemberment Benefit. If Injury to the Participant results in any one of the Losses shown below, the Participant (or his designated beneficiary in the case of death) is eligible for the percentage for the Loss shown below of the Accidental Death or Dismemberment Benefit stated in Item No. 9(d) of the Benefit Schedule. Up to $5,000 for burial costs in the event of death will also be available as an additional benefit under this Plan, subject to all other limitations of the Plan. Any Loss identified below must take place within 365 days of a covered Occurrence.

Loss	Benefit Amount
Life	100%
Both Hands	100%
Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Use of Both Arms and Both Legs	100%

Use of Both Arms or Both Legs	75%
Use of One Arm and One Leg	75%
Speech	50%
Hearing in Both Ears	50%
One Hand	50%
One Foot	50%
Sight of One Eye	50%
Use of One Arm or One Leg	50%
One Thumb	25%

If a Bodily Injury is covered as an Accidental Death or Dismemberment under this Plan, such Bodily Injury shall only be covered as an Accidental Death or Dismemberment and any other payments made under this Plan for the same Bodily Injury shall be used to reduce benefits that may be due for a covered Accidental Death, Dismemberment, or Loss of Use.

"Loss of Hand or Foot" means complete severance through or above the wrist or ankle joint. "Loss of Sight" means the total, permanent loss of sight of the eye(s). "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing in Both Ears" means total and permanent Loss of Hearing in both ears that is irrecoverable and cannot be corrected by any means.

"Loss of a Thumb " means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the thumb and the hand).

"Severance" means the complete and permanent separation and dismemberment of the part from the body.

Accident Disability Benefits. A Participant is eligible for the Accident Disability Benefit up to the maximum weekly amount shown in the Benefits Schedule if a Participant is Disabled by an Bodily Injury that is a direct result of, and from no other cause but a Covered Occurrence after the Elimination Period identified in Item No. 8(a) of the Benefits Schedule is met. The Disability must begin within: (a) 90 days after the date of the Occurrence that caused the Disability; or (b) 365 days after the date of the Occurrence that caused the Disability, provided that the Participant received medical treatment from a Provider within 30 days from the date of the Occurrence that caused the Disability; and provided further that the Participant has remained under the continuous care of a Provider.

Accident Disability Benefits will be paid at normal pay periods at the lesser of the Participant's Hourly Wage minus Other Income Benefits or the Maximum Weekly Benefit shown in Item No. 8(c) in the Schedule of Benefits subject to the Combined Benefit Amount.

No Accident Disability Benefits will be paid if the Participant refuses to participate in any medically recommended rehabilitation program or if the Disability is treatable by medical care that is reasonable and of a form that an ordinary prudent person in the same or similar circumstances would undergo and the Participant has not availed himself or herself of the treatment. A Participant is required to submit proof of continued Disability and of continuous care of a Provider. Failure to submit the requested proof will result in suspension and or denial of Accident Disability Benefits.

A participant shall no longer be entitled to Accident Disability Benefits after the first of the following dates:

1. the date the Participant dies; or
2. the date the Participant is no longer Disabled; or
3. the date the Benefit Period shown in the Schedule of Benefits ends; or
4. the date the Participant fails to submit satisfactory proof of continuing Disability; or

5. the date the Participant voluntarily resigns his employment or is terminated for cause or is incarcerated for any reason.

Once a Participant's Accident Disability Benefits are eligible for reimbursement under the Plan, separate periods of Disability resulting from the same or related causes are a continuous period of Disability.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes or the later Disability occurs after eligibility under the Plan ends. A Participant is not eligible for Accident Disability Benefits for successive periods of Disability that result from entirely different and unrelated causes unless such periods of Disability are separated by at least 14 full days during which the Participant is not Disabled and returns to Active Service.

If an otherwise Disabled Participant returns to work for the Company while in rehabilitative status, he or she will be eligible for Accident Disability Benefits for the equivalent of up to 20 hours per week, provided he or she is unable to able to work the hours (not to exceed 40 per week) of his or her regular shift during this rehabilitative status. Such payment of Accident Disability Benefits while on rehabilitative status shall not exceed 90% of the Disabled Participant's average weekly wage. The maximum that a Participant may obtain such benefits while on rehabilitative status shall not exceed a maximum of twelve (12) months in any one period of Disability.

Accidental Medical Expense Benefit. A participant is eligible for Accidental Medical Expense Benefits for Covered Expenses that result directly, and from no other cause, from Bodily Injury that results from an Occurrence. A Covered Expense is deemed to be incurred on the date that such treatment, service or supply that gave rise to the expense or the charge was rendered or obtained. Accident Medical Expense Benefits are only payable for Usual and Customary charges incurred for the Medically Necessary care of a Participant. Covered expenses must be incurred within the Benefit Period shown in the Schedule of Benefits.

Covered Expenses are:

1. Hospital or Skilled Nursing Facility charges. Hospital room and board charges are limited to the cost of a semi-private room unless the Covered Person's condition requires confinement in a private room or intensive care unit;
2. Medical, surgical, podiatric, optometric, dental (limited to Injury to sound natural teeth), Nurse, and physical therapy services provided by or at the direction of a Doctor;
3. Chiropractic Care provided it is recommended by a Doctor for the treatment of the Employee's Bodily Injury and services are not rendered by the Doctor recommending the treatment;
4. Physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a Doctor;
5. Charges for medical or surgical treatment, services, supplies, prescription drugs and any other service that is Medically Necessary;
6. Charges for Medical Emergency ground ambulance services.

Payment of Accidental Death and Dismemberment Benefits, Accident Disability Benefits and Accidental Medical Expense Benefits are each and in total further subject to:

1. The Combined Benefit Amount Per Participant and Per Occurrence stated in Items Nos. 9(a) and 9(b) of the Benefit Schedule;
2. the Annual Aggregate stated in Item No. 9(c) of the Benefit Schedule; and
3. The Benefit Period stated in Item No. 7 of the Benefit Schedule.

Payment of applicable benefits under this plan are made as follows:
If the Participant is deceased, applicable benefits will be paid in the following order:

(1) the beneficiary designated by the deceased Participant,

(2) if there is no beneficiary designated, then applicable benefits will be paid to the legal spouse of the deceased Participant,

(3) if there is no designated beneficiary and no spouse, then applicable benefits will be paid in equal shares to any children of the deceased Participant,
(4) if there is no designated beneficiary, spouse or children of the deceased Participant, then applicable benefits will be paid to the Participant's parents,
(5) if there is no designated beneficiary, spouse, children, or parents of the deceased Participant, then applicable benefits will be paid to the Participant's siblings.
(6) if there is no designated beneficiary, spouse, children, parents or siblings of the deceased Participant, then applicable benefits will be paid to the deceased Participant's estate.

If the Participant is not deceased, Accidental Disability Benefits will be paid in the following order:
(1) The Participant,
(2) if the Participant is incapable of handling his own affairs, the trustee designated for the Participant by power of attorney or court order,
(3) if the Participant is incapable of handling his own affairs, and a trustee has not been designated by power of attorney or court order, to the beneficiary designated by the Participant as trustee for the Participant.

GENERAL INFORMATION

The Company has rejected coverage for its Texas Employees under the Texas Workers' Compensation Act and hereby adopts this Plan as of the Effective Date, to provide the benefits as set forth herein for Occurrences. The agent of the Plan for service of legal process is identified in item No. 4 of the benefits schedule. Legal process may also be served on a plan trustee or the plan administrator.

The Company shall serve as the Plan Administrator for all purposes under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. A Third Party Administrator may be appointed by the Company to carry out the day-to-day responsibility for administration of the Plan.

This Plan shall apply to Occurrences to Participants sustained solely in the furtherance of the business of the Company by a Participant. This Plan specifies the only benefits for which a Participant is eligible in the event of such Occurrence. The Plan document shall govern in all cases as to eligibility and benefits, including limitations and exclusions. Provision of benefits to a Participant pursuant to this Plan shall not constitute an admission of liability on the part of the Company for the Occurrence. If there is a discrepancy between the Plan and the Summary, the Plan controls.

CLAIM PROCEDURE

Every Participant is eligible to receive benefits under this Plan. However, initial receipt and continuing receipt of benefits is contingent upon compliance with the terms and conditions of this Plan. A Participant who fails to comply with the conditions and requirements herein shall not be entitled to receive or continue to receive benefits.

Reporting. A Participant must immediately report any Occurrence to his Supervisor or designee. The Participant must report every Occurrence, regardless of the nature or severity. Failure to immediately report an Occurrence may subject the Participant to disciplinary action up to and including termination and denial of benefits.

Drug Screen. Upon reporting an Occurrence, a drug screen may be requested as required by the Company's policies and procedures. Failure of a Participant to submit to a drug screen upon request will result in a denial of benefits under this Plan.

Medical Treatment. The Participant's treatment and care will be conducted as follows:

A. The Participant will be sent to a Provider. Participant will be required to accept referral within an approved referral network so that the cost of treatment for the Occurrence will be maintained by the Company. If a Participant chooses to go to a physician of his choice, the Company will not be responsible for such expenses incurred by the Participant. In addition, the Company reserves the right to require that a Participant undergo an initial and subsequent evaluation by a Provider prior to allowing the Participant to return to work after an Occurrence.

B. The Company will pay for all prescription drugs prescribed by an authorized Provider in treatment of an injury.

Second Opinion. The Plan may require a second or additional medical opinions relating to any Occurrence. Failure of a Participant to submit to a second opinion upon request may result in denial of benefits under this Plan.

Weekly Contact. A Participant must contact the Human Resource Department or Safety Department at the facility's office weekly while receiving benefits to report on his progress and expected recovery time. Failure to do so will cause the Participant's entitlement to continuing benefits under this Plan to be discontinued.

Social Security. If the Participant receives or is entitled to receive Social Security disability benefits for the same period of time for which salary continuance benefits are payable hereunder, the weekly benefit provided hereunder will be reduced by the total amount of such Social Security disability benefits.

Failure to Return to Work. If, after treatment, whether emergency or long term, the authorized Provider releases the Participant to return to work, whether at full capacity, part-time, or light duty, and the Participant fails to return to work, all medical payments and salary continuance benefits will immediately cease.

Termination. Upon Participant's voluntary separation of employment with the Company, termination for cause, or incarceration, all Accidental Disability Benefits shall cease.

Claim Submission and Response. When a benefit is due, the Participant should submit his claim to the person or office designated by the Plan Administrator to receive claims. Under normal circumstances, a final decision shall be made as to a claim within 15 days after receipt of the claim. If the claim is for urgent care, a final decision shall be made as to the claim within 72 hours after receipt of the claim. If a claim is denied during the claims period, the Plan Administrator or Third Party Administrator must notify the Participant in writing. The denial must include the specific reasons for it, the Plan provisions upon which the denial is based, and the claims review procedure. If no action is taken during the claims period, the claim is treated as if it were denied on the last day of the claims period.

Notice of Denial. In the event that a claim for benefits is to be denied in whole or in part, then the Plan Administrator or Third Party Administrator shall provide the Participant or the Participant's representative with written or electronic notification of the Plan's adverse determination. The notice of denial shall contain the following:

(a) the specific reason for the adverse determination;
(b) reference the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
(c) a description of any additional material or information necessary for the Participant to perfect the claim for appeal and an explanation of why that material or information is necessary;
(d) a description of the Plan's review procedures and the time limits applicable to those procedures;
(e) a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination upon review; and

(f) in the case of an adverse benefit determination involving a claim for urgent care, a description of the expedited review process applicable to urgent claims.

If the notice of denial of a claim for benefits relates to a claim involving urgent care, the notice may be provided to the Participant or the Participant's representative orally, provided that a written or electronic notification is furnished to the Participant or the Participant's representative no later than three days after the oral notification.

Timing of the Notice of Denial. The deadline for providing the notice of a claims denial depends on the type of claim being denied and the reason the claim is being denied, as set forth below.

If the claim is being denied because the Participant or the Participant's representative did not follow the Plan's procedure for submitting the claim, the Plan Administrator or the Third Party Administrator must notify the Participant or the Participant's representative of the correct procedure within five days after the claim is received. *Exception for Urgent Care*: If the claim is for urgent care, the notification must be given within 24 hours after the claim is received.

If the claim is being denied because the Participant or the Participant's representative followed Plan procedures but did not submit sufficient information for the Plan Administrator or the Third Party Administrator to determine whether the claim is covered or payable by the Plan, the Plan Administrator or Third Party Administrator shall notify the Participant or the Participant's representative of the additional information needed within five days after receipt of the claim, and the Participant or the Participant's representative shall be given 45 days after the date the notice is received to provide the missing information. The Plan Administrator or the Third Party Administrator shall then review the additional information and notify the Participant or the Participant's representative within 15 days after the additional information is received of the Plan's determination with regard to the claim. If no additional information is received during the 45-day response period, the Plan Administrator or the Third Party Administrator shall send a notice of claim denial within 15 days after the end of the 45-day period. *Exception for Urgent Care*: If the claim is for urgent care, the Plan Administrator or the Third Party Administrator shall notify the Participant or the Participant's representative of the additional information needed within 24 hours after the claim is received, and the Participant or the Participant's representative shall be given 48 hours to provide the missing information. The Plan Administrator or the Third Party Administrator shall then review the additional information and notify the Participant or the Participant's representative within 48 hours after the additional information is received of the Plan's determination with regard to the claim. If no additional information is received during the 48-hour response period, the Plan Administrator or the Third Party Administrator shall provide a notice of denial of the claim within 48 hours after the end of the response period.

If the Participant or the Participant's representative has followed Plan procedures and has submitted sufficient information for a determination to be made, but the Plan Administrator or the Third Party Administrator has determined that the claim is to be denied, then the deadline for the Plan Administrator or the Third Party Administrator to provide the notice of denial is 15 days after the receipt of the claim. *Exception for Urgent Care*: If the claim being denied is for urgent care, then the deadline for providing the notice of denial is 72 hours after receipt of the claim.

When a Claim is Received. The Plan will be deemed to have received a claim for benefits if a claim or a Participant's representative makes a written communication, except in the case of urgent care, in which case the claim may be communicated orally, reasonably calculated to bring a request for a claim to the attention of the Plan Administrator or the Third Party Administrator.

Manner of Giving Notice. Notice given in writing shall either be sent by first class mail or by hand delivery. Notice may only be given electronically (that is, by email) if the Plan Administrator or the Third Party Administrator insures that the message is received by using the return-receipt electronic mail feature and if the

Participant is advised in the text of the notice of the Participant's right to receive, free of charge a paper copy of the notice.

Definition of Claim Involving Urgent Care. "Urgent care" means medical care or treatment with respect to which the application of the periods for making non-urgent care determinations: (i) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function; or, (ii) would, in the opinion of a physician familiar with the Participant's medical condition, subject the Participant to severe pain that cannot be adequately managed without the care or treatment. Whether a claim should be treated as an "urgent care" claim can either be determined by a physician with knowledge of the Participant's medical condition or by an individual acting on behalf of the Plan, provided that individual applies the judgment of a reasonable individual who is not a trained health professional.

Appeal Procedure. Once an initial denial is issued, the Plan Administrator or the Third Party Administrator shall not give any further consideration to the claim. The Participant may then appeal the initial claim denial. If a claim has been denied, the Participant or the Participant's representative has the right to appeal the denial, as described below.

Right to Reconsideration. Within 180 days after the date of the notice of denial is received, the Participant, or the Participant's representative, may request further review of the original claim by filing a written request for reconsideration with the Plan Administrator, by hand delivery or first class mail. *Exception for Urgent Care*: If an appeal relates to an urgent care claim, the appeal may be verbal.

Right to Submit Comments. Within 180 days after the date the notice of denial is received, in addition to having the original claim reviewed, the Participant or the Participant's representative may also submit written comments, documents, records, and other information related to the claim, even if the Participant had not previously submitted those documents or information.

Right to Review Documents. During the period that a claim is being reconsidered, the Participant or the Participant's representative may have access to and copies free of charge of all documents, records, and other information relevant to the claim that has been denied.

Decision by Plan Administrator. The Plan Administrator shall notify the Participant or the Participant's representative of the Plan Administrator's findings within 30 days after receipt of the request for review of the claim. This review shall take into account all comments, documents, records and other information submitted by the Participant relating to the claim, without regard to whether such information was considered in the initial benefit determination. *Exception for Urgent Care*: If the claim being reviewed involves urgent care, the Plan Administrator shall notify the Participant or the Participant's representative of the Plan Administrator's finding within 72 hours after receipt of the request for review. When an appeal of medical or disability benefits involves medical judgment, the Plan Administrator shall consult with a medical or vocational expert with relevant experience and shall disclose the identity of the expert. There shall be no de novo review by an arbitrator or court of any decision by the Plan Administrator and any review shall be limited to determining whether the decision was so arbitrary and capricious so as to be an abuse of discretion.

Contents of the Plan Administrator's Notification. If, upon review, the claim is again denied, the Plan Administrator shall provide a written notice of the denial containing:

(a) the specific reasons for the adverse determination;
(b) reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the benefit determination is based;
(c) a statement that the Participant is entitled to receive, upon request, reasonable access to and copies of, all documents and records relevant to the review of the claim, including any reports, and the identities, of any experts whose advice was obtained;

(d) a statement of the Participant's right to bring civil action under section 502(a) of ERISA following an adverse arbitration of the benefit determination.

Right to Bring Civil Action. If the appeal of the original decision is denied upon review the Participant shall have the right to bring a civil action against the Plan under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

AMENDMENT AND TERMINATION

Amendment. The Sponsor has the sole right to amend this Plan. An amendment may be made by (i) a certified resolution or consent of the Sponsor, or (ii) by an instrument in writing executed by the appropriate officer of the Sponsor. The amendment must describe the nature of the amendment and its effective date.

Termination. The Sponsor may terminate this Plan by executing a notice of termination specifying the date of termination. Likewise, this Plan shall automatically terminate if there is a general assignment to or for the benefit of the creditors of the Sponsor. This Plan shall also terminate upon any action by the Company or an insurance carrier to cancel, non-renew, or otherwise fail to renew an occupational injury insurance policy that was purchased in conjunction with the adoption of this Plan document.

Any amendment or termination to the Plan, however, shall not affect the benefits available to an existing claim.

FUNDING OF PLAN

The Plan is funded by the general assets of the Company. The Company may obtain insurance to provide funds to the Company to pay for any or all of the benefits called for under this Plan. Any such insurance contract or proceeds shall be owned by Company, and shall not be considered an asset of the Plan. If such insurance coverage terminates or for any reason is not available to Company, benefits under this Plan shall terminate or not be payable. Company has no obligation to establish a fund or trust for the payment of benefits under this Plan. The Plan Administrator is not required to give bond for the performance of its duties unless required by a law that cannot be waived. Any payments paid to a Participant, whether funded by insurance or not, shall not be considered a collateral source. The Company is entitled to a credit or offset for any such payments, whether the source of the funds is general Company assets or insurance procured by Company.

BENEFITS SCHEDULE

Company Information

Plan Number:	**IAWL09200**
Effective Date of Plan:	**12/31/2013**
Company Name:	**HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC**
Federal Tax ID:	**76-0414069**
Plan Administrator:	**Billy Robinett** **13131 Champions Drive** **Ste. 110** **Houston, TX 77069**
Telephone:	**832-859-5052**
Type of Coverage:	Occupational Accident Protection
Plan Type:	**518**
Beneficiary:	**Estate or Designated Person**

Benefit Limits

6. Effective Date of Plan: **12/31/2013**

7. Combined Benefit Period: **156** weeks

8. Weekly Accident Disability Benefits:

(a)	Elimination Period:	5 business days
(b)	Percentage of Weekly Earnings:	75 %
(c)	Maximum Weekly Indemnity Benefit:	$900
(d)	Medical Expense Benefit Period:	**156** weeks

9. Combined Benefit Amounts:

(a)	Combined Benefit Amount Per Participant:	$250,000
(b)	Combined Benefit Amount Per Occurrence:	$2,500,000
(c)	Annual Aggregate:	$5,000,000

(d) Accidental Death and Dismemberment Benefit: 10 times Participant's annual salary to a maximum of $150,000, less other payments made for benefits under Plan

ADOPTION OF PLAN BY AFFILIATES

An affiliated company or entity, with the approval of the Sponsor, may adopt this Plan by agreeing in writing to be bound by the terms, conditions, and limitations in this Plan. Such a company shall be considered a Affiliated Employer in this Plan. The Sponsor shall not be liable for any obligations under the Plan of an adopting affiliated company or entity and an adopting affiliated corporation shall not be liable for any obligations of the Sponsor under this Plan.

ADMINISTRATION OF THIS PLAN

A Plan Administrator shall administer this Plan. A Third Party Administrator may be appointed by the Plan Administrator to administer the day-to-day operation of the Plan. The Plan Administrator has the exclusive responsibility for the general administration of the Plan. The Plan Administrator shall make available to each Participant for his examination those records, documents, and other data required under ERISA, but only at reasonable times during business hours. No Participant has the right to examine any data or records reflecting information pertaining to any other Participant. The Plan Administrator is not required to make any other data or records available other than those required by ERISA.

COORDINATION OF BENEFITS

If a Participant is covered under one or more other plans including, but not limited to, automobile or health insurance, the benefits payable for expenses under this Plan incurred in a calendar year will be reduced by the amount of any benefits payable by such other plan so that the total benefits paid with respect to any one Accident or Occurrence will not exceed 100% of the expenses incurred. The Plan Administrator will determine which plan is the primary plan that will pay its benefits first according to the following rules. When only one of the plans has a coordination of benefits provision, then the plan without such a provision will be the primary plan. If both plans have such a provision, the plan under which the Participant is covered as an Employee will be the primary plan. If both of the foregoing rules do not establish which plan is the primary plan, then the plan that has covered the person for the longer period of time will be the primary plan.

HEALTH CARE PROVIDERS

The Company may designate one or more medical providers to administer medical treatment to Participants (hereinafter referred to as "Provider" or "Providers"), and the Company may change Providers at any time. At a Participant's request, any health care provider that has not been designated as a Provider may be approved by the Company, the Plan Administrator, or by a Third Party Administrator who is retained by the Company to administer claims arising under this Plan ("Third Party Administrator") prior to the time a Participant incurs an expense that is payable or reimbursable under the Plan. A Provider may provide treatment to a Participant only when the Participant submits to the Provider at the time of treatment the physician's authorization and report form provided by and available from the Plan Administrator. Notwithstanding the foregoing, a medical provider that has not been designated as a Provider may be utilized to provide emergency medical treatment if an injury occurs when the Participant is not at his regular place of employment or if an emergency vehicle takes the injured Participant to a health care provider that has not been designated as a Provider. Any continued medical treatment after emergency medical treatment, however, shall be administered by a designated Provider. Except as provided above, benefits shall not be paid under this Plan for treatment received from a health care provider that has not been designated as a Provider in accordance with this Plan.

Appendix A

DEFINITIONS

The following terms used in this document have the specific meanings indicated below:

"Accident" or "**Accidental"** means an event which:

1. was sudden, unforeseen, unplanned or unexpected;
2. occurred at a specifically identifiable time and place; and
3. occurred during the Plan Year.

"Active Service" means a Participant is either 1) actively at work performing all regular duties on a full-time basis either at his or her employer's place of business or someplace the Company requires him or her to be; or 2) actively at work performing restricted or modified duty work at the direction of the Company in the course of his or her Scope of Employment.

"Affiliated Employer" means a company or entity which have adopted this Plan in accordance with Article VIII of the Plan.

"Benefit Period" is the maximum period of time that benefits may be paid under the Plan for any one Bodily Injury, Occupational Disease or Cumulative Trauma. It is shown on the Schedule of Benefits. Each Occurrence shall have a separate Benefit Period that begins with the date of Occurrence.

"Bodily Injury" means an identifiable physical injury to the physical structure of a Participant's body, including resulting death, caused by an Accident that occurs within the Scope of Employment during the Plan Year. Bodily Injury includes Occupational Disease or Cumulative Trauma that arises from an Accident.

"Company" or **"Employer"** means the company listed in Item No. 1 of the Benefits Schedule and any Affiliated Employers that may adopt this Plan.

"Covered Expense" means expenses actually incurred by or on behalf of a Participant for treatment, services and supplies that result directly from Bodily Injury that results from an Occurrence that are otherwise covered by the Plan, and from no other cause. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. A Covered Expense shall never exceed the Usual and Customary charge for a service, treatment or supply.

"Cumulative Trauma" means damage to the physical structure of the body of a Participant occurring as a result of repetitious, physically traumatic activities that occur within the Scope of Employment during the Plan Year. Cumulative Trauma does not include Bodily Injury or Occupational Disease.

"Disease" means a condition marked by a pronounced deviation from the normal healthy state of a Participant.

"Disability" or "**Disabled"** means Bodily Injury, Cumulative Trauma or Occupational Disease resulting from an Occurrence which causes the Participant to be unable to perform the material duties of the occupation, business or employment which the Participant held at the time of the Bodily Injury. The Participant must be under the continuous care of a Provider during the period of Disability.

"Doctor," "Treating Physician," "Treating Provider," or **"Provider"** means an authorized health care provider approved by the Company and who is a licensed health care provider acting within the scope of his or her license and rendering care or treatment to a Participant that is appropriate for the conditions and locality. It does not include a Participant or a member of the Participant's Immediate Family or household.

"Effective Date" means the date stated in Item No. 6 of the Benefits Schedule.

"Elimination Period" means the number of consecutive working days after Accidental Bodily Injury occurs during which the injured Participant must be Disabled, but for which no indemnity is payable or reimbursable under this Plan. A working day is considered any day on which the Participant would normally be at work. The Elimination Period is stated in Item No. 8(a) of the Benefit Schedule.

"ERISA" means the federal Employee Retirement Income Security Act of 1974, as amended, ("ERISA").

"Hospital" means a lawful institution that:

1. is licensed and operated according to the law of the jurisdiction in which it is located pertaining to hospitals for the care and treatment of sick and injured persons;
2. is open at all times;
3. functions chiefly for the care and treatment of sick and injured persons as admitted inpatients;
4. is supervised by one or more licensed physicians at all times;
5. provides 24 hour services of Nurses; and
6. has on its premises or available on a prearranged basis, organized facilities for diagnosis and major surgery.

"Hourly Wage," for purposes of calculating a Accident Disability Benefit, means the Payroll paid to a Participant for the most recent six (6) week period, or shorter period if employed less than six (6) weeks, prior to the Occurrence giving rise to the Bodily Injury, Cumulative Trauma, or Occupational Disease divided by the average number of hours worked by the Participant in that period of time. For salaried Participants, the hourly wage shall be the Payroll paid to the Participant during the most recent six (6) week period, or shorter period if employed less than six (6) weeks, prior to the Occurrence, divided by the number of work hours applicable to that salary if known, or by forty (40) hours per week, if not known. For Participants paid on commission, the Participant's hourly wage shall be his or her Payroll divided by fifty-two (52) to arrive at an average weekly wage. That average weekly wage will then be divided by forty (40) to determine the Participant's hourly wage for purposes of calculating a Accident Disability Benefit.

"Medical Expense" means a Participant's expense for medical procedures or supplies, provided the expense is medically necessary, usual and customary and prescribed by a Provider acting within the scope of his license.

"Medically Necessary" means medical services, procedures or supplies that are:

1. required, recognized and professionally accepted nationally by physicians as the usual, customary and effective means of diagnosing or treating the condition;
2. the most economical supplies or levels of service that are appropriate and available for the safe and effective treatment of the Participant; and
3. not primarily for the convenience of the Participant, the Participant's family or the Participant's physician or other provider of medical services, supplies or procedures.

Even if the service, supply or procedure is Medically Necessary, this Plan will not cover services, procedures or supplies otherwise excluded under this Plan.

"Nuclear Material" means "source material", "special nuclear material" or "by-product material", as these terms have been given meaning in the U.S. Atomic Energy Act of 1954 or in any law amendatory thereof.

"Nurse" means a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) or person currently licensed as a nurse in the state in which the service was performed, practicing within the scope of such license.

"Occupational Disease" means a Disease arising out of a Participant's assigned duties in his/her Scope of Employment during the Plan Year that causes damage or harm to the physical structure of the body. Occupational Disease does not include Bodily Injury or Cumulative Trauma. Occupational Disease does not include ordinary Diseases of life to which the general public is exposed outside of a Participant's assigned duties in his Scope of Employment or a Disease resulting directly from an Accident.

“Occurrence” or **“Covered Occurrence”** means an Accident or series of related Accidents resulting in Bodily Injury to a Participant that arises out of the Participant’s Scope of Employment and occurs while the Plan is in force. As respects Occupational Disease or Cumulative Trauma, Occurrence means the date during the Plan Year on which symptoms of such Occupational Disease or Cumulative Trauma first manifest themselves.

"Other Income Benefits" means any amounts that a Participant or a Participant's dependents receive (or are assumed to receive) under:

1. any Workers' Compensation, occupational Disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary Disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted. If paid as a lump sum, We will prorate these benefits over the period for which the sum is given. If no time is stated, the lump sum will be prorated over a five year period. If no specific allocation of a lump sum is made, then the total sum will be an Other Income Benefit.
2. any Social Security or retirement benefits the Participant receive or any third party receives (or is assumed to receive) on the Participant's behalf or for the Participant's dependents; or, if applicable, that the Participant's dependents receive (or are assumed to receive) because of the Participant's entitlement to such benefits.
3. any proceeds payable under any group insurance or similar plan. If there is other insurance that applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, We will pay Our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one Plan, without other insurance, bears to the total benefits under all such policies.

“Participant” means a person who is employed in the Company’s regular business at one of its Texas locations, or at a location outside of Texas for a period of less than ninety (90) consecutive days during the Plan Year, is under the Company’s direction and control, and receives pay by means of a salary, wage, or commission directly from the Company as reported to the Internal Revenue Service. A Participant must be acting within his or her Scope of Employment at the time and place of the Occurrence causing the Bodily Injury. Participant specifically includes executive officers unless excluded by amendment to this Plan. Under no circumstances shall the term Participant include a leased employee, a temporary employee, an independent contractor, or a third-party agent.

“Payroll” means the amount of compensation by the Company to a Participant, including overtime and commission as reported to the Internal Revenue Service. For Participants receiving payment by commission, Payroll shall mean the average annual earnings paid by the Company to the Participant over the three year period immediately preceding the date of loss. For Participants receiving payment by commission that have less than a three year employment history with the Company, average monthly earnings will be multiplied by 12 to calculate the Payroll. The maximum annual Payroll that will be recognized under this Plan per Participant for is $62,400, regardless of whether a Participant has annual earnings in excess of this sum.

"Plan" means this Plan, including all subsequent amendments.

"Plan Administrator" means the Company.

"Plan Year" means the period ending 12 months from the Effective Date stated in Item No. 6 of the Benefits Schedule.

"Pre-Existing Condition" means a condition or injury(ies) that existed or for which diagnosis, treatment, or care, including prescription, or medical advice was recommended or received within the six (6) month period immediately prior to a Participant's date of hire by the Company.

"Rehabilitation" means only those procedures that are performed for the purpose of restoring the function of motion, speech or vision lost as a result of Bodily Injury, Occupational Disease or Cumulative Trauma.

"Scope of Employment" means an activity of any kind or character that involves the furtherance of the Company's business, trade or profession at the Company's regular workplace(s) or while temporarily away from the Company's regular workplace in furtherance of its business, trade or profession. Scope of Employment does not include a Participant's transportation to and from his or her workplace.

"Skilled Nursing Facility" means a section, ward or wing of a Hospital or a freestanding healthcare facility that: provides room and board; provides nursing care by or under the supervision of a nurse; provides physical, occupational and speech therapy furnished by the facility or by others under arrangements made by the facility; provides medical social services; provides drugs, biologicals, supplies, appliances and equipment ordinarily furnished for use in such a facility; provides medical services by staff physicians; has an agreement with a Hospital for diagnostic and therapeutic services, the transfer of patients and exchange of clinical records; provides other services necessary to the health and care of patients that are generally provided by such facilities; and is licensed or registered in accordance with local and state laws and regulations.

"Supervisor" means a Participant's immediate supervisor or the person in charge at the time of an Occurrence or Accident.

"Third Party Administrator" means an agent appointed or retained by the Company to process claims under the Plan. The Company may change the company or agent serving in this capacity from time to time at its sole discretion.

"Terrorism" means an act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General of the United States to be an act of terrorism pursuant to the Terrorism Risk Insurance Act. Terrorism is also activity that involves a violent act or an act dangerous to human life, property or infrastructure that is committed by an individual or individuals; and, that appears to be part of an effort intended to intimidate or coerce a civilian population; or to influence the policy of any government by coercion;. Multiple incidents of terrorism which occur within a seventy-two hour period and appear to be carried out in concert or to have a related purpose or common leadership shall be considered to be one incident.

"Usual and Customary" means the expense is: (1) Usual when it is the fee regularly charged that the patient is responsible to pay, in the absence of insurance or other third party reimbursement, to a health care provider or physician for a given treatment, service or supply; and (2) Customary in relation to what other physicians and health care providers in the same geographic area charge for the same and similar treatment, service or supply.

Appendix B

EXCLUSIONS

The following are excluded from eligibility under the Plan. No benefits will be paid for any loss, Occurrence or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following:

1. Liability arising out of employment relationships including, without limitation, claims for any type of discrimination, discharge, coercion, criticism, demotion, reassignment, discipline, defamation, harassment, humiliation, sexual harassment, claims arising under the U.S. Americans with Disabilities Act, claims arising out of the Texas Labor Code, and all other claims affecting or arising out of the employment relationship whether arising out of state or federal statutes or regulations or the common law.
2. Liability under the following laws of the United States: the Federal Employers Liability Act, the Longshore & Harbor Workers Compensation Act, the Jones Act, the Non-Appropriated Instrumentalities Act, the Defense Base Act, the Outer Continental Shelf Lands Act, the Federal Coal Mine Health and Safety Act of 1969, the Migrant and Seasonal Agricultural Worker Protection Act, the Employee Retirement Income Security Act of 1974 or any other federal workers or workmen's compensation law or other federal occupational disease law or any other federal laws obligating an employer to pay damages to a Participant due to Bodily Injury arising out of or in the Scope of Employment or any other federal regulations or amendments to those laws.
3. Fines, assessments, penalties or interest pursuant to federal, state, local, or other statute.
4. Any workers' compensation law, unemployment compensation law, disabilities benefits law or other similar law.
5. An intentionally self-inflicted Bodily Injury, Occupational Disease or Cumulative Trauma, while either sane or insane, or Bodily Injury, Occupational Disease or Cumulative Trauma intentionally caused or intentionally aggravated by the Participant.
6. Occurrences, Bodily Injury or charges resulting from or occurring (a) during the commission or attempted commission of a crime, assault or felony; or (b) while engaged in an illegal act, illegal occupation or felonious act or (c) service in the military of any country or any civilian non-combatant unit serving with such forces; or (d) as a result of horseplay.
7. War, invasion, acts of foreign enemies, hostilities, or warlike operations (whether war be declared or not), civil war, mutiny, revolution, rebellion, insurrection, uprising, military or usurped power, confiscation by order of any public authority or government de jure or de facto, martial law, riots, strikes, or civil disturbance. This exclusion also excludes from coverage all costs or expenses directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, retaliating against, or responding to the above.
8. Any diagnostic procedure, treatment, service or supply which is not Medically Necessary or that was in excess of Usual or Customary Charges.
9. Expenses for routine physical examinations or tests not connected with the actual Bodily Injury.
10. Charges and expenses for vocational rehabilitation.
11. Charges for any mental, emotional or psychological condition not directly attributable to an organic brain syndrome that results from a Bodily Injury, independent of Disease, bodily infirmity or other cause.
12. Occurrences after which the Participant tests positive for alcohol or any chemical substance that was obtained or consumed in violation of the U.S. Controlled Substances Act in force at the time and location of the occurrence.
13. Occurrences while employed in violation of law with the Company's actual knowledge or the actual knowledge of any of the Company's executive officers.
14. Exposure to the following:
    a. asbestos, asbestos fibers or asbestos containing products;
    b. silicon or silica;
    c. mold, microbes or fungus; or

d. the hazardous properties, including radioactive, toxic or explosive properties, of Nuclear Material except nuclear or radiological medicine which is:
    1. used for patient care and diagnosis;
    2. approved by OSHA, JCAHO, or the American Hospital Accreditation Association; and
    3. not used for research purposes or clinical tests.

15. All statutory causes of action, including, without limitation, Title VII of the U.S. Civil Rights Act of 1964, the U.S. Civil Rights Act of 1991, the U.S. Civil Rights Act of 1866, the U.S. Age Discrimination in Employment Act, the Employee Retirement Income Security Act, the U.S. Fair Labor Standards Act, the U.S. Bankruptcy Code, the Texas Commission on Human Rights Act, the Texas Workers' Compensation Act, the U.S. Railway Labor Act and the U.S. National Labor Relations Act.
16. The following common law causes of action:
    a. breach of any contract of employment, whether written, oral or implied.
    b. breach of duty of good faith and fair dealing.
    c. breach of any non-competition agreement.
    d. tortuous interference with contractual relations
    e. negligent or intentional infliction of emotional distress.
    f. negligent hiring, negligent promotion, or negligent retention (unless resulting in Bodily Injury).
    g. claims against you based on assault and battery by you or at your direction, defamation, invasion of privacy, false light publicity, negligent invasion of privacy, misrepresentation, fraud, false imprisonment, false arrest, malicious prosecution, unreasonable search or retaliatory discharge.
17. Fees associated with missed or cancelled Provider appointments.
18. Any and all types of Herpes, Simplex Type 2 Genital Herpes, Syphilis, Gonorrhea, psychiatric and/or emotional Disease, emotional distress or disorder and pollution related sickness, Disease or death.
19. Heart attack or stroke unless proximately caused by and arising out of an Accident.
20. Accidental Disability Benefit or Medical Expenses incurred outside the United States, except that emergency medical care for Bodily Injury to Participants who have traveled temporarily out of the United States while in the Scope of Employment is excepted from this exclusion.
21. Charges for:
    a. biofeedback and other forms of self-care or self-help training or any related diagnostic testing;
    b. hypnosis, acupuncture, or chiropractic treatment unless referred by a Provider;
    c. the purchase, rental or repair of environmental control devices, including but not limited to, air conditioners, humidifiers or air purifiers; or
    d. services performed by a person who normally lives with an injured Participant, the spouse of an injured Participant, a parent of an injured Participant or the injured Participant's spouse, a child of the injured Participant or the injured Participant's spouse or a brother or sister of the injured Participant or of the injured Participant's spouse.
22. Participant's participation in any recreational, social or athletic activity not constituting part of the Participant's Scope of Employment, whether or not such participation occurs on Company premises or during its normal business hours.
23. Any pre-existing condition.With regard to aircraft:
    a. boarding, alighting from, riding or being struck by any aircraft owned, operated or leased by you;
    b. riding as a pilot, operator or crew member in any aircraft;
    c. flying in any aircraft that is rocket propelled;
    d. flying in any aircraft which is being used for aerobatics, racing or an endurance contest;
    e. crop dusting, seeding, fertilizing, spraying, fighting a fire, exploring, patrolling, pursuing animals or birds, aerial photography, banner towing, skywriting or any test or experimental flight; or
    f. flying when the flight requires a special permit or waiver from a governmental authority.
25. Terrorism;
26. Travel to or from work;

27. An act of a third person intended to injure the Participant because of personal reasons and not directed at the Participant as an employee of the Company or because of his or her employment with the Company;
28. An act of God, unless employment with the Company exposed the Participant to a greater risk of Injury from an act of God than ordinarily applies to the general public;
29. Osteoarthritis, arthritis, or any other degenerative process of the joints, bones, tendons or ligaments;
30. Occurrences, Bodily Injury or charges which were incurred prior to the Effective Date or after the Plan is terminated.

SUSPENSION OF BENEFITS

A Participant's entitlement to continuing benefits under this Plan may be forfeited, suspended, or discontinued if the Participant fails to comply with or satisfy any of the requirements or provisions of this Plan. Without limiting the foregoing, and by way of example only, a Participant shall not be entitled to benefits under this Plan if:

(a) the Occurrence or alleged Occurrence is (i) not an Occurrence covered by this Plan, (ii) determined to be intentional or feigned, or (iii) determined to be an attempt to defraud;
(b) the Occurrence is not reported immediately to the Supervisor or designee;
(c) the Participant utilizes a health care provider other than an authorized Provider;
(d) the Participant fails to follow the treatment and advice prescribed by the Provider;
(e) the Participant does not obtain treatment within 30 days of an on-the-job-injury;
(f) the Participant refuses or fails to obtain a second opinion prior to surgery, if requested to do so;
(g) the Participant fails to give the Company a weekly progress report by contacting the Company once each week while receiving benefits;
(h) the Participant fails to report to his Supervisor for work immediately upon being released in whole or in part by the Provider to return to work;
(i) the Participant was under the influence of drugs or alcohol at the time of the Occurrence;
(j) the Occurrence was caused by horseplay, scuffling, fighting, altercation, or other inappropriate behavior;
(k) the Participant fails to execute immediately upon request a medical authorization for release of medical records to the Third Party Administrator;
(l) the injury resulted from an intentional or willful act of the Participant or of another;
(m) at the time of the injury, the Participant was in violation of state, federal, or local law;
(n) the Participant tests positive for drugs or alcohol;
(o) the Occurrence arises from or is aggravated by a Pre-Existing Condition;
(p) the Participant becomes employed by another employer while receiving benefits under this Plan;
(q) the Participant fails to provide a complete statement, affidavit, or deposition upon request concerning the incident that the Participant believes resulted in an injury;
(r) the Participant was untruthful in regard to any aspect of the required information supplied as part of the employment process including, without limitation, information as to physical or mental abilities to perform the job; and
(s) the Participant refuses to submit to drug and/or alcohol testing.
(t) If a Provider determines that a Participant has reached Maximum Medical Improvement.

Appendix C

SUBROGATION

This provision shall apply to all benefits provided under any section of the Plan. A covered employee may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the covered employee may have a claim against that other person or Another Party for payment of the medical expenses or other charges. In that event, the Plan will be Subrogated to all rights the covered employee may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the covered employee may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the covered employee procures or may be entitled to procure regardless of whether the covered employee has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits or collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the covered employee agrees that acceptance of benefits is constructive notice of this provision.

The covered employee must:

a. Execute and deliver a Subrogation and Reimbursement Agreement;
b. Authorize the Plan to sue, compromise and settle in the covered employee's name to the extent of the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the covered employee's rights to Recovery when this provision applies;
c. Immediate Reimbursement of Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
d. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
e. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the covered employee will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. If the Plan pays any medical or other benefits for the injuries or illness before these papers are signed, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the covered employee will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement. Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the covered employee does not receive full compensation for all of his charges and expenses.

Definitions Applicable to this Section. The following terms used in this section are defined as follows:

a. **Another Party** shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a covered

employee's injuries or illness. "Another Party" shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a covered employee's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

b. **Recovery** shall mean any and all monies paid to the covered employee by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

c. **Subrogation** shall mean the Plan's right to pursue the covered employee's claims for medical or other charges paid by the Plan against Another Party.

d. **Reimbursement** shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Employee Retains an Attorney. If the covered employee retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the covered employee's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the covered employee's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the covered employee's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A covered employee or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A covered employee or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the covered employee or his attorney is not the rightful owner of the Recovery and should not he in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Employee is a Minor or is Deceased. These provisions apply to the parents, trustee, guardian or other representative of a minor covered employee and to the heir or personal representative of the estate of a deceased covered employee, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Employee Does Not Comply. When a covered employee does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered employee and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefit plan maintained by the Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a covered employee to enforce this provision, then that covered employee agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Appendix D

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall 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 plan, including insurance contracts and collective bargaining agreements, 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 Pension and Welfare Benefit 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 administrator may make a reasonable charge for the copies.

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 employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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 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 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 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. 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 Federal court. If it should happen that plan fiduciaries misuse the 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, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

EMPLOYEE ACKNOWLEDGEMENT

I acknowledge that I have received and read The **HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC** Occupational Injury Benefit Plan Summary and, in consideration of my participation in the **HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC** Occupational Injury Benefit Plan and my eligibility to receive its benefits, I hereby agree to abide by the terms of the Plan and related insurance contract, if any. I certify that I have been advised that the Company does not carry Workers Compensation Insurance. Therefore, as consideration for my eligibility to participate under this Occupational Injury Benefit Plan, I am not eligible for benefits under the statutory workers' compensation systems of Texas or any other state. Additionally, I understand that receipt of this Summary does not constitute an employment contract nor does payment of any benefit(s) hereunder constitute an admission of liability on the part of the Company.

I, the undersigned, have received and read a copy of The Summary Plan Description. I have also been given a copy of the **HPV Staff, LLC/Mongolian Dining Venture I, LLC/Houston Subs Unlimited, LLC/Sure Fire Tacos, LLC** Dispute Resolution Program and acknowledge that I have read or have had the opportunity to read the Dispute Resolution Program.

Employee Name (printed):

_____

Signature:

_____

Address:

_____

_____

Date Signed: _____