The Wendy's Company

A Summary Plan Description for the

Group Insurance Plan for Management & Administrative Support Employees and Shift Managers/Shift Managers

Effective January 1, 2019

Table of Contents

INTRODUCTION

This Summary Plan Description (SPD) summarizes the benefits offered to you as an eligible employee of The Wendy's Company (Wendy's). A complete summary of your benefits consists of this Summary Plan Description, the premium information available at wendysbenefits.com and the Administrative Coverage Booklets provided upon your request by the Plan Administrator. Wendysbenefits.com shows how much you contribute toward your benefits for the coming year and contains charts showing highlights of your coverage options. For further information about each of the available benefits, you may request from the Wendy's Benefits Service Center, the Administrative Coverage Booklet containing a detailed description of that benefit.

If you have questions about this SPD or any of your benefits, you can call the Wendy's Benefit Service Center toll-free at 1.855.557.9603; Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern Time or you can find information online at https://my.benefitsnow.com.

Except as described below, Wendy's benefits are offered under the Wendy's Company Group Insurance Plan, which is referred to as the "Plan" in this summary. Eligibility for different benefits available under the Plan is determined by job classification. If you meet the eligibility criteria described below, you are eligible for the following benefits:

- Medical and prescription drug
- Dental
- Vision
- Health Savings Accounts (Payroll practice outside of the Plan)
- Limited purpose healthcare flexible spending account
- Dependent day care flexible spending account (Payroll practice outside of the Plan)
- Commuter benefits (Payroll practice outside of the Plan)
- Life insurance
- Accidental death & dismemberment (AD&D) insurance
- Supplemental life insurance
- Business travel accident insurance
- Short-term disability coverage (Payroll practice outside of the Plan)
- Long-term disability coverage
- Employee assistance program
- Telemedicine – MDLIVE (Outside of the Plan)

Este folleto es una descripción resumida del plan, en Inglés, de sus derechos y beneficios de acuerdo al The Wendy's Company Group Insurance Plan. Si tiene alguna pregunta sobre el Plan, también puede llamare a la Centro de servicios de beneficios de Wendy's al 855.557.9603. Las horas de oficina son de 9:00 AM a 6:00 PM tiempo del este, de lunes a viernes.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

YOU

To be eligible to participate in the Plan, you must be a full-time employee in an eligible job classification working 30 hours or more per week.

You are not eligible to participate in the Plan if you are a leased, temporary or part-time employee, a non-resident alien or a member of a collective bargaining unit (unless the collective bargaining agreement provides for your eligibility).

Management (except as described below) and support administrative employees are eligible for all benefits under the Plan. Restaurant managers and Shift managers/shift supervisors are not eligible for business travel accident insurance benefits but are eligible for all other benefits under the Plan.

Except as described for certain benefits, eligible employees and their eligible dependents are eligible for group insurance benefits after successfully completing 30 days of employment in an eligible position. Rehired employees with a break in service of less than 91 days, who were covered under the group insurance benefit plans during their past employment with Wendy's, are reinstated into their previously elected benefits as of their date of rehire into an eligible position.

All employees are eligible for commuter benefits.

YOUR DEPENDENTS

Your eligible dependents include:

- Your legal spouse. Common- law spouses, domestic partners, life partners and/or fiancées are not defined as eligible dependents under the plan.
- Your child, legal stepchild, adopted child, child placed with you for adoption, foster child or a child for whom legal guardianship has been awarded to you and who is:
  - Less than age 26
  - Any age but incapable of earning a living due to a mental or physical handicap, which begins while the child would otherwise be eligible to participate, and who is under the regular care and attendance of a physician

DEPENDENT ELIGIBILITY VERIFICATION

After you enroll a dependent for the first time, the Wendy's Benefits Service Center will send a dependent eligibility verification package to your home. You will have 60 days to provide proof that your dependents who are enrolled in a Wendy's medical, dental and/or vision plan meet the definition of an eligible dependent. Failure to provide the requested documentation by the given deadline will result in discontinuation of the dependent's insurance coverage.

Examples of acceptable legal documentation include:

- Spouse:
  - Marriage Certificate
- Disabled Child:
  - Signed Physician Letter
  - Supplemental Security Income Letter
- Child:
  - Birth or Naturalization Certificate
  - Hospital Birth Record
  - Adoption Paperwork, Legal Guardian Court Order
  - Divorce Decree or Custody Agreement
  - Qualified Medical Child Support Order

MEASUREMENT AND STABILITY PERIODS FOR MEDICAL, DENTAL, VISION AND EMPLOYEE ASSISTANCE PROGRAM BENEFITS

If you are expected to work at least 30 hours at your time of hire, you will be eligible for medical, dental, vision and employee assistance program benefits after successfully completing 30 days of employment.

If you are in a part-time job classification, you will be eligible for medical, dental, vision and employee assistance program benefits if you complete one year of service with an average of 30 or more hours worked per week. If you actually average at least 30 hours per week over an applicable "measurement period," you will be eligible for medical, dental, vision and employee assistance program benefits as of the first day of the applicable "stability period."

The applicable "measurement period" is: (a) an initial measurement period that begins with the first pay period beginning after your date of hire and ending with the pay period that includes your first anniversary; and (b) a standard measurement period that begins with the first pay date on or after October 15 and ending with the last pay date before October 15 of the following year.

The applicable "stability period" is: (a) an initial stability period that begins on the first day of the month starting after the first anniversary of your date of hire and running for 12 months thereafter; and (b) a standard stability period that is the 12-month calendar year.

If you average more than 30 hours per week during a measurement period, you will remain eligible to participate in medical, dental, vision and employee assistance program benefits for the entire stability period unless you terminate employment during that stability period.

If you have a change in employment status and you are expected to work at least 30 hours per week in your new role, you will be eligible to enroll in the medical, dental and vision benefits as of the date of the status change. You will be given the opportunity to change your coverage elections consistent with the change in status, but your prior elections will continue unless you elect otherwise.

If you are not credited with an hour of service for a period of time for any reason (including your termination of employment) your eligibility will be determined as follows: (a) if you have not been credited with an hour of service for 13 or more consecutive weeks, you will be treated as a new employee for medical, dental, vision and employee assistance program benefits; (b) otherwise, your prior service (plus imputed service if the absence related to an FMLA leave, military leave or jury duty) will count toward the average hours worked for the measurement period in which the return occurs and your prior classification will continue to apply for the stability period in which your return occurs.

To the extent that these eligibility rules do not address a specific eligibility issue, Wendy's has the discretion to make eligibility determinations consistent with applicable law and regulations.

PARTICIPATION

Full-time employees generally become a participant in the Plan after completing 30 days of employment in an eligible position, provided you enroll as described below. Coverage begins on the 31st day.

Part-time employees who have satisfied the average hours eligibility requirement for the related measurement period are eligible to become a participant for medical, dental, vision and employee assistance program benefits, if you have enrolled as described below. Coverage begins on the first day of the related stability period.

If you are promoted or demoted into a job that results in a change in your benefits eligibility, you will not be required to complete another waiting period for the benefits associated with the promotion or demotion. Any benefit changes resulting from your promotion or demotion will be effective as of the date of the promotion or demotion (assuming you meet the waiting period based on your total service).

If you terminate employment while participating in the Plan and are rehired in an eligible position within 91 days, you are reinstated into your previously enrolled benefit elections as of your rehire date. If you are rehired after 91 days, you must complete the 30-day waiting period and re-enroll, if applicable, before again becoming a participant for all benefits.

If you work for a restaurant that is acquired from a franchisee, you will have 30 days from the date of acquisition to enroll in the Plan if you are employed in a full-time position or if you had been credited with at least one year of service with the franchisee prior to the date of acquisition. Benefits become effective on your date of acquisition or as soon as administratively possible after that date.

ENROLLMENT

Benefit enrollment is managed by the Wendy's Benefit Service Center. When you first become eligible to participate in Wendy's benefits, you will receive a post card in the mail with instructions on how to enroll in the benefits for which you must pay a contribution. If you do not enroll when you first become eligible, generally, you must wait until the next Annual Enrollment period, which usually begins during the fall for coverage effective the following January 1.

You are automatically enrolled in the benefits fully paid for by Wendy's when you satisfy the participation requirements. These benefits are:

- Basic life insurance
- Accidental death & dismemberment (AD&D) insurance
- Short-term disability coverage
- Long-term disability coverage
- Business travel accident insurance
- Employee assistance program

Benefit Options Include:

- Medical (including prescription drug), dental or vision coverage for yourself, spouse or child(ren)
- Health Savings Account (HSA) with pre-tax employee contributions and employer contributions
- Limited Purpose Healthcare Flexible Spending Account or Dependent Daycare Flexible Spending Account (FSA)
- Supplemental Life insurance coverage for yourself, spouse, or child(ren)
- Commuter benefits

Initial Enrollment: If you want medical, dental or vision coverage, you must select a plan during the initial enrollment period; there is no default coverage when you first become eligible. Even if you don't want to enroll in any benefit options, you should visit the enrollment site or call the Wendy's Benefit Service Center to designate your life insurance beneficiary.

If you do not enroll by the deadline, you and your dependents will not have medical, dental or vision coverage; you will not participate in a flexible spending account or optional life insurance. Your next opportunity to enroll will be the next Annual Enrollment period (assuming you continue to qualify for the coverage) or if you experience a qualifying life status event. Refer to the "Making Changes During the Year" section of this SPD to see if any life change you experience may allow you to make changes to your benefits.

Annual Enrollment: After your initial enrollment, you will re-enroll in benefits on a yearly basis during the Annual Enrollment period in the fall for coverage effective the following January 1.

If you do not enroll during Annual Enrollment, your prior elected medical, dental, vision and supplemental life insurance coverage will stay the same, but your elections to contribute to a Flexible Spending Account or the Health Savings Account will not carry over. For you to continue making contributions to the Flexible Spending Accounts or the Health Savings Account, you must re-enroll in these accounts each year.

Monthly Enrollment for Commuter benefits: See the commuter benefit section for a discussion of the rules regarding enrollment in commuter benefits.

PAYING FOR YOUR BENEFITS

You are required to pay contributions by payroll deduction for the medical, dental, and vision benefits, supplemental life insurance and flexible spending accounts you elect during enrollment. Your contributions will be deducted on a per- paycheck basis. In the event you leave Wendy's or drop coverage during a pay period, you will not receive a refund of your contributions. Your last day of medical, dental and vision coverage will be the last day of the pay period in which your employment ends. All other benefits under the Plan will end on the day your employment ends.

If you are on an unpaid Leave of Absence (including a FMLA Leave) and fail to timely pay premiums while on leave, your coverage will be discontinued.

The premiums you pay for medical, dental and vision insurance are on a pre-tax basis. Your contributions to Flexible Spending Accounts and Health Savings Accounts are also paid on a pre-tax basis. This means you do not pay federal income tax or Social Security tax on those contributions. If for any reason you miss deductions for the Flexible Spending Accounts or Health Savings Accounts make up contributions will not be deducted from your paycheck and your annual goal elected for these benefits may not be met for the year.

Your elections are binding for the plan year (except for your Health Savings Account contribution). You can only change your benefits coverage due to a qualifying life status event or during the Annual Enrollment period.

The IRS allows you to make changes to your employee Health Savings Account contribution at any time during the year. This means you have the flexibility to start, stop or change your employee Health Savings Account contribution at any time during the plan year. Any changes you make to your employee Health Savings Account contributions go into effect the first of the month following the date you made the change.

MAKING CHANGES DURING THE YEAR

According to IRS guidelines, the benefit coverage you elect to pay for on a pre-tax basis—such as medical, dental and vision coverage, as well as Flexible Spending Account contributions—must stay in effect for the entire calendar year. However, you may change your benefits during the year if you experience a "qualifying life status event." If you experience one of the following qualifying life status events, notify the Wendy's Benefits Service Center within 60 days of the event to make a change to your coverage. Any changes you make to your benefit coverage must be consistent with the event. Qualifying events include:

- Marriage, divorce, legal separation or annulment
- Birth of a child, adoption, or placement for adoption
- Death of a dependent
- Change in your spouse's or child's employment status that affects eligibility for benefits
- Your child gaining access to other coverage through his/her employer
- Dependent reaching the age of ineligibility for coverage under the Wendy's Plan

OTHER QUALIFYING EVENTS

If you decline coverage during the Annual Enrollment period for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may enroll yourself and your dependents in the Wendy's plan later if: (i) you or your dependents lose eligibility for that other coverage; or (ii) the employer stops contributing to the other coverage. However, you must request enrollment no later than 60 days after the other coverage ends or after the employer stops contributing to the other coverage.

If you or your dependent child lose eligibility for coverage, or become eligible for premium assistance, under Medicaid or the Children's Health Insurance Program, you may be eligible to enroll yourself and your dependents in medical insurance under the Plan. However, you must request enrollment within 60 days of the qualifying life status event.

If you have a new dependent as a result of marriage, birth or adoption, you may be able to enroll yourself and your dependents for coverage. However, you must request enrollment no later than 60 days after the marriage, birth or adoption, and the changes you make must be consistent with the qualifying life status event.

You will be required to provide legal documentation to the Wendy's Benefits Service Center for any new dependent that you add to the medical, dental or vision plan. The documentation must meet the definition of an eligible dependent. Proof includes a marriage certificate, birth certificate, adoption decree, or other legal document.

To request special enrollment or obtain additional information, contact the Wendy's Benefit Service Center at 1.855.557.9603.

MORE FREQUENT CHANGES FOR COMMUTER BENEFITS

You must make a new election for commuter benefits each month.

WENDY'S BENEFIT SERVICE CENTER

Whether you're ready to enroll or have questions about your benefit options, the Wendy's Benefit Service Center representatives are only a click or phone call away. Through the Wendy's Benefit Service Center, you can:

- Learn more about your benefit options and get answers to your benefit questions
- Make your annual benefit elections
- Update dependent and beneficiary information
- Make qualifying life status event changes to your coverage during the plan year

After the enrollment period ends, you will receive a personalized confirmation statement summarizing the benefits you've chosen.

Review this information carefully and contact the Wendy's Benefit Service Center at 1.855.557.9603 or online at https://my.benefitsnow.com with any questions.

WHEN COVERAGE ENDS

Your and your dependents' coverage under Wendy's benefits will terminate effective at 11:59 p.m. on the date that any one of the following events occurs:

- The last day of the pay period in which your employment with Wendy's terminates for medical, dental and vision coverage
- Your termination date for all other benefits
- You stop making premium payments
- You are no longer in a benefits-eligible position (either because of a transfer into an ineligible position or because you ceased to average sufficient hours during an applicable measurement period)
- The Wendy's Plan is terminated

Your dependents' coverage will also terminate effective at 11:59 p.m. on the date that they are no longer eligible dependents and/or on the date they are no longer enrolled as dependents in the Wendy's Plan.

If you or any of your dependents loses coverage under the medical, dental or vision benefits, limited purpose healthcare flexible spending account or employee assistance program, you or your dependents may be entitled to continue coverage as provided by the federal law known as COBRA.

Dependent children that reach age 26 will have coverage terminate on the last day of the month in which they turn age 26.

If you work for a restaurant that is sold to a franchisee your medical, dental and vision coverage with Wendy's will end on the last day of the month in which your restaurant is sold.

MEDICAL

MEDICAL PLANS

Anthem BlueCross BlueShield (BCBS) administers your medical benefit options.

Wendy's offers employees a choice of three Consumer Driven Health Plan (CDHP) options. Each of these options has distinct features and benefits.

Details about each of these medical options, including the deductibles, out-of-pocket maximums, your contributions, and Wendy's contributions that apply to each option, can be found on the wendysbenefits.com website throughout each year. You may also request a copy of Anthem BCBS's Medical Benefit Booklet for The Wendy's Company for complete details about each of the CDHP benefit options, including a description of the coverage and limitations and including the following important legal notices (Appendix A), by calling the Wendy's Benefit Service Center at 1.855.557.9603:

HIPAA and GINA Notice of Privacy Practices	Medicare Part D Notice
CHIPRA Notice	Statement of Rights under the Newborns' and Mothers' Health Protection Act
Notice of Special Enrollment Rights	Notice under Women's Health and Cancer Rights Act
Patient Protections and Affordable Care Act Notices	Notice of Wellness Program Disclosures
General COBRA Notice	Health Insurance Marketplace

CONSUMER DRIVEN HEALTH PLANS

Consumer Driven Health Plans (CDHPs) encourage you to think about healthcare in a different way. By providing the tools and transparency you need to become more informed consumers of healthcare, CDHPs empower you to take control of your health and the money you spend on your healthcare.

All of the CDHP options include:

- Preventive care: Wendy's pays 100% for preventive care—such as well-child care, adult periodic exams and preventive diagnostic screenings.
- Deductible: Your deductible is the amount you pay for non-preventive care before Wendy's starts sharing your costs for medical care.
- Coinsurance: Once you meet your deductible, Wendy's and you share the cost of your medical care; this cost-sharing is called coinsurance.
- Out-of-pocket maximum: This is the most you will pay in any calendar year for charges deemed "reasonable and customary" and for other medical expenses covered by the plan.
- Prescription drug coverage: Coverage is provided for most preventive and non-preventive medications to assist you with treatment and prevention of medical conditions.
- Health Savings/Reimbursement Account: All CDHPs offer special savings accounts to help you pay for your out-of-pocket healthcare expenses. Your eligibility to participate in either a Health Savings Account (HSA) or a Health Reimbursement Account (HRA) will be determined upon your enrollment into a medical plan.

There are important limits on coverage for "non-urgent" emergency room visits. Refer to the Medical Benefits Booklets for more information.

You may obtain a list of in-network provider, without charge, at www.anthem.com or by calling 1.866.205.6128. A provider's network status may change. Call the telephone number on your I.D. card to confirm a provider's network or out-of-network status.

If you go to an out-of-network provider, you are responsible for paying the difference between the allowed amount and the amount billed by the out-of-network provider. In some cases, the difference can be substantial. In addition, in the event that a provider waives your obligation to pay your copayments, coinsurance and/or the deductible, any waived amount shall be disregarded. For example, if the provider's billed amount is $10,000, you would have owed $5,000 for your share of the deductible and coinsurance, but the provider only requires you to pay $1,000, the claim will be processed as if the provider's billed amount had been $6,000 (the waived $4,000 payment is disregarded).

INABILITY TO MAKE PAYMENT

If the Plan is unable to make payment to any Participant or other person to whom a payment is due under the Plan because: (i) the Plan cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, or (ii) the benefit payment is unclaimed (for example, the benefits check is uncashed), then any payment otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due. No such forfeiture shall inure to the benefit of the Employer or a Participating Employer and the value of such forfeiture shall be used to pay administrative expenses and claims under the Plan. In the event the Participant or other person is located or desires to claim such payment within 12 months after the forfeiture of such benefit, then such payment will be reinstated for the benefit of the Participant.

Under this provision, after the check is stale, it is credited back into the plan account to be used to pay claims or other plan expenses. If the employee or provider comes forward within 12 months (sometimes 24 months) after the forfeiture, the check is re-issued. After that, the claims is time-barred. Under this provision, there is no amount to be escheated to the state.

HEALTH SAVINGS ACCOUNT (Payroll practice outside of the Plan)

A Health Savings Account (HSA) is a special bank account opened through Your Spending Account, with the banking partner UMB Bank. HSAs are available to all eligible employees who enroll in a CDHP medical plan option and who do not have other medical coverage, including coverage with a spouse's plan, individual insurance policies, Medicare, Medicaid or any other government- sponsored plan.

Both you and Wendy's can contribute to your HSA. In fact, when you choose medical coverage in a CDHP and qualify for an HSA, Wendy's will make per pay period contributions (beginning the first of the month after your benefits become effective) into your account. Wendy's will also make matching contributions if you contribute to your HSA. Visit wendysbenefits.com for more information about Wendy's contributions to your HSA.

In addition to the money Wendy's contributes, you also can elect to deposit money into your HSA through regular, pre-tax payroll deductions. You can change the amount you contribute throughout the year. The IRS determines a maximum amount that can be contributed each year. This maximum includes any contributions that you make in addition to the contributions Wendy's makes. If you are age 55 or older, you may be eligible to make additional "catch up" contributions up to $1,000. The $1,000 catch-up contribution is automatically included in the maximum employee HSA contribution you are allowed to make.

HOW AN HSA CAN WORK FOR YOU

Once the money is in your HSA, you decide how and when to spend the money toward your healthcare needs. Use your HSA to pay for expenses that apply to the plan's deductible or coinsurance, including prescription drugs, office visits, lab tests, surgery or hospitalization the choice is yours.

If you don't use all the money in your account during the plan year, the balance rolls over and continues to accumulate and earn interest. Once your account balance reaches $1,000, you have the option to invest it. And like other savings and investment accounts, your HSA belongs to you and is completely portable. It's just one more way Wendy's helps you save—for medical expenses now and during retirement, or a time you may not be covered by a group health plan.

For a complete list of eligible expenses and regulations governing your HSA, visit the IRS website at irs.gov, and select Publication 969, "Health Savings Accounts and Other Tax Favored Health Plans." You pay an IRS penalty of 20% if you use your HSA funds for non-qualified health expenses.

USING YOUR HSA

Once you have completed your enrollment, you will receive a HSA debit card from Your Spending Account at your home address.

When activating the Your Spending Account debit card you will be asked to set up a PIN of your choice. Also PIN's numbers can be changed by following these steps:

1. Call the number on the back of your current Your Spending Account card.
2. You will be required to provide your card number, ZIP code, and three-digit security code located on the back of the Your Spending Account debit card.
3. After providing the above information, you will be asked to select a four-digit PIN of your choice.

Note: The same PIN applies to all Your Spending Account cards on your account.

You should also consider designating a beneficiary for your HSA. This will ensure a person(s) or entity of your choosing will receive the account balance in the event of your death. To designate a beneficiary, you can log onto https://my.benefitsnow.com and log into Your Spending Account, download the beneficiary form and mail or fax the complete form to UMB Bank.

CUSTOMER IDENTIFICATION PROGRAM

Before your HSA can be opened, Your Spending Account performs a screening of your enrollment data to establish and maintain a Customer Identification Program pursuant to the USA Patriot Act, the Bank Secrecy Act, the Money Laundering Control Act and all other applicable laws. As a result of this review, you may receive a request for additional information directly from Your Spending Account. Typically, the bank requests items such as a copy of a current utility bill, valid driver's license or Social Security card with data matching that on record (same name, address, non- expired documents, etc.). If you fail to respond to this request, your HSA will not be opened until you comply with the request for additional information.

Once you pass the initial screening, Your Spending Account will not require further documentation to keep your HSA open.

If your account is closed for any reason and then reopened later, you will be eligible for the Wendy's contribution starting the first of the month following the date the account is re-opened. You will not be eligible for retroactive Wendy's contributions.

ROLLOVER OPTION

If you have an HSA with another banking provider, you can roll that money over to Your Spending Account or keep your money where it is. Note that IRS rules only allow one HSA rollover during a 12 month period. For rollover instructions contact Your Spending Account directly at 1.855.557.9603.

HEALTH REIMBURSEMENT ACCOUNT

Once you select a CDHP Plan, you will be asked a few questions to determine if you're eligible for an HSA. If you are not eligible to enroll in an HSA, you will automatically be enrolled in a Health Reimbursement Account (HRA) through Anthem BCBS. Wendy's will credit amounts to your HRA depending on the medical plan and coverage tier you elect. Just like the HSA, funds in an HRA may be used to meet your CDHP deductible and other eligible healthcare expenses, and any unused balance may be carried over from year-to-year.

Unlike the HSA, you are not able to make additional contributions to the HRA and your unused balance is forfeited when your coverage under the Plan ends, employment with Wendy's ends, or, if later, when your COBRA continuation coverage ends. Eligible claims filed with Anthem BCBS are automatically deducted from the balance in your HRA before you are billed for services.

TELEMEDICINE – MDLIVE (Outside of the Plan)

If you're enrolled in a Wendy's medical plan, you and your family can access telemedicine through the service provider MDLIVE at anytime, anywhere. Telemedicine is like having your own personal doctor on call, 24 hours a day seven days a week. It connects you with a U.S. Board Certified doctor via video chat, phone or email, or on-the-go using a smartphone. The doctor can diagnose your symptoms, prescribe medication and send prescriptions to your pharmacy. The cost of a visit is only $40 for medical treatment and $90, $95 or $250 for behavioral health treatment depending on the type of provider you select. Telemedicine is also a terrific resource while you are traveling or on vacation.

While the service is not for emergencies, the doctors can treat a wide variety of conditions, including:

Medical Conditions

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Ear Infection
- Fever
- Insect Bites
- Pink Eye
- Rashes
- Sore Throat
- And more!

Behavioral Health Conditions

- Addictions
- Bipolar disorders
- Child and adolescent issues
- Depression
- Eating disorders
- Grief and Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression

And more!

For more information or to register with MDLIVE log on to mdlive.com/wendys or call 1.888.632.2738.

PRESCRIPTION DRUGS

All CDHP options offer the same prescription drug benefits, which are administered by CVS Caremark.

YOUR PRESCRIPTION DRUG BENEFITS

There are three covered methods for filling your prescription drugs—at in-network retail pharmacies, at CVS pharmacies or through the mail order service. You can choose any option for maintenance medications, but by using the mail order service or filling your prescriptions at a CVS pharmacy, you'll pay less. The mail order service is only available for maintenance medications. The Plan will not cover the cost of any prescription drug filled at an out-of-network pharmacy.

The amount you will pay depends on how you fill the prescription, whether the drug is a "preventive drug" under IRS rules, how the drug is classified (generic, brand preferred, brand non-preferred, specialty), and whether you have satisfied your medical plan deductible or maximum out-of-pocket limit.

Preventive drugs are not subject to a deductible and the price described in the table below applies. Until you meet your annual maximum medical out-of-pocket limit, covered prescriptions are available at 20% of the discounted costs, but never more than $70 per prescription filled at an in-network retail facility or $90 per prescription filled at a CVS pharmacy or through the mail order service.

Non-preventive drugs are subject to your annual medical plan deductible. Until you meet your annual medical plan deductible, you pay 100% of the discounted cost of your medications whether you fill your prescriptions at an in-network retail pharmacy, at a CVS pharmacy or through the mail order service. Once you meet your annual medical plan deductible, you'll pay 20% of the discounted cost, but never more than $70 per prescription filled at an in-network retail pharmacy or $90 per prescription filled at a CVS pharmacy or through the mail order service, until you meet your annual maximum medical out-of-pocket limit.

Once you have satisfied your maximum medical out-of-pocket limit, prescription drug copays will not apply.

30-DAY SUPPLY AT AN IN-NETWORK RETAIL PHARMACY (Cost for all preventive drugs or after satisfying deductible for non-preventive drugs)	90-DAY SUPPLY AT A CVS PHARMACY OR THROUGH THE MAIL ORDER SERVICE (Cost for all preventive drugs or after satisfying deductible for
You pay 20% of the discounted cost up to a maximum of: ▪ $20 for Generics ▪ $40 for Brand/Formulary ▪ $70 for Brand/Non-Formulary	You pay 20% of the discounted cost up to a maximum of: ▪ $20 for Generics ▪ $60 for Brand/Formulary ▪ $90 for Brand/Non-Formulary

The classification of a particular prescription drug may be updated periodically. To determine the current classification of a particular drug, visit the CVS Caremark website at www.caremark.com or call CVS Caremark at 1.888.202.1654.

The Plan does not cover all prescription drugs and related services and supplies. Refer to the benefits booklet for a full listing of all of the applicable exclusions. There is a lifetime maximum for coverage of fertility medications. If you purchase a brand name drug when a generic is available, you will be required to pay the brand name copayment plus the difference in cost between the brand name and generic drug alternatives. This cost difference will not count against your annual deductible and out-of-pocket limits.

SPECIALTY DRUG COVERAGE

Specialty or biotech drugs, are a category of drugs that target and treat specific chronic or genetic conditions, including biopharmaceuticals (bioengineered proteins), blood-derived products, complex molecules, and select oral, injectable, and infused medications. These drugs are used to treat highly-sensitive conditions such as hemophilia, multiple sclerosis (MS), hepatitis C (Hep C), rheumatoid arthritis (RA), respiratory syncytial virus (RSV) and immune deficiencies and also includes growth hormones. To confirm if your specialty drug is covered, contact CVS Caremark's Patient Services Department at 1.888.202.1654. To access your prescription drug benefits for any specialty drug therapies, call CVS Caremark's specialty pharmacy at 1.800.237.2767 (TDD 1.800.863.5488).

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

The prescription drug program includes some administrative procedures that may limit the prescription medications that are provided under the program. These limits are designed to assure that your medications are the most appropriate and cost-effective for your condition. These limits include, but are not limited to:

- Quantity limits
- Prior authorization
- Step therapy
- Advanced control specialty formulary

For more information about these limits and your prescription drug benefits, see the CVS Caremark website at www.caremark.com or call CVS Caremark at 1.888.202.1654.

DENTAL

Anthem BlueCross BlueShield administers the dental plan and utilizes the Anthem BCBS National Dental GRID network. With the Anthem dental plan, you are free to use any dentist. And because dental coverage is a separate election, you can choose dental coverage even if you don't enroll in a medical plan through Wendy's.

If you visit an out –of-network dentist, Anthem will send any payable benefits directly to you unless you assign the payment directly to the out-of-network dentist. This assignment will need to be designated when the out-of-network dental claim is submitted to Anthem. Speak to your out-of-network dentist regarding that dentist's procedure to make the assignment.

YOUR BENEFITS

BENEFIT*	COVERAGE
Deductible ▪ Individual ▪ Family	 $50 $150
Calendar Year Maximum	$1,500
Preventive Services (Deductible does not apply) ▪ Includes cleaning and X-rays	100%
Basic Services (Deductible applies) ▪ Includes fillings and extractions	80%
Major Services (Deductible applies) ▪ Includes crowns, bridges and dentures ▪ Includes oral surgery**	50%
Orthodontic Services (Deductible applies) ▪ Lifetime maximum	50% $1,500

*All expenses over $500 require a pre-determination of benefits prior to services being rendered.
**The oral surgery benefit does not cover the removal of impacted wisdom teeth.

Keep in mind, if you enroll in a medical plan option, eligible dental expenses can be reimbursed using the available funds in the HSA or the HRA. To have dental expenses reimbursed through the HRA you must complete and submit a separate HRA claim form with supporting documentation to Anthem.

For more details about the dental plan, visit Anthem BCBS's website at www.anthem.com or call Anthem BCBS at 1.866.205.6128.

To request a copy of Anthem BCBS's Dental Benefit Booklet for The Wendy's Company call the Wendy's Benefit Service Center at 1.855.557.9603.

VISION

Wendy's offers two vision plans through VSP. VSP offers you the flexibility of choosing a provider in VSP's network or an out-of-network provider, and will reimburse you up to the amount allowed under the plan.

Because vision benefits are a separate election, you can choose vision coverage even if you don't enroll in medical coverage through Wendy's.

Keep in mind, if you enroll in a medical plan option, eligible vision expenses can be reimbursed using the available funds in the HSA or the HRA. To have vision expenses reimbursed through the HRA you must complete and submit a separate HRA claim form with supporting documentation to Anthem.

VISION PLAN OPTIONS – In Network

	VSP 1	VSP 2
Frequency	Exam every 12 months Lenses every 12 months Frames every 12 months	Exam every 12 months Lenses every 12 months Frames every 24 months
Co-Pay	Exam $10 Materials $10	Exam $15 Materials $15
Lenses	$10 Glass or plastic, single-vision, lined bifocal or lined trifocal prescription lenses	$15 Glass or plastic, single-vision, lined bifocal or lined trifocal prescription lenses
Lens Options	Covered options: photochromic/tints, polycarbonate lenses, scratch coating, UV protection coating, $30 progressive lenses, $20 anti-reflective coating;	Covered options: polycarbonate lenses, scratch coating, UV protection coating, $30 progressive lenses
Frames	Frames are covered up to $150 after $10 copay or Featured frames are covered up to $200 after a $10 copay 20% off any amount above the allowance	Frames are covered up to $130 after $15 copay or Featured frames are covered up to $180 after a $15 copay 20% off any amount above the allowance

Necessary Contact Lenses	Necessary contact lens services and materials are covered after $10 copay	Necessary contact lens services and materials are covered after $15 copay
Elective Contact Lenses – Materials	Instead of eyeglasses, elective contact lens services and materials are covered up to $150 after $10 copay for any type of prescription contact lenses	Instead of eyeglasses, elective contact lens services and materials are covered up to $130, after $10 copay for any prescription contact lenses
Elective Contact Lenses – Fitting and Evaluation Services	Contact lens fitting and evaluation services are covered after $60 copay	Contact lens fitting and evaluation services are covered after $60 copay
Value-Added Benefits	20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses	

Individuals with severe visual problems that are not correctable with regular lenses and individuals who have been diagnosed with diabetes and certain ophthalmological conditions may be entitled to additional benefits. Refer to the benefits booklet for a full description of this coverage, limits and exclusions.

VISION PLAN OPTIONS – Out-of-Network

Except for the copayment amounts, the out- of-network coverage is the same under both plans:

Examination Copayments $10 (VSP 1) or $15 (VSP 2)
Materials Copayment $10 (VSP 1) or $15 (VSP 2)
Exam $50 every 12 months
Single Vision Lenses $55 every 12 months
Bifocal Lenses $75 every 12 months
Trifocal Lenses $100 every 12 months
Lenticular Lenses $125 every 12 months
Frames $70 every 24 months
Necessary Contact Lenses $210 every 12 months (for lenses, fitting and evaluation fees)
Elective Contact Lenses $105 every 12 months (for lenses, fitting and evaluation fees)

YOUR VISION BENEFITS

VSP benefits are designed to protect your visual wellness, so you may pay extra if you choose certain cosmetic or elective eyewear options. Before selecting your eye care, ask your doctor what is covered by your vision plan.

Although not covered under either plan, VSP offers discounted rates for laser surgery and easy access to the procedures through VSP-contracted doctors, surgeons and laser centers.

For more information about vision benefits, contact VSP at 1.800.877.7195 or visit them online at www.vsp.com.

TRUHEARING AID DISCOUNT

VSP offers covered members access to hearing aid discounts through TruHearing. If you are enrolled in one of the VSP benefit plans TruHearing waives the membership fee and you can begin receiving discounts on hearing aids and hearing aid supplies.

A TruHearing membership gives you the following:

- Access to national network of licensed hearing aid professionals
- Selection of more than 90 digital hearing aids
- Savings up to $1,300 per hearing aid purchase
- Deep discounts on additional hearing aid supplies

For more information about this discount, contact TruHearing at 1.877.396.7194 or visit them online at vsp.truhearing.com.

FLEXIBLE SPENDING ACCOUNTS

The Limited Purpose Healthcare Flexible Spending Account and Dependent Day Care Flexible Spending Account are administered by Your Spending Account. These flexible spending accounts (FSAs) can reduce your taxable income by allowing you to pay for many out-of-pocket healthcare and dependent day care expenses with pre-tax dollars.

The money you elect to contribute to your FSA is deducted from your pay in equal amounts throughout the year. Before you make your FSA elections, be sure to estimate your yearly expenses carefully—IRS rules require that any unused funds in your Dependent Care FSA account at the end of the plan year are forfeited. IRS rules also allow $500 in your Limited Purpose Healthcare Spending to be rolled over into the next plan year and that any funds over $500 remaining be forfeited. You can't change the amount of your contributions unless you experience a qualifying event.

USING YOUR FSA

Accessing your FSAs is easy. The Limited Purpose Healthcare FSA comes with a Your Spending Account debit card you can use directly at the point of purchase. You can file for reimbursement of eligible dependent day care expenses directly from your Dependent Day Care FSA by going to my.benefitsnow.com and logging into the Your Spending Account system. You can also pay for out-of-pocket expenses using your own personal credit card, cash or check, then file for reimbursement. You have until the next following March 31 to submit claims for eligible expenses incurred during a calendar year.

LIMITED PURPOSE HEALTHCARE FSA

A Limited Purpose Healthcare FSA allows you to use pre-tax dollars to pay for eligible medical, dental and vision care expenses, even if you don't choose any of those benefit options through Wendy's.

If you decide to participate in a Limited Purpose Healthcare FSA, you elect an annual contribution amount—as little as $100 or as much as the applicable IRS limit. The amount you choose to contribute is deducted in equal installments from each paycheck.

The following chart details which types of expenses are eligible or not for reimbursement from your Limited Purpose Healthcare FSA.

ELIGIBLE EXPENSES
▪ Out-of-pocket costs from your medical plan after you've met your annual medical plan deductible, such as coinsurance, whether or not your medical plan coverage is through Wendy's
▪ Prescription drug costs after you've met your annual medical plan deductible, such as coinsurance and co- payments, whether or not your prescription drug coverage is through Wendy's
▪ Out-of-pocket costs from your dental plan, such as coinsurance and amounts that exceed reasonable and customary limits
▪ Dental expenses not covered or reimbursed by your dental plan, such as adult orthodontia or dependent orthodontic care above the plan limits
▪ Vision care, glasses and contact lenses above vision plan limits, including corrective eye surgery
▪ Hearing aid expenses

INELIGIBLE EXPENSES
▪ Out-of-pocket costs from your medical plan before you've met your annual medical plan deductible
▪ Prescription drug costs before you've met your annual medical plan deductible
▪ Employee per-paycheck costs for medical, dental, prescription and vision plan coverage
▪ Health club fees
▪ Medically-unnecessary cosmetic surgery
▪ Expenses paid by a medical, dental, prescription, vision or other healthcare plan
▪ Non-prescription drugs for general well-being, such as over-the-counter vitamins and herbal/dietary supplements
▪ Over-the-counter drugs without a prescription

USING YOUR HSA/HRA AND LIMITED PURPOSE HEALTHCARE FSA TOGETHER

If you contribute money to a Limited Purpose Healthcare FSA, you participate in a CDHP, and either you contribute to a Health Savings Account or you received credits to a Health Reimbursement Account, you can use your HSA/HRA and FSA together for an even greater advantage.

Use your FSA funds first when possible, since only $500 can rollover to the following year.

HSA/HRA
▪ Your HSA/HRA account can be used to pay for medical and prescription drug expenses to help you meet your annual medical plan deductible.
LIMITED PURPOSE HEALTHCARE FSA
▪ Your FSA can only be used to pay for eligible medical expenses after you have met your annual medical plan deductible.
▪ Your FSA can be used to pay for eligible dental and vision expenses prior to meeting your annual medical plan deductible.

Once you've met your annual medical plan deductible you will need to call Your Spending Account to open up your Limited Purpose Healthcare FSA and allow you to pay for qualified medical expenses from your FSA. Your Spending Account can be reached at 855.557.9603

DEPENDENT DAY CARE FSA (Payroll practice outside of the Plan)

A Dependent Day Care FSA allows you to use pre-tax dollars for expenses related to childcare, or the care of a disabled spouse or elderly parent.

If you decide to participate in a Dependent Day Care FSA, you will elect an annual contribution amount— as little as $100, or as much as $2,500 if you are married filing separate tax returns—and $5,000 per individual or married couple filing a joint tax return.

ELIGIBLE EXPENSES

You can use your Dependent Day Care FSA to pay eligible day care expenses for your eligible dependents. Eligible dependents are those who:

- You can claim on your federal income tax return and
- Spend at least eight hours each day at your home

A child must be under the age of 13, or be physically or mentally disabled. An adult must be physically or mentally disabled, and be totally dependent on you for support.

If you are married, you may contribute to the Dependent Day Care FSA as long as your spouse is working, is attending school full time, or is mentally or physically disabled. The Dependent Day Care FSA may not be used to pay for occasional child care when there is a stay-at-home parent.

Eligible expenses include:

- Licensed nursery school and elder care centers
- Eligible childcare centers and after-school care
- In-home caregivers and babysitting fees for a disabled child, spouse, or elderly parent
- Day camp (overnight camp expenses are not eligible)

For details, refer to IRS Publication 503, "Child and Dependent Care Expenses," on the IRS website at irs.gov or call the IRS at 1.800.829.3676.

Both the Dependent Day Care FSA and the Federal Dependent Care Income Tax Credit can lower your tax bill, but in different ways. Your tax advisor can help you make a decision that will maximize your tax savings.

For more information about the FSAs, visit https://my.benefitsnow.com.

COMMUTER BENEFITS (Payroll practice outside of the Plan)

The Commuter Benefit allows you to elect to pay for certain parking and other commuting costs through payroll deductions. You must elect by the 10th of each month for expenses for the next month.

ELIGIBLE EXPENSES

You can use your Commuter Benefit to pay for "eligible commuting or parking products" from approved providers.

Eligible parking expenses include expenses for monthly parking at or near your employer's business premises or the location from which you commute via mass transit or van-pool. Parking at or near your home does not constitute an eligible parking expense.

Eligible transit products include vouchers or a commuter check card that can be used to pay for expenses for passes, tokens, farecards or similar items for buses, trains or ferries operated by approved transit providers.

Eligible vanpool products include vouchers or a commuter check card that can be used to pay for expenses for vanpool services (seating at least six people in addition to the driver) that are provided by approved vanpool providers. Vanpool vehicles must be used at least 80% of the time transporting employees between home and work with at least half of the seats filled with commuters (excluding the driver).

TAX TREATMENT OF COMMUTER BENEFITS

A portion of your eligible expenses can be paid for on a pre-tax basis. The pre-tax limits for 2019 are $265 per month for Eligible Parking Expenses and $265 per month for Eligible Transit and Vanpool Products ($530 per month in the aggregate).

If the monthly cost of your actual commuter expenses exceeds these limits, you will need to pay the difference with a personal credit card.

PAYMENT OF ELIGIBLE EXPENSES

When you enroll for a month (by the 10th of the prior month), you will elect to have your elected deduction amount (a) paid directly to the parking provider, (b) paid indirectly to the parking provider by issuing one or more commuter checks made payable to the parking vendor mailed to your home address, (c) paid indirectly to the Transit Expense or Vanpool Expense provider by issuing a voucher to you, or (d) loaded onto a "Commuter Check Card." The Commuter Check Card is a reloadable debit card that can only be used to pay for Eligible Transit Products, Eligible Vanpool Products or Eligible Parking Expenses.

MORE INFORMATION ABOUT COMMUTER BENEFITS

For more information about the Commuter Benefit, visit https://my.benefitsnow.com.

LIFE AND AD&D INSURANCE

Wendy's provides basic life and AD&D insurance at no cost to you. If you need additional protection, you may purchase supplemental life insurance for yourself and your dependents.

Upon leaving Wendy's or going on severance you have the ability to convert or port your Basic and Supplemental life coverage to individual whole life policies. Approximately two weeks after your termination date or date your severance begins you will receive a packet with conversion paperwork from Unum.

The premium for Wendy's-provided basic life coverage and employee supplemental life cover over $50,000 is considered taxable income by the IRS. You will see the amount recorded as "GTLI", Group Term Life Imputed Income, on your pay stub. You will be responsible for paying the taxes on this premium amount.

For complete details about the basic and supplemental life insurance and AD&D insurance, request a copy of the Group Term Life Insurance Policy issued to The Wendy's Company by Unum by calling the Wendy's Benefit Service Center at 1.855.557.9603.

BASIC LIFE INSURANCE

To provide for your family when you no longer can, Wendy's provides a Company-paid life insurance benefit in an amount equal to one times (1x) your annual base salary. Coverage is rounded up to the nearest $1,000, if not already an exact multiple thereof and there is a $1,000,000 maximum benefit.

You will need to designate a beneficiary for this coverage. A beneficiary is the person who will receive the proceeds of the life insurance policy in the event of your death. To designate a beneficiary log onto https://my.benefitsnow.com or call the Wendy's Benefits Service Center at 1.855.557.9603.

SUPPLEMENTAL LIFE INSURANCE

Beyond the basic life insurance benefits provided by Wendy's, you may elect additional coverage for you, your spouse and your dependent children.

FOR YOU

You may purchase supplemental life insurance in increments of $10,000. All amounts are rounded down to the next lower multiple of $10,000, if not already an exact multiple thereof. Your basic and supplemental life insurance combined cannot exceed the lesser of $1,500,000 or ten times your annual base salary (the ten times annual base salary amount is not rounded).

You may be required to complete an Evidence of Insurability (EOI) form if you elect more than three times your annual base salary or $750,000 in coverage. Coverage will not be effective and payroll deductions will not begin until your EOI form is received and approved by the plan provider, Unum. EOI forms are automatically mailed to employees within two weeks of enrolling in supplemental life insurance coverage.

If you have reached age 70, your amount of life insurance will be:

- 50% of the amount of life insurance you had prior to age 70; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70.

There will be no increases in your amount of life insurance after age 70 (or the later date you first become insured).

To designate a beneficiary for employee supplemental life insurance, log onto https://my.benefitsnow.com or call the Wendy's Benefits Service Center at 1.855.557.9603.

FOR YOUR SPOUSE

You may purchase supplemental life insurance for your spouse, in increments of $10,000, up to $250,000, but no more than 100% of employee's combined basic and supplemental life insurance. All amounts are rounded down to the next lower

multiple of $10,000, if not already an exact multiple thereof.

If your spouse is also an employee of Wendy's and is eligible for life insurance, you may not elect supplemental life insurance on your spouse.

Your spouse may be required to complete an EOI form if either you are newly-eligible for benefits and you elect more than $50,000 in coverage for your spouse or you increase your elected level of supplemental spousal life insurance by more than $10,000.

Coverage will not be effective and payroll deductions will not begin until your EOI form is submitted and approved by Unum. The beneficiary for this coverage is the employee.

If your spouse has reached age 70, your spouse's amount of life insurance will be:

- 50% of the amount of life insurance your spouse had prior to age 70; or
- 50% of the amount of life insurance shown above if your spouse becomes insured on or after age 70.

There will be no further increases in your spouse's amount of life insurance after age 70 (or the later date your spouse first become insured).

FOR YOUR ELIGIBLE DEPENDENTS

You may purchase $10,000 of supplemental life insurance for your eligible children.

A flat rate of $0.18 per bi-weekly pay period insures your children. This rate applies regardless of the number of children covered. The beneficiary for this coverage is the employee.

AD&D INSURANCE

If you are involved in an accident that is covered under the plan, you or your surviving beneficiary will receive an Accidental Death and Dismemberment (AD&D) insurance benefit. This benefit is in addition to your basic life insurance coverage, and provides an additional amount equal to one times (1x) your annual base salary up to a $1,000,000 maximum (called the "Principal Sum" in the chart below). The beneficiary for this coverage is the same as the beneficiary you designate for your basic life insurance coverage.

The benefit will be paid only if an accidental bodily injury results in one or more of the covered losses listed below within 365 days from the date of the accident.

FOR LOSS OF:	THE BENEFIT WILL BE:
Life	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum

Speech and hearing	Principal Sum
Quadriplegia	Principal Sum
Triplegia	Three Quarters of the Principal Sum
Paraplegia	Three Quarters of the Principal Sum
Hemiplegia	Half the Principal Sum
One hand or one foot	Half the Principal Sum
Sight of one eye	Half the Principal Sum
Speech or hearing	Half the Principal Sum
Thumb and index finger of the same hand	One quarter of the Principal Sum
Uniplegia	One quarter of the Principal Sum

ADDITIONAL AD&D BENEFITS FOR YOU

Repatriation	Seatbelt(s) and Air Bag
Education Benefits – Each Qualified Child	Exposure and Disappearance
Burn	Child Care
Coma	Felonious Assault
Rehabilitation Physical Therapy	

For more details about the AD&D plan, view the Group Life and Accidental Death and Dismemberment Plan document on https://my.benefitsnow.com or call the Wendy's Benefits Service Center at 1.855.557.9603.

BUSINESS TRAVEL ACCIDENT INSURANCE

Wendy's provides full-time management (other than restaurant managers) and support administrative employees with a Wendy's-paid Business Travel Accident benefit in an amount equal to three times your annual base salary. Coverage is rounded to the nearest $1,000, up to a $2,000,000 maximum benefit. The maximum combined coverage for all employees injured in a single incident is $6,000,000.

The Business Travel Accident benefit covers you while you are traveling on a required business trip away from your normal place of business. Coverage begins from the actual start of a planned trip and ends when you return to work or home, whichever comes first. Your business trip may start from home, work or another location. Commuting travel to and from work is not covered.

To designate a beneficiary log onto https://my.benefitsnow.com or call the Wendy's Benefits Service Center at 855.557.9603.

For complete details about the business travel accident insurance, request a copy of the business travel accident policy by calling the Wendy's Benefit Service Center at 1.855.557.9603.

DISABILITY INSURANCE

Wendy's provides time off and income protection in the event of a serious illness, injury or other disability.

Administration of Wendy's short- and long-term disability benefits is handled by Unum. To learn more about your coverage contact Wendy's Benefit Service Center at 1.855.557.9603. To apply for a disability leave of absence contact Unum at 1.888.246.7060 or unum.com/claims.

SHORT-TERM DISABILITY (Payroll practice outside of the Plan)

Wendy's provides Company-paid Short-Term Disability (STD) benefits to full-time employees who have 30 days of continuous service in an eligible position.

Eligibility for STD pay for a non- work-related accident or illness begins on the 8th day of the absence once proof of disability is received and reviewed. Should you become physically unable to work due to a medically-diagnosed condition, you may be eligible to receive up to 26 weeks of STD benefits.

Benefits are calculated on base salary, as of the beginning date of the disability, as follows:

- Week 1: unpaid waiting period (you may use your available sick, personal, or vacation days during this period)
- Week 2 (8th day of disability): 100% of base pay
- Weeks 3 – 26: 70% of base pay

Note that STD benefits may be reduced by other income you receive.

LONG-TERM DISABILITY

Wendy's provides Company-paid Long-Term Disability (LTD) benefits to full-time employees who have 30 days of service in an eligible position.

Should you become unable to work for 180 days due to a medically-diagnosed condition, you are eligible to apply for LTD benefits. Under the plan, Unum will pay 60% of your income—for as long as you continue to meet the plan's definition of disability—generally up to the normal Social Security retirement age. Income is defined as actual base earnings and WIN/BIP incentive earnings averaged over the 12 months prior to the date of disability. The plan has a maximum monthly benefit of $20,000.

Note that LTD benefits may be reduced by other income you receive. With limited exceptions, there is a lifetime cumulative maximum of 24 months of LTD benefits for disabilities due to mental illness, alcoholism or drug abuse and for disabilities based primarily on self-reported symptoms.

Wendy's pays 100% of the premium for your LTD benefits. Normally, because the premium is Wendy's- paid, IRS regulations mandate that any LTD benefits you collect are considered taxable income. However, to protect your LTD benefits from taxation, Wendy's adds your LTD premiums to your W-2. This means you pay the tax on the premium, and any LTD benefits you receive will not be subject to applicable Federal, State, and local taxes. You will see the amount recorded on your paystub as "LTDI" which means LTD Imputed Income, on your pay stub.

EMPLOYEE ASSISTANCE PROGRAM

Because we care about your well-being, Wendy's provides you and your eligible dependents with access to Wendy's Employee Assistance Program (EAP).

Administered by Anthem Blue Cross & Blue Shield, this confidential service gives you free access to fully-licensed and certified counselors who can help you navigate through professional, personal, family, and other life challenges.

Covered services include:

- Marital/family problems
- Financial concerns
- Drug/alcohol abuse
- Identity Theft
- Legal concerns
- Work conflicts
- Eldercare and childcare concerns
- Emotional concerns

Wendy's EAP program pays for up to four in-person counseling sessions per year. You also have access to Anthem EAP advisors through their 24/7 Helpline at 1.800.999.7222. Additional information is available online at AnthemEAP.com, enter Wendys.

ADMINISTRATIVE INFORMATION

PLAN ADMINISTRATION

The Wendy's Company is the Plan Administrator and has the primary responsibility for the general administration of the Plan. The Plan Administrator appoints claims administrators to be responsible for the claims processing (the initial approval or denial of claims and decisions regarding the appeal of any denied claims) for those benefits for which a separate claims administrator has been appointed; provided, however, that in carrying out such responsibility, the claims administrator shall comply with the requirements of Employee Retirement Income Security Act (ERISA). The Plan Administrator has also delegated to the claims administrators the responsibility for the general administration of the benefits. The Plan Administrator and each claims administrator, as appropriate, in its sole discretion and within the scope of its authority, shall have the power and absolute discretion to decide benefit claims and appeals, make reasonable rules and regulations, administer the benefits, and interpret the terms of the Plan. Their good faith determinations and interpretations shall be binding and conclusive on all persons.

PLAN INFORMATION

Plan Name	The Wendy's Company Group Insurance Plan
Plan Number	501
Type of Plan	Welfare benefit plan, providing medical, prescription drug, dental, vision, limited purpose healthcare flexible spending account, health reimbursement account, employee assistance program, long-term disability, accidental death and dismemberment, business travel accident and life insurance benefits
Plan Year	Calendar year (January 1 – December 31)
Plan Sponsor and Plan Administrator	The Wendy's Company One Dave Thomas Blvd. Dublin, OH 43017 (614) 764-3100
Plan Sponsor Tax ID Number (EIN)	38-0471180
Participating Employers	The plan covers employees of The Wendy's Company and its subsidiaries. A complete list of participating employers may be obtained by written request.
Agent for Service of Legal Process	General Counsel The Wendy's Company One Dave Thomas Blvd. Dublin, OH 43017 Service of legal process may also be made on the plan administrator

Type of Funding	Self-insured by Wendy's and participant contributions: ▪ Medical and prescription drug ▪ Dental Self-insured by Wendy's: ▪ Health Reimbursement Account ▪ Short-term disability insurance Insurance contract, premiums paid by Wendy's: ▪ Basic life and AD&D insurance ▪ Business travel accident insurance ▪ Long-term disability insurance ▪ Employee assistance program ▪ Telemedicine Insurance contract, premiums paid solely by participants: ▪ Vision ▪ Supplemental life insurance Funded by participant contributions: ▪ Limited purpose healthcare flexible spending account ▪ Dependent day care flexible spending account ▪ Commuter Benefits Funded by Wendy's and participant contributions: ▪ Health savings account

Type of Administration	▪ Medical, health reimbursement account and dental: Self-insured with claims administration by Anthem ▪ Prescription drug: Self-insured with claims administration by CVS Caremark ▪ Vision: Insurer administration by Vision Service Plan (VSP) ▪ Limited purpose healthcare flexible spending accounts: Self-insured with claims administration by Your Spending Account ▪ Dependent care flexible spending accounts: Self-insured with claims administration by Your Spending Account (outside of the Plan) ▪ Life, AD&D and long-term disability insurance: Insurer administration by Unum ▪ Short-term disability: Self-insured with claims administration by Unum (outside of the Plan) ▪ Business travel accident insurance: Insurer administration by Life Insurance Company of North America ▪ Employee assistance program: Insurer administration by Anthem Blue Cross Blue Shield ▪ Commuter benefits: Self-insured with claims administration by Your Spending Account (outside of the Plan) ▪ Health Savings Accounts: Individual Accounts administered by Your Spending Account (outside of the Plan) ▪ Telemedicine: Insurer administration by MDLIVE (outside of the Plan)

AMENDMENT OR TERMINATION

Although Wendy's expects to continue the benefits described in this document, Wendy's has the right to amend or end the Plan or any benefits offered under it, prospectively or retroactively, in whole or in part, at any time and without prior notice to participants, in its sole discretion. Also, benefits may be discontinued at any time for any groups of employees or inactive participants. Your cost for coverage is also subject to change at any time.

No amendment or termination may diminish any vested accrued benefits arising from the incurred but unpaid claims as of the effective date of the amendment or termination.

FAMILY MEDICAL LEAVE ACT

In accordance with the Family and Medical Leave Act of 1993 (FMLA), eligible employees are allowed up to 12 weeks of unpaid leave for:

- Your own serious illness
- The birth of your child or a child's placement with you for adoption or foster care
- To care for a seriously ill child (including a child for whom you have assumed the obligations of a parent, even if you are not the biological or legal parent), spouse or parent
- A covered family member's call to active duty in the U.S. Armed Forces

FML also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member who has incurred a serious injury or illness while on active duty.

FML benefits may be taken continuously or on an intermittent schedule, but can total no more than 12 or 26 weeks (as described above) in a 12-month period of time.

To be eligible for FML, you must have at least 12 months of continuous service with Wendy's and have worked 1,250 hours within the 12 months preceding the leave.

BENEFIT COVERAGE DURING FML

During approved FML leaves, both you and Wendy's continue to pay the designated cost for benefit coverage. Unless your coverage is cancelled because you fail to timely pay your share of the applicable premiums, after the expiration of the leave period, or your notice that you will not return to work, you will be offered continued coverage for medical, dental, vision insurance, access to the Employee Assistance Program and the continuation of your Limited Purpose Healthcare FSA, if applicable, under the Consolidated Omnibus Reconciliation Act (COBRA).

For additional information or to apply for FML, contact Wendy's FML administrator, Unum at 1.888.246.7060 or unum.com.

USERRA RIGHTS

As required by federal law, Wendy's provides benefits during or following a period of qualified military service. You must continue to pay your share of the cost of coverage during your military leave of absence. If Wendy's pays a portion of the premium payment on your behalf to continue your coverage while you are on military leave, you may be required to reimburse Wendy's for your portion of the premium payment whether or not you return to work.

If you do not continue your coverage during your military leave, your coverage will be reinstated when you return on a timely basis from military leave.

NO ALIENATION OF BENEFITS

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign your right to benefits to a provider who rendered medical, dental or vision services.

The plan administrator reserves the right to pay plan benefits to someone acting on your behalf if you are not competent to receive plan benefits, or to your estate if you die while plan benefits are still owed to you. If the plan administrator pays benefits to a third party in good

faith, benefits will not be paid again.

COURT ORDERS

If you become divorced, certain court orders could require you to provide healthcare coverage to your dependent child(ren). A court order of this type is known as a Qualified Medical Child Support Order (QMCSO). If the QMCSO satisfies legal requirements and you are eligible to participate, you may enroll yourself and your eligible children covered by the QMCSO in the medical, dental and vision plans. A copy of the QMCSO procedures may be requested from the Wendy's Benefit Service Center at 1.855.557.9603.

APPEALS PROCESS

Disagreements about benefit eligibility or payment amounts can occasionally arise. In most cases, they are resolved quickly by the appropriate claims administrator. If you can't resolve the disagreement, formal appeal procedures are in place for your use.

REVIEW OF DENIED CLAIMS DUE TO ELIGIBILITY

All determinations as to your eligibility or the eligibility of your dependents for coverage under the plan (other than a rescission of coverage), which are not accompanied by a claim for benefits will be made by Wendy's. The decision of Wendy's will be final and will not be subject to review. To file a claim for eligibility, you must submit a written request to the Wendy's Benefit Service Center.

You are encouraged to provide supporting documents listing dates of action, like a copy of personal enrollment confirmation with appeals concerning eligibility, to substantiate your claim.

REVIEW OF BENEFIT DETERMINATION

For each benefit, the claims administrator has procedures for applying for benefits and for requesting a review of a benefit determination. The determination of the claims administrator is final. For insured benefits, the insurance carrier is the claims administrator. For self-insured welfare benefits, the third-party administrator is the claims administrator.

Please refer to the booklet or certificate for each benefit for the claims procedure that applies to that benefit. If the claims procedures in the booklet or certificate do not address an issue or are ambiguous, then the rules below apply to the extent they address the issue or resolve the ambiguity.

The following procedures for processing benefit claims do not apply to the Dependent Day Care Flexible Spending Account or the Employee Assistance Program, which are not ERISA plans. They do not apply to claims for medical or dental benefits, because the claims procedure for medical and dental benefits is described in full in the Anthem BCBS booklet for the medical and dental coverage. They do not apply to claims for vision benefits, because the claims procedure for vision benefits is described in full in the VSP Vision booklet for the vision coverage.

STANDARDS TO REVIEW A CLAIMS DENIAL

Each benefit (other than medical, dental or vision) requires only one level of appeal. In order for a claimant to pursue his or her rights as explained in the "Rights After Appeal" section below, he or she must first exhaust the appeal rights for the applicable benefit.

The claimant and/or the authorized representative may inspect, or request copies of, free of charge, all documents and other information relevant to the denied claim, and may submit written comments, documents, records, and other information to the claims administrator in connection with the review of his or her claim. The review of the claimant's appeal of a denied claim shall be reviewed without giving deference to the initial adverse benefit determination and will not be conducted by the

individual who made the initial review, nor a subordinate of such individual, but shall be conducted by the claims administrator in its capacity as the Plan's fiduciary designated to resolve claims appeals for the benefit. If the claim is denied upon review and notice of such denial upon review is provided to the claimant as provided in these procedures, the claimant may pursue his or her rights as set forth in the "Rights After Appeal" section described below.

RESPONSE DATES FOR APPEALS OF DENIALS

For life, AD&D and disability claims, the decision on review will be made within 45 days after the request for review is received by the claims administrator, or within 90 days if special circumstances require an extension of time. If such an extension of time is taken, the claims administrator shall notify the claimant in writing within the initial 45-day period and shall state the circumstances for extension. If the claimant does not receive notice of the decision within the initial 45-day period, or within the 45-day extension period, if applicable, the claim shall be deemed to have been denied on review.

For all other claims, the decision on review will be made within 60 days after the request for review is received by the claims administrator, or within 120 days if special circumstances require an extension of time. If such an extension of time is taken, the claims administrator shall notify the claimant in writing within the initial 60-day period and shall state the circumstances for extension. If the claimant does not receive notice of this decision within the initial 60-day period, or within the 60- day extension period, if applicable, the claim shall be deemed to have been denied on review.

RIGHTS AFTER APPEAL

If you are not satisfied with the claims administrator's final decision, you have the right to file suit in a federal court within 12 months after the date of the claims administrator's final decision. No legal action may be brought for benefits until all appeal rights have been exhausted.

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:

- Examine, without charge, all Plan documents, 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 Employee Benefits Security Administration
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The plan administrator may make a reasonable charge for the copies
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Continue healthcare coverage (at your expense) for yourself, your spouse, or your dependents if there is a loss of that coverage as a result of a qualifying event. Review this summary and the documents governing the appropriate health program on the rules governing your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you or your representative have a right to know why this was done, to obtain copies of documents relating to the decisions 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 materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require

the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is improperly denied or ignored, in whole or in part, or if you have an unresolved issue with respect to a Qualified Domestic Relations Order (QDRO), you may file suit in a state or federal court. If it should happen that a Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States 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 if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you should have any questions about the Plan, please contact the Wendy's Benefit Service Center (contact information listed in the table below). If you have any questions about this Summary Plan Description or about your rights under ERISA, you may contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 to discuss questions about this statement of rights or about any rights under ERISA. The Wendy's Benefit Service Center will be happy to furnish the address and telephone number.

CONTACTS

If you have benefits questions, contact the Wendy's Benefit Service Center or any of the designated claims administrators for answers.

WHO TO CALL:	HOW TO REACH THEM:
General Questions Wendy's Benefit Service Center	1.855.557.9603 (Monday – Friday, 9 a.m. – 6 p.m. Eastern time) https://my.benefitsnow.com
401(k) Retirement Plan Questions Empower	1.888.411.4015 (Monday – Friday, 8 a.m. – 10 p.m. Eastern time) www.empower-retirement.com/participant
Medical Plan / Health Reimbursement Account Anthem BlueCross BlueShield	1.866.205.6128 www.anthem.com
Dental Plan Anthem BlueCross BlueShield	1.866.205.6128 www.anthem.com
Vision Plan Vision Service Plan	1.800.877.7195 www.vsp.com
Prescription Drugs CVS Caremark	1.888.202.1654 www.caremark.com
Flexible Spending Accounts & Health Savings Account Your Spending Account	1.855-557-9603 https://my.benefitsnow.com

Commuter Benefits Wendy's Benefit Service Center	1.855.557.9603 (Monday – Friday, 9 a.m. – 6 p.m. Eastern time) https://my.benefitsnow.com
Life & AD&D Insurance Unum	1.888.246.7060 http://unum.com
COBRA – coverage after you terminate employment Alight	1.855.557.9603 https://my.benefitsnow.com
Employee Assistance Program Anthem BlueCross BlueShield	1.800.999.7222 www.anthemEAP.com, enter Wendys
Telemedicine MDLIVE	1.888.632.2738 www.mdlive.com/wendys
Short-Term and Long-Term Disability Unum	1.888.246.7060 http://unum.com
Business Travel Accident Life Insurance Company of North America	1.866.700.0262 No website available

This is the Summary Plan Description (SPD) for The Wendy's Company Group Insurance Plan (the Plan) for eligible management, administrative and shift-supervisor employees in the United States. For a complete SPD, this handbook must be read together with the annual Benefits Guide and the benefits booklets or certificates describing the benefit programs for the applicable year, which are incorporated by reference into this SPD. The benefits booklets or certificates are available upon request.

If this SPD contains information that is not included in the official plan documents, this SPD is considered incorporated by reference into the plan documents.

APPENDIX A

Wendy's International, LLC

2019 Required Notices

HIPAA and GINA NOTICE OF PRIVACY PRACTICES

This notice applies to employees enrolled in medical, prescription drug, dental, vision or other health benefits under The Wendy's Company Group Insurance Plan.

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.

This notice describes the privacy practices for the medical, prescription drug, dental, vision, health care flexible spending account, employee assistance, and any other health benefit programs from time to time included in The Wendy's Company Group Insurance Plan (the "health plan"). This notice does not apply to disability benefits, life insurance, workers' compensation, leaves of absence (including leaves under the Family and Medical Leave Act), or any non-health plans or benefits.

Protected health information ("PHI") is health information that identifies you and relates to your medical history (i.e., the medical care you receive, or the amounts paid for that care) that is created or obtained by the health plan in connection with your eligibility for or receipt of benefits under the health plan.

Federal law requires that the health plan maintain the privacy of PHI, give you this notice of the health plan's legal duties and privacy practices, and follow the terms of this notice as currently in effect.

The Company contracts with claims administrators, insurers, and other third parties to provide health plan services. The activities of the health plan as described in this notice include the activities of the third parties when performing services for the health plan. PHI may be shared among the components of the health plan and the third parties providing services for the components of the health plan in the course of treatment, payment, and plan operations.

When their services involve the use of PHI, the third parties will be required to perform their duties in a manner consistent with this notice. However, a third party providing a fully insured benefit, or an employee assistance program may give you a separate notice of privacy practices describing its privacy practices. If so, the third party will follow its own privacy practices to the extent those practices are more restrictive (i.e., more protective of your privacy) than those described in this notice.

1. How the Health Plan Uses and Shares PHI for Treatment, Payment, and Plan Operations

   Below are some examples of ways that the health plan may use or share information about you for treatment, payment, and plan operations. For each category, a number of uses or disclosures will be listed, along with an example. However, not every use or disclosure in a category will be listed. The health plan may use or share your PHI for:

   - Treatment: The health plan may use or disclose your PHI to facilitate medical treatment or services by providers. The health plan may disclose PHI to doctors, dentists, pharmacies, hospitals, and other health care providers who take care of you. For example, doctors may request medical information from the health plan to supplement their own records. The health plan may also send certain information to doctors for patient safety or other treatment-related reasons.

   - Payment: The health plan will use or disclose your PHI to determine and pay for covered services. Payment activities include determining eligibility; conducting pre-certification, utilization, and medical necessity reviews; coordinating care; calculating cost sharing amounts; coordination of benefits; reimbursement and subrogation; and responding to questions, complaints, and appeals. For example, the health plan may use your medical history and other health information to decide whether a particular treatment is medically necessary and what the payment should be. During that process, the health plan may disclose information to your provider. The health plan may also forward information to another plan in order for it to process or pay claims on your behalf. The health plan will mail explanation of benefits forms and other information to the employee at the address it has on record for the employee.

   - Plan Operations: The health plan will use and disclose your PHI for plan operations. Operational activities include quality assessment and improvement; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management, and care coordination. For example, the health plan may use PHI to provide disease management programs for participants with specific conditions, such as diabetes, asthma, or heart failure. Other operational activities requiring use and disclosure of PHI include administration of pharmaceutical programs and payments; and other general administrative activities, including data and information systems management

and customer service. The health plan is prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

The health plan may also disclose PHI to providers or other health plans for the payment, treatment, and certain operational activities of the provider or other health plan.

2. How the Health Plan Uses and Shares PHI for Communications About Benefits

The health plan may use or disclose PHI to send you treatment reminders for services, such as mammograms or prostate cancer screenings. Also, the health plan may use or disclose your PHI about alternative medical treatments and programs or health- related products and services that may be of interest to you. For example, the health plan might send you information about smoking cessation or weight-loss programs.

3. Disclosures that the Health Plan May Make to Others Involved in Your Health Care

The health plan may disclose PHI to a family member, a friend, or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls the health plan with prior knowledge of a claim, the health plan may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure. See *Contact Information*, below.

4. Disclosures You May Authorize the Health Plan to Make

The health plan will not use or disclose your PHI for any reason other than those listed in this notice unless you provide a written authorization. For example, unless you provide a written authorization, the health plan is prohibited from selling your PHI, or using or disclosing your PHI for marketing activities that result in financial remuneration to the health plan.

You may give the health plan written authorization to use and/or disclose your PHI to anyone for any purpose. If you give the health plan an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure made pursuant to your authorization while it was in effect.

5. Disclosures that the Health Plan May Make to The Wendy's Company

The health plan will share enrollment information about you and your family members with The Wendy's Company. The health plan will also periodically disclose PHI to the Wendy's Support Center Benefits Team, HRIS department and legal department (collectively, the "Plan Administration Staff") so that the Plan Administration Staff can assist participants with benefits questions, problems, and appeals; perform financial planning and projections; monitor the performance of third parties; and oversee and assist with the administration of the health plan. The Wendy's Company and Plan Administration Staff will only use the PHI for these purposes or as authorized by you or as required by law. Specifically, the Company will:

- Not use or further disclose PHI other than as permitted or required by the health plan document or as required by law or permitted by a participant's authorization;
- Ensure that any agents (including a subcontractor) to whom the Company provides PHI received from the health plan agree to the same restrictions and conditions that apply to the Company with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any non-health benefits under The Wendy's Company Group Insurance Plan or another employee benefit plan of the Company, except as authorized by a participant;
- Report to the health plan's Privacy Officer any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for, of which the Company becomes aware;
- Make an individual's PHI available to him or her for access, amendment, and accounting in accordance with the federal privacy regulations.
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the health plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance

by the health plan with federal regulations;

- Return PHI to the health plan (when feasible), destroy PHI (where return is not feasible, and retention is not required by law), or continue to maintain the privacy of all PHI (where return is not feasible or retention is required by law);

- Use its best efforts to require only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested;

- Ensure adequate separation between the Company and the health plan so that PHI disclosed to the Company: (a) will not be disclosed to employees who are not members of the Plan Administration Staff, and (b) will be used by the Plan Administration Staff for only permitted purposes;

- Ensure that the adequate separation is supported by reasonable and appropriate security measures;

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the health plan;

- Ensure that any agents (including subcontractors) to which it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect such electronic PHI;

- Report to the health plan any security incident of which it becomes aware that results in a use or disclosure of electronic PHI in violation of the health plan, and, for all other security incidents involving electronic PHI, report these to the health plan in aggregate on a quarterly basis or such other periodic basis as mutually agreed to by the Company and the health plan; and

- Provide an effective mechanism for resolving issues of noncompliance through investigation and resolution by the health plan's Privacy Officer and as otherwise provided under ERISA.

6. Other Uses and Disclosures of PHI

There are state and federal laws that may require or allow the health plan to release your health information to others. The health plan may provide information for the following reasons:

- Health Oversight Activities: The health plan may disclose your PHI to a government agency authorized to oversee the health care system or government programs, or its contractors (e.g., state insurance department, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections, and licensure activities.

- Legal Proceedings: The health plan may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

- Law Enforcement: The health plan may disclose your PHI to law enforcement officials under limited circumstances. For example, in response to a warrant or subpoena, for the purpose of identifying or locating a suspect, witness, or missing person; or to provide information concerning victims of crimes.

- For Public Health Activities: The health plan may disclose your PHI to a government agency that oversees the health care system or government programs for activities, such as preventing or controlling disease or activities related to the quality, safety, or effectiveness of an FDA regulated product or activity.

- Required by Law: The health plan may disclose your PHI when required to do so by law.

- Workers' Compensation: The health plan may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation laws and similar programs.

- Victims of Abuse, Neglect, or Domestic Violence: The health plan may disclose your PHI to appropriate authorities if the health plan reasonably believes that you're a possible victim of abuse, neglect, domestic violence, or other crimes.

- Coroners, Medical Examiners and Funeral Directors: In certain instances, the health plan may disclose your PHI to coroners, medical examiners or funeral directors. This may be necessary to identify a deceased person or determine the cause of death.

- Research: The health plan may disclose your PHI to researchers, if certain established steps are taken to protect your privacy.

- Threat to Health or Safety: The health plan may disclose your PHI to the extent necessary to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of others.

- For Specialized Government Functions: The health plan may disclose your PHI in certain circumstances or situations to a correctional institution if you are an inmate in a correctional facility, to an authorized federal official when it's required for lawful intelligence or other national security activities, or to an authorized authority of the Armed Forces.

- For Cadaveric Organ, Eye, or Tissue Donation: The health plan may disclose your PHI for the purpose of facilitating organ, eye, or tissue donation and transplantation.

7. Individual Rights

You have the following individual rights regarding the PHI that the health plan maintains about you.

- Right to Request Restrictions on Use and Disclosure of PHI. You have the right to request restrictions on how the health plan uses or discloses your personal health information for treatment, payment, or health care operations. The health plan will consider, but is not required to agree to, your request for a restriction. Generally, you have the right to require a health care provider to restrict the disclosure of your PHI to the health plan. However, to obtain such a restriction, you would need to pay your health care provider in full for services and supplies because the restriction would prevent the health plan from making payments on your behalf to your health care provider.

- Right to Request Confidential Communications. You may request that when the health plan sends communications to you that contain PHI (e.g., an Explanation of Benefits), it sends them to you by alternative means or to an alternative location. A request must include the alternative location (e.g., fax number, address, etc.) to which you would like the health plan to send the information. The health plan will accommodate reasonable requests in cases where you have stated that normal communications would endanger you. The health plan may, but is not required to, accommodate other requests. You may also direct the health plan to limit disclosures to family members or others who are involved in your care or the paying for your care.

- Right to Inspect and Copy Your PHI (Access). You have the right to inspect and/or obtain a copy of the PHI that the health plan maintains about you in a designated record set. A fee will be charged for copying and postage. A designated record set contains PHI that the health plan collects, maintains, or uses to administer or make decisions regarding your enrollment, payment, claims adjudication, or case/medical management. There are some exceptions as to what information may be accessed. For example, information compiled for legal proceedings cannot be accessed. If the health plan denies access to your information, in part or in whole, it will notify you in writing. The denial will include the reason for the denial, your review rights (if applicable), and information on how to file a complaint.

- Right to Request Amendments to Your PHI. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer using the contact information list on the last page of this notice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

  The health plan may deny your request if you ask the health plan to amend information that: is not part of the PHI kept by or for the health plan; was not created by the health plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information that you would be permitted to inspect and copy;

or is accurate and complete. If the health plan denies the request, you may file a written statement of disagreement with the health plan.

- Right to an Accounting of Disclosures of Your PHI. You have the right to request an accounting of certain disclosures of PHI. Your request must be in writing and must specify the time period for which you are requesting information. The period cannot go back more than six (6) years from the date of your request. The accounting will not include disclosures made to you or with your written authorization or in the course of treatment, payment, or health care operations. If you request such an account more than once in a twelve (12)-month period, the health plan will charge a reasonable fee.

- Right to Notice of Breaches of Unsecured PHI. The health plan is required to provide you with notice of breaches of your unsecured PHI.

- Right To A Paper Copy Of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a copy of this notice, you must submit your request in writing to the Privacy Officer using the contact information list on the last page of this notice.

A request to exercise any of these rights must be in writing. For more information, or to begin the formal process of exercising any of these rights, see *Contact Information*, below.

8. Contact Information

If you want to exercise any of the individual rights described in this notice, for further information, or for a copy of this notice, contact:

Health Plan Privacy Officer
Senior Director of Total Rewards
The Wendy's Company
One Dave Thomas Blvd.
Dublin, OH 43017
phone: 614-764-3100
e-mail: Benefits@wendys.com

9. Complaints

You have the right to file a written complaint if you think this notice and/or your privacy rights have been violated. You won't be retaliated against or denied any health plan benefit or service because you file a complaint. Your complaint should be in writing and include: your name, full address, home and work telephone numbers, e-mail address; the name, full address, and phone number of the person or entity that you believe violated your privacy rights; and a description of what happened (e.g., how, why, and when you believe this notice and/or your privacy rights were violated). Your complaint may be filed with:

The Health Plan's Privacy Officer; and/or
Secretary of the U.S. Department of Health and Human Services.

The health plan's Privacy Officer will investigate and address any issues of noncompliance with this notice of which he or she is notified or becomes aware.

10. Revisions to the Notice

This notice is effective October 15, 2018. The Company reserves the right to change the terms of this notice and to make the new notice effective for all PHI maintained by the health plan. The Company will promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your rights, the health plan's duties, or other practices stated in this notice. Except when required by law, a material change to this notice will not be implemented before the effective date of the new notice in which the material change is reflected. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect. You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, the right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

IMPORTANT NOTICE FROM THE WENDY'S COMPANY 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 The Wendy's Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, 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. The Wendy's Company has determined that the prescription drug coverage offered by The Wendy's Company 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 Wendy's coverage will not be affected. If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop The Wendy's Company coverage, Medicare will be your only payer. You can reenroll in the employer plan at annual enrollment or if you have a special enrollment event for the Wendy's Plan.

Your eligibility for the Wendy's Plan does not depend on whether or not you choose to enroll in a Medicare prescription drug plan. However, if you have enrolled in Medicare Part A or B, you will not be eligible to contribute to a Health Savings Account. Instead, if you participate in one of the CDHP options, The Wendy's Company will credit equivalent company contributions to a Health Reimbursement Account. If you decide to join a Medicare Drug Plan, The Wendy's Plan will coordinate your coverage with that plan.

If you do decide to join a Medicare drug plan and drop your current Wendy's coverage, be aware that you and your dependents will be able to get this coverage back.

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 Wendy's 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 did not have that coverage. For example, if you go nineteen 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 person listed below for further 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 Wendy's 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
- 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.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 15, 2018
Name of Entity/Sender: The Wendy's Company
Contact--Position/Office: Senior Director – Total Rewards
Address: One Dave Thomas Blvd, Dublin, OH, 43017
Phone Number: (614) 764-3100

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment"

opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid

- Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/Phone: 1-877-438-4479

All other Medicaid

Website: http://www.indianamedicaid.com

Phone 1-800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/hawk-i

Phone: 1-800-257-8563

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus

CHP+ Customer Service: 1-800-359-1991/

State Relay 711

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/

Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331

Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-442-6003

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/ombp/nhhpp/

Phone: 603-271-5218

Hotline:

NH Medicaid Services Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/

Phone: 919-855-4100

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/seniors/ health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: (855) 632-7633

Lincoln: (402) 473-7000

Omaha: (402) 595-1178

NEVADA – Medicaid

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx

http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/

Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Medicaid Website: https://dhcfp.nv.gov/

Medicaid Phone: 1-800-992-0900

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/

CHIP Website: http://health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/

Phone: 307-777-7531

To see if any other states have added a premium assistance program since **July 31, 2018**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Wendy's Company Group Insurance Plan (the Plan), under federal law, 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
- 96 hours following a cesarean section

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, The Wendy's Company Group Insurance Plan (the Plan) may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

However, to use certain out-of-network providers or facilities, or to reduce your out-of pocket costs, you may be required to obtain pre-certification. For more information about the Newborns' and Mothers' Health Protection Act, call the Wendy's Benefit Service Center at 1.855.557.9603.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment in medical coverage for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in The Wendy's Company Group Insurance Plan (the Plan) as long as you request enrollment no more than 60 days after your other coverage ends (or after the employer stops contributing toward 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 the Plan as long as you request enrollment by contacting the Wendy's Benefit Service Center no more than 60 days after the marriage, birth, adoption or placement for adoption.

If you and your eligible dependents are not already enrolled in the Plan, you may be able to enroll yourself and your eligible dependents if (1) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (2) you or your dependents become eligible for premium assistance under state Medicaid or CHIP, as long as you request enrollment no more than 60 days from the date of the Medicaid/CHIP event.

To request special enrollment or obtain more information, contact the Wendy's Benefits Service Center at 1.855.557.9603.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, the medical plan options offered to you by The Wendy's Company provide benefits for mastectomy- related services. These services include:

- reconstruction of the breast involved in the mastectomy;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of mastectomy (including lymphedemas).

The plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. If you would like more information about the Women's Health and Cancer Rights Act, call the Wendy's Benefit Service Center at 1.855.557.9603.

PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

The health coverage offered under the Wendy's plan options does not require you to designate a Primary Care Physician (PCP). You have the right to designate any PCP (or pediatrician for any child) who participates in a network under the health coverage offered under the Wendy's plan and who is available to accept you or your family members.

You do not need prior authorization from Wendy's, the insurer, or from any other person (including a PCP) in order to obtain access obstetrical or gynecological care from a health care professional in a network under the health coverage offered under the Wendy's plan. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a preapproved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your identification card or refer to www.anthem.com.

NOTICE OF WELLNESS PROGRAM DISCLOSURES

Tobacco Free Premium Credit

Rewards for participating in this wellness program are available to all employees. If you think you might be unable to achieve the tobacco free standards for the tobacco free premium credit under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the premium credit under this program, you might qualify for an opportunity to earn the same reward a different way. Call the Wendy's Benefits Service Center at 1.855.557.9603 and we will work with you to find another way to qualify for the premium credit.

Engage Wellness Rewards Program

Wendy's provides all employees, spouses and adult children who are enrolled in the Wendy's medical benefits with an opportunity to

participate in the Engage Wellness Rewards Program (the "Wellness Rewards Program") which provides participating individuals with the opportunity to earn incentives. Individuals are not required to participate in the Wellness Rewards Program, but only participating individuals are eligible for the incentives.

Individuals who participate in the healthy lifestyle activities will be credited with points. The healthy lifestyle activities include participation in tracking healthy behaviors like participation in physical activity, tracking food and sleep, reviewing claims, and other activities. The individual can elect to exchange points for up to $200 in gift cards or HSA contributions each year (10 points for each $1 of gift card or HSA contribution, as selected by the individual) or for entries for a quarterly sweepstakes (1 point for 1 sweepstakes entry). Contact the Wellness Administrator at benefits@wendys.com for more information about the healthy lifestyle activities and incentives.

If you think you might be unable to meet a standard for a reward under this wellness program, you will be given the opportunity to earn the same reward by a different means. Contact the Wellness Administrator to find another activity or challenge with the same reward that is right for you in light of your health status.

The Wellness Rewards Program will restrict the use and disclosure of protected health information received and/or maintained in connection with the Wellness Rewards Program in accordance with HIPAA Notice of Privacy Practices. This Wellness Rewards Program may use aggregate information it collects to help Wendy's design programs based on identified health risks for its workforce, but the Wellness Rewards Program will never disclose your personal information to Wendy's except as necessary to respond to an individual's request for a reasonable accommodation or as expressly permitted by law. An individual's medical information will not be used to make decisions regarding the individual's employment. You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Rewards Program, nor may you be subjected to retaliation if you choose not to participate.

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 medical plan and the Wellness Rewards Program, and you will not be required to waive the confidentiality of your health information as a condition of obtaining incentives under the Wellness Rewards Program. Anyone who receives your information for purposes of providing you services as part of the medical plan or the healthy lifestyles credits program will abide by the same confidentiality requirements.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation related to the wellness benefits, call the Wendy's Benefit Service Center at 1.855.557.9603.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This notice applies to employees enrolled in medical, prescription drug, dental, vision or other health benefits under The Wendy's Company Group Insurance Plan.

Federal Continuation of Coverage (COBRA)

If you are enrolled in the medical, dental, or vision coverage, limited purpose healthcare flexible spending account or eligible for the employee assistance program (a "Health Plan"), you and your family may have the option to temporarily continue coverage in certain instances when coverage would otherwise end. COBRA does not apply to other benefits.

The right to continue coverage was created by a federal law, The Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Health Plan coverage. It can also become available to other members of your family who are covered under the Health Plan when they would otherwise lose their coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

You may have other options available to you when you lose coverage under a Health Plan. 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. 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.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your children could become qualified beneficiaries if coverage under the Health Plan is lost because of a qualifying event. Under the Health Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

- If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Health Plan because either one of the following qualifying events happens:
  -- your hours of employment are reduced; or
  -- your employment ends for any reason other than your gross misconduct.

- Your spouse will become a qualified beneficiary if he or she loses coverage under the Health Plan because any of the following qualifying events happens:
  -- you die;
  -- your hours of employment are reduced;
  -- your employment ends for any reason other than your gross misconduct; or
  -- you get divorced or legally separated from your spouse.

- Your children will become qualified beneficiaries if they lose coverage under the health plan because any of the following qualifying events happens:
  -- you die;
  -- your hours of employment are reduced;
  -- your employment ends for any reason other than your gross misconduct;
  -- you get divorced or legally separated; or
  -- the child stops being eligible for coverage under the Health Plan as an eligible dependent.

Qualified beneficiaries also include a child born to, adopted by, or placed for adoption with the covered employee who satisfies the health plan eligibility requirements and becomes covered under the health plan during the period of COBRA coverage. If you have a new child while covered under COBRA, and you want to add the child to your COBRA continuation coverage, you must notify the COBRA Administrator in writing within 31 days of the birth, adoption, or placement for adoption.

Giving Notice that a Qualifying Event Has Occurred

If your employment ends (for a reason other than gross misconduct) or your hours are reduced, the Health Plan will send you, your covered spouse and your covered children a COBRA election form explaining how to elect COBRA continuation coverage. In the event of your death, the Health Plan will send your covered spouse and children a COBRA election form explaining how they can elect COBRA continuation coverage.

In the event of divorce, legal separation or a child's losing eligibility for coverage, you or a family member must notify the COBRA administrator, Alight, within 60 days after the qualifying life status event occurs. The notice must be in writing. Oral notice, including notice by telephone, is not acceptable. You may be asked to supply supporting documentation.

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the employee covered under the health plan and the names and addresses of the qualified beneficiaries, the qualifying event, and the date of the qualifying event. If a qualifying event is a divorce, the notice should include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary (spouse or parent, if applicable) or by an authorized representative of the qualified beneficiary. If you fail to provide timely notice, the qualified beneficiary will lose all rights to COBRA continuation coverage under the Health Plan. The Health Plan will send the qualified beneficiary a COBRA election form if it

receives this notice within the 60 days.

Electing COBRA Coverage

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. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee. If one member of a family elects COBRA, the single person premium applies. If two or more members of a family elect COBRA, the family premium applies.

In order to elect COBRA continuation coverage, you must return the COBRA election form to the address shown on the COBRA election form within 60 days from the later of: (a) the date of the qualifying event; (b) the date that the COBRA election form is sent; or (c) the date the Health Plan coverage would otherwise end. If you fail to meet this deadline, your right to COBRA continuation coverage will be lost.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 60 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Paying for COBRA Continuation Coverage

- First payment for COBRA coverage: You must make your first payment for continuation coverage not later than 45 days after the date of your election. If the first payment for continuation coverage is not made within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Health Plan.

- Monthly payments for COBRA coverage: After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments. Under the Health Plan, each of these monthly payments for COBRA continuation coverage is due on the first day of the month. If you make a monthly payment on or before the first day of the month, your coverage under the Health Plan will continue for that month without any break.

- Grace periods for monthly payments: Although monthly payments are due on the first day of every month, you will be given a grace period of 30 days to make each monthly payment. Your continuation coverage will be provided for each month as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month, but before the end of the grace period for the coverage period, your coverage under the Health Plan may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Health Plan.

Payments sent through the U.S. mail are considered to be made as of the date of the postmark. If you make a payment near the end of a grace period, you risk not having sufficient time to correct any errors (such as late or missed pick-ups by the U.S. Postal Service).

Coverage During the Continuation Period

If coverage under the Health Plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the Annual Enrollment periods or, if a qualifying event occurs, to the same extent that active employees may do so.

Cost of COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary is required to pay is 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the Health Plan (including both Wendy's and the employee's share of the cost) for coverage of a similarly situated plan participant or beneficiary

who is not receiving continuation coverage.

When Does COBRA Continuation Coverage End?

COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, your divorce or legal separation, or a child's losing eligibility as an eligible dependent, COBRA continuation coverage lasts for up to 36 months.

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

- When the employee is on a leave of absence for United States military (uniformed) service, COBRA continuation coverage lasts up to 24 months. If you leave your job to perform United States military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you and your dependents have the right to be reinstated in the health plan when you are reemployed within the time periods specified by law.

There are only two ways in which an 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 Health Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. You must send notice (including proof of the Social Security determination) to the COBRA administrator within 60 days after you receive the determination (or, if the determination was received before the qualifying event, within the first 60 days of COBRA continuation), but no later than the end of the 18-month period. If you fail to provide timely notice, the right to the disability extension will be lost. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the COBRA administrator within 30 days after the Social Security Administration's determination. The disability extension ends after the Social Security Administration determines the qualified beneficiary is no longer disabled. You will be required to pay up to 150% of the group rate during the 11-month extension.

- Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated, or if the child stops being eligible under the Health Plan as a dependent child, but only if the event would have caused the spouse or child to lose coverage under the Health Plan had the first qualifying event not occurred. You must notify the COBRA administrator of the second qualifying event within 60 days of the second qualifying event. If you fail to provide timely notice, the right to the extension will be lost.

COBRA continuation coverage will be terminated before the end of the maximum period if:

- any required payment is not paid by the deadline;

- after the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both);

- after the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan;

- after the date the qualified beneficiary qualifies under the disability extension, the beneficiary is no longer disabled; or

- Wendy's ceases to provide any group health plan for its employees.

The qualified beneficiary must notify the COBRA Administrator of the beneficiary's entitlement to Medicare, entitlement to coverage under another group health plan, or that the beneficiary is no longer disabled within 30 days of the event.

COBRA continuation coverage may also be terminated for any reason the health plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Notwithstanding the foregoing, COBRA continuation coverage of a health care flexible spending account arrangement will not continue past the last day of the calendar year in which the initial qualifying event occurred.

Are there other 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 COBRA continuation should be addressed to the COBRA administrator, Alight by phone at 1.855.557.9603 or online at https://my.benefits.conexis.com. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Health Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and the COBRA Administrator informed of any changes in the addresses of family members and/or any new dependents. You should also keep a copy for your records of any notices you send to the COBRA Administrator.

HEALTH INSURANCE MARKETPLACE NOTICE

This notice applies to all employees.

PART A: General Information

The Health Insurance Marketplace provides a new way to buy health insurance. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered

by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2018 to December 15, 2018 for coverage starting January 1, 2019.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Wendy’s Benefit Services Center at 1.855.557.9603.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about 2019 Medical Coverage Offered by Wendy’s

This section contains information about medical coverage offered by Wendy’s. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

This information is numbered to correspond to the Marketplace application.

3. **Employer name** Look at your paystub	4. **Employer Identification Number (EIN)** Plan Sponsor: The Wendy's Company 38-0471180	
5. **Employer address** One Dave Thomas Blvd.	6. **Employer phone number** 1.855.557.9603	
7. **City** Dublin	8. **State** Ohio	9. **ZIP code** 43017
10. **Who can we contact about employee health coverage at this job?** Wendy's Benefits Service Center		
11. **Phone number** 1.855.557.9603	12. **Email address** Associates may find more information at https://mybenefitsnow.com. Benefits information is not available via email.	

Employees eligible for Wendy's medical benefits include:

- Employees classified in the Wendy's payroll system as full-time (who are not part-time, temporary, non-resident aliens, or a member of a collective bargaining unit that did not negotiate for eligibility); and

- All other employees (including part-time and temporary) who, during measurement cycles are identified as consistently working an average of 30 or more hours per week (see plan summary information for more details).

- Medical coverage is available to the spouse and children (through the last day of the month of their 26th birthday) of an eligible employee.

Wendy's medical coverage meets the minimum value standard and the cost of the medical coverage is intended to meet the federal standard of affordability for benefits-eligible associates.

The federal government wants you to know: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly associate), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.