
# Your 2010 Denny's Benefit Plan Options

This overview highlights the benefit options available to you for 2010. It provides help on choosing the right benefits option for you and your family.You'll also find tips to help you choose the coverage best for you.
If you have any questions, call the Benefits Department at 1-800-859-2244, Monday-Friday, 8:00 AM - 5:00 PM EST.

November 2009

# Medical and Prescription Drug Plan

# At-A-Glance

The Denny's Medical Plan is designed to ease the financial burden of major illness and provide financial protection for routine medical issues. The plan provides three Preferred Provider Organization (PPO) medical options. Each of the PPO plans covers the same services, but differ in the amount of the deductible, copayments and other out-of-pocket expenses.

Also, depending on your location, you also have Health Maintenance Organization (HMO) options available to you. For more information on HMOs and what they cover, contact the HMO directly, or call the Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST).

## Understanding Your PPO Plan Options

You have three Preferred Provider Organization (PPO) medical options through Aetna.

- **Option 1: $500 Deductible Plan** — Consider this option if you use a significant amount of healthcare services or have a chronic condition. With this option, you will pay fewer out-of-pocket costs, but your deductions for coverage will be more per paycheck.
- **Option 2: $1,500 Deductible Plan** — Consider this option if you don't use healthcare services regularly or don't have a chronic condition. With this option, you will have higher out-of-pocket costs when you receive care, but your deductions for coverage will be lower per paycheck.
- **Option 3: $150 Deductible Plan** (limited to $25,000 in covered benefits per individual each plan year) — Consider this option if you rarely use healthcare services. It provides limited benefits, but will cost you the least in deductions for coverage per paycheck. This option pays up to $25,000 per person in benefits for covered services each year — and doctor office visits and other non-surgical or non-hospital costs have a $1,000 per person annual limit. (The $1,000 limit is included in the $25,000 covered services limit.) Also, for doctor office visits and preventive care services, you don't have copayments. Instead, you'll pay a flat percentage of the cost of care after you meet the annual deductible. Prescription drug benefits are limited to $250 per calendar year.

## How the Plans Work

### PPO Options

A PPO is a network of doctors, hospitals and other healthcare providers who agree to offer care at lower, negotiated rates. Aetna's Choice POS II network offers a large choice of providers and rich discounts on health services, which will lower your out-of-pocket costs. When you use network providers, the plan pays a higher level of benefits for most covered services after you meet an annual deductible.

Coverage for care you receive when you use network providers is 80% of negotiated charges after the deductible. You also have the flexibility to receive care outside the network and receive a lower level of benefits after you meet an annual deductible. Coverage for care you receive outside the network is generally 60% of the reasonable and customary (R&C) charge after you meet the annual out-of-network deductible. R&C is the usual charge for specific services in the geographic region where you are treated.

If you use both network and out-of-network providers:

- Network care will count toward the network deductible and out-of-pocket limit
- Out-of-network care will count toward the out-of-network deductible and out-of-pocket limit.

For example, if you use both network and out-of-network providers, you will have to meet a separate deductible for each.

To locate a provider near you, check DocFind at www.aetna.com. When asked to select your plan, choose Aetna Open Access Plan, then choose Aetna Choice POS II (Open Access).You also may call Aetna at 1-800-972-7894 for additional assistance in locating a network provider or facility.

## Medical Options Comparison Chart

This chart shows how the PPO options' financial features compare — and how they pay for key covered services.

| | OPTION 1 $500 Deductible Plan | | OPTION 2 $1,500 Deductible Plan | | OPTION 3 $150 Deductible Plan | |
|---|---|---|---|---|---|---|
| | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** |
| **Annual deductible** | | | | | | |
| - Individual<br>- Family | $ 500<br>$ 1,000 | $ 1,000<br>$ 2,000 | $ 1,500<br>$ 3,000 | $ 3,000<br>$ 6,000 | $ 150<br>$ 300 | $ 300<br>$ 600 |
| **Annual out-of-pocket limit** | | | | | | |
| - Individual<br>- Family | $ 2,500<br>$ 5,000 | $ 5,000<br>$ 10,000 | $ 7,500<br>$ 15,000 | $ 15,000<br>$ 30,000 | None<br>None | |
| **Lifetime maximum benefit*** | $2,000,000/person | | $2,000,000/person | | None<br>($25,000 annual benefit maximum/person; if not surgery or hospitalization up to $1,000 annual maximum/person) | |
| **Routine office visit/exam** | 100% after $25 copay (primary care physician)<br><br>$40 copay (specialist) | 60% of R&C** after deductible | 100% after $25 copay (primary care physician)<br><br>$40 copay (specialist) | 60% of R&C** after deductible | 80% after deductible | 60% of R&C**after deductible |

| | OPTION 1 $500 Deductible Plan | | OPTION 2 $1,500 Deductible Plan | | OPTION 3 $150 Deductible Plan | |
|---|---|---|---|---|---|---|
| | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** | **Network** | **Out-of-Network** |
| **Emergency room care** | 80% after deductible and $100 copay; N/A if admitted | 80% of R&C** after deductible and $100 copay; N/A if admitted.<br><br>Non-emergency Use: 60% of R&C** after deductible and $100 copay | 80% after deductible and $100 copay; N/A if admitted | 80% of R&C** after deductible and $100 copay; N/A if admitted<br><br>Non-emergency Use: 60% of R&C** after deductible and $100 copay | 80% after deductible and $100 copay; N/A if admitted | 80% of R&C** after deductible and $100 copay; N/A if admitted<br><br>Non-emergency Use: 60% of R&C** after deductible and $100 copay |
| **Urgent care*** ** | 80% after deductible and $50 copay | 60% of R&C** after deductible and $50 copay; 80% of R&C* | 80% after deductible and $50 copay | 60% of R&C** after deductible and $50 copay; 80% of R&C | 80% after deductible and $50 copay | 60% of R&C** after deductible and $50 copay |
| **Most other covered care** | 80% after deductible | 60% of R&C** after deductible | 80% after deductible | 60% of R&C** after deductible | 80% after deductible | 60% of R&C** after deductible |

** Your lifetime maximum benefit is the combined total amount of benefit payments you may receive from the Denny's Medical Plan. This means that if you change your medical plan option from one PPO plan to another (does not include HMO plans), the benefits you received when covered under both the first and second plan options (and any successive options) would be used to determine whether you have reached the lifetime maximum benefit.*

*** R&C is the reasonable and customary charge — the usual charge for specific services in the geographic region where you are treated.*

**** No coverage for non-urgent procedures.*

## HMO Options

HMOs provide care through a network of doctors, hospitals and other healthcare providers who have agreed to offer services at discounted rates. You *must* use network providers to receive benefits. When you enroll in an HMO, you may have to choose a primary care physician to coordinate all your care and provide referrals to specialists. For more information about your HMO options, refer to your annual enrollment form.

## Earn $300 in 20 Minutes with the Health Assessment

As a Denny's Medical Plan participant, you have the opportunity to complete a confidential **online Health Assessment (HA)** through the Simple Steps To A Healthier Life® program. When you participate, you get instant feedback about how healthy you are. Your health risks are determined by the answers you provide. Simply go to www.aetnanavigator.com, register and answer a series of questions about your health, medical conditions and certain lifestyle behaviors.

The Simple Steps To A Healthier Life® program is provided by Denny's as part of our commitment to your health. There is no cost to you for participating.

After completing the HA, you will receive an online wellness report with your results and a personalized action plan. This report can be used to learn where you might be at risk for certain health issues, so you can take steps to improve your health with the help of your doctor. The health information provided by you and your results are confidential and will not be shared with Denny's in any way.

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Your personalized action plan may include recommended participation in one or more of these online Healthy Living Programs:

- **The Relax™ Program** helps you manage your everyday stress. You'll target the sources of stress, identify the signs of stress and find ways to cope and feel better.
- **The Balance™ Program** provides support to help you lose weight. You'll have access to tools to track your weight online, plus get healthy recipes and fitness videos.
- **The Nourish™ Program** shows you how to eat healthier — giving you ways to change unhealthy eating habits.
- **The Overcoming™ Program** suggests ways you can get control over depression by setting goals and changing your thought patterns and habits. This program also provides tips on getting a good night's sleep without medication.
- **The Breathe™ Program** gives you the support you need to quit smoking like how to reduce cravings and resist a relapse.

**Each time you complete an online wellness program in 2010, Simple Steps To A Healthier Life® will enter your name into a quarterly drawing for a $50 gift card. Drawings will begin in late March 2010**.

## Wellness Credit

To reward your progress and success on the path to better health, Denny's provides a special rewards program for Simple Steps To A Healthier Life participants. Program participants who meet certain eligibility criteria will qualify for a $25 monthly wellness credit toward medical premiums — that's a savings of $300 a year. *The wellness credit will appear in your bi-weekly paychecks.*

## Wellness Credit Criteria

- To be eligible for the wellness credit, you must be an active, full-time salaried employee enrolled in a medical plan offered by Denny's as part of the employee benefits program at the time you complete the Health Assessment.
- The credit only applies when you complete the Simple Steps To A Healthier Life® Health Assessment — a credit is not available for spouses who complete the HA. Dependent children are not eligible to complete the HA.
- If at any point during the 2010 plan year your coverage terminates, the $25 monthly wellness credit will cease at the point of coverage termination.

## Disease Management Program

When you enroll in an Aetna PPO or HMO plan and have certain chronic conditions, such as heart disease, diabetes or asthma, you can receive additional medical support through the Disease Management Program. Services include:

- A personal assessment of your condition
- A nurse consultant assigned to you, if necessary
- Educational materials about your condition

## Precertification

The precertification program is designed to improve delivery of care and help ensure that you and your dependents receive the most appropriate care while avoiding unnecessary costs.

You, your dependents or a doctor **must** precertify by notifying Aetna not fewer than 48 hours before:

- An organ and tissue transplant
- Home health services
- Receiving durable medical equipment over $1,000
- Reconstructive surgery

In addition, for a stay in the hospital, skilled nursing facility or rehabilitation facility, you **must** precertify five business days before admission.

If you do not precertify, your benefits will be reduced by 50%.

To precertify, contact Aetna at 1-800-972-7894.

## Prescription Drugs

When you enroll in any Denny's PPO medical plan option, your prescription drug program is administered by Medco Health Solutions, Inc. (Medco). You can fill your prescriptions in several ways:

- At any Medco network pharmacy (you will need to provide your Medco prescription drug card, which you will receive in the mail). Visit www.medco.com for a list of participating pharmacies.
- Through Medco's mail-order program by:
  - Mailing your completed form and prescription to the address on the order form. Order forms are available at www.medco.com.
  - Having your physician fax your prescription to Medco.
  - Visiting www.medco.com to order refill prescriptions.

**Please Note:** The Denny's HMSA and Kaiser HMOs include prescription drug coverage as part of their benefits. For more information on your HMO prescription drug coverage, contact your HMO directly or call the Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST).

## Determining the Cost of Your Prescriptions

The cost of your prescription will vary depending on:

- Whether it is in Medco's formulary, and
- If you fill it at a retail pharmacy or through the mail-order program.

### What is a Formulary?

A formulary is a list of preferred prescription medications that cost less. Many factors play a role in the decision to classify a drug as formulary or non-formulary, including cost and drug effectiveness. For example, if three different drugs are available to treat the same medical condition and have the same effectiveness and safety — but one of these drugs is significantly lower in price than the other two — the least expensive drug will be listed as preferred.

There are three different classes of prescription drugs:

- **Generic** — These prescription medications are the least expensive and have the same active ingredients as their brand-name counterparts.
- **Formulary** — These brand-name prescription medications are favored by the pharmacy provider and are listed on the formulary. Preferred drugs are more expensive than generic drugs, but cheaper than non-preferred drugs.
- **Non-Formulary** — These brand-name prescription medications are not on the formulary, and are typically the most expensive drug option.

### Summary of Prescription Drug Costs

| Prescription Drugs | *Retail (at pharmacy) up to 30-day supply …* | *Mail order** up to 90-day supply …* |
|---|---|---|
| **Generic** | 100% after $10 copay | 100% after $25 copay |
| **Formulary** | 100% after $30 copay | 100% after $75 copay |
| **Non-Formulary** | 100% after $50 copay | 100% after $125 copay |

** Prescription drug benefits are limited to $250 a year in the $150 Deductible Plan.*
*** Mail order is mandatory for all ongoing maintenance medications.*

## Where to Go For More Information

The Medco web site (www.medco.com) offers a wealth of information on your prescription drug plan including:

- Ordering a prescription
- Drug costs and facts, including side effects
- Prescription refill status
- Status of claims and claims history
- Plan features and benefits
- Location of pharmacies

Also, www.medco.com allows you to sign up for reminders so you can remember when to order refills, order additional ID cards and download claim forms.

This At-A-Glance gives an overview of some of the benefit plans you are eligible for as an employee of Denny's. If there is any discrepancy between this document and the official plan documents, the plan documents will govern. Denny's reserves the right to amend, modify or terminate these plans at any time. This document in no way is intended to constitute a contract of employment.

# Dental Plan
# At-A-Glance

Denny's offers two dental care plan options:

- Option 1 — The $25 Deductible Plan
- Option 2 — The $50 Deductible Plan

Both provide coverage for most dental care, including preventive check-ups and cleanings, X-rays, fillings and root canals. Option 1 also covers major restorative and orthodontia services.

## How the Plans Work

With both plans, you can see the dental provider of your choice. However, Aetna offers a network of dentists who have agreed to charge lower, fixed fees for services — so you save money by staying in the network.

To find an Aetna network dental provider, visit www.aetna.com or call 1-877-238-6200.

You must meet a calendar-year deductible before the plan pays for most services. The chart shows the major provisions of each dental option.

| Type of Coverage/ Treatment | Option 1 $25 Deductible Plan | Option 2 $50 Deductible Plan |
|---|---|---|
| **Preventive treatment includes:**<br>• **Two exams and teeth cleanings per year**<br>• **Annual fluoride treatments for children under age 16**<br>• **One bitewing X-rays per calendar year** | 100% of reasonable and customary charges with no deductible | 100% of reasonable and customary charges with no deductible |
| **Basic restorative treatment includes*:**<br>• **Fillings**<br>• **Root canal treatment**<br>• **Tooth extractions** | 80% of reasonable and customary charges after $25 deductible | 80% of reasonable and customary charges after $50 deductible |
| **Major restorative treatment includes:**<br>• **Crowns**<br>• **Inlays**<br>• **Onlays** | 50% of reasonable and customary charges after $25 deductible | Not Covered |

| Type of Coverage/ Treatment | Option 1 $25 Deductible Plan | Option 2 $50 Deductible Plan |
|---|---|---|
| • **Some prosthodontic services**<br>• **Bridges**<br>• **Partial and full dentures** | | |
| **Orthodontia treatment covers braces and their related treatment** | 50% of reasonable and customary charges with no deductible, up to a maximum lifetime benefit of $2,000 per covered participant | Not Covered |
| **Calendar-year maximum benefit per person** | $1,000 for preventive, basic and major services combined | $750 for preventive, basic and major services combined |

*Your dentist should call Aetna at 1-877-238-6200 to verify eligibility and coverage.

For a complete listing of what is (and isn't) covered under the dental plans, call Aetna Member Services at 1-877-238-6200.

## Predetermination of Dental Benefits

If you expect charges for planned dental work, including orthodontia, to cost $350 or more, you should find out in advance how much the plan will pay by requesting a pre-treatment estimate.

To do this, your dentist completes a form describing the proposed treatment and related charges and sends it to Aetna. Aetna will determine how much it will pay for the service requested and, if appropriate, recommend alternative treatment that is less costly. If Aetna recommends a less costly alternative and you still choose the more expensive option, you pay the amount over what Aetna would have paid for its recommended treatment.

# Vision Plan

# At-A-Glance

Denny's provides vision coverage through Vision Service Plan (VSP) for eye exams, lenses and frames, or contacts. You can see the vision provider of your choice, but you will get the highest benefit when you see a VSP network doctor.

## How the Plan Works

You are eligible for the vision plan immediately on your date of hire. Your spouse or domestic partner and dependent children up to age 19 — or age 23, if full-time students — are also eligible for coverage.

### Using VSP Network Doctors

Each time you receive care from a VSP network doctor, the plan typically pays the full cost after you pay a copayment — or flat, predictable dollar amount. Claim filing is not required.

When you see a VSP network doctor, the plan covers:

- One eye exam each calendar year after you pay a $10 copayment.
- One pair of glasses *or* contact lenses each calendar year. $10 copayment applies to glasses only.
- One pair of frames every 24 months, after you pay a $10 copayment.

Call VSP at 1-800-877-7195 or go to www.vsp.com to locate VSP network doctors in your area.

### Using Non-VSP Providers

The plan provides benefits when you receive care from non-VSP providers, but you will receive a lower level of benefit and generally pay more out of pocket. Also, you are required to pay the cost at the time of service and submit a claim to VSP for reimbursement.

The plan pays for covered services you receive from a non-VSP provider, up to the reimbursable amount shown in the chart on the next page. When you have a non-VSP provider claim, send your itemized bill, along with the patient's name and covered member's name and ID number to VSP, within six months of care to:

VSP
P.O. Box 997105
Sacramento, CA  95871-7105

To receive a claim form, go to vsp.com and select "Out-of-Network Reimbursement Form" and follow the instructions or call VSP member services at 1-800-877-7195. Keep a copy of the claim for your records.

Here's how benefits are paid for covered vision care and eyewear:

| Vision Care Expenses | VSP Network Doctor | Non-VSP Provider |
|---|---|---|
| | After your $10 copayment, the plan pays*: | |
| Exams – once per calendar year | Covered in full after $10 copay | Up to $35 |
| Lenses – once per calendar year | | |
| • single vision<br>• lined bifocal<br>• lined trifocal | Covered in full after $10 copay | Up to $25<br>Up to $40<br>Up to $55 |
| Frames – once every two calendar years | Covered up to $120, plus 20% off any out-of-pocket costs | Up to $45 |
| Contacts – once per calendar year | Up to $120; no copay applies** | Up to $105** |

** A separate copayment of $10 each applies to the exam at the time of service and either lenses or frames at the time eyewear is ordered.*
***When you choose contacts instead of glasses, the allowance applies to the cost of your contacts and contact lens exam, including fitting and evaluation. The exam is in addition to your vision exam to ensure proper fit of contacts.*

## What's Not Covered

The vision plan does not cover:

- More than one vision exam in a calendar year
- Lenses, if more than one in a calendar year, unless replacement is prescribed by your doctor
- Frames, if more than one in a calendar year, unless you have prior approval from VSP
- Replacement of contacts, if more than once in a calendar year, unless you have prior approval from VSP
- Expenses above the contacts' reimbursement limit
- Plano lenses
- Two pairs of glasses in place of lined bifocals
- Lost or broken lenses and frames, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Eye exams or any corrective eyewear required by an employer as a condition of employment
- Services for which a claim is filed more than 180 days after completion of the service

- The following cosmetic eyewear, over and above the covered expense for the basic lenses:
  - Blended lenses
  - Oversized lenses
  - Progressive multi-focal lenses
- Coating of the lens or lenses
- Laminating of the lens or lenses
- Frames exceeding the cost agreed to by the VSP network doctor and VSP
- Certain limitations on low vision care
- Cosmetic lenses
- Optional cosmetic processes
- UV (ultraviolet) protected lenses
- Non-VSP provider services that are not listed in the non-VSP provider reimbursement schedule.

For a complete listing of what is and isn't covered under the plan, call VSP at 1-800-877-7195.

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# Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage

# At-A-Glance

Life insurance provides financial protection for your family or beneficiary when you die.

If you are an eligible salaried employee, Denny's provides Basic Life Insurance and Accidental Death and Dismemberment (AD&D) at no cost to you. We also offer optional employee-paid Supplemental Life Insurance coverage for you, your spouse or domestic partner and your children. A Personal Accident Insurance Plan is also available for AD&D coverage for you and your family. Please see the PAI At-A-Glance for more information.

You can take your Supplemental Life Insurance coverage (up to a maximum of $750,000) with you if your Denny's employment ends for any reason — other than illness or injury — if you have not reached age 70. In some cases, you may convert your Group Life Insurance to an individual policy.

## Basic Life Insurance

Denny's provides Basic Life Insurance coverage equal to one times your annual base pay, rounded up to the nearest $1,000 — up to a maximum of $1,500,000 (combined with supplemental life amounts).

Your annual base pay is your base pay:

- If you are an existing employee, as of the first of October before the calendar year your coverage is effective (i.e., the amount of coverage you have in 2010 is based on your base pay as of October 1, 2009), or
- If you are newly hired, at your hire date.

Annual base pay does not include other forms of pay such as bonuses, commissions, incentive pay and overtime pay.

If you are promoted to a salaried position from an hourly position, your life insurance coverage amount is based on your annual base pay as of the day you became a salaried employee.

## Basic Accidental Death & Dismemberment (AD&D) Benefits

Basic AD&D Insurance coverage provides financial protection, if you die or suffer dismemberment or loss of sight or hearing as the result of an accident.

Eligible salaried employees have Basic AD&D Insurance coverage equal to one times your annual base pay, rounded up to the nearest $1,000 — up to a maximum of $1,500,000.

Below is a schedule of benefits outlining your AD&D benefits. Death benefits from this Plan are paid in addition to your benefits from the Life Insurance Plan.

| **Schedule of Benefits** | **Dismemberment Schedule** | |
|---|---|---|
| | **Loss** | **Benefit Amount** |
| | Life | Full Benefit Amount |
| | Two or more members* | Full Benefit Amount |
| | Quadriplegia | Full Benefit Amount |
| | Speech & hearing | Full Benefit Amount |
| | Paraplegia | 75% of Benefit Amount |
| | One member* | 50% of Benefit Amount |
| | Speech | 50% of Benefit Amount |
| | Hearing | 50% of Benefit Amount |
| | Hemiplegia | 50% of Benefit Amount |
| | Uniplegia | 25% of Benefit Amount |
| | Thumb and index finger of same hand | 25% of Benefit Amount |
| **Additional Benefits** | ▪ Air Bag – Lesser of $10,000 or 10%<br>▪ Child Education – Lesser of 2% or $2,000 each year for four years (per child)<br>▪ Coma Benefit – 1% of benefit amount up to 100 months<br>▪ Child Care – Up to the lesser of 3% or $3,000 (per child)<br>▪ Exposure and Disappearance – Benefit paid<br>▪ Paralysis – Benefits paid according to set schedule<br>▪ Repatriation – Lesser of actual cost or $5,000<br>▪ Seatbelt – Lesser of $25,000 or 10%<br>▪ Spouse Education – Up to $3,000 | |

** Member is defined as hand, foot or sight of one eye.*

## Supplemental Life Insurance

You can increase the amount of your life insurance coverage by purchasing Supplemental Life Insurance. Your available coverage is to a maximum of $1,500,000 for basic and supplemental combined.

### For You

You can purchase Supplemental Life coverage for yourself in the amount of:

- One times your annual base pay, rounded up to the nearest $1,000
- Two times your annual base pay, rounded up to the nearest $1,000
- Three times your annual base pay, rounded up to the nearest $1,000
- Four times your annual base pay, rounded up to the nearest $1,000

Here's an example of how basic and supplemental coverage combine to provide you comprehensive coverage.

**Example**

If your annual base pay is $20,000 and you choose supplemental coverage of two times pay, you will have $60,000 in coverage — $20,000 (one times pay) of Company-paid Basic Life Insurance plus $40,000 of Supplemental Life Insurance coverage (an additional two times pay).

### For Your Spouse/Domestic Partner

You can purchase supplemental life coverage for your spouse or domestic partner in the amount of:

- $20,000
- $40,000
- $60,000
- $80,000
- $100,000

*Important*

If you and your spouse/domestic partner both work for the Company, your spouse/domestic partner will not be eligible to be covered for dependent supplemental coverage under you.

### For Your Children

You can purchase supplemental life coverage for your children in the amount of:

- $5,000 or $10,000 for each eligible child age six months or older
- $2,500 for children under age six months

Children are eligible for coverage up to age 19 — or up to age 23 if they are full-time students who are financially dependent on you for support.

## Evidence of Insurability (EOI)

Evidence of insurability (EOI) — or proof of good health — is required for some supplemental coverage amounts. In addition, you will be required to provide evidence of insurability if:

- You enroll in any of the supplemental coverage options after your initial enrollment period — or 30 days after your date of hire
- You move from “hourly” to “salaried” status and you do not enroll within 30 days of the date your employment status changes
- You increase coverage to an amount over $500,000 for yourself (Basic Life Insurance and Supplemental Life Insurance amounts combined)
- You increase coverage by more than one times your pay during annual enrollment
- You increase coverage for your spouse or domestic partner to an amount over $40,000

If EOI/proof of good health is required, your additional supplemental coverage will not become effective until Minnesota Life, our plan administrator, approves your insurance application. As part of the application process, you may be contacted for additional information. Once all of the required information has been received, you will be notified as to whether you have been approved for coverage.

## Effect of Life Insurance on Income Taxes

Since your Basic Life Insurance is paid by the Company, you will be taxed annually on amounts of coverage over $50,000. This tax, called imputed income, is required by the IRS and will be added to your regular earnings on your W-2 form. If your Basic Life Insurance coverage amount is less than $50,000, you will not be taxed on that coverage.

# Naming a Beneficiary

## For Your Coverage

It is important to name a beneficiary who will receive benefits from the Life and Basic AD&D plans if you die. Your beneficiary for basic life can be different from your beneficiary for supplemental life. To change a beneficiary, you must complete a Salaried Benefits Change Form if outside of the enrollment period. You may change your beneficiary designation at any time.

To request a form, call the Denny's Total Rewards Department at 1-800-859-2244 or go to www.mydennys.com, click on employee benefits and print a copy of the Salaried Benefits Change Form.

Because family situations change, you should periodically review your beneficiary designation.

If there is no valid beneficiary named at the time of your death, benefits will be paid in this order:

1. Your lawful spouse, if living, otherwise;
2. Your natural or legally adopted child (children) in equal shares, if living, otherwise;
3. Your parents in equal shares, if living, otherwise;
4. The personal representative of your estate.

## For Your Dependent's Coverage

You are automatically the beneficiary for your spouse/domestic partner or dependent child's life insurance. If you are deceased at the time of payment, the benefits for your dependent's death will be paid to the executor or administrator of your estate.

## Travel Assistance Program

In addition to Basic Life, Basic AD&D and Supplemental Life Insurance coverage, you have benefits and services to protect you while traveling on Denny's corporate business or for your personal travel.

The Travel Assistance Program is administered by Europ Assistance USA (EA-USA) and covers all U.S.-based Denny's employees, spouses and dependents while traveling 100 miles or more from home (including in the United States). The dependents' coverage does not require travel with the employee.

Through the Travel Assistance Program, Denny's employees and their dependents have access to Medical Assistance as well as other convenient services. For more information, contact the Total Rewards Department at 1-800-859-2244.

This At-A-Glance gives an overview of some of the benefit plans you are eligible for as an employee of Denny's. If there is any discrepancy between this document and the official plan documents, the plan documents will govern. Denny's reserves the right to amend, modify or terminate these plans at any time. This document in no way is intended to constitute a contract of employment.

# Disability Coverage

# At-A-Glance

Short- and Long-Term Disability coverage provides income in the event you are unable to work due to illness or injury.

Denny's provides Short- and Long-Term Disability income benefits at no cost to you. You can also purchase additional Long-Term Disability coverage if you want a higher percentage of your income replaced during your disability.

## Short-Term Disability (STD) Insurance

### How the Short-Term Disability Plan Works

Short-Term Disability provides a steady income if you are unable to work because of a disability resulting from an injury or illness. To be eligible for benefits:

- You must be unable to perform all material duties of your regular occupation because of sickness or injury for more than three consecutive work days.
- Your disability must begin while you are covered under this plan.
- Your disability must be approved by The Hartford (the independent disability review agency) by calling 1-800-741-4306.

You are eligible for STD coverage after you complete six months of service.

STD benefits are payable for up to:

- 13 weeks if you have six months to one year of Company service.
- 26 weeks if you have one or more years of Company service.

## Benefit Amounts

The benefit you receive under the STD plan depends on your base salary and length of service. You receive 50% or 100% of your weekly pay as of the date you became disabled. Your weekly pay does not include commissions, overtime earnings, incentive pay, bonuses or other compensation. Ordinary income taxes apply to the benefit you receive.

| If your length of service is …* | 100% of your base weekly pay will be paid for …** | 50% of your base weekly pay will be paid for …** | Payment begins … |
|---|---|---|---|
| 6 months – 1 year | 1 week | 12 weeks | Day one of your disability |
| At least 1 year, but fewer than 3 years | 4 weeks | 22 weeks | |
| At least 3 years, but fewer than 5 years | 8 weeks | 18 weeks | |
| 5 years or more | 20 weeks | 6 weeks | |

*You are not eligible for STD coverage if you have fewer than six months of service with the Company.

** Length of disability must be approved by Denny's independent disability review agency. You cannot receive more than 26 weeks of STD benefits per disability.

## How STD Affects Other Benefits

Your other Denny's benefits, including medical, dental, vision and life insurance will remain in effect during your disability. The cost of these benefits will be deducted from your STD paycheck. If your STD paycheck does not cover the full cost of benefits, you will be responsible for paying any remaining costs to the Denny's Total Rewards Department.

If you become totally disabled during a regularly scheduled vacation, your disability pay will begin after the previously scheduled vacation time ends. Vacation benefits will continue to accrue during your Short-Term Disability period.

Any holidays that may occur during a disability absence will not be paid in addition to Short-Term Disability benefits, nor will they be carried forward.

## Returning to Work

If eligible under the Family Medical Leave Act (FMLA), you are entitled to be reinstated to your same or comparable position if you return to work within 12 weeks of your disability. If you return to work after 12 weeks and your position has been filled, the Company will attempt to find you a similar position.

## If You Are Unable to Return to Work

If you are unable to return to work after receiving the maximum 26 weeks of disability pay, you may be separated from the active payroll. At that time, you may be eligible to receive Long-Term Disability benefits.

## How Payments Coordinate With Other Disability Benefits

The STD benefit you receive from Denny's will be less any payments you may receive from other sources, Social Security and federal, state and local government disability programs.

If you work in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, you must file a claim with both the state and Denny's independent disability review agency when you become disabled, since these states have mandatory disability benefit programs. If your disability is approved, you will receive a disability check from these states. Your Denny's benefit will be equal to your Denny's STD benefit minus the benefit you receive from the state in which you work.

If a benefit is payable for less than a week, the plan will pay 1/5th of the weekly benefit amount for each day you are disabled.

Benefits are not coordinated with income you may receive from private insurance that you purchased on your own.

Workers' Compensation injuries are not covered under the Short-Term Disability Policy.

# Long-Term Disability (LTD) Insurance

## How the LTD Plan Works

Basic LTD coverage paid by Denny's replaces 40% of your monthly base pay, if you become totally disabled. Monthly base pay is your monthly salary, excluding commissions, overtime earnings, incentive pay, bonuses or other compensation. Your monthly base pay is determined by your rate of pay at the time your disability occurred.

You may purchase Buy-Up LTD coverage that pays you an additional 20% benefit to replace a total of 60% of your monthly base pay. Read the Preexisting Condition Section on page 6 of this At-A-Glance document for more information. You are eligible for both the Basic LTD of 40% and the additional 20% Buy-Up LTD coverage immediately on your date of hire.

Here are the features of your Long-Term Disability coverage:

- The minimum monthly benefit is $50 and the maximum is $15,000. The maximum is the total amount available from the combination of the Basic and Buy-Up LTD benefits.
- LTD benefits begin after 180 days of approved total disability.
- The LTD benefit you receive will be less any payments you may receive from other sources, such as Workers' Compensation, Social Security, state disability or disability pay from any group insurance plan.
- Your LTD premiums are paid on an after-tax basis. After-tax means that you do not pay income tax on any disability benefits that you receive.

## When Benefits Are Paid

Your disability must begin while you are covered under the LTD plan. Benefits begin when you:

- Have been unable to work because of total disability for 180 days
- Are under the care of a doctor
- Provide proof of disability to Hartford Insurance Company — the LTD plan administrator — and they have approved your disability.

During the time you are on LTD, you will not have to make contributions toward your 20% additional LTD coverage.

**What is Total Disability?**
You are considered totally disabled if:

- During the first 24 months benefits are payable, you are unable to perform the substantial and material duties of your *own* occupation and do not perform other paid work for which you are or become qualified by education, training or experience.
- After the first 24 months of benefit payments, you are unable to perform the duties of *any* occupation for which you are or become qualified by education, training or experience. The skills, responsibilities, income and degree of social acceptance of your job prior to your disability are considered when evaluating your prospects for employment.

## How Long Benefits Continue

Benefits continue as long as you are totally disabled, to the earliest of the date you:

- Are no longer disabled
- Fail to provide the required proof of total disability
- Reach the maximum time shown in the chart below

| Maximum Time Benefits Are Payable | |
|---|---|
| **Age When You Became Totally Disabled …** | **Benefits Are Payable For …** |
| Before 62 | The period up to your 65th birthday |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and over | 12 months |

## For Disabilities Caused by Mental and Emotional Illness

If you are totally disabled because of a mental or emotional disease or disorder of any type (as defined by the Hartford Insurance Company), LTD benefits will continue for a maximum of 24 months. After 24 months, benefits will end. If you are confined to a hospital or institution licensed to provide care and treatment for mental or emotional disorders, that period will not count as part of the 24-month limit.

## Preexisting Conditions

Preexisting conditions apply if you are enrolled in the additional (20%) Buy-Up LTD benefit. A preexisting condition is any condition, advice or treatment received, prescribed or recommended within 12 months of the date your coverage under the Denny's plan began.

Benefits for a disability resulting from a preexisting condition will not be paid until:

- No medical treatment has been received, prescribed or recommended for the condition for 12 months after your LTD coverage begins.
- You have been covered under the Denny's plan for 12 months before the disability begins.

# Personal Accident Insurance (PAI)

## At-A-Glance

Personal Accident Insurance (PAI) provides financial support in the event of an accidental death or physical loss.

Denny's provides salaried employees basic Accidental Death and Dismemberment (AD&D) coverage equal to one times your base annual salary.

In addition, you can purchase PAI coverage for yourself only or yourself and covered dependents.

### How PAI Works

PAI is AD&D coverage that pays benefits upon death or a specified physical loss caused by an accident, such as the loss of hands, feet, sight, speech or hearing. This plan provides coverage for accidents occurring on or off the job, in or away from the home or while traveling.

You can choose coverage for yourself only or for you and your family in one of the following amounts:

- $25,000
- $50,000
- $100,000
- $150,000
- $250,000
- $500,000

You are only eligible to elect the $250,000 and $500,000 coverage amounts if it does not exceed 10 times your base annual salary as of October 1, 2009 (or, if you are a new hire, as of your date of hire).

When you choose family coverage, your spouse/domestic partner and eligible dependent children are automatically covered.

The benefit you receive is based on the amount of coverage you choose and your family make-up at the time of the accident.

| Family Member | Benefit equal to a percentage of your coverage amount |
|---|---|
| Spouse/domestic partner only | 60% of your coverage |
| Spouse/domestic partner and children | 50% of your coverage for spouse/domestic partner, plus 15% for each child |
| Children only | 20% of your coverage for each child |

If your employment ends with Denny's, you can convert Denny's group PAI to an individual policy.

## How Benefits Are Paid

If you die as a result of an accident that occurred while you were covered under this plan, the plan will pay the full coverage amount you have selected. If you have family coverage and your spouse/domestic partner or child's death is caused by an accident, the plan will pay a percentage of your coverage amount.

The plan also covers other specified physical losses caused by an accident and occurring within one year of the accident while covered. Benefits depend on the severity of the physical loss. In addition, the full coverage amount is paid *once* for all losses resulting from a single accident. Once paid, no later losses caused by that same accident are covered.

| Loss | PAI Benefit* |
|---|---|
| Both hands or both feet | Maximum benefit |
| Sight of both eyes | Maximum benefit |
| One hand and one foot | Maximum benefit |
| Either hand or foot<br>and sight of one eye | Maximum benefit |
| Movement of both upper and lower limbs (quadriplegia) | Maximum benefit |
| Movement of any three limbs (triplegia) | Three-quarters of maximum benefit |
| Movement of both lower limbs (paraplegia) | Three-quarters of maximum benefit |
| Movement of both upper and lower limbs of one side of the body (hemiplegia) | Two-thirds of maximum benefit |
| Movement of one limb (uniplegia) | One-half of maximum benefit |
| Both speech and hearing | Maximum benefit |
| One hand or one foot | One-half of maximum benefit |
| Sight of one eye | One-half of maximum benefit |
| Speech or hearing | One-half of maximum benefit |
| Thumb and index finger<br>of either hand | One-quarter of maximum benefit |

*Spouses/domestic partners and children receive a percentage of your coverage amount.

For this plan, loss means:

- Actual severance through or above the wrist and ankle joint
- Entire and irrecoverable loss of sight
- Actual severance through or above metacarpophalangeal joints for thumb and index finger
- Entire and irrecoverable loss of speech or hearing

## Additional Benefits

PAI also includes family benefits that are in addition to the death or physical loss benefits previously described. These benefits are paid if you die because of an accident covered by this plan. Benefits include:

- Dependent education benefit
- Daycare benefit
- Survivor benefit

# Naming a Beneficiary

It is important to name a beneficiary who will receive benefits from the plan if you die. To name a beneficiary, you must complete a Benefits Change Form. You may change your beneficiary designation at any time. To request a form, call the Denny's Benefits Department at 1-800-859-2244.

Because family situations change, you should periodically review your beneficiary designation.

You will automatically be the beneficiary for your own covered loss, other than for your death. If there is no valid beneficiary named at the time of your death, benefits will be paid to your estate in this order:

5. Your lawful spouse, if living, otherwise;
6. Your natural or legally adopted child (children) in equal shares, if living, otherwise;
7. Your parents in equal shares, if living, otherwise;
8. The personal representative of your estate.

## For Family Coverage

You will automatically be the beneficiary for benefits payable for the covered loss of a dependent if you have chosen family coverage.

# Flexible Spending Accounts

# At-A-Glance

Flexible Spending Accounts (FSAs) allow you to set aside tax-free dollars from your paycheck to pay for eligible health and dependent daycare expenses — which means you keep more money in your pocket. In many cases, you save between 15% – 30% on eligible expenses.

Denny's offers two types of FSAs:

- Healthcare FSA
- Dependent Care FSA

You can participate in one or both of the accounts. Up to $5,000 pre-tax from your paycheck can be set aside each year. *If you are a highly-compensated employee, you are not eligible to enroll in the Dependent Care FSA.*

All the money in your FSA must be used for eligible expenses, as determined by the Internal Revenue Service (IRS). In addition, the following rules apply:

- If you have money left over in your Healthcare FSA at the end of 2010, you can use your remaining 2010 balance for 2011 expenses incurred up through March 15, 2011. You have until April 15, 2011, to submit Healthcare FSA claims for expenses incurred between January 1, 2010, and March 15, 2011. Any funds left in your 2010 account after April 15, 2011, will be forfeited.
- If you have money left over in your Dependent Care FSA at the end of 2010, you have until April 15, 2011, to submit your claims for expenses incurred between January 1, 2010 and December 31, 2010. Any funds left in your 2010 account after April 15, 2011, will be forfeited. Dependent Care expenses must have been incurred during 2010.

Here's a summary of both accounts:

| Type of Account | What You Can Use It For | How Much You Can Set Aside |
|---|---|---|
| Healthcare FSA | • Most over-the-counter medications that are used to treat a health condition such as:<br>– Antacids<br>– Allergy and asthma medicines<br>– Pain relievers (such as aspirin or ibuprofen)<br>– Bandages, first aid kits, rubbing alcohol<br>– Contact lens cleaning solution<br>– Canes<br>– Crutches<br>– Thermometers<br>• Deductibles, coinsurance and | From $100 to $5,000 each calendar year. These funds can be used by you and dependents you claim on your federal tax return. |

| | | |
|---|---|---|
| | copayments from your medical, vision and dental plans<br>• Prescription drug copayments<br>• Physical exams<br>• Contact lenses, eyeglasses and eye exams<br>• Dental services<br>• Braces<br>• LASIK eye surgery<br>• Weight loss programs prescribed by a doctor<br>• Hearing aids | |
| Dependent Care Spending Account | Eligible dependents include:<br>• Your children under age 13 who qualify as dependents for tax purposes<br>• A spouse or dependent of any age who is mentally or physically disabled and who qualifies as a dependent for tax purposes (spouse and dependents age 13 and older must spend at least eight hours a day in your home if you are seeking reimbursement for services provided outside the home)<br><br>Eligible expenses include:<br>• Licensed nursery school and daycare centers for children or disabled dependents<br>• Family or adult daycare centers<br>• Services from a care provider (must be over age 19 and not claimed as a dependent on your tax return) | From $100 to $5,000 each calendar year ($2,500 each year if you are married filing separate returns) |

## Enrollment

You may enroll in the FSAs either:

- During the annual enrollment period. Your participation becomes effective at the start of the new plan year.
- Within 30 days of your date of hire. Your participation becomes effective when Denny's Total Rewards Department receives your enrollment materials, but no later than 30 days from your date of hire.
- Within 30 days of a qualifying event (such as marriage, birth of a child, etc). Your participation becomes effective when Denny's Total Rewards Department receives your change in status and re-enrollment materials, but no later than 30 days from the date of the qualifying event.

Please note: Your FSA elections do not roll over from year to year. You must enroll each year during annual enrollment if you wish to continue participation.

## How FSAs Work

During the enrollment period, you decide how much of your pre-tax pay to set aside. The amount you elect is based on your best estimate of what your family's healthcare and dependent daycare needs will be for that year. The amount you elect is:

- Divided equally over the number of pay periods in the year
- Deducted from your pre-tax pay
- Deposited in your spending account(s)

There are two ways to pay for eligible expenses from your FSA — using your Aetna VISA FSA Debit Card or using an Aetna FSA Claim Form.

### Aetna VISA FSA Debit Card

For your Healthcare FSA, you can use your Aetna VISA FSA Debit Card at any healthcare service provider who accepts VISA, such as the doctor's office. The card is convenient and there are no claim forms to submit. It works just like a debit card you'd use with your normal checking account — except the funds are withdrawn from your FSA. The card has an expiration date, so if you plan to continue participating in an FSA from year to year, **keep your card until you receive a new one**.

Appropriate documentation may be required for certain items (i.e., over-the-counter items, out-of-network providers, deductibles, etc.), so remember to keep your receipts — you may need to submit them to Aetna for verification of your expenses. For additional information on necessary documentation, visit www.aetnafsa.com. *The Aetna VISA FSA Debit Card is not available for Dependent Care expenses.*

### *Using the Aetna VISA FSA Debit Card*

Due to the IRS rules, that began January 1, 2008, you will be limited to where you can use your Aetna VISA FSA Debit Card. The IRS is requiring "non-medical" merchants (like grocery stores, drug stores, etc.) to agree to certain inventory management guidelines in order to accept FSA debit cards, like the Aetna VISA FSA Debit Card.

Before you use your Aetna VISA FSA Debit Card at a grocery store, drug store, etc., check to see if you can use the card there during 2010. Merchants that use the required

inventory system will display an Inventory Information Approval System — or IIAS — logo. *You can continue to use your card at your doctor's office, the hospital and all medical providers.* Check www.aetnafsa.com regularly for the most up to date list of compliant non-medical merchants like Sam's Club, Walgreen's and Wal-mart.

Remember, your FSA Debit Card will be accepted at any medical provider — like your doctor or the hospital.

### Aetna FSA Claim Form

For dependent daycare expenses *and* healthcare expenses, you may submit a Request for Reimbursement Form along with your receipt for services to Aetna. You will receive a check for reimbursement in the mail or — for added convenience — you may set up direct deposit so that your reimbursements automatically are deposited into your checking or savings account.

FSA claim forms are available at www.aetna.com. You also can link to Aetna from www.mydennys.com.

## The Pre-Tax Advantage

When you set aside pre-tax dollars from an FSA to pay for your expenses, you save federal, state and FICA taxes on that money. That's because money you set aside in your FSAs is taken out of your pay before taxes are determined.

That can mean a savings of 15% – 30% — or about $15 to $30 on every $100 you spend for healthcare or dependent care services. The savings vary depending on your income tax rate.

**Example**

Here's a rough estimate of how a typical, non-married tax filer, with an annual income of $25,000, can increase his/her take-home pay by $573.

| | With FSA | Without FSA |
|---|---|---|
| Gross Income | $25,000 | $25,000 |
| Pre-Tax Contribution to Healthcare FSA | $2,000 | $0 |
| Income Subject to Tax | $23,000 | $25,000 |
| Social Security and Medicare | $1,760 | $1,913 |
| Federal Income Tax | $1,749 | $2,049 |
| State Income Tax (6% assumption)* | $1,380 | $1,500 |
| After-Tax Health Care Expenses | $0 | $2,000 |
| Net Pay | $18,111 | $17,538 |
| **Savings through the Healthcare FSA** | **$573** | **$0** |

** State taxes will vary depending on the state.*

Because you don't pay Social Security taxes on your FSA contributions, the earnings used to calculate your Social Security benefits at retirement will not include these amounts. This could result in a small reduction in your Social Security benefit. However, your savings on current taxes will usually outweigh any reduction in future Social Security benefits.

## Healthcare FSA

You may set aside from $100 to $5,000 each calendar year in your Healthcare FSA to reimburse yourself for medical, dental, vision and prescription drug expenses not covered by any other benefit plan. However, you cannot use the account for healthcare premiums, expenses that are cosmetic in nature or for care that is not medically necessary.

For more information on Healthcare FSAs and a complete list of eligible expenses, go to the IRS web site at www.irs.gov/pub/irs-pdf/p502.pdf. There you'll find "Publication 502 — Medical and Dental Expenses." You also can call 1-800-TAXFORM to request a printed copy of this publication. For a final determination on eligible expenses, contact Aetna at 1-888-238-6226.

### Ineligible Healthcare Expenses

The following is a summary of ineligible healthcare expenses under the Healthcare FSA:

- Some over-the-counter medications and supplies — for example, nicotine patches or non-prescription eyewear such as sunglasses or clips
- Cosmetic care — for example, teeth whitening, dermabrasion, chemical peels or spider vein treatment

- General wellness care — for example, health club dues, special foods, vitamins taken for general health, exercise programs and equipment or weight loss programs
- Marriage/family counseling is not qualified for reimbursement

## Dependent Care FSA

You may set aside from $100 to $5,000 each calendar year to reimburse yourself for eligible dependent care expenses so that you — and your spouse/domestic partner if you're married — can work outside the home or attend school full-time.

| Your Family Situation | What You Can Set Aside |
|---|---|
| If you are married and filing separate tax returns | You and your spouse/domestic partner may each set aside up to $2,500 |
| If you and your spouse/domestic partner are both working, but one of you earns less than $5,000 a year | You may only set aside as much as the spouse/domestic partner with the lower income earns |
| If one spouse/domestic partner does not work because of a disability or is a full-time student | You may set aside up to $2,400 a year if you have one eligible dependent child or up to $4,800 a year if you have two or more eligible dependent children |
| If you are unmarried and working but earn less than $5,000 a year | You may only set aside as much as you earn |

For more information on Dependent Care FSAs and a list of eligible expenses, go to the IRS web site at www.irs.gov/pub/irs-pdf/p503.pdf. There, you'll find "Publication 503 — Child and Dependent Care Expenses." You also can call 1-800-TAXFORM to request a printed copy of either publication. For a final determination on eligible expenses, contact Aetna at 1-888-238-6226.

### Ineligible Dependent Care Expenses

The following are not eligible for reimbursement under the Dependent Care FSA:

- Amounts you pay to an immediate family member under age 19 or any person you claim as a dependent on your federal income tax return
- Expenses for dependent care when you or your spouse/domestic partner is not working
- Transportation expenses
- Child support payments
- Tuition expenses
- Education expenses for the first grade and above
- Camp expenses, except summer day camps outside of the school year
- Food, clothing and entertainment
- Cleaning and cooking services not provided by the care provider
- Amounts you claim as a dependent care tax credit

## Important Rules About FSAs

The federal regulations governing Section 125 of the Internal Revenue Code include specific rules which apply to FSAs.

- **Advance Enrollment.** You must decide how much to contribute for a calendar year before the year starts. This should be based on your best estimate of the eligible expenses you and your family will have for the coming year. Once you enroll for the year, you will not be able to change your contributions unless you have a qualified status change.
- **Use It or Lose It.** If you have money left over in your Healthcare FSA at the end of 2010, you can use your remaining 2010 balance for 2011 expenses incurred up through March 15, 2011. You have until April 15, 2011, to submit Healthcare FSA claims for expenses incurred between January 1, 2010, and March 15, 2011. For the Dependent Care FSA, you have until April 15, 2011, to submit your claims for expenses incurred during 2010. Any amounts left in your account will be forfeited.
- **Uniform Reimbursement Requirement.** For the Healthcare FSA, once you make your initial contribution for the year, you can be reimbursed for up to the total amount that you have chosen to contribute for the plan year, regardless of the actual balance in your account. For the Dependent Care FSA, you will only be reimbursed up to the amount actually in your account at the time of your expense. Any reimbursement requested for amounts over your current balance will not be paid until additional contributions are received.
- **Enrollment.** Your enrollment is for one plan year only. Each year during annual enrollment, you must re-enroll to continue participating in either FSA.
- **Status Change.** If you have a qualifying change in status, any change in your enrollment or contribution amount must be consistent with the event. You must notify the Denny's Total Rewards Department within 30 days of any status change event in order to make any changes.

### Qualifying Change in Status Events includes:

- A change in your legal marital status (marriage, divorce, legal separation or death of spouse/domestic partner)
- A change in your number of dependents (birth, adoption, placement for adoption or death)
- A change in your employment status or worksite of employee, spouse/domestic partner or dependent (must affect benefit eligibility)
- Your dependent satisfies (or no longer satisfies) dependent eligibility requirements
- You change residences (must have material effect on eligibility)
- You begin or terminate adoption proceedings

### Additional Qualifying Events for Dependent Care FSAs Only

- Cost changes (exception — no change is permitted if the caregiver is a relative)
- A significant coverage change/curtailment (change in provider or eligibility for state-funded school)
- A change in coverage of spouse/domestic partner or dependent under other employer's plan

- **Terminations.** If your employment is terminated, voluntarily or involuntarily, you may file claims against your account as long as care was provided before your termination date. You may continue submitting claims until April 15, 2011, for expenses incurred in 2010. You can continue your Healthcare FSA through COBRA after you have terminated employment.
- **Leaves of Absence.** If you take a leave of absence during the year, you may continue making contributions to your Healthcare FSA while on leave, or you may stop making contributions. If you stop making contributions, you will not be able to file claims for expenses incurred during your leave.
- **No Commingled Accounts.** Your Healthcare and Dependent Care FSAs are separate accounts. You can't use funds from your Healthcare FSA to pay for dependent care expenses and vice versa.
- **Different Definition of Dependent.** Unlike some of Denny's benefit programs, for the FSAs, a dependent is defined as a person you legally claim as a dependent on your income tax return.