The Wendy's Company

A Summary Plan Description for the

Group Insurance Plan for Wendy's Employees

Effective January 1, 2027

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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 (includes wellness and telehealth benefits)
- Dental
- Vision
- Expat Medical, Dental and Vision benefits
- 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

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

So long as you are employed by Wendy's, you are eligible for commuter and employee assistance program benefits under the Plan.

You are not eligible to participate in any other benefits under the Plan if you are a leased or temporary employee, a non-resident alien, a member of a collective bargaining unit (unless the collective bargaining agreement provides for your eligibility) or a part-time employee who has not satisfied the average hours eligibility requirements described below.

You are eligible to participant an all of the benefits under the Plan if you are a "regular full-time employee" working 30 hours or more per week after completing 30 days of employment, so long as you timely enroll as described below. Coverage for someone who enrolls when first eligible would be effective on the 31st day of employment.

You are eligible to participate in medical, dental, vision, HSA/HRA (as applicable) and a small life insurance benefit if you are a part-time employee who has satisfied the average hours eligibility requirement described below for the related measurement period for the related stability period, so long as you timely enroll as described below. Part-time employees are not eligible for business travel accident insurance, AD&D, FSAs, supplemental life and disability benefits under the Plan.

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 or if you transfer directly from Quality Supply Chain Co-op, Inc., 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 QSCC or the franchisee prior to the date of transfer or the acquisition. Benefits become effective on your date of transfer, the date of acquisition or as soon as administratively possible after that date.

YOUR DEPENDENTS

Your eligible dependents include:

- Your legal spouse and domestic partner. Common- law spouses, fiancées and other life partners who do not qualify as a domestic partner are not defined as eligible dependents under the plan.
- Your child, legal stepchild, adopted child, a child placed with you for adoption, foster child, a child for whom legal guardianship has been awarded to you, or a child of your domestic partner 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
- Domestic Partner
  - Affidavit of Domestic Partnership
- 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

TAXATION OF DOMESTIC PARTNER BENEFITS

Benefits provided for domestic partners and their children are not eligible for favorable tax treatment unless the applicable domestic partner or child qualifies as your tax dependent. You will be taxed on any benefits provided for your domestic partners and children unless you submit a tax certification form.

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 and vision 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 and vision 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 and vision 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 and vision 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.

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 or the $5,000 life insurance, as applicable
- Accidental death & dismemberment (AD&D) insurance
- Short-term disability coverage
- Long-term disability coverage
- Business travel accident insurance
- Employee assistance program
- Expat medical, dental and vision insurance as set forth in the applicable insurance policy

Benefit Options that require enrollment elections include:

- Medical (including prescription drug), dental or vision coverage for yourself, spouse, domestic partner 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, domestic partner 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 and your commuter benefit 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 and your commuter benefits at any time during the year. This means you have the flexibility to start, stop or change your employee Health Savings Account contribution and commuter benefits at any time during the plan year. Any changes you make to your employee Health Savings Account contributions and commuter benefits 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
- Creation or termination of a qualifying domestic partnership
- 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, adoption or creation of a domestic partnership, 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 (or the end of your severance period if you are terminated and receive severance benefits from Wendy's)
- Your termination date for all other benefits (or, for benefits other than flexible spending accounts, the end of your severance period if you are terminated and receive severance benefits from Wendy's)
- 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

Note: employees who are receiving severance benefits may remain eligible to receive the benefits in effect on the date of severance, for the period that severance benefits are payable by Wendy's.

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.

If you die while employed and covered under the medical, dental or vision benefits, Wendy's will pay the premium for COBRA continuation coverage for up to six months for your enrolled dependents who timely elect to continue coverage.

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	Notice under Women's Health and Cancer Rights Act
Notice of Special Enrollment Rights	Notice of Wellness Program Disclosures
Patient Protections and Affordable Care Act Notices	Health Insurance Marketplace
Statement of Rights under the Newborns' and Mothers' Health Protection Act	Statement of Rights and Protections Against Surprise Medical Bills.
General COBRA Notice	

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 Smart-Choice, 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 can also 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.

Note: There are adverse tax consequences if you use your HSA to pay for expenses of a domestic partner or a child of your domestic partner who does not qualify as your tax dependent.

USING YOUR HSA

Once you have completed your enrollment, you will receive an HSA debit card from Smart-Choice at your home address.

When activating the Smart-Choice 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 Smart-Choice card.
2. You will be required to provide your card number, ZIP code, and three-digit security code located on the back of the Smart-Choice 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 Smart-Choice 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 Smart-Choice, download the beneficiary form and mail or fax the complete form to UMB Bank.

CUSTOMER IDENTIFICATION PROGRAM

Before your HSA can be opened, Smart-Choice 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 Smart-Choice. 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, Smart-Choice 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 Smart-Choice 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 Smart-Choice 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.

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

Wendy's offers two dental plan options through Delta Dental. With the 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, Delta Dental 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 Delta Dental. Speak to your out-of-network dentist regarding that dentist's procedure to make the assignment.

YOUR BENEFITS

BENEFIT*	DENTAL 1	DENTAL 2
Deductible ▪ Individual ▪ Family	 $25 $75	 $50 $150
Calendar Year Maximum	$3,000	$1,000
Preventive Services (Deductible does not apply) ▪ Includes cleaning and X-rays	100%	100%
Basic Services (Deductible applies) ▪ Includes fillings and extractions	90%	80%
Major Services (Deductible applies) ▪ Includes crowns, bridges and dentures ▪ Includes oral surgery**	60%	50%
Orthodontic Services ▪ Lifetime maximum	60% $3,000 for children and adults	50% $1,000 for children only

*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 Delta Dental's website at https://www.deltadentaloh.com/ or call Delta Dental at 800.524.0149.

To request a copy of Delta Dental'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 $175 after $10 copay or Featured frames are covered up to $225 after a $10 copay 20% off any amount above the allowance	Frames are covered up to $150 after $15 copay or Featured frames are covered up to $200 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 $175 after $10 copay for any type of prescription contact lenses	Instead of eyeglasses, elective contact lens services and materials are covered up to $150, 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
Lightcare (Instead of Frames & Lenses)	$175 allowance for ready-made non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts	$150 allowance for ready-made non-prescription sunglasses or non-prescription blue light filtering glasses instead of prescription glasses or contacts
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 $50 every 12 months
Bifocal Lenses $75 every 12 months
Trifocal Lenses $100 every 12 months
Progressive Lenses $75 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 Smart-Choice. 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 a limited amount in your Limited Purpose Healthcare Spending account to be rolled over into the next plan year and any funds that rollover limit must 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 Smart-Choice 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 Smart-Choice 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. Note, you cannot use your FSA to pay for expenses of a domestic partner or the child of a domestic partner who does not qualify as your tax dependent.

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
▪ Over-the-counter medicines and drugs, whether or not you have a prescription
▪ Menstrual supplies

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

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 a limited amount 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 Smart-Choice to open up your Limited Purpose Healthcare FSA and allow you to pay for qualified medical expenses from your FSA. Smart-Choice 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 but not to exceed the IRS limit that applied based on your tax return filing status.

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 childcare 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.

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 vanpool. 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, up to the annual maximum determined by the IRS, can be paid for on a pre-tax basis.

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.

$5000 LIFE INSURANCE

For employees who do not otherwise qualify for the Basic Life Insurance benefit, Wendy's provides a Company-paid life insurance benefit of $5,000.

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

Employees who are eligible for the basic life insurance benefit provided by Wendy's 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

For employees who are eligible for the basic life insurance benefit, 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

FOR LOSS OF:	THE BENEFIT WILL BE:
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 regular full-time 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 $4,000,000 maximum benefit. The maximum combined coverage for all employees injured in a single incident is $20,000,000. The policy will pay out for Accidental Death/Dismemberment, not all injuries, unless the injury is included in the dismemberment chart located in the policy.

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 regular 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 six 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: ▪ Expat Medical, Dental and Vision insurance ▪ 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 and health reimbursement account: Self-insured with claims administration by Anthem ▪ Dental : Self-insured with claims administration by Delta Dental ▪ 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 Smart-Choice ▪ Dependent care flexible spending accounts: Self-insured with claims administration by Smart-Choice (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 AIG ▪ Employee assistance program: Insurer administration by Anthem Blue Cross Blue Shield ▪ Commuter benefits: Self-insured with claims administration by Smart-Choice (outside of the Plan) ▪ Health Savings Accounts: Individual Accounts administered by Smart-Choice (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 Delta Dental	1.800.524.0149 https://www.deltadentaloh.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 Smart-Choice	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
Short-Term and Long-Term Disability Unum	1.888.246.7060 http://unum.com
Business Travel Accident AIG	1.877.244.6871 aig.com/us/travelguardassistance

This is the Summary Plan Description (SPD) for The Wendy's Company Group Insurance Plan (the Plan) for eligible Wendy's employees in the United States. For a complete SPD, this handbook must be read together with the annual open enrollment materials 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

A copy of the annual required notice package can be found at:

https://wendysbenefits.com/legal-notices-shift/