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2024 Field Benefits Guide

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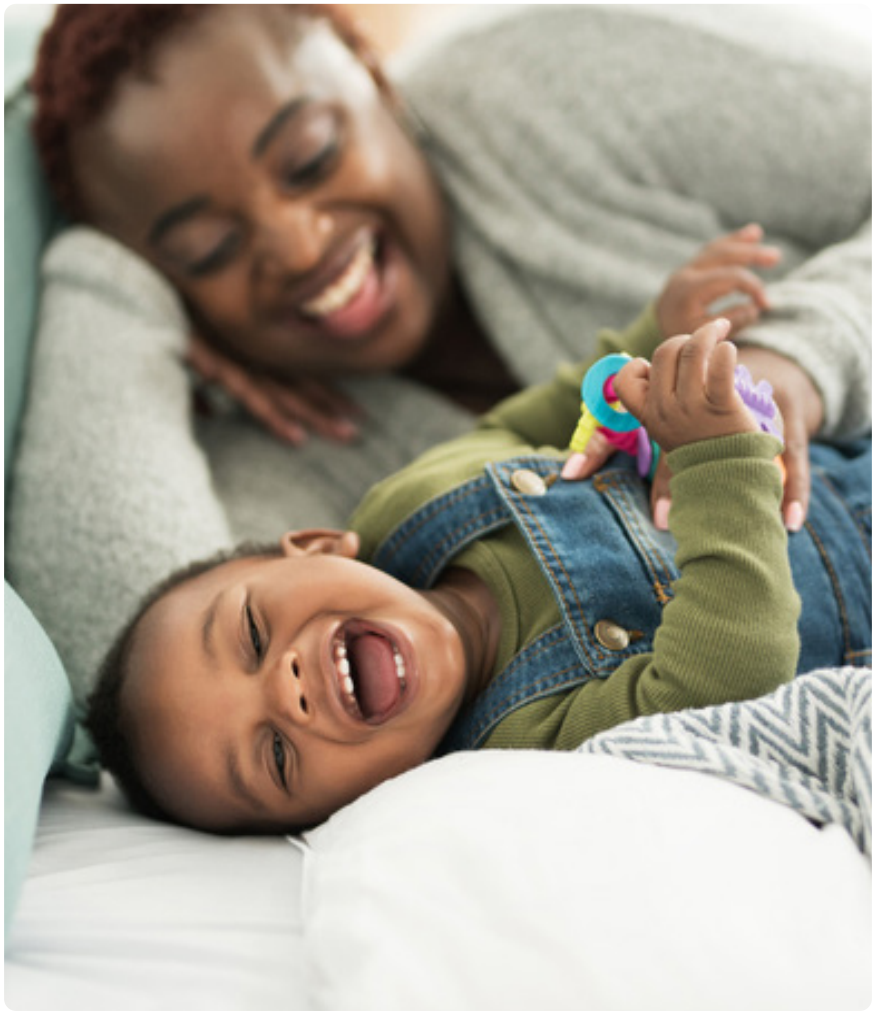


Care is more than something we say; it is what we do at G6 Hospitality. We care about the WHOLE person and work to design benefit plans to support you and your family's changing wellness needs.

We work to keep your costs low while making sure we offer quality benefits for you and your family. Be sure to review the benefits that are available to you in 2024, and choose what's just right for you.

About this guide

This user-friendly, clickable guide will help you choose your 2024 benefits. You can also refer to it throughout the year as you're making health care decisions. Use the menu at the top of each page to move from section to section. The links throughout the guide will quickly take you to another page in the guide, a website, a reference document or will populate an email.

Get more info at G6Benefits.com

G6Benefits.com has everything you need to understand and use your benefits. No password or login needed. Your spouse can access it, too! On it, you will find this guide, the Real-Life Examples which help you choose a plan, and important legal and plan documents.

Your Aetna Health Concierge can help!

The Aetna Health Concierge can help you understand your benefits and provide tools to make more informed decisions about your health care. Call (800) 374-3985 or visit aetna.com to send a message.

Your Aetna Health Concierge can help you:

- Locate in-network providers near you
- Understand a diagnosis, test result, treatment or procedure
- Get second opinions if your doctor recommends surgery
- Review and resolve health care claim issues
- Put together questions for your next doctor visit
- Answers questions about counseling services, treatments and medications

Go to aetna.com for more information about what your Aetna Health Concierge can do for you.

Health care can be complicated. Whether it's a wellness screening or a complicated surgery, your concierge can help you make sense of your options and work better with your doctor.

Steps to enroll

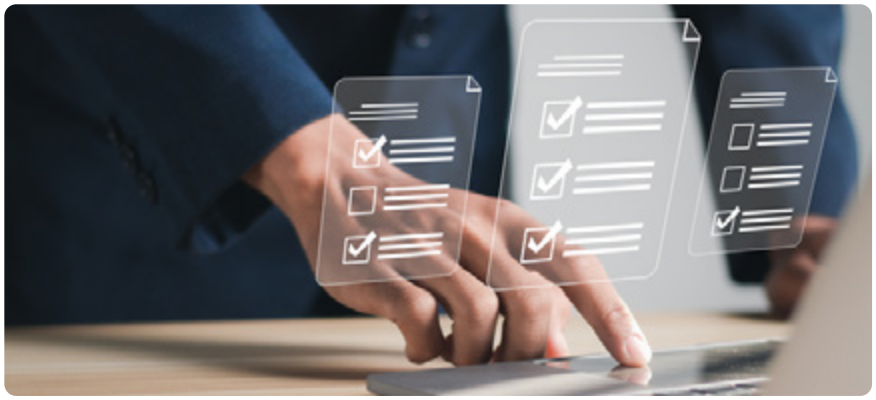
Follow these steps to enroll in your 2024 benefits. The benefits you choose will be effective through December 31, 2024. After your initial enrollment, you can only make changes to your benefit elections if you have a Qualified Life Event. See the Qualified Life Event page for more information.

Read this guide
Learn more about the G6 Hospitality benefits program, designed to protect your health and financial well-being.

Enroll via Workday within 30 days of your eligibility
Go to Workday to enroll for your benefits. You must access Workday from a work location or VPN.

Things to remember

- You must enroll within 30 days of your eligibility date or you will not have benefits through G6.
- Each fall, you will have the opportunity to review your benefits elections during Open Enrollment. We encourage you to review your benefits elections at that time, including your enrolled dependents and beneficiary designations.



Eligibility

Team Members' eligibility for benefits is determined by whether your job status is full-time or part-time and your length of service.

You are eligible to enroll if you are a full-time team member or a part-time team member eligible for benefits. You can only make changes if you experience a Qualified Life Event.

Full-time team members

- Eligible for benefits the first of the month following hire unless otherwise noted

Part-time team members

- Eligibility will be based on average hours worked in the first 11 months of employment
- If average hours worked per week are less than 30, you are not eligible for benefits
  - If average hours worked per week are 30 or greater, you are eligible for benefits effective the first of the month following one year of service
  - If benefits are elected, coverage is effective for a minimum of 12 months

Eligible dependents

- Your legal opposite-sex or same-sex spouse
- Children under the age of 26, regardless of student, dependency or marital status. "Children" refers to natural children, adopted children (including children placed for adoption), stepchildren, children for whom a court order for medical coverage is required and for whom you have legal guardianship
- Children who are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return, may continue coverage past age 26

Documentation for dependents

You must provide the Social Security Number for all covered dependents who are at least six months old.

Dependent verification

When a new dependent is added to the plan, you are required to provide documentation (such as birth or marriage certificates) to verify eligibility. You will receive a notice requesting the documentation and if you do not provide it, your dependent(s) will be dropped from coverage.

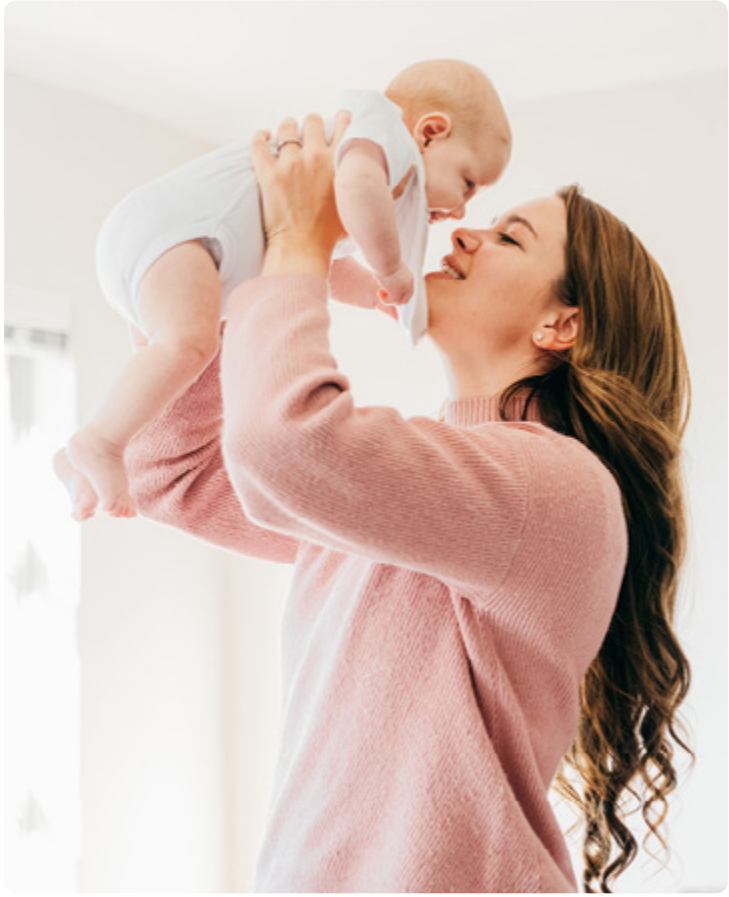
Qualified Life Events

You can make changes to your benefits during the year if you have a Qualified Life Event. You must request your benefits change within 31 days of the event by going to Workday. You will be required to provide documentation to support the Qualified Life Event.

Typical Qualified Life Events include, but are not limited to:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or other eligible dependent
- Change of employment status (example: changing from full-time to part-time)
- Change in your spouse's or child's employment resulting in gain or loss of eligibility for employer benefits
- Qualification by the Plan Administrator of a Medical Child Support Order
- You or your dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility*
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP*

**You must request a benefits change within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. The 31 day notice is still required for all other special enrollments.*



Medical coverage

We offer two medical plan options: the Value Plan and the Classic Plan. Both are administered through Aetna and have the same network of providers. Call (800) 374-3985 or go to aetna.com and click on Member Resources for more information.

Our medical plans provide you access to in- and out-of-network providers. When you visit an in-network provider, you receive the highest level of benefits and save on out-of-pocket costs. The Plans feature different deductibles, coinsurance, copays and coverage levels. Both plans cover preventive care at 100%.

	Value Plan	Classic Plan
Pay Check Deductions	Lower	Higher
Yearly Deductible	Higher	Lower
Medical Copay	No	Yes
Preventive Services	Covered at 100%	Covered at 100%
Coinsurance	Member is responsible for 30% coinsurance after deductible is met, and until the out-of-pocket maximum is reached	Member is responsible for 20% coinsurance after deductible is met, and until the out-of-pocket maximum is reached
Health Savings Account	Yes	No
Health Care FSA	Yes, if you do not enroll in the optional HSA	Yes

Medical plan highlights

	IN-NETWORK		OUT-OF-NETWORK	
	Value Plan	**Classic Plan**	**Value Plan**	**Classic Plan**
	Member Responsibility	**Member Responsibility**	**Member Responsibility**	**Member Responsibility**
Office Visit	30% after deductible	$30	50% after deductible	40% after deductible
Specialty Office Visit	30% after deductible	$50	50% after deductible	40% after deductible
Teladoc	$49, then 30% after deductible	$15	N/A	N/A
Urgent Care	30% after deductible	$50	50% after deductible	40% after deductible
Annual Deductible				
Single	$4,000	$1,500	$8,000	$3,000
Family	$12,000	$4,500	$24,000	$9,000
Coinsurance Paid by the Plan	70%	80%	50%	60%
Out-of-Pocket Maximum				
Per Covered Person	$6,000	$4,000	$12,000	$8,000
Per Family	$12,000	$8,000	$24,000	$16,000

Continued on next page

	IN-NETWORK		OUT-OF-NETWORK	
	Value Plan	**Classic Plan**	**Value Plan**	**Classic Plan**
	Member Responsibility	**Member Responsibility**	**Member Responsibility**	**Member Responsibility**
Services				
Preventive Care (Wellness exams and immunizations)	Covered at 100%		Covered at 100%	
Maternity Care	30% after deductible	First office visit will apply toward your copay, but all pre-natal visits and delivery charges are subject to your annual deductible and coinsurance	50% after deductible	40% after deductible
Hospital Admission (Your costs per admission. If not medically necessary, no payment will be made.)	30% after deductible	$500 in-patient copay, plus 20% after deductible	50% after deductible (Failure to pre-certify may result in reduction of payment by 50%)	40% after deductible (Failure to pre-certify may result in reduction of payment by 50%)
Outpatient Surgery (Your costs per outpatient surgery)	30% after deductible	20% after deductible	50% after deductible	40% after deductible
Emergency Room (If not a true emergency, services will be subject to a higher copay, the deductible and coinsurance)	30% after deductible	Emergency: $300 copay plus 20% Non-Emergency: $600 copay plus 20% after deductible	30% after deductible	Emergency: $300 copay plus 20% Non-Emergency: $600 copay plus 20% after deductible
Mental Health Services	30% after deductible	20% after deductible	50% after deductible	40% after deductible
X-Rays and Labs	30% after deductible	20% after deductible	50% after deductible	40% after deductible

Wellness benefits

These benefits are available to all medical plan participants and paid for by G6 Hospitality.

Wondr Health
Wondr Health is an easy-to-follow, online program that teaches you how, when and why to eat in order to manage your weight and help prevent chronic diseases such, as diabetes. It's a personalized program that includes weekly online lessons to build the skills, habits and mindset for eating the right way. You can participate by visiting wondrhealth.com/G6 or their app.

Aetna Second Opinion
When you need a treatment or surgery for an injury or illness, get a free second opinion. Aetna 2ndMD reviews your case and may provide a different diagnosis, alternative to surgery or a new treatment plan. You'll have a live consult with a specialist or a treatment team depending on your condition, and it usually takes 30 minutes or less.

Transform Diabetes Care
If you're managing diabetes, there's something that can help. Transform Diabetes Care is a 12-month program that can help keep your diabetes in check. It can help you find the best ways to manage your diabetes and help you live well, stay motivated and achieve your best health. For questions about diabetes, or for additional support, please call Aetna Member Services at the number on your member ID card.

Aetna Comprehensive Infertility Program
Infertility is a common problem. But experiencing it can understandably be an emotional and stressful time. Aetna has a special team of nurses who have experience in infertility care. With sensitivity and compassion, they'll help you understand the precertification process, review your benefits and share other helpful information. Through the Aetna Comprehensive Infertility Program, services include benefits such as artificial insemination (AI) and ovulation induction (OI). Call Aetna at the Member Services number on your ID card and they will explain your benefits coverage, talk about the provider network and answer your questions.

Aetna Cancer Support Center
A cancer diagnosis is life changing. And you probably have a million things on your mind as you navigate your treatment. Aetna provides you with resources and support you may need to manage your care, understand your benefits and locate the right providers. The Aetna Cancer Support Center brings resources to your fingertips, serving as your trusted source for information and guidance on what to expect while managing cancer treatment and care.

Aetna Behavioral Health network providers
You already have access to trained professionals for in-person counseling. But it's not always easy to find the time to talk with someone when you need help. With personalized programs for every member of your family and health solutions specifically designed to help families find care that works for them, Aetna is dedicated to find care that works so that every family can thrive. Call Aetna at the Member Services number on your ID card for more details.

Teladoc – Your 24/7/365 medical resource

Teladoc offers easy, low-cost access to U.S. board certified and licensed doctors to all team members enrolled in a G6 Hospitality medical plan. Doctors specialize in internal medical, family practice and pediatrics. They have an average of 15 years of experience and are credentialed every three years.

Medical plan	Cost per Teladoc visit
Value Plan	$49 then 30% after deductible is met
Classic Plan	$15 copay

Get the care you need now

Teladoc doctors can treat many medical conditions including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Ear infection
- Respiratory infection
- Sinus problems
- Skin problems
- And more!

Mental health

Teladoc offers mental health support. You can receive counseling and psychiatric care from the comfort of your own home. You choose a therapist and appointments are available seven days a week, 7:00 a.m. to 9:00 p.m. local time.

Follow these simple steps to access Teladoc:

1. Call (855) TELADOC (835-2362) or log in to teladoc.com/aetna to request a visit with a doctor
2. Talk to the doctor
3. Receive treatment including a prescription, if applicable

Prescription drug highlights

When you enroll in a medical plan, you receive prescription drug coverage through OptumRx. You can fill prescriptions at any of the participating pharmacies in the OptumRx network. For more information, call (844) 775-7416 or go to optumrx.com/oe_premium/landing.

	Value Plan	Classic PPO
Short-Term medication – 30-day Retail		
Preventive Therapy Drug List	$10 copay	N/A
Generics	30% of Rx cost after deductible	$10 copay
Preferred	30% of Rx cost after deductible	20% of Rx Cost; $22 min; $45 max
Non-Preferred	30% of Rx cost after deductible	20% of Rx Cost; $37 min; $75 max
Long-Term medications		
30-Day Long-Term Medication - Retail (Prescriptions filled at a retail pharmacy more than two times)		
Preventive Therapy Drug List	$25 copay	N/A
Generics	50% of Rx cost after deductible	$25 copay
Preferred	50% of Rx cost after deductible	20% of Rx Cost; $100 min; $200 max
Non-Preferred	50% of Rx cost after deductible	20% of Rx Cost; $176 min; $352 max
90-Day Long-Term medications - Mail order or CVS		
Preventive Therapy Drug List	$25 copay	N/A
Generics	30% of Rx cost after deductible	$25 copay
Preferred	30% of Rx cost after deductible	20% of Rx Cost; $56 min; $113 max
Non-Preferred	30% of Rx cost after deductible	20% of Rx Cost; $94 min; $188 max
Specialty medications		
All	30% of Rx cost after deductible	20% of Rx Cost; $60 min; $120 max

Formulary

The formulary is a list of approved medications, both generic and name-brand, that are less expensive. Your prescription will be filled with the medication on the formulary. If you take a medication that's not on the formulary, you may pay more. The covered drug list can be found on optumrx.com/oe_premium/landing.

Preventive Therapy Drug List - Value Plan only

The Preventive Therapy Drug List is a list of medications that help treat specific chronic conditions. You pay a copay when you use approved medications on this list. The covered drug list can be found on optumrx.com/oe_premium/landing.

90-day prescriptions

If a prescription is for a long-term maintenance medication, OptumRx will notify you of the option to save money on the cost of the prescription by filling a 90-day prescription. You can fill a 90-day prescription at any CVS pharmacy or through home delivery.

Home delivery

Home delivery from OptumRx is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medication for delivery to your home, office or location of your choosing. Enroll in home delivery online at optumrx.com.

Health Savings Account (HSA)

The optional HSA is a feature of the Value Plan that has triple tax savings. Money is deducted from your paycheck tax-free, grows tax-free in your account and can be used tax-free to pay for eligible expenses. Call (866) 451-3399 or go to wexinc.com for more information..

What is it?	A tax-advantaged savings account offered through WEX Benefits, the G6 Hospitality HSA partner.
Who is eligible for the HSA?	You have to be enrolled in the Value Plan to contribute to the HSA. You cannot have an HSA if you are enrolled in the Classic Plan.
Do I have to enroll each year?	Yes
Who contributes to the HSA?	You do
What are the 2023 contribution limits?	Single coverage: $4,150 Family coverage: $8,300 If you are age 55 or older, you can contribute an additional $1,000
What can the money be used for?	You can use the money to pay for eligible medical, dental, vision and prescription drug expenses. Click here for more information about eligible expenses.
Can the money be invested?	Yes, if your balance is over $1,000. Go to wexinc.com for more information.
Can I roll over the unused money from year-to-year?	Yes. Your account carries over every year.
Can I use the money on eligible health care expenses if I leave the company?	Yes. The money is yours to keep if you leave G6 Hospitality and you can use the money in retirement to pay for eligible expenses. There may be rules around when and how you can use your money. Go to irs.gov for more information.
How do I set up my account?	When you enroll, select that you want an HSA and your contribution amount.
When can I use the money in my account?	Your money is available when it is deposited each pay period through payroll deductions.
How do I use the money in my account?	You will be provided with a debit card. Simply use the debit card when you want to pay for an eligible expense or you can withdraw money and reimburse yourself. Be sure to save your receipts, in the event you are asked to provide them.

Flexible Spending Accounts

The Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars – money taken out of your paycheck before income or Social Security taxes. Our FSAs are administered by WEX Benefits. Call (866) 451-3399 or go to wexinc.com for more information.

Health Care Flexible Spending Account (Health Care FSA)

This FSA allows you to set aside pre-tax dollars to help pay for certain out-of-pocket health care expenses. If you are enrolled in the Value Plan and choose to enroll in the optional HSA, you cannot enroll in the Health Care FSA, per IRS rules.

Understanding the Health Care FSA	
Eligible Expenses	Most medical, dental and vision care expenses that are not covered by your health plan, such as copays, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications
Ineligible Expenses	Over-the-counter medications are not covered unless you have a prescription
Annual Contribution Limit	Maximum contribution is $3,050* per year
Carryover	If you have money left over at the end of 2024, you can carry over $610* into 2025 to use for eligible expenses

If you leave G6

You will lose any money remaining in your account. You cannot take it with you.

*IRS limit subject to change.

Dependent Care Flexible Spending Account (Dependent Care FSA)

This FSA allows you to set aside pre-tax dollars to help pay for day care services for your eligible dependents. The Dependent Care FSA is not for health care expenses.

Understanding the Dependent Care FSA	
Eligible Expenses	Dependent care expenses (such as day care, after-school programs or elder care programs) so you and your spouse can work or attend school full-time
Qualified Person	A qualifying child under age 13 whom you can claim as a dependent; if the child turned 13 during the year, the child is a qualifying person for the part of the year he or she was under age 13 Your disabled spouse who is not physically or mentally able to care for himself or herself Any disabled person who is not physically or mentally able to care for himself or herself whom you can claim as a dependent or could claim as a dependent
Annual Contribution Limits	Maximum contribution is $5,000* per year ($2,500* if married and filing separate tax returns)

If you are concerned about the "use or lose it' rule of the Health Care FSA, consider the Value Plan and the optional HSA. HSA dollars carry over from year-to-year, and there's no "use it or lose it" rule.

If you leave G6

You will lose any money remaining in your account. You cannot take it with you.

Use it or lose it!

Estimate your expenses carefully because the law requires that you use your account balance during the plan year (the "use it or lose it" rule).

Health Care FSA: You can carry over $610* unused amounts remaining in the 2024 Health Care FSA into 2025. If you are concerned about the "use or lose it" rule of the Health Care FSA, consider the Value Plan and the optional HSA. HSA dollars carry over from year-to-year, and there's no "use it or lose it" rule.

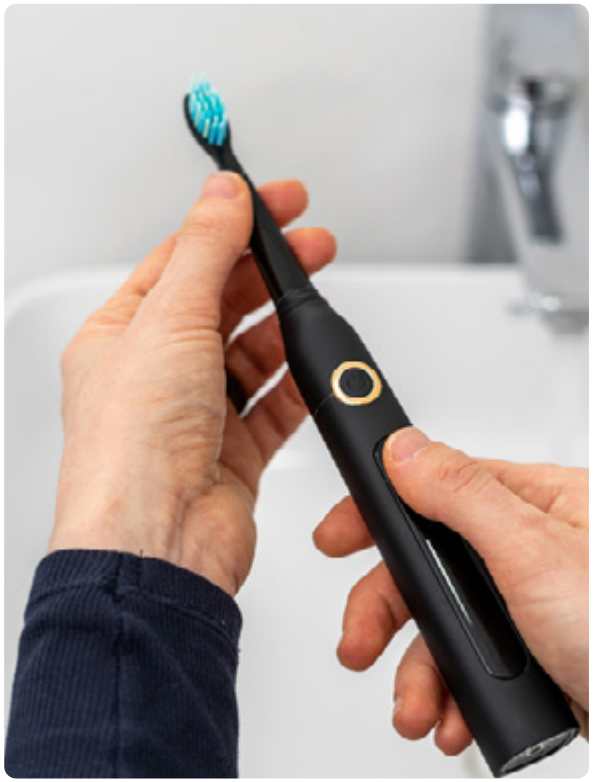
Dependent Care FSA: All funds need to be used by December 31 or they will be forfeited.

*IRS limit subject to change.

Dental coverage

The dental plans offer both in-network and out-of-network coverage. You can take advantage of discounted prices for dental care through Delta Dental's extensive provider network. For more information, go to deltadentalins.com.

Each dental plan includes two annual cleanings and associated oral examinations. Preventive services are covered at 100%.



	DENTAL PPO	
	High	**Low**
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Preventative Services Covered at... (Does not apply toward Annual Benefit Maximum)	100%	100%
Basic Services Covered at...	80%	80%
Major Services Covered at...	$50	50%
Annual Benefit Maximum	$1,500	$750
Office Visit Copay	$0	$0
Orthodontics (Adult/Child)	50%	Not Covered
Lifetime Orthodontic Maximum	$1,500	Not Covered

Vision and hearing coverage

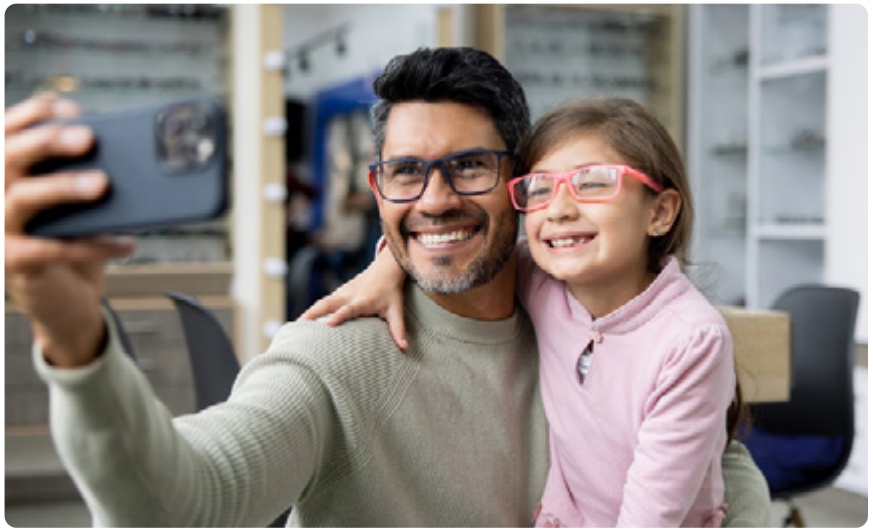
The vision plan offers in-network and out-of-network benefits. VSP is the vision plan administrator.

To access in-network benefits, you must inform the provider when you schedule your appointment. To find a participating provider in your area, visit vsp.com, or call a member services representative at (800) 877-7195.

	VISION PLAN	
	In-Network	**Out-of-Network Reimbursement**
Eye Exam	$10 copay	Up to $50
Single Vision Lenses	$20 copay	Up to $50
Lined Bifocal Lenses	$20 copay	Up to $75
Lined Trifocal Lenses	$20 copay	Up to $100
Scratch-resistant Coating	Covered in full	N/A
Frames	$20 copay ($180 retail allowance); frames may be purchased every calendar year	Up to $70
Contact Lenses Exam	Up to a $60 copay	N/A
Contact Lenses	$180 allowance	Up to $135

Hearing aid coverage

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP members. You can save up to $2,400 on a pair of hearing aids with TruHearing. Your dependents and extended family members are eligible, too. Call TruHearing at (877) 396-7194 and mention that you have coverage through VSP. They will assist you in setting up an appointment for hearing aids. You can also find more information at vsp.truhearing.com.



Transportation benefit

Team members can take advantage of the tax-free transportation benefit if they commute to work by public transit (bus, rail or ferry) or vanpool by paying for transit or parking with pre-tax dollars.

Note: Tollway charges are not eligible expenses.

Transit Spending Account	Parking Spending Account
• Set aside up to $300* pre-tax dollars each month • Pay for transit passes with your WEX Benefits Debit Card	• Set aside up to $300* pre-tax dollars each month • Pay for parking passes with your WEX Benefits Debit Card at your transit authority • Or purchase passes out-of-pocket and get reimbursed via check or direct deposit

How to use your spending account:

1. **Up to $300* per month is deducted from your paycheck before taxes.**
   You can adjust your deduction amount anytime. To increase, decrease or stop your deduction, go to Workday to change your benefits. Changes will be effective the first of the month after the election is changed.
2. **Use your WEX Benefits debit card for all transactions** or submit parking pass expenses for reimbursement. Access your account 24/7 on wexinc.com.

*IRS limit subject to change

After enrolling, you can use your debit card the first of the month after two deductions have been withheld from your paycheck.

Visit wexinc.com to learn more. Contact the WEX Benefits Participant Services Team at 1-866-451-3399, Monday to Friday, 7 a.m. to 7 p.m. CT or via email at customerservice@wexhealth.com with questions.

Legal plan

G6 Hospitality offers an optional Legal plan benefit to you through MetLife. You pay the cost of coverage. For a monthly fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters – with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter. For non-covered matters, such as divorce, that are not otherwise excluded, your plan provides four hours of network attorney time and services per year. This program is designed to provide you with legal assistance for a variety of needs, including:

- Representation in court for moving traffic violations
- Mortgage and deed of trust document assistance
- Trial defense services for covered legal matters
- Demand letters on your behalf
- Contract and document review
- Power of attorney
- Immigration assistance
- Will preparation and updates
- Representation for uncontested adoption
- Toll-free phone consultations for any legal matter
- Tax assistance for state and local taxes, as well as IRS audits
- Home equity loan assistance
- Identity management and identity theft defense
- Protection from domestic violence
- Property tax assessments
- Boundary title disputes
- Sale, purchase or second home refinancing

Contact the MetLife Legal Plan at (800) 821-6400 or go to legalplans.com. The Group Number is 101065, and the password is 101065.

Income protection benefits

Basic Life Insurance and Accidental Death & Dismemberment (AD&D)

Basic Life Insurance and AD&D coverage are provided at no cost to eligible team members. Your coverage amount is based on your annual salary, rounded up to the next higher $1,000, up to a maximum amount. Part-time hourly team members are not eligible for Basic Life Insurance and Basic AD&D coverage.

BASIC LIFE AND AD&D INSURANCE	
Field Team Members (full-time)	Your base annual salary, up to the nearest $1,000, to a maximum of $250,000

Supplemental Life and AD&D coverage

SUPPLEMENTAL LIFE AND AD&D COVERAGE	
Coverage for Team Members	You may purchase 1, 2, 3, 4 or 5 times your base annual salary, up to a maximum of $500,000
Coverage for Spouse	You may purchase Supplemental Life coverage for your spouse, in increments of $10,000, up to $250,000, not to exceed 50% of your own basic and supplemental coverage
Coverage for Child(ren)	You may purchase supplemental coverage for your children in any of these amounts: $2,500, $5,000, $7,500 or $10,000
Your per-paycheck costs for coverage are based on your age and the amount of coverage you elect	

Detailed information can be found in the plan documents, available online or by calling Team Member HR Services at (469) 737-3366.

Supplemental Life and AD&D

When you're first eligible for Supplemental Life and AD&D:

- You may purchase up to 5x your base annual salary up to guaranteed issue (GI) without evidence of insurability (EOI)
- If your request is more than the GI, you'll need to provide EOI
- GI for team members is $300,000 or 3x annual base salary, whichever is less

If you enroll your spouse when first eligible:

- You may buy up to the GI amount without providing EOI
- Your spouse will need to provide EOI to be eligible for coverage over the GI
- GI for spouses age 69 and younger is $50,000

Designate a beneficiary

Make sure you designate a beneficiary for your Life and AD&D insurance benefits. You can change or update beneficiaries at any time on Workday.

Life insurance support

Unum life insurance representatives can assist you through the claims process and help you with financial and legal issues. To file a life insurance claim, call (888) 556-3727.

Leaves of Absence

Leaves of Absence

Leave of Absence requests are administered by Unum. If you need to file a request, make sure to notify your manager or supervisor of your absence from work. To submit your request and/or claim, call (866) 779-1054, Monday to Friday, 7 a.m. to 7 p.m. CT.

You, or the person calling on your behalf, will need to provide the following information.

- Name of the company where you work (G6 Hospitality, Motel 6 or Studio 6)
- Policy number (#467761)
- Your name and Social Security Number or team member ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)
- Supervisor's name and telephone number
- Last day worked and first day absent from work due to your claim and/or Leave of Absence request
- Date expected to return to work or actual date if already returned to work

If eligible for a Leave of Absence, a certification of health care provider form may be required. The form will be mailed in your initial Leave of Absence packet within two business days of filing your Leave of Absence. You will be provided 15 days from the date the Leave of Absence is requested to complete and return this form.

Disability benefits

Disability coverage is provided by G6 Hospitality to eligible team members. When you call in a Leave of Absence to Unum, your Disability benefits are automatically reviewed to determine eligibility.

Short-Term Disability

GROUP	BENEFITS
Field Managers	After a five-day waiting period, covers 60% of your pay for each week you are disabled; the maximum STD period is 13 weeks (5 day waiting period and 12 weeks of STD)

Long-Term Disability

Long-Term Disability covers 60% of your base annual earnings up to a $10,000 monthly maximum. Benefits begin after 90 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. This benefit will be offset by other pay replacement income you may receive, such as Social Security disability benefits.

How to file a disability claim

Call Unum at (866) 779-1054, Monday to Friday, 7 a.m. to 7 p.m. Central Time:

- When your health care provider has determined you are unable to work due to illness, non-work related injury or pregnancy
- Thirty days before a disability based on the expected delivery date of a child or prescheduled medical treatment

Remember:
If you are injured at work, notify your manager or supervisor immediately. Do NOT use this toll-free number for work-related injuries.

Planning for retirement

The 401(k) Plan, administered by Fidelity, is designed to help you reach your investment goals. To enroll in the plan or to get more information, call (800) 835-5097 (English) or (800) 587-5282 (Spanish), or go to 401k.com.

FREE MONEY

Company matching contributions

As a plan participant, you will receive a 100% employer match on the first 3% of pay you contribute to your 401(k) account, and a 50% match on the next 2% of your pay contributed, up to a maximum employer match of 4% of your total pay. You can contribute up to the IRS limit in 2024. Annual limits are subject to change due to IRS adjustments.

How the 401(k) plan works

You are eligible to enroll in the G6 Hospitality LLC 401(k) Savings Plan the first of the month following hire if you are at least 21 years old. Once you are eligible to participate in the 401(k) Plan, you can enroll at any time during the year.

Catch-up contributions

If you are or will be age 50 or older in this calendar year, you can make "catch-up contributions" to your account. The catch-up contribution is intended to help you accelerate your progress toward your retirement goals. You can contribute up to the IRS limit in 2024. Annual limits are subject to change due to IRS adjustments.

Additional benefits

These additional benefits are offered at no cost to you.

Paid Time Off
Paid Time Off is available to eligible Team Members to provide opportunities to take care of personal circumstances, including illness, injury, health condition (Team Member, spouse, or child), rest, relaxation, and personal pursuits. Team Members are encouraged to take advantage of this benefit as it is earned. Please refer to the Absence worklet in Workday for available time.

Employee Assistance Program (EAP)
The EAP offers free and confidential assessments, short-term counseling, referrals and follow-up services to team members who have personal and/or work-related problems. Contact the Unum EAP at (800) 854-1446 (English) or (877) 858-2147 (Spanish) or go to lifebalance.net. The user ID is lifebalance and the password: lifebalance.

Each team member and each member of their household can use up to three face-to-face sessions per issue, per year, at no charge.

Business Travel Accident
G6 Hospitality provides Business Travel Accident insurance to eligible team members at no cost. Benefits are paid in the event of death while traveling on company business. In addition, if you are traveling in a place where medical facilities do not exist or are very limited, medical evacuation is provided where necessary. G6 Hospitality provides this benefit at no cost to you.

Coverage includes 24-hour worldwide business travel protection, travel assistance services and emergency medical evacuation.

Discounts

Pet insurance

To align with our pet friendly hotel policy, you can purchase pet insurance for your "fur babies" through Nationwide. This insurance can help with veterinary costs and more. Learn more and enroll directly with Nationwide at benefits.petinsurance.com/g6hospitality or by calling (877) 738-7874.

Perks at Work

All G6 Hospitality team members are eligible for Perks at Work. Perks at Work partners with 30,000 merchants to offer discounts on computers, electronics, hotels, restaurants, shoes, apparel and more.

Visit perksatwork.com to log in with your team member ID# and temporary password "savings" to access the Perks at Work site. In addition, you can share the savings by inviting up to five family members and friends to join, too.

LA Fitness

We are pleased to offer a discounted membership benefit available through G6 Hospitality and LA Fitness!

Get access to all LA Fitness facilities in the US through this offer from now until 10/01/2024 for $0 initiation and $34.99 monthly per person, for you and your family members*.

*$49 annual fee required. Some amenities may be available for an additional fee, such as personal training, racquet sports and leagues.

Corporate America Family Credit Union

The Corporate America Credit Union offers G6 Hospitality team members a wide array of in-person, online and mobile banking options. The Corporate America Credit Union offers no- or low-fee checking accounts and high-yield savings accounts, like money markets, share certificates and IRAs.

To find out more and to join, go to cafcu.org/G6 or call (800) 359-1939.

Team member contributions

You can receive an additional $520 for you and $520 for your covered spouse if you certify that you're tobacco-free. If you do not take advantage of these incentives, you'll pay more for your 2023 medical plan paycheck costs.

	MEDICAL COVERAGE (BI-WEEKLY PREMIUMS)	
	Classic Plan	
	Rate with No Incentives	**Rate with Max Incentives***
Team Member	$139	$99
Team Member + Spouse	$387	$307
Team Member + Children	$321	$281
Team Member + Family	$555	$475
	Value Plan	
	Rate with No Incentives	**Rate with Max Incentives***
Team Member	$67	$27
Team Member + Spouse	$217	$137
Team Member + Children	$179	$139
Team Member + Family	$323	$243

Dental Premiums

	DENTAL COVERAGE (BI-WEEKLY PREMIUMS)	
	High Plan	Low Plan
Team Member	$15.31	$7.83
Team Member + Spouse	$30.62	$15.66
Team Member + Children	$35.97	$18.40
Team Member + Family	$51.28	$26.23

Vision Premiums

	VISION COVERAGE (BI-WEEKLY PREMIUMS)
Team Member	$3.58
Team Member + Spouse	$6.64
Team Member + Children	$6.96
Team Member + Family	$10.25

Team Member Supplemental Life

Biweekly rates per $1,000 of coverage

Age	Rate
<35	$0.037
35-39	$0.042
40-44	$0.065
45-49	$0.115
50-54	$0.189
55-59	$0.309
60-64	$0.485
65-69	$0.789
70 & Over	$1.154

Spouse Supplemental Life

Biweekly rates per $1,000 of coverage

Age	Rate
<35	$0.086
35-39	$0.108
40-44	$0.155
45-49	$0.197
50-54	$0.288
55-59	$0.448
60-64	$0.677
65-69	$1.039
70 & Over	$1.760

Child Supplemental Life

Biweekly cost per coverage level

Coverage Level	Rate
$2,500	$0.052
$5,000	$0.104
$7,500	$0.156
$10,000	$0.208

Legal Plan

Biweekly Cost	Weekly Cost
$7.62	$3.81

Supplemental AD&D

Biweekly rates per $1,000 of coverage

Team member	$0.009
Spouse	$0.015
Child	$0.015

Important contacts

Most of our providers have convenient apps you can download from the Apple Store or Google Play for your smartphone.

Benefit	Provider	Phone Number	Web Site/Passwords
Aetna Health Concierge	Aetna	(800) 374-3985	**aetna.com**
Medical	Aetna | Group Number: 865280	(800) 374-3985	**aetnanavigator.com**
Wondr Health	Wondr Health	(855) 999-7549	**wondrhealth.com/g6**
Aetna Second Opinion	2nd.MD	(866) 410-8649	**2nd.MD**
Diabetes Care	Transform Diabetes Care	(800) 374-3985	**aetnanavigator.com**
Virtual Medical Visit	Teladoc/Aetna	(855) Teladoc (835-2362)	**teladoc.com/aetna**
Prescription Drugs	OptumRx	(844) 775-7416	**optumrx.com**
HSA & FSAs	WEX Benefits | Group Number: 21594	(866) 451-3399	**wexinc.com**
Dental PPO	Delta Dental | Group Number: 15521	(800) 521-2651	**deltadentalins.com**
Vision	VSP Vision Care | Group Number: 30027768	(800) 877-7195	**vsp.com**
Transportation Benefit	WEX Benefits | Group Number: 21594	(866) 451-3399	**wexinc.com**
Legal Plan	MetLife | Group Number: 101065	(800) 821-6400	**legalplans.com** Password: 101065

Continued on next page

Benefit	Provider	Phone Number	Web Site/Passwords
Life and AD&D Coverage	Unum | Group Number: 467759-002	(800) 445-0402	**unum.com**
Leave of Absence Request	Unum | Group: G6/Motel6/Studio6	(866) 779-1054	**unum.com**
Short-Term Disability	Unum | Group Number: 467761-001	(866) 779-1054	**unum.com**
Long-Term Disability	Unum | Group Number: 467759-001	(866) 779-1054	**unum.com**
401(k) Savings Plan	Fidelity | Group Number: 29401	English: (800) 835-5097 Spanish: (800) 587-5282	**401k.com**
Credit Union	Corporate America Family Credit Union	(800) 359-1939	**cafcu.org/G6**
Pet Insurance	Nationwide	(877) 738-7874	**benefits.petinsurance.com/g6hospitality**
Employee Assistance Program	Unum | Group: G6/Motel6/Studio6	English: (800) 854-1446 Spanish: (877) 858-2147	**lifebalance.net** Username: lifebalance, Password: lifebalance
Benefits & Payroll Questions	G6 Hospitality	(469) 737-3366	**teammemberhrservices@g6hospitality.com**

Required Notices

G6 HOSPITALITY LLC GROUP INSURANCE PLAN NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the G6 Hospitality LLC Group Insurance Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan, which became effective April 14, 2003.

The Plan often needs access to your protected health information to provide payment for health services and perform plan administrative functions. We want to assure participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. G6 Hospitality requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

PROTECTED HEALTH INFORMATION

Your protected health information is protected by the HIPAA Privacy Rule. Generally, this is information that identifies an individual to a health care provider, health plan, or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

HOW WE MAY USE YOUR PROTECTED HEALTH INFORMATION

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease). We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain team members of G6 Hospitality for the purpose of administering the Plan. These team members will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures.

Your protected health information cannot be used for employment purposes without your specific authorization.

YOUR RIGHTS

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request.

Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment, or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases we are not legally obligated to agree. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment), and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breaches will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us, upon request. To obtain a paper copy of this notice, please contact the person listed below.

OUR LEGAL RESPONSIBILITIES

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice. We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

G6 Hospitality LLC
G6 Hospitality Benefits Department
4001 International Parkway
Carrollton, TX 75007
(469) 737-3366

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. The person listed above can provide you with the appropriate address upon request, or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

COBRA RIGHTS NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the G6 Hospitality Benefits Department at (800) 558-5955.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.Healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members you should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Date: January 1, 2015
Name of Entity/Sender: G6 Hospitality LLC
Contact/Office: WEX Benefits
Address: PO Box 2079 Omaha, NE 68103-2079
Phone Number: 886-451-3399

NOTICE REGARDING WELLNESS PROGRAM

The G6 Hospitality Wellness Program is a voluntary wellness program available to all team members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you and your covered spouse will be asked to complete a biometric screening, which will include a blood test for cholesterol, triglycerides, and glucose level.

You and your covered spouse will also be asked to declare your tobacco use status during enrollment. You and your covered spouse are not required to participate in the blood test or other medical examinations.

However, team members and their covered spouses who choose to participate in the wellness program will receive an incentive of up to $40 per person pay period for completing the biometric screening and being tobacco free. Although you and your spouse are not required to participate in the biometric screening or the tobacco cessation program that is offered to tobacco users, only team members who do so will receive the incentive.

If you are unable to participate in the health-related activity required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the G6 Hospitality Benefits Department at (469) 737-3366.

The results from your biometric screening and tobacco user declaration will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and G6 Hospitality may use aggregate information it collects to design a program based on identified health risks in the workplace, the G6 Hospitality Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

The only individual(s) who will receive your personally identifiable health information are your doctors, members of your doctor's office staff, or the health professionals who perform your biometric screening in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the G6 Hospitality Benefits Department at (800) 558-5955.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the G6 Hospitality or your medical plan administrator.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in G6 Hospitality medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 31 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in G6 Hospitality medical coverage as long as you request enrollment by contacting the benefits manager no more than 31 days after the marriage, birth, adoption or placement for adoption. For more information, contact G6 Hospitality Benefits Department at (800) 558-5955.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

IMPORTANT NOTICE FROM G6 HOSPITALITY LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with G6 Hospitality, and your options under Medicare's prescription drug coverage. This information can help you decide whether to join a Medicare drug plan.

If you are considering a plan, you should compare your current coverage, including drugs covered, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. G6 Hospitality has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?
You can join a Medicare drug plan when you first become eligible for Medicare, and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare drug plan, your current G6 Hospitality coverage will not be affected. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current medical coverage and prescription drug benefits if you choose to enroll in the Medicare prescription drug plan. However, your medical and prescription coverage is a bundled benefit and cannot be paid for separately.

If you do decide to join a Medicare drug plan and drop your current G6 Hospitality coverage, be aware that you and your dependents will not be able to get this coverage back until the next plan year.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?
You should also know that if you drop or lose your current coverage with G6 Hospitality and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you lacked coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:
Contact the G6 Hospitality Benefits Department at (469) 737-3366 for more information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through G6 Hospitality changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE:
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:
Visit www.medicare.gov.

1. Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

2. Call (800) MEDICARE (800-633-4227). TTY (877) 486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security on the web at www.socialsecurity.gov, or call (800) 772-1213. TTY (800) 325-0778.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and if you are required to pay a higher premium (a penalty).

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