Wendy’s International, LLC
2023 Required Notices

Table of Contents ... Page

HIPAA and GINA Notice of Privacy Practices ... 3
Medicare Part D Notice ... 8
CHIPRA Notice ... 10
Statement of Rights under the Newborns' and Mothers' Health Protection Act ... 14
Notice of Special Enrollment Rights ... 14
Notice under Women's Health and Cancer Rights Act ... 14
Patient Protections and Affordable Care Act Notices ... 15
Notice of Wellness Program Disclosures ... 16
General COBRA Notice ... 17
Health Insurance Marketplace Notice ... 24
Coronavirus Extensions ... 26
Your Rights and Protections Against Surprise Medical Bills ... 27

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 care 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.

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/or 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 Amendment 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 health 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 accounting 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 notify you of any breach 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
Vice President 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. Any complaints to us shall be made in writing to the Health Plan's Privacy Officer at the contact information noted above. 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). We encourage you to express any concerns you may have regarding the privacy of your information. You won't be retaliated against or denied any health plan benefit or service because you file a complaint. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call toll-free (877) 696-6775, by e-mail to OCRComplaint@hhs.gov, or to Region V Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite240, Chicago, IL 60601, Voice Phone (312) 886-2359, FAX (312) 886-1807, or TDD 312-353-5693.

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

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.

11. Effective Date

This Notice is effective October 15, 2022.

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, 2022
Name of Entity/Sender: The Wendy's Company
Contact--Position/Office: Vice President – 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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	MASSACHUSETTS Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
INDIANA Medicaid	**MINNESOTA 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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA Medicaid and CHIP (Hawki)	**MISSOURI Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/m11edicaid-a- to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS Medicaid	**MONTANA Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@MT.gov
KENTUCKY Medicaid	**NEBRASKA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA Medicaid	**NEVADA Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE Medicaid	**NEW HAMPSHIRE Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA – Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

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

The Wendy's Company Group Insurance Plan (the Plan), under federal law, does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a vaginal delivery
- 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.

Sydney Preferred Rewards Program

Wendy's provides all employees and spouses/domestic partners who are enrolled in the Wendy's medical benefits with an opportunity to participate in the Sydney Preferred 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, health care flexible spending account or employee assistance program coverage under The Wendy's Company Group Insurance Plan.

Federal Continuation of Coverage (COBRA)

If you are enrolled in in medical, prescription drug, dental, vision, health care flexible spending account or employee assistance program coverage under The Wendy's Company Group Insurance Plan (the Plan), you and your family members may have the option to temporarily continue coverage in certain instances when coverage would otherwise end, COBRA does not apply to other benefits. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

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

Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because of the following qualifying events:

- 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 from your spouse.

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

- 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 Plan as a “dependent child.”

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 who 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 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), your hours are reduced, or you die while you are actively employed, your employer will notify the Health Plan and 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 divorce, a court-ordered legal separation, a child’s losing eligibility for coverage, or your death after your employment had ended, you or a family member must notify the COBRA Administrator, WageWorks, 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 written 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, 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 the 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 written 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

Once the COBRA Administrator (WageWorks) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate for your continuation coverage (see below).

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.

Paying for COBRA Continuation Coverage

- First payment for COBRA coverage: You must make your first payment for COBRA 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 each 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 that any claims you submit for benefits while your coverage is suspended may be denied and may need 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).

Cost

Each qualified beneficiary is required to pay the entire cost of COBRA 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 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.

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 Open Enrollment periods or, if a qualifying event occurs, to the same extent that active employees may do so.

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 court-ordered legal separation, or a child 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 a 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 an employee becomes entitled to Medicare 8 months before the date on which his 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 you are 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 also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the COBRA Administrator (WageWorks) in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must send written notice (including proof of the Social Security determination) to the COBRA Administrator (WageWorks) 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 first 18 months of COBRA continuation coverage. If you fail to provide timely written notice, the

right to the 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 (or at the end of the 11-month extension period, if earlier). You will be required to pay up to 150% of the group rate during the 11-month extension period.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, your spouse and dependent 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 dependent children getting COBRA continuation coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. 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 terminate 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 COBRA 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 coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible (during the Medicare initial enrollment period) because you are still employed, you will have an 8-month special enrollment period to sign up for Medicare Part A or B beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Health Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods and https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Plan Administrator
Benefits Administrative Committee The Wendy's Company
One Dave Thomas Blvd.
Dublin, OH 43017
Phone: 614-764-3100
e-mail: Benefits@wendys.com

COBRA Administrator
WageWorks
1.855.557.9306
My.Benefits.Conexis.Com

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, 2022 to December 15, 2022 for coverage starting January 1, 2023.

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 2023 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**	4. **Employer Identification Number (EIN)**	
Look at your paystub	Plan Sponsor: The Wendy's Company 38-0471180	
5. **Employer address**	6. **Employer phone number**	
One Dave Thomas Blvd.	1.855.557.9603	
7. **City**	8. **State**	9. **ZIP code**
Dublin	Ohio	43017
10. **Who can we contact about employee health coverage at this job?**		
Wendy's Benefits Service Center		
11. **Phone number**	12. **Email address**	
1.855.557.9603	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 or domestic partner and children (through the last day of the month of their 26th birthday) of an eligible employee or domestic partner.

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.

CORONAVIRUS EXTENSIONS

As part of the federal government's response to the COVID-19 pandemic, deadlines to take certain actions have been extended if those deadlines would have fallen during the "COVID-19 National Emergency Period." In general, the COVID-19 National Emergency Period began on March 1, 2020 and ends on the earlier of the date specified by the federal Department of Labor or 60 days after the end of the COVID-19 national emergency. A deadline falling during this period is extended for the lesser of 12 months or the remainder of the COVID-19 National Emergency Period. This extension affects:

- Deadline to request special enrollment changes to your ERISA plan elections in connection with your marriage, birth, adoption, placement for adoption, divorce, loss of other group health insurance and loss of Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Filing claims for benefits or appeals of adverse benefit determinations for ERISA plan benefits.
- Requesting an external review for medical, dental and vision benefits.
- Providing notice of a COBRA qualifying event due to divorce, loss of dependent status, or determination of disability by Social Security.
- Electing COBRA continuation coverage.
- Paying COBRA premiums (note, claims incurred after the paid-to-date-of-coverage will be denied unless and until the applicable COBRA premiums have been paid).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service you receive from an out-of-network provider or facility.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or the out-of-network services described in this notice toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Service (HHS) at 1-800-985-3059 beginning January 1, 2022.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

This notice is effective on December 31, 2022.