Your Denny's Benefits Program

Benefits are an important part of your total rewards from Denny's. Our goal is to provide a comprehensive, balanced and competitive benefits package that offers flexibility and choice.

This Summary Plan Description (SPD) describes the plans in the Denny's Benefits Program, including medical and prescription drug, dental, vision, Flexible Spending Accounts, life, accidental death and dismemberment, disability and personal accident coverage offered by Denny's to eligible employees. It is intended to help you use the program's benefits most effectively.

This SPD is designed to be easy to use — whether you read it cover-to-cover or simply use it as a reference when you have a specific question:

- The first page of each section gives you a summary at-a-glance.
- You also will notice that tips for using your benefits, examples, and other important plan information are highlighted on selected pages.

We hope this helps you locate the information you need quickly and makes it easy to understand.

Inside This SPD

The Employee Retirement Income Security Act of 1974 (ERISA) requires that employers provide employees with Summary Plan Descriptions (SPDs) of certain benefit plans. While this SPD provides you with most of the information you'll need to know about the Denny's Welfare Benefit Plans, it provides only a summary of these benefits and does not cover all the details. The details are provided in the official plan documents. If you have questions about Denny's Benefit Plans or would like to view the plan documents, contact the Denny's Total Rewards Department.

The Benefit Plans outlined in this SPD are based on legal requirements, documents and/or insurance contracts. The plan administrator has sole authority to interpret the plan provisions and to exercise discretion as it deems necessary or appropriate in the interpretation and administration of the plans.

Although these plans have been summarized in everyday language, this SPD does not replace the legal documents governing the plans. If there are any differences between this information and the official plan documents, the plan documents govern. Denny's reserves the right to amend, modify or terminate these plans at any time and for any reason. This document in no way is intended to constitute a contract of employment.

This summary supersedes all earlier descriptions of the Denny's, Inc. Welfare Benefit Plan for Salaried Employees as of January 1, 2008. Because the benefits described in this summary may change, Denny's will provide you with updated information as required by law.

If you have any questions about the plans described in this SPD, contact the Denny's Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST) or via email at totalrewards@dennys.com.

Participating In Denny's Benefits

Who Is Eligible

The benefits described in this SPD are provided for you — the eligible employees of Denny's — and for your eligible dependents.

You

You are eligible to participate in Denny's benefits if you are:

- A regular, full-time salaried employee, and
- Scheduled to work at least 30 hours per week

Your Dependents

You may cover your eligible dependents under the plans. Your eligible dependents include:

- Your spouse — a person of the opposite sex to whom you are legally married, or who is recognized as a common law spouse in your state of residence
- Your same-sex domestic partner
- Your unmarried dependent children up to age 19 — or age 23 if they are full-time students — including a legal dependent by a court ruling or qualified medical child support order
- Your unmarried dependent children of any age who were disabled at or before age 19 — or 23 for full-time students — and are mentally or physically unable to care for themselves
- Children eligible for coverage include your children by birth, stepchildren, children for whom you have legal guardianship or your legally adopted children, a child placed with you for adoption and foster children.

You may be required to provide a copy of your marriage certificate, domestic partnership affidavit, proof of full-time student status or other documentation proving eligibility.

Your parents, grandparents and siblings are not eligible for coverage — even if you have custody or provide full support.

Domestic Partner Eligibility

For domestic partner eligibility, you and your partner must have met eligibility requirements for a period of at least 12 months. You and your partner must:

- Reside together in an exclusive mutual commitment similar to that of marriage
- Share financial assets and obligations
- Be of the age of consent
- Not be related by blood to a degree of closeness that would prohibit a legal marriage in the state of residence
- Not be legally married to any other person or have another domestic partner

You must provide proof of the domestic partnership to have coverage, including:

- An affidavit of spousal equivalency signed by both partners
- At least three of the following, which must be dated to confirm that your relationship has existed for a period of at least 12 months:
  - A contractual commitment for financial responsibility
  - Joint mortgage, lease or ownership of a residence shared by the domestic partners
  - Joint ownership of significant assets, such as bank accounts, investment accounts or motor vehicles
  - Designation of domestic partner as sole beneficiary for life insurance or retirement accounts
  - Designation of domestic partner as primary beneficiary of your will, if one has been executed
  - Designation of powers of attorney for durable property and/or health care

You will also have to provide satisfactory proof of insurability for your domestic partner to have life insurance coverage.

When Coverage Begins

This chart shows when you become eligible for coverage under each benefit plan and when your coverage begins.

Benefit	When You Are Eligible	When Coverage Begins
▪ Medical and Prescription Drug ▪ Dental ▪ Vision ▪ Flexible Spending Accounts ▪ Supplemental Life Insurance ▪ Personal Accident Insurance	Immediately on date of hire	Upon online submission of your enrollment elections within your first 30 days of employment
Simple Steps To A Healthier Life® (personalized online health assessment)	Immediately on date of hire	Upon enrollment in the medical plan and completion of the online health assessment
Basic Life and AD&D Insurance Travel Assistance Program	Immediately on date of hire	Immediately on date of hire
Short-Term Disability	Immediately on date of hire	After six months of service
Long-Term Disability	Immediately on date of hire	Immediately on date of hire

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you and your enrolled dependents will start the day after you return to work for one full day. However, for purposes of medical, dental and vision coverage, you will be treated as if you are actively at work if your absence is for medical reasons.

Newborns are covered at birth, as long as you enroll them for coverage within 30 days of birth and provide proof of the birth such as the hospital certificate with footprints.

Enrolling

To enroll in the Denny's Benefits Program, you must complete the online enrollment process through the Denny's, Inc. website at www.mydennys.com within 30 days of becoming eligible. Each fall, you will have the opportunity to make new benefit selections for the coming calendar year.

If you do not complete your online enrollment by the 30-day (or annual enrollment) deadline, you will have ***only***:

- Basic Life Insurance and AD&D coverage equal to one times your annual base salary
- Basic Long-Term Disability coverage equal to 50% of your annual base salary

Cost of Coverage

Denny's pays the full cost of basic benefits:

- Simple Steps To A Healthier Life® (personalized online health assessment when you enroll in a medical plan)
- Basic Life and Accidental Death and Dismemberment (AD&D) Insurance
- Travel Assistance Program
- Short-Term Disability (STD) coverage

You and Denny's share the cost of your healthcare benefits:

- Medical and prescription drug coverage
- Dental coverage

You pay the full cost for these voluntary benefits if you choose to enroll:

- Vision coverage
- Healthcare and Dependent Care Flexible Spending Accounts (FSAs)
- Supplemental Life Insurance
- Personal Accident Insurance (PAI)
- Additional LTD coverage (to bring total replacement income to 60%)

Paying for Your Denny's Benefits

Each year, Denny's shares in the cost of your benefits — giving you flexibility to choose only the benefits you want and need. Benefit choices have a specific cost for coverage. Generally, you will pay more for higher coverage levels or to cover more people. For some benefits, like Supplemental Life Insurance, your cost is based on your age and annual base salary.

Paying with Before-Tax Dollars

Benefits that are paid for with before-tax dollars are deducted from your pay before federal income tax, Social Security taxes and, in most states, state income taxes. This provides you with a tax advantage; when your taxable pay is less, so is your overall tax bill.

Although using before-tax dollars reduces your taxable pay, benefits based on your pay, such as life insurance, aren't reduced. These benefits will continue to be based on your full annual base salary.

Paying for benefits with before-tax dollars means your future Social Security benefits may be slightly reduced. While the before-tax advantage provided now may outweigh reduced benefits later, it's a good idea to consult a tax advisor if you have questions or concerns.

More for Your Money

Your contributions for these benefits are made with before-tax dollars:

Medical and prescription drug coverage
Dental coverage
Vision coverage
Personal Accident Insurance
Supplemental Life Insurance
Healthcare and Dependent Care FSAs

Changing Coverage During the Year

Generally, once you make benefit selections, they remain in effect for the rest of the plan year — January 1 through December 31. You cannot make changes during the year unless you have a qualifying family or employment status change, special enrollment period event or other qualifying situation as described in this section.

Qualifying Family or Employment Status Changes

Based on Internal Revenue Service (IRS) regulations, a family/employment status change includes:

- Your marriage, divorce or legal separation (there must be a court order granting the divorce or legal separation)
- Beginning or ending a domestic partner relationship
- Death of your spouse/domestic partner or other dependent
- Birth or legal adoption of a child
- Your spouse/domestic partner's beginning or ending employment
- A change in your spouse/domestic partner's employment classification, for example moving from part-time to full-time employment or vice versa
- A significant change in your spouse/domestic partner's health coverage related to your spouse/domestic partner's employment
- Unpaid personal leave of absence by you or your spouse/domestic partner
- Your dependent reaching an ineligible age

In all cases, a change in your coverage level or option must be due to and consistent with your change in employment or family status. For example, if you divorce your spouse, you may drop the spouse from coverage but you cannot change the medical option you currently have.

The Denny's Total Rewards Department must receive your written request, with appropriate documentation, to change your benefit selection within 30 days of a qualified change in family or employment status. Otherwise you must wait until the next annual enrollment period to make changes.

A form to request a benefit change can be found at the back of this SPD. You must submit documentation of the event for which you seek a benefit change. Examples include:

- Birth certificate
- Death certificate
- Hospital certificate for a newborn showing you as parent
- Marriage license
- Affidavit for domestic partner coverage as described on page 3
- Court order granting a divorce, legal separation or custodial change

Special Enrollment Events

If you were eligible for Denny's medical coverage but declined coverage because you had other health insurance coverage, you may enroll in Denny's benefits if you lose coverage under the other group health plan for one of three reasons:

- Your eligibility for the other group health plan coverage ends
- COBRA coverage available through the other coverage ends because it has been completely used
- Employer contributions to the other coverage end

You may also enroll yourself and a new dependent because of marriage, birth, adoption or placement for adoption. If you are already enrolled in coverage yourself, you can add dependents and change coverage options.

Judgments, Decrees and Orders

You may make a change that corresponds to any judgment, decree or order (including a court-approved settlement agreement) requiring Denny's medical coverage for your dependent child or foster child. In the case of a child whom you're required to cover because of a qualified medical child support order (QMCSO), coverage will begin on the date specified in the order, or if none is specified, the date of the order.

You may decrease your coverage for that child if the court order requires the child's other parent to provide coverage and your current or former spouse/domestic partner's plan actually provides that coverage.

Qualified Medical Child Support Order (QMCSO)

The plan will comply with any medical child support order (as defined under Section 609(a) of ERISA) that is a qualified medical child support order. When Denny's receives a court order, it will be reviewed to determine if it is a qualified medical child support order. If the order is qualified:

- The child will be added to your medical coverage and you will be notified by Denny's.
- Medical ID cards will be sent to the child's case worker when they are received by Denny's, along with any health booklets.

If your coverage level increases to employee + 1 or employee + 2 or more when your child is added, your cost for coverage will also increase.

If you terminate employment, coverage ends immediately. Your child is eligible, however, for up to 18 months of COBRA coverage. See page 10 for information on COBRA coverage.

Medicare or Medicaid Entitlement

You may change your medical coverage selection mid-year if you, your spouse/domestic partner or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. You're limited, however, to reducing your medical coverage only for the person who becomes entitled to Medicare or Medicaid. You are also limited to adding medical coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act

You may drop medical coverage mid-year when you begin an approved unpaid leave that satisfies the provisions of the Family and Medical Leave Act (FMLA). For information about what happens if you drop coverage or fail to make payments for coverage during your family medical leave and then return from leave, see page 9. Upon your return from leave, you have the right to be reinstated to the same selections you made before taking your family medical leave.

When Coverage Ends

Your coverage under a plan in the Denny's Benefits Program ends:

- The date you are no longer eligible for coverage
- The end of the last pay period for which you made any required contribution for coverage
- The last day you are employed with Denny's
- The date you become an active member of the armed forces
- The date the plan is terminated
- The day you die

… whichever is earliest.

Your dependent's coverage under a plan in the Denny's Benefits Program ends:

- The date you are no longer eligible for coverage
- The date your dependent is no longer eligible for coverage (see page 3 for information on dependent eligibility)
- The date your dependent becomes an active member of the armed forces
- The end date of a court order for you to provide health coverage for your dependent
- The date the plan is terminated

… whichever is earliest.

When Your Dependent Child Is a Full-Time Student

Dependent coverage automatically ends on the day the dependent no longer meets eligibility requirements. No benefits will be paid to, or on behalf of, ineligible dependents. These eligibility requirements affect dependents who are full-time students:

- If a dependent child is a full-time student, having 12-credit hours or more, coverage ends on the date your child graduates or reaches age 23.
- If a dependent student between ages 19 and 23 withdraws from school, coverage ends on the last day of the semester of the withdrawal.

Coverage for full-time students who have not reached age 23 continues during regular school breaks as long as they are enrolled for the next scheduled session.

It is your responsibility to notify the Denny's Total Rewards Department when your dependent no longer meets these eligibility requirements. To change your coverage level — for example from family to employee + 1 — because a dependent is no longer eligible for coverage, you will need to call the Denny's Total Rewards Department at 1-800-859-2244.

Once you notify Denny's of your dependent change and your coverage level changes, your contributions for coverage may decrease too. Remember, though, that you must notify the Denny's Total Rewards Department to make coverage level changes. If you do not provide notification and therefore make contributions for dependents who are no longer eligible, those contributions cannot be refunded.

If an eligible dependent receives care and pays for that care as if she/he were still covered under Denny's Benefits Program, you must reimburse the plan for any expenses your dependent has once your dependent is no longer eligible for coverage.

Certificates of Coverage

If you or your dependent loses health coverage under the plan, you automatically will receive a certificate showing your creditable coverage under the plan. You will receive this certificate when coverage ends and again when any COBRA coverage ends.

You may need to provide this certificate if you become eligible under another group health plan or wish to buy an insurance policy that does not cover certain medical conditions you have before you enroll. Proof of prior coverage may reduce the length of time you're subject to any pre-existing condition limits under a new plan.

You may also request a certificate at any time during the 24-month period following your initial loss of coverage and/or loss of COBRA coverage.

In some cases, you can continue medical, prescription drug and dental coverage when that coverage would otherwise end. See *Situations Affecting Coverage*, beginning on page 9, for details.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA restricts how a group health plan may apply pre-existing condition exclusions, requires plans to provide documentation of coverage under this plan for employees and dependents to use in applying for another group coverage, permits special enrollment periods and prohibits discrimination based on health status.

HIPAA also requires the plan to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice will describe how the plan may use or disclose your health information and under what circumstances it may share your health information without your authorization (generally, to carry out treatment, payment or healthcare operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the plan's privacy notice for more information. You can obtain a copy of the notice by contacting the Denny's Total Rewards Department.

Situations Affecting Coverage

Family and Medical Leave

The Family and Medical Leave Act (FMLA), which went into effect on August 5, 1993, allows eligible employees to take up to 12 weeks of combined paid and unpaid, job-protected leave during a 12-month period for specific medical and/or family reasons.

You are eligible for family medical leave if you have been with Denny's for one year and have completed 1,250 hours of service in the previous 12 months.

The following reasons qualify for family medical leave:

- Birth of your child, or the placement of a child for adoption or foster care in your home
- Care for an immediate family member — your spouse/domestic partner, child or parent — with a serious health condition
- Your inability to work because of a serious health condition

Going on Leave

You must give 30 days advance notice to Denny's if your leave is foreseeable. If you cannot give 30 days notice, you should provide as much notice as possible. Leave request forms are available from the Denny's Total Rewards Department. To provide notice of leave, complete a leave request form and return it to the Total Rewards Department. Denny's may require a doctor's notice as proof of a serious health condition. If requested, you must provide a doctor's notice within 15 days of Denny's request. Denny's may also require you to get a second or third medical opinion. Any expenses you have for obtaining the additional medical opinions will be paid by Denny's.

While on Leave

If you are on leave because of a family member's or your own health condition, you may be asked to provide medical proof of that condition periodically, and that proof must be provided within 15 days of Denny's request.

If you are covered by a plan in the Denny's Benefits Program before going out on leave, your coverage will continue as long as you make any required contributions. You decide whether to make those contributions with pre-tax dollars from your pay or after-tax dollars. You can make pre-tax contributions from your pay after you return from leave to make up for contributions you missed.

If you want to make contributions on an after-tax basis for your medical coverage, you can either:

- Pay on a per pay period basis while you are out on leave
- Make a lump sum payment after you return from leave to make up for the contributions you missed

Any benefits that you earn before leaving will be unaffected by your leave.

When You Return to Work

When you return from leave, you will be restored to your original or an equivalent position, with equivalent pay, benefits and other employment terms as if you had not taken the leave if your leave was designated as FMLA leave. Certain employees may not be restored, however, if their reinstatement would cause substantial economic problems for Denny's.

Denny's will require a medical release from your doctor before you can return to work. You can send the release to the Denny's Total Rewards Department before you return. Otherwise, you must present it to your supervisor on the day you return and also fax a copy to the Total Rewards Department.

If You Do Not Return to Work

If you do not come back to work when your leave ends, you will be eligible to continue healthcare coverage through COBRA. The date you should have returned to work will be the date your coverage is considered to end for determining COBRA coverage. See *Continuing Coverage Under COBRA*, beginning on this page, for details.

More Information

For more information on family medical leave, contact the Denny's Total Rewards Department. For more information on the Family and Medical Leave Act (FMLA), you may contact the Denny's Total Rewards Department or the Wage and Hour Division of the U.S. Department of Labor.

Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 24 months, as long as you give Denny's advance notice of the leave (with certain exceptions). This extension will run concurrently with any COBRA coverage that you otherwise could elect. If Denny's does not receive notice to extend your coverage, benefits will cease on the 30th day of military leave. Your total leave, when added to any prior periods of military leave from Denny's, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more for coverage than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full coverage amount as required under COBRA.

If you take a military leave, but your coverage under the plan is terminated (for instance, because you do not elect the extended coverage), you will be treated as if you had not taken a military leave upon re-employment when determining whether exclusions or waiting periods apply.

Continuing Coverage Under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice with appropriate documentation to: Plan Administrator, Denny's, Inc., Total Rewards Department, 203 E. Main Street, Spartanburg, SC 29319, or fax to 1-864-597-8888.

How Is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Denny's, Inc. Total Rewards Department in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA for Healthcare FSAs

You may also be eligible for COBRA continuation of coverage with regard to unused money in your Healthcare Flexible Spending Account (FSA). Coverage may continue through the end of the calendar year in which you experience your qualifying event. If you:

- take COBRA continuation coverage for your Healthcare FSA, you may use your balance to pay for expenses you have during the calendar year. You continue to make after-tax contributions and pay an administrative fee for the rest of the calendar year.
- choose not to continue your Healthcare FSA, you may use any remaining account balance only to cover expenses you had while you were working at Denny's.

COBRA Questions

If you have any questions about COBRA coverage or the application of the law, contact the Denny's Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST) or via email at totalrewards@dennys.com. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Also, you must notify Denny's in writing immediately if:

- Your marital status has changed
- You, your spouse or a dependent has a change in address
- A dependent loses eligibility for dependent coverage under the terms of the Denny's plan (e.g., age, loss of student status or marriage)

All initial notifications about qualifying events and questions about Denny's group healthcare plans should be directed to the Denny's Total Rewards Department.

Medical and Prescription Drug Coverage

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. Denny's offers three Preferred Provider Organization (PPO) medical options through Aetna. Each of the PPO plans covers the same services, but differs in the amount of the deductible, copayments and other out-of-pocket expenses. Depending on your location, you may also have a Health Maintenance Organization (HMO) option available to you. Your HMO will provide a certificate of coverage.

	Option 1 $500 Deductible Plan	**Option 2 $1,500 Deductible Plan**	**Option 3 $150 Deductible Plan**
Considerations	▪ Low deductible ▪ Lowest out-of-pocket costs ▪ Highest contributions for coverage	▪ Highest deductible ▪ Higher out-of-pocket costs than Option 1 ▪ Lower contributions for coverage than Option 1	▪ Lowest deductible ▪ Limited benefits ▪ Lowest contributions for coverage
Annual Deductible	Network ▪ $500/person ▪ $1,000/family Out-of-Network ▪ $1,000/person ▪ $2,000/family	Network ▪ $1,500/person ▪ $3,000/family Out-of-Network ▪ $3,000/person ▪ $6,000/family	Network ▪ $150/person ▪ $300/family Out-of-Network ▪ $300/person ▪ $600/family
Annual Out-of-Pocket Maximum	Network ▪ $2,500/person ▪ $5,000/family Out-of-Network ▪ $5,000/person ▪ $10,000/family	Network ▪ $7,500/person ▪ $15,000/family Out-of-Network ▪ $15,000/person ▪ $30,000/family	▪ Plan provides annual maximum benefits: ▪ $1,000/person limit for office visits and other routine care (services ***other than*** hospitalization and surgery) ▪ $25,000/person total limit
Preventive Care and Office Visits	Network ▪ Plan pays 100% after $25 copay; no deductible ▪ Mammograms covered at 100%; no copay or deductible Out-of-Network ▪ Plan pays 60% of R&C after deductible		Network ▪ Plan pays 80% after deductible Out-of-Network ▪ Plan pays 60% of R&C after deductible
Most Other Covered Services	Network ▪ Plan pays 80% after deductible Out-of-Network ▪ Plan pays 60% of R&C after deductible		Network ▪ Plan pays 80% after deductible Out-of-Network ▪ Plan pays 60% of R&C after deductible
Prescription Drugs*	▪ Plan pays 100% after copay: ▪ Network Retail Pharmacy (30-day supply) – $10 generic; $25 formulary; $40 non-formulary ▪ Mail Order Program (90-day supply) – $25 generic; $60 formulary; $100 non-formulary		

* Option 3 has an annual maximum benefit of $250 per person for prescription drugs.

How the HMO Plans Work

HMOs provide care through a network of doctors, hospitals and other healthcare providers who have agreed to offer services at negotiated rates. If you enroll in an HMO, you may be required to use network providers to receive benefits. If that is true for your HMO, you will be asked to choose a primary care physician to coordinate all your care and provide referrals to specialists.

For more information on HMOs and what they cover, contact the HMO directly or call the Denny's Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST).

How the PPO Options Work

A PPO is a network of doctors, hospitals and other healthcare providers who agree to offer care at lower, negotiated rates. When you use network providers, the plan pays a higher level of benefits for most covered services.

Coverage for care you receive when you use network providers is 80% of negotiated charges after the deductible. With the $500 and $1,500 deductible plans, most preventive services received from network providers are fully covered after you pay a $25 copayment. You also have the flexibility to receive care outside the network and receive a lower level of benefits. 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, as determined by Aetna.

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. Also, the expenses you incur using network providers will count only toward your network out-of-pocket limit, and any expenses you incur using out-of-network providers will count only toward your out-of-pocket limit.

Finding a Network Provider

To locate a participating network provider in your geographic area:

- Call the number on your medical ID card.
- Go to www.aetna.com.
- Contact the Denny's Total Rewards Department for help.

Network Advantages

Each time you need care, you can choose a PPO network provider or a non-network provider. Network providers agree to charge for services based on lower fees negotiated in advance with the plan administrator. These fees are generally less than those charged by non-network providers. What you will pay is based on this overall lower cost. In addition, when you use the network you will not have to pay any charges above the negotiated fee.

This chart shows some differences in cost and responsibility when you use network or non-network providers.

Network	Out-of-Network
You must see PPO network providers to receive network-level benefits.	You may see any provider you want, but you pay more for care.
Generally, your physician or the hospital will submit your claim form for you.	You fill out and submit the claim form.
You do not pay charges above the negotiated fee because network providers have agreed to these limits.	You are required to pay all charges above R&C, in addition to your share of the cost.

If You Live Outside the PPO Network Service Area

Some eligible employees may live outside the network service area where there are few, if any, network providers. Your home ZIP code will determine whether you live in or outside the

network service area. Your enrollment materials will tell you if you are outside the network service area. If you or your covered dependents live outside the network service area or if no PPO provider provides the specialty care you seek, you will receive network-level benefits for covered care — generally 80% after the deductible — no matter what provider you see. The plan will pay the same percentage of your covered cost, as if you lived in the network service area and used network providers.

How the PPO Plan Pays Benefits

Before your PPO Plan pays for most covered services for you or a covered dependent, you must first meet an annual deductible for most expenses for the period January 1 through December 31. While you must meet the calendar-year deductible for many services, for some network services, such as doctor office visits, after you pay a flat dollar copayment, the plan pays the rest.

If you enroll dependents, the covered expenses of each enrolled person will go toward meeting the family deductible for the calendar year. Each person, however, cannot have more than the individual deductible amount count toward the family deductible. If one person in the family meets the individual deductible, the plan begins paying a percentage of that person's covered expenses.

If you use network providers, your deductible is lower than if you were to use non-network providers. Keep in mind the individual calendar-year deductible and family calendar-year deductible are lower when you use network providers. You may also choose to use both network and non-network providers. When you use network and non-network providers, only network expenses count toward the network deductible and only non-network expenses count toward the non-network deductible.

Reasonable and Customary (R&C)

Plan payment for covered services you receive out-of-network is based on reasonable and customary (R&C) charges — the usual cost for services in your geographic area, as determined by Aetna. If you go to a non-network provider whose fee is higher than R&C, you will have to pay any amounts above R&C out of your pocket — in addition to your normal share of the cost for services under the plan.

Annual Limit on Your Share of Covered Expenses

To protect you against large medical expenses that could be financially devastating, Option 1 (the $500 Deductible Plan) and Option 2 (the $1,500 Deductible Plan) limit the amount you pay out of your pocket toward covered expenses in any one calendar year. Once your expenses, including your deductible, reach the out-of-pocket maximum, the plan pays 100% for most covered care for the rest of the calendar year.

Expenses that do not count toward the out-of-pocket maximum are:

- Costs for care not covered as an eligible expense by the plan
- Charges above R&C
- Copayments
- Inpatient or outpatient treatment of mental/nervous disorders or substance abuse
- Non-compliance penalties, such as failure to precertify care

You have no out-of-pocket maximum when you enroll in Option 3 (the $150 Deductible Plan).

Maximum Plan Benefits

Option 1 (the $500 Deductible Plan) and Option 2 (the $1,500 Deductible Plan) feature a total lifetime maximum. These options will pay up to $2,000,000 toward the covered expenses of each enrolled person for the length of time the person is covered by the Denny's plan.

Option 3 (the $150 Deductible Plan) pays up to $25,000 per person in benefits for covered services each year. Doctor office visits and other non-surgical or non-hospital costs have a $1,000 per person annual limit. The $1,000 per person annual limit counts toward the $25,000 per person maximum for covered services each year. Prescription drug benefits are limited to $250 per calendar year.

Some services and treatments have specific lifetime and/or calendar year limits. See *PPO Covered Services*, next, for details on special limits or circumstances for specific covered services.

PPO Covered Services

This chart provides an overview of the three PPO options — plan features as well as how each plan pays benefits for specific covered services. The cost of care is covered, if the care is considered medically necessary for treating or diagnosing an illness or injury.

	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	$500	$1,000	$1,500	$3,000	$150	$300
▪ Family	$1,000	$2,000	$3,000	$6,000	$300	$600
Annual Out-Of-Pocket Limit						
▪ Individual	$2,500	$5,000	$7,500	$15,000	None	
▪ Family	$5,000	$10,000	$15,000	$30,000	None	
Lifetime Maximum Benefit[1]	$2,000,000/person		$2,000,000/person		None ($25,000 annual maximum benefit/person; $1,000 annual maximum benefit/person for non-hospital/surgical services)	
Routine and Preventive Covered Services						
Routine Office Visits/Exams	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Lab, X-ray and Other Diagnostic						
▪ Performed at freestanding facility or independent lab	100%	60% of R&C after deductible	100%	60% of R&C after deductible	100%	60% of R&C after deductible
▪ Performed at outpatient hospital and/or all complex imaging	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
Adult Preventive Care[2] (Including exam and diagnostic tests performed in doctor's office)	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Well Woman Care[2]						
▪ **Mammograms** 1 baseline if 35-39; 1 every year if 40 or older	100%, up to $400/year	60% of R&C after deductible	100%	60% of R&C after deductible	100% at a freestanding facility 80% after deductible at outpatient hospital	60% of R&C after deductible
▪ **Pap Smear**	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Well Child Care (children under age 18)[2]						
▪ **Routine Office Visits** ▪ **Immunizations**	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Hospital and Emergency Services						
Hospital Inpatient[3]	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay
Hospital Outpatient, (Including allergy testing, chemotherapy, dialysis, lab tests and X-rays, pre-admission testing, radiation therapy and surgical services)	80% after deductible; $150 copay for outpatient surgery	60% of R&C after deductible; $150 copay for outpatient surgery	80% after deductible; $150 copay for outpatient surgery	60% of R&C after deductible; $150 copay for outpatient surgery	80% after deductible; $150 copay for outpatient surgery	60% of R&C after deductible; $150 copay for outpatient surgery

	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
Surgery	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay
Second Surgical Opinion	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Emergency Care	80% after deductible and $100 copay (copay waived if admitted)	80% of R&C after deductible and $100 copay (copay waived if admitted) Non-emergency use: 60% R&C after deductible and $100 copay	80% after deductible and $100 copay (copay waived if admitted)	80% of R&C after deductible and $100 copay (copay waived if admitted) Non-emergency use: 60% R&C after deductible and $100 copay	80% after deductible and $100 copay (copay waived if admitted)	80% of R&C after deductible and $100 copay (copay waived if admitted) Non-emergency use: 60% R&C after deductible and $100 copay
Urgent Care Facility[4]	80% after deductible and $50 copay (copay waived if admitted)	60% of R&C after deductible and $50 copay (copay waived if admitted)	80% after deductible and $50 copay (copay waived if admitted)	60% of R&C after deductible and $50 copay (copay waived if admitted)	80% after deductible and $50 copay (copay waived if admitted)	60% of R&C after deductible and $50 copay (copay waived if admitted)
Maternity Care						
Initial Visit to Confirm Pregnancy	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Pre-natal Visits	100%	60% of R&C after deductible	100%	60% of R&C after deductible	100%	60% of R&C after deductible
Delivery and Surgery	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay
Newborn Inpatient 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
Other Covered Services						
Ambulance Services	80% after deductible	80% of R&C after deductible	80% after deductible	80% of R&C after deductible	80% after deductible	80% of R&C after deductible
Blood Transfusions, Blood and Blood Plasma	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
Chiropractic (up to $500 benefit/year)	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Durable Medical Equipment[3]	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
Home Health Care[3] (up to 40 visits/year)	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
Hospice Care (Inpatient – up to 30 days; Outpatient – up to $5,000/year)	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay	80% after deductible and $250 copay	60% of R&C after deductible and $250 copay
Infertility Services (Testing and diagnostic services only)	80% after deductible; 100% after $25 copay for office visits	60% of R&C after deductible	80% after deductible; 100% after $25 copay for office visits	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Medical and Surgical Supplies	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

	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
Mental Health and Substance Abuse						
▪ **Inpatient** (up to 30 days/year)	80% after deductible and $250 copay	50% of R&C after deductible and $250 copay	80% after deductible and $250 copay	50% of R&C after deductible and $250 copay	80% after deductible and $250 copay	50% of R&C after deductible and $250 copay
▪ **Outpatient** (up to 50 visits/year)	60% after deductible	50% of R&C after deductible	60% after deductible	50% of R&C after deductible	60% after deductible	50% of R&C after deductible
Organ Tissue and Transplant Services[3] ($10,000 lifetime benefit for transportation and lodging[1])	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
Private Duty Nursing ($10,000 lifetime benefit)	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
Speech, Physical and Occupational Therapy (up to 35 visits/year combined)						
▪ **Speech Therapy** (up to $125 benefit/visit)	100% after $25 copay/visit	60% of R&C after deductible	100% after $25 copay/visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
▪ **Physical and Occupational Therapy** (up to $125 benefit/visit)	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
Skilled Nursing/Extended Care Facility[3] (60 days/calendar year after or in lieu of hospital stay)	80% of semi-private room rate after deductible and $250 copay	60% of semi-private room rate after deductible and $250 copay	80% of semi-private room rate after deductible and $250 copay	60% of semi-private room rate after deductible and $250 copay	80% of semi-private room rate after deductible and $250 copay	60% of semi-private room rate after deductible and $250 copay
Vasectomies and Tubal Ligations (Covers employee/spouse/domestic partner only)	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

[1] 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 count toward determining whether you have reached the lifetime maximum benefit.

[2] For adult preventive care and well woman care there is an annual maximum of $400 per person. There is no annual maximum for well child care (children up to age 18). See below for more information.

[3] Precertification required. See Precertification on page 19 for more information.

[4] No coverage for non-urgent procedures.

Adult Preventive Care

All three PPO options cover adult preventive care and well woman care up to a $400 annual maximum per person. Covered services include:

- Routine physical exam after a $25 copay per visit
- Routine annual OB/GYN exam and Pap Smear after a $25 copay per visit
- Routine mammograms, prostate cancer screenings and colon screenings
- Immunizations.

You can use in-network or out-of-network providers. But, you'll pay more out of your pocket if you use out-of-network providers, and out-of-network care will be subject to the annual deductible.

There's no annual maximum for well child care (children up to age 18).

Simple Steps to a Healthier Life® Health Assessment

As a Denny's Medical Plan participant, you have the opportunity to complete a confidential online Health Assessment (HA) and get instant feedback about how healthy you are compared to national averages for your age and gender. Simply go to www.aetnanavigator.com, register and answer a series of questions about your health, medical conditions and certain lifestyle behaviors.

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.

Your personalized action plan may include some of these Healthy Living Programs:

- Weight Loss
- Stress Relief
- Healthier Diet
- Healthy Heart
- Fighting Cancer
- Alcohol Awareness
- Fighting Diabetes

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:

- Organ and tissue transplant
- Home health services
- Receiving durable medical equipment
- Reconstructive surgery

In addition, for a stay at a 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 $500. To precertify, contact Aetna at 1-800-972-7894.

What's Not Covered by the PPO Options

The PPO Medical Plans do not cover:

- Abortion, except therapeutic abortions
- Acupuncture
- Infertility treatment with drugs or surgery, such as artificial insemination, in-vitro fertilization, reverse sterilization, GIFT, ZIFT or any combination
- Biofeedback treatment
- Non-prescription birth control drugs, medicines or devices used to prevent pregnancy, except surgical placement of Depo-Provera
- Charges above reasonable and customary (R&C) guidelines
- Charges for non-covered health services
- Chelation therapy, except treatment for heavy metal poisoning
- Cosmetic procedures, such as plastic surgery, salabrasion, chemosurgery and other skin abrasion procedures associated with the removal or revision of scars, tattoos, actinic changes, and/or which are provided to treat acne
- Charges for services or supplies provided before your effective date of coverage under this plan, or after your coverage is terminated under this plan
- Custodial care, including institutions such as homes for the aged, rest homes and schools for the mentally retarded
- Dental care or treatment, except for care covered by the Medical Plan

- Education or training, except for diabetic training, education or instruction
- Experimental, investigational or unproven services
- Illness or injury received at the time or when attempting an assault or felony — or injuries received while involved in an illegal occupation, except illness or injuries you have because of a medical condition or resulting from domestic violence
- Hearing aids and exams
- Charges for which no legal liability would exist had coverage under this plan existed — or charges prohibited by law in your jurisdiction at the time you incur the expense
- Services outside the scope of a physician or other provider's license
- Luxury services and supplies such as mineral baths, massages, telephones, radio and television
- Maintenance treatment or medical or non-medical health-related services that do not seek to cure or are provided in times when the patient's medical condition is not changing
- Charges for mileage costs, completion of claim forms or preparation of medical reports
- Treatment of any illness or injury received in the military, naval or air service of any country
- Charges for any illness or injury provided without charge or that would have been provided without charge if this plan weren't in effect
- Services for weight control, including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.
- Occlusal guards
- Routine foot care, including treatment of corns or calluses, care of toenails (except surgery for ingrown nails) or other foot tissue or mycotic toenails when no indication of metabolic disease is present; treatment of foot weakness or strain, such as fallen arches, flat feet, weak feet, chronic foot strain or orthotics or supportive devices to support the feet
- Charge for a covered service if already paid under other coverage provided by the plan
- Organ/tissue transplant charges:
  - Exceeding the usual and reasonable charges for the non-Aetna transplant facilities
  - For animal to human transplants
  - For artificial or mechanical devices designed to replace human organs that are not for approved transplant services
  - For experimental, investigational or unproven transplant services
  - Incurred for services required to meet the patient selection criteria for the approved transplant procedure including, but not limited to programs such as chemical dependency, detoxification and rehabilitation services, nicotine treatment or caffeine addiction, weight loss program services and expenses, nutritional supplements, appetite suppressants and supplies
  - For or associated with allogeneic bone marrow transplants, autologous bone marrow transplants or peripheral blood stem cell transplants for lung cancers, melanomas, colon cancer or AIDS
  - For solid organ transplants, allogeneic bone marrow transplants, autologous bone marrow transplants and peripheral blood stem cell transplants for conditions that are not considered appropriate based on plan guidelines for transplantation
  - For services otherwise excluded from this plan
- Treatment not recommended or approved by a doctor
- Radial keratotomy (RK), refractive keratoplasty or similar procedures
- Charges for sales tax or other tax imposed by law
- Charges for services that are self-administered or provided by an immediate relative
- Sleep disorders, unless there is documented evidence of sleep apnea
- Speech therapy to correct a non-organic speech defect
- Surgery to reverse voluntary sterilization procedure
- Charges for technical medical assistance or standby physician services

- Telephone consultations
- Temporomandibular joint dysfunction (TMJ)
- Service or supplies for sex reassignment surgery or hormonal treatments
- Travel expenses whether or not recommended by a doctor, unless listed as a covered service
- Treatment not provided by a licensed doctor or other provider
- Services or supplies provided by the Veterans Administration or by any hospital or institution owned, operated or maintained by the U.S. Government for a service-related illness or injury
- Hospital services not consistent with or required in treating an illness or injury for which you are admitted
- Charges for eyeglasses or contact lenses and exams for their prescription or fitting (see *Vision Coverage*, beginning on page 33)
- Nutritional supplements or vitamins, even if a written prescription is provided
- Charges for treatment of any illness or injury caused by war, act of war, riot, civil disobedience, nuclear explosion, nuclear accidents, or similar event whether a declared or undeclared war, except for illness or injury resulting from a medical condition or domestic violence
- Charges related to any illness or injury for which coverage is available in whole or in part under any Workers' Compensation Act or similar legislation

Determinations as to whether a new or existing drug, medical test, device or procedure is covered under the plan are made at the sole discretion of the plan administrator. You may obtain additional information about whether a drug or service is covered from the plan administrator or claim administrator.

Transplant Services

Organ or tissue transplant coverage is provided for approved transplant services obtained from a transplant facility through Aetna Networks, a preferred provider network of specialized professionals and facilities. When you go outside the Aetna network, coverage is provided at a reduced benefit level. See *PPO Covered Services*, beginning on page 16 for details on what the plan pays for covered services.

Covered transplant services include hospital charges, physician charges, ancillary services and prescription drugs for these transplants:

- Heart
- Lung
- Kidney
- Pancreas
- Liver
- Allogeneic bone marrow
- Autologous bone marrow
- Peripheral blood stem cell
- Cornea

Transplant Evaluation

The plan covers an initial evaluation for transplantation, including diagnostic testing, lab work, tissue typing, donor identification, harvesting and storage of bone marrow, therapeutic services, inpatient or outpatient healthcare services, surgical services and any services provided by a healthcare provider.

If a second opinion is required during the evaluation, the Transplant Case Manager will notify the potential transplant candidate covered by this plan. You can request a referral to a second Aetna transplant facility for another evaluation. If both evaluations determine the person is unacceptable for the transplant procedure, the plan will not pay for any further transplant-related services and supplies, even if a third facility accepts the person as a transplant candidate.

The plan will pay benefits beginning on the date you or your covered dependent receives an initial evaluation, and benefits will end:

- One year from the date the transplant procedure was actually performed
- The date the covered person is no longer eligible for plan benefits

… whichever occurs first.

Eligible Transplant Expenses

Eligible expenses include usual and reasonable expenses a covered person has for services and supplies, including:

- Initial evaluation, screening and candidacy determination
- Organ and tissue acquisition, including donor expenses not covered under the donor's benefit plan, such as:
  - Organ procurement from a non-living donor, including removing, preserving and harvesting the organ
  - Organ procurement from a living donor, including screening the potential donor, transporting the donor to and from the site of the transplant and medical services to remove the donated organ are provided to the donor in the interim and for follow-up care
- Eligible transportation, lodging and meal expenses

Covered organ and tissue transplantation expenses include inpatient room and board and ancillary charges, nursing care, inpatient drugs, outpatient facility charges, professional services and follow-up care, including immunosuppressant therapy. The plan covers transportation for the covered transplant recipient and one companion to and from an Aetna transplant facility, unless the recipient is a minor child; then, transportation for two companions will be covered. In addition, the plan covers the reasonable and necessary expenses for lodging and meals for the transplant recipient and one companion. Transportation, lodging and meal costs are covered only if the transplant recipient lives more than 50 miles from the Aetna transplant facility.

The plan covers up to two transplants for the lifetime of a covered person. If a re-transplant is needed, a new benefit period will begin at the time of initial evaluation for that transplant. Multiple organ/tissue transplants performed at the same time, such and heart and lung, are considered one transplant.

See *What's Not Covered by the PPO Options,* beginning on page 19, for exclusions to organ/tissue transplant services.

Pre-Existing Conditions and Creditable Coverage

A pre-existing condition is any condition for which you or your dependents received medical treatment or services, or took prescribed drugs or medicines, within six months before your date of hire. The PPO Plans do not cover pre-existing conditions until you have been employed for 12 months.

Pre-existing conditions do not include pregnancy or medical treatment of a newborn, adopted child under age 18 or child placed with you for adoption who is under age 18 if you enroll the child within 30 days of the birth, adoption or placement for adoption.

The pre-existing condition limit may be reduced by previous medical coverage if you become covered in a Denny's plan within 63 days of the date your previous coverage ends. You will receive "creditable coverage" or credit for previous healthcare coverage. Your creditable coverage equals the number of days you were covered by the previous plan and reduces the 12-month limit on a pre-existing condition. COBRA coverage also counts as creditable coverage, as long as you do not have a break of 63 days or more between the time you are covered by COBRA coverage and the time you become covered by the Denny's Medical Plan.

Proving Previous Coverage

Generally, when your coverage under a previous healthcare plan ends, you will receive a certificate showing your creditable coverage under the plan.

- If you are a new hire and/or choose medical coverage during annual enrollment, you should provide any certificate of previous coverage to the Denny's Total Rewards Department. This certificate will be reviewed, and you and your dependents will be credited with coverage to reduce the plan's pre-existing condition limitation.
- If your coverage or your dependent's coverage under this plan ends, you or your dependent will automatically receive a certificate of creditable coverage from the medical plan provider showing when coverage began and ended, and any waiting period satisfied.

Some health plan providers — including Medicaid and TRICARE — do not automatically provide a certificate when your coverage ends. If this happens, you should contact the plan administrator and ask for a certificate of creditable coverage.

If you don't receive a certificate, you can show that you have creditable coverage by providing documents, records or third-party statements, or through phone calls to a third party. Denny's Medical Plan will give you credit for coverage as long as you attest to the period of coverage, present evidence showing coverage and cooperate with any efforts to verify your previous coverage.

Notification of Creditable Coverage

If you enroll in Denny's Medical Plan and show proof of creditable coverage, you will receive a notice from the claim administrator that explains whether any pre-existing condition limitation will apply to you. This notice will include details on the information used to make the determination, along with an explanation of the plan's appeal process. You will also have an opportunity to provide additional evidence of prior coverage.

About Hospital Stays for Mothers and Newborns

Health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage for Reconstructive Surgery After a Mastectomy

As required by federal law, all Denny's healthcare options cover reconstructive breast surgery needed after a mastectomy, and reconstruction of the other breast to produce a symmetrical appearance, as well as prostheses and treatment of any physical complications of the surgery. These services are covered in the same way as other surgeries and services under each option.

Prescription Drug Coverage

Prescription drug benefits are provided under all Denny's medical plans. When you enroll in any Denny's PPO option, as well as many of the HMOs, your prescription drug benefits are 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.

The Denny's Kaiser and HMSA 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 Denny's Total Rewards Department at 1-800-859-2244 (Monday to Friday from 8:00 AM to 5:00 PM EST).

What Is a Formulary?

A formulary is a list of preferred prescription medications that cost less than their similar brand-name counterparts. 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.

Determining the Cost of Your Prescriptions

The cost of your prescription will vary depending on:

- Whether you fill it at a retail pharmacy in Medco's network or through the mail order program. (Remember — prescriptions filled at a retail pharmacy that is not in Medco's network are not covered under this plan.)
- The class of prescription drug you purchase.

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 Medco's preferred prescription drugs. Preferred drugs have been shown to be just as effective as similar non-formulary medications, but they are more cost-effective and therefore a better value.
- **Non-Formulary** – These brand-name prescription medications are not on the formulary and are typically the most expensive drug option.

Prescription Drug Benefits Through Medco

The following chart provides a summary of your prescription drug benefits.

	What the Plan Pays*
Network Retail Pharmacy (up to 30-day supply)	
Generic	100% after $10 copay
Formulary	100% after $25 copay
Non-Formulary	100% after $40 copay
Mail Order** (up to 90-day supply)	
Generic	100% after $25 copay
Formulary	100% after $60 copay
Non-Formulary	100% after $100 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 website (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 Medco network 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. And the site's "My Rx Choices" tool helps you research lower cost alternatives to prescription medications you may already be taking.

Medications Requiring Advance Approval

These medications covered by the prescription drug program require pre-authorization by Medco:

- Tretinoin, if you are age 24 or older
- Growth hormones
- Cerezyme
- Prolastin
- Epogen/Procrit
- Diflucan, except 150 mg tablets
- DDAVP, except injectable dosage form
- Sporanox capsules
- Lamisil tablets

For medications requiring advance approval, you must ask your doctor to request approval, using a Medco coverage review form, and explain in writing why the medication is being prescribed. Coverage review forms are available on Medco's website at www.medco.com/coverage. Your doctor may call Medco or you may fax the completed form to Medco Managed Care.

Fax form to 1-800-837-0959
or
Your doctor can call in the information to 1-800-753-2851

If you receive approval, the authorization is valid for up to one year from the date of your doctor's letter of medical necessity. During this time, you can purchase the medication at a participating pharmacy or through mail order, as

long as you are still a plan member. If the request is not approved, the medication will not be covered and you will be responsible for the full cost of the prescription.

What's Not Covered by the Prescription Drug Program

Most prescriptions for medically necessary conditions are covered by the prescription drug program. The program, however, does not cover:

- Weight management agents
- Depigmentation agents
- Photo-aged skin products
- Hair growth agents
- Implant contraceptive products
- Injectable contraceptive products
- Yohimbine for impotence
- Oral and injectable fertility agents
- Serums, toxoids and vaccines
- Over-the-counter equivalents
- Over-the-counter drugs, except insulin
- Prescriptions obtained from a non-participating pharmacy
- Durable medical equipment, except respiratory therapy supplies and non-insulin syringes
- Prescriptions refilled in excess of your doctor's specification or any prescription refilled more than one year after the doctor's original order

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's PPO Medical Plan, including the prescription drug program.

The *Participating in Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Medical Plan, including prescription drug coverage, indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

Dental Coverage

At-a-Glance

Denny's offers two dental care plan options:

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

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

	Option 1 $25 Deductible Plan	Option 2 $50 Deductible Plan
Considerations	▪ Lower deductible ▪ Lower out-of-pocket costs ▪ Higher contributions for coverage	▪ Higher deductible ▪ Higher out-of-pocket costs ▪ Lower contributions for coverage
Annual Deductible	$25/person	$50/person
Annual Maximum Benefit	$1,000/person for preventive, basic and major services combined	$750/person for preventive and basic services combined
Preventive and Basic Services	Plan pays 80% of R&C	Plan pays 80% of R&C after deductible
Major Services	Plan pays 50% of R&C after deductible	Not covered
Orthodontia Services	Plan pays 50% of R&C after deductible $2,000/person maximum lifetime benefit	Not covered

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.

Network Advantages

To help save on your out-of-pocket dental costs, you can choose a dental provider from the Aetna Dental PPO network. Using the network is voluntary but participating dentists offer services at preferred rates, lowering the cost of care for you.

To find a participating provider near you, call 1-877-238-6200 or go online to www.aetna.com.

Important Information

When you enroll in either dental option, you will receive a dental ID card with all enrolled dependents listed. You can use any dentist you choose. Your dentist can call Aetna at 1-800-451-7715 to verify eligibility and benefits.

If you have questions about benefits and covered services, call Aetna at 1-877-238-6200. Customer service representatives are available from 8 a.m. – 8 p.m. Eastern Time, Monday – Friday.

How Dental Expenses Are Paid

The Dental Plan covers a percentage of your eligible dental care expenses. Dental plan options pay the reasonable and customary — or R&C — cost of covered care as established by the claim administrator. R&C is the "going rate" for services in a geographic area. Here's how it works:

- You meet the calendar-year deductible for covered expenses when required by the plan.
- The plan pays a percentage of covered charges.
- You pay the rest.

The plan will not pay charges above R&C; you are responsible for additional charges. The plan continues paying a percentage of your covered services until you reach the calendar-year maximum for benefits for your dental option for the plan year, January 1 through December 31.

Dental Plan Covered Services

The following chart shows the major provisions of each dental option. You will find more detailed lists of covered services following this summary chart.

Covered Services	Option 1 $25 Deductible Plan	Option 2 $50 Deductible Plan
Preventive Treatment ▪ Two exams and teeth cleanings per year ▪ Annual fluoride treatments for children under age 16 ▪ One bitewing X-ray per year	80% of R&C no deductible	80% of R&C after deductible
Basic Restorative Treatment * ▪ Fillings ▪ Root canal treatment ▪ Tooth extractions	80% of R&C after deductible	80% of R&C after deductible
Major Restorative Treatment ▪ Crowns ▪ Inlays ▪ Onlays ▪ Bridges ▪ Partial and full dentures	50% of R&C after deductible	Not Covered
Orthodontia Treatment (covers braces and their related treatment)	50% of R&C after 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 and basic services combined

* Your dentist should call Aetna at 1-800-451-7715 before you receive treatment to verify eligibility and coverage.

Preventive covered services include:

- Exam, including teeth cleaning — up to two per calendar year
- One fluoride treatment per calendar year for children under age 16
- Full-mouth X-rays and panoramic X-rays once every 36 rolling months
- Bitewing X-rays — one per calendar year
- Sealants on posterior teeth of eligible children under age 16 — one treatment per tooth every 36 rolling months
- Prophylaxis — up to two per calendar year
- Space maintainers for children under age 14 to replace prematurely lost or extracted teeth
- Emergency care to relieve pain

Basic covered services include:

- Fillings
- Stainless steel crowns
- Root canal therapy
- Osseous surgery
- Periodontal scaling, root planing and other treatment of gums
- Simple extractions
- Surgical extractions
- Anesthesia when medically necessary for a covered, complex surgical procedure and billed as part of the surgery charge

Major covered services *(available with Option 1 only)* include:

- Gold or crown restorations resulting from extensive cavities or fracture, when tooth cannot be restored with amalgam, silicate, acrylic or plastic restoration
- Repair of crowns, inlays and bridgework
- Adjustments to dentures during the initial installment only
- Recement bridge
- Fixed bridgework
- Partial and full dentures, including adjustments during six-month period following installation

Orthodontia covered services for eligible children and adults ***(available with Option 1 only)*** include:

- Oral exam and diagnosis
- Braces or orthodontic appliances and adjustments
- X-rays
- Care and treatment

If you have questions regarding whether a particular dental service or procedure is covered under either dental option, 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.

What's Not Covered by the Dental Plan

Dental Plan Options 1 and 2 do not cover:

- Bleaching of discolored teeth
- Charges for porcelain crowns, porcelain fused to metal, resin processed to metal type crowns, or any cast restorations if you are under age 12
- Charges over and above reasonable and customary
- Charges you have before your effective date of coverage under this plan
- Charges for services and supplies not dentally necessary
- Charges for cosmetic purposes, unless otherwise specified by the plan
- Dental services that do not meet common dental standards
- Dental benefits for local anesthesia billed separately
- Charges for drugs or services that are covered under the Medical Plan
- Dental services provided by someone other than a dentist, except scaling or cleaning of teeth or fluoride application by a licensed hygienist under a dentist's supervision

- Any treatment not recommended or approved by a dentist
- Education or training
- Charges for services provided by a company's dental department or clinic
- Charges for services in excess of limitations documented by the plan
- Charges for services and supplies for experimental treatment or that are investigative and not proven safe and effective
- Charges for facings, veneers or similar material placed on molar crowns or pontics
- Charges for illness, injury or dental condition you have while taking part in an assault or felony, or injuries you have while engaged in an illegal occupation
- Dental implants and related procedures
- Appliances, restorations or any procedure for:
  - Increasing vertical dimension for restoring occlusion
  - Replacing tooth structure loss resulting from attrition
  - Correcting congenital or developmental malformations
  - Aesthetic purposes
- Charges for relining or rebasing a denture or partial within the first six months after the appliance was placed
- Additional treatment because of lack of your cooperation with the dentist or non-compliance with prescribed dental care, resulting in liability
- Charges for which no legal liability would exist had coverage under the plan not existed, and charges prohibited by any law of the jurisdiction in which you live at the time you have the expense
- Services provided by a dentist or other provider acting outside the scope of his license
- Costs for mileage, completion of claim forms and preparation of medical reports
- Charges for missed appointments
- Athletic mouth guards
- Charges for services provided to you at no cost or that would have been provided at no cost if this plan were not in effect
- Charges under one coverage of this plan that are payable under another coverage of this plan
- Personalization of crowns, dentures or bridgework
- Pontics, except for the replacement of missing teeth
- Services or supplies which can be paid for by any government agency
- Charges for repetitive treatment or the same treatment by more than one dentist
- Replacement of any appliances if you alter the appliance
- Replacement of cast restorations more than once every five years
- Replacement of lost, stolen or missing appliances, or replacement or repair of orthodontic appliances
- Charges for extracted teeth until you have been covered under the plan for 24 months
- Charges for replacement of prosthodontic appliances more than once every five years, unless a new appliance is needed for the loss of additional natural teeth
- Replacement of substructure, cores or posts more than once every five years
- Sales tax or other tax imposed by law
- Charges for an intentionally self-inflicted illness or injury, unless due to a medical condition
- Use of specialized dental techniques
- Charges for take home items, such as fluoride rinse, toothbrushes or floss
- Telephone consultations
- Charges for any temporary procedure or appliance
- Any travel expenses
- Any services provided by an immediate relative
- Services or supplies provided by the Veterans Administration or in any hospital or institution owned, operated or maintained by the U.S. government for a service-related illness or injury
- Replacement of a lost or stolen appliance
- Charges for treatment of any illness, injury or dental condition caused by war, act of war, riot, civil disobedience, nuclear explosion, nuclear accidents or similar events whether declared or undeclared war
- Charges for services that you are entitled to under any Workers' Compensation or occupational disease law

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Denny's Benefits Program* sections — is the summary plan description for Denny's Dental Plan.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Dental Plan indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

Vision Coverage

At-a-Glance

Denny's provides vision coverage through Vision Service Plan (VSP) for eye exams, lenses and frames, and contacts. You can see any vision care provider you want, but there are advantages to using VSP network doctors:

- You will receive a higher level of benefits when you use VSP network doctors.
- You do not have to file claims for reimbursement when you receive services.
- VSP has a large national network of doctors and eyewear providers to choose from.

Most network services are covered at 100% after your copay each time you receive care.

How the Plan Works

Using VSP Network Doctors

Generally, each time you receive care from a VSP network doctor, the plan pays the full cost after you pay a $10 copayment. Covered services include:

- One eye exam each calendar year
- One pair of glasses or contact lenses each calendar year ($10 copayment applies to glasses only)
- One pair of frames every 24 months

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, at:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

To receive a claim form, go to www.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.

The following chart shows what the Vision Plan pays for covered vision care and eyewear. Keep in mind that you pay a $10 copay for your exam at the time of service and then pay another $10 copay for either lenses or frames at the time eyewear is ordered.

Finding VSP Network Doctors

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

Vision Plan Covered Services

The following chart shows the major provisions of the Vision Plan, including how often each service is covered. Remember that, while you can see any vision provider you want, you will receive a higher level of benefits when you use VSP network doctors.

Covered Services	VSP Network Doctor	Non-VSP Provider	How Often Covered
Exams	100% after $10 copay	Up to $35	Once per calendar year
Lenses			
▪ Single vision		Up to $25	
▪ Lined bifocal	100% after $10 copay	Up to $40	Once per calendar year
▪ Lined trifocal		Up to $55	
▪ Lenticular		Up to $80	
Frames	Up to $120, plus 20% off any out-of-pocket costs	Up to $45	Once every two calendar years
Contact Lenses *			
▪ Medically Necessary	100% after $10 copay**	Up to $210**	Once per calendar year
▪ Elective Services	Up to $120**	Up to $105**	

* Contact lens benefits are covered in lieu of lenses and frames.

** 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.

Value Added Discounts

The Vision Plan offers you discounts on other eyewear and services as well:

- 20% discount on plano lenses, effective May 1, 2007
- 20% discount on additional complete pairs of non-prescription sunglasses
- Discounts on non-covered eyeglasses and contact lens services are available from any VSP doctor within 12 months of your last covered eye exam.

What's Not Covered by the Vision Plan

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 once in two calendar years, 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 reimbursement limit for contacts
- 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.

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's Vision Plan.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and plan administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Vision Plan indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

Flexible Spending Accounts (FSAs)

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 day care expenses — which means you keep more money in your pocket. In many cases, you save between 15% and 30% on eligible expenses.

Denny's offers two types of FSAs:

- Healthcare FSA
- Dependent Care FSA

A Flexible Spending Account allows you to set aside a portion of your pay in a special account. You can then use the money in your account(s) to reimburse yourself for qualified healthcare and dependent care expenses. Your taxable pay is reduced by the amount you set aside in your account(s), so you pay lower income taxes and Social Security taxes.

You can participate in one or both accounts. You decide whether you'd like to participate and how much money you'd like to set aside in each account each year.

Type of Account	What You Can Use it For	How Much You Can Set Aside	Annual Deadlines
Healthcare FSA	▪ Deductibles ▪ Copayments ▪ Healthcare expenses not covered under your medical, dental or vision plan ▪ Many over-the-counter medications	▪ From $100 to $5,000 each calendar year ▪ These funds can be used by you and your dependents who are eligible for tax-free health benefits.	▪ Funds for each plan year must be used by March 15 of the following year. ▪ Claims must be received by Aetna by April 15 of the following year.
Dependent Care FSA	▪ Services provided by babysitters or caregivers, including your relatives whom you do not claim as exemptions on your federal tax return ▪ Expenses for a housekeeper whose services include care of an eligible dependent ▪ Services provided by a licensed elder care center, child care center or nursery school ▪ Social Security and other taxes you pay a caregiver	▪ From $100 to $5,000 each calendar year ($2,500 each year if you are married filing separate returns)	▪ Funds for each plan year must be used by the end of the year. ▪ Claims must be received by Aetna by April 15 of the following year.

If you are a Highly Compensated Employee (HCE), you are not eligible to enroll in the Dependent Care FSA.

Annual Enrollment Required!
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 the 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 day care 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 paycheck before taxes are taken out
- Deposited in your spending account(s)

There are two ways to pay for eligible expenses from your FSA:

- 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. You can also use the FSA Debit Card for other expenses, such as over-the-counter items. See below for more details.
- For dependent day care expenses and eligible Healthcare FSA expenses for which you do not pay with your FSA Debit Card, 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.

The Pre-Tax Advantage

When you set aside pre-tax dollars in an FSA to pay 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% to 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.

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 at retirement. 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.

FSA Debit Card

The Aetna VISA FSA Debit Card can be used at a provider's office or hospital with the appropriate merchant category code (relating to health care).

The debit card transactions will be accepted as long as the account balance (elected amount minus any reimbursed expenses) is enough to cover the entire amount being purchased with the card. Additional documentation will be required if the amount of the transaction is not a known copay amount or if it is a coinsurance payment.

When the FSA Debit Card is used for prescriptions, and the employee is participating in the Denny's pharmacy plan through Medco, there will be no need for further documentation and the transaction will be substantiated or approved at the point of service.

When the card is used for other eligible FSA expenses, such as over-the-counter medicines purchased at a drug store, it may be necessary for further documentation to be submitted to approve the transaction in accordance with IRS requirements, so remember to keep your receipts. If further documentation or substantiation is not received, the debit card will still be available for use. However, you may receive a Form 1099 at year-end for expenses not substantiated per IRS guidelines.

Due to new IRS rules, beginning 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 2008. 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.

Eligible Healthcare Expenses

You can use your Healthcare FSA to reimburse yourself for healthcare expenses that are considered "medical care" under section 213(d) of the Internal Revenue Code, as long as the expenses are not reimbursed by any healthcare plan and are incurred before the end of any applicable grace period. The expenses must be for your medical care or the medical care of your dependent who are eligible for tax-free health benefits.

A person who qualifies for tax-free health plan benefits, includes any of the following individuals:

- Your opposite-sex spouse
- A person for whom you can claim an exemption on your federal taxes
- A person who meets all of the following criteria:
  - Is your child (by birth or adoption), stepchild or foster child; your sibling or, step-sibling; or the descendant of your child, stepchild, foster child or sibling
  - Lives with you for more than half the year
  - Doesn't provide more than half his own support for the year
  - Is age 18 or younger for the entire calendar year; age 23 or younger and a full-time student for the entire calendar year; or permanently and totally disabled at any time during the calendar year (regardless of age)
  - Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household
- Another dependent, domestic partner or same-sex spouse who meets all of the following criteria:
  - Receives more than half of his or her support from you during the calendar year
  - Can't be claimed as anyone's "qualifying child" dependent
  - Is your relative or, if the person is not your relative, he or she must live with you for the entire calendar year as a member of your household (except for temporary reasons such as vacation, military service or education) and the relationship cannot be in violation of local law
- Is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household.

Tax rules change, so you should check with your tax advisor about the eligibility of specific expenses. You can get additional information about eligible healthcare expenses from IRS Publication 502, "Medical and Dental Expenses," which is available from your local IRS office and on the IRS website in the forms and publications section at http://www.irs.gov.

Eligible expenses include:

- Acupuncture
- Ambulance service
- Artificial limbs
- Auto equipment such as special hand controls to assist the physically disabled
- Braille books and magazines
- Chiropractic care
- Contact lenses needed for medical reasons that are not covered by the Vision Plan
- Contraceptives that are not covered by the Medical Plan
- Crutches
- Dental treatment not covered by the Dental Plan
- Drug abuse inpatient treatment
- Drugs that do not require a physician's prescription (over-the-counter medications), as long as they are for medical care, and not merely beneficial to your overall general health. Examples of reimbursable expenses include charges for pain relievers, cold and fever remedies, antibiotic ointments, and allergy medications.
- Eye exams, lenses and frames not covered in full by the Vision Plan
- Fertility enhancement, as follows:
  - Procedures such as in vitro fertilization (including temporary storage of eggs or sperm), and
  - Infertility surgery, including an operation to reverse a prior sterilization procedure
- Guide dog or other animal used by a visually-impaired or hearing-impaired person
- Hearing exams and hearing aids
- Hospital services
- Laboratory fees
- Laser eye surgery
- Lead-based paint removal to protect a child who has, or who has had, lead paint poisoning from continued exposure
- Legal fees directly related to committing a mentally ill person
- Lodging while you receive medical care away from home. Care must be provided by a doctor in a licensed hospital or treatment facility, and the lodging must be primarily for, and essential to, medical care.
- Long-term care services required by a chronically ill person, if provided in accordance with a plan of care prescribed by a licensed healthcare practitioner
- Medical information plan that maintains your medical information so it can be retrieved from a medical data bank for your medical care
- Medical services and supplies not covered by the Medical Plan
- Mental health care not covered by the Medical Plan
- Organ donor expenses
- Osteopathic services
- Oxygen and oxygen equipment
- Prescription drugs not covered by the Medical Plan
- Psychiatric care not covered by the Medical Plan
- Smoking cessation programs
- Specialized equipment for the disabled, including:
  - Cost and repair of special telephone equipment that allows a hearing-impaired person to communicate over a regular telephone
  - Equipment that displays the audio part of television programs as subtitles for hearing-impaired people
- Sterilization surgery
- Termination of pregnancy
- Transportation expenses if primarily for, and essential to, medical care
- Wheelchairs

The following healthcare expenses also qualify for tax-free reimbursement through a Healthcare FSA:

- Healthcare copayment, deductible and coinsurance amounts
- Healthcare expenses that are above the reasonable and customary charge or healthcare plan maximums

Ineligible Healthcare Expenses

Just as important as understanding what's eligible for reimbursement through your Healthcare FSA is knowing what's not generally eligible, including the following:

- Expenses for which you've already been reimbursed by other healthcare plans (including Medicare, Medicaid and Denny's or any other medical, dental and vision plans)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that are not deductible on your federal income tax return
- Babysitting, child care and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn
- Controlled substances
- Cosmetic dental work
- Cosmetic surgery (any procedure to improve the patient's appearance that does not meaningfully promote the proper function of the body, or prevent or treat illness or disease)
- Custodial care in an institution
- Diaper service
- Electrolysis
- Funeral and burial expenses
- Healthcare plan contributions, including those for Medicare, your spouse's employer's plan, or any other private coverages
- Health club dues
- Household help, even if such help is recommended by a physician
- Illegal medical services or supplies
- Maternity clothing
- Medical savings account (MSA) contributions
- Over-the-counter health aids that do not treat a specific medical condition, including those recommended by your physician
- Over-the-counter drugs that are beneficial to health, but are not for medical care (for example: vitamins, weight loss aids)
- Nutritional supplements, unless obtained legally with a physician's prescription
- Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness
- Prescription drugs for cosmetic purposes
- Weight loss programs not prescribed by a doctor
- Special schooling for a problem child, even if the child may benefit from the course of study or disciplinary methods
- Transportation to and from work, even if a physical condition requires special means of transportation
- Upfront patient administration fees paid to a physician's practice
- Vitamins or minerals taken for general health purposes

For more information on Healthcare FSAs and a complete list of eligible expenses, go to the IRS website 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.

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 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 are both working, but one of you earns less than $5,000 a year	You may only set aside as much as the spouse with the lower income earns
If one spouse 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

Effective May 2007, if you are a Highly Compensated Employee (HCE), you are not eligible to participate in the Dependent Care FSA.

Eligible Dependent Care Expenses

The Dependent Care FSA is strictly monitored by the IRS, and only those expenses that are incurred before the end of the year and comply with Section 129 of the Internal Revenue Code of 1986 are covered. Keep in mind that the expenses must be work-related to qualify as eligible expenses. The IRS considers expenses "work-related" only if they meet ***both*** of the following rules:

- They allow you (and your spouse) to work or look for work.
- They are for the care of a qualifying individual.

You can pay the following work-related expenses through your Dependent Care FSA:

- Wages paid to a baby sitter, unless you or your spouse claims the sitter as a dependent. Care can be provided in, or outside of, your home.
- Services of a dependent care center (such as a day care center or nursery school) if the facility:
  - Provides care for more than six individuals (other than those who reside there)
  - Receives a fee, payment or grant for providing its services
  - Complies with all applicable state and local laws and regulations
- Cost for adult care at facilities away from home, such as family day care centers, as long as your dependent spends at least eight hours at home
- Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home which are at least partly for the care of a qualifying individual, are covered as long as the person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

You can get additional information about eligible dependent care expenses from IRS Publication 503, "Child and Dependent Care Expenses," which is available from your local IRS office and on the IRS website in the forms and publications section at http://www.irs.gov.

Questions about Eligible FSA Expenses?

If you have any questions about what's considered an eligible expense under either FSA, you can call Aetna Member Services at 1-888-238-6226 or visit www.aetnafsa.com.

You can also contact your local IRS office or visit the IRS website at http://www.irs.gov.

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 the age of 19 or any person you claim as a dependent on your federal income tax return
- Expenses for dependent care when you or your spouse is not working
- Transportation expenses
- Child support payments
- Tuition expenses
- Education expenses for the kindergarten and above
- All overnight camp expenses
- Other 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

In addition, you cannot use your Dependent Care FSA to reimburse yourself for services that:

- Allow you to participate in leisure-time activities
- Allow you to attend school part-time
- Enable you to attend educational programs, meetings or seminars
- Are primarily medical in nature (such as in-house nursing care)

For more information on Dependent Care FSAs and a list of eligible expenses, go to the IRS website 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 this publication. For a final determination on eligible expenses, contact Aetna at 1-888-238-6226.

Important Rules About FSAs

The federal regulations governing Section 125 of the Internal Revenue Code include specific rules that 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 the calendar year, you can use your remaining balance for expenses incurred up through March 15 of the following year. You have until April 15 of the following year to submit Healthcare FSA claims. For the Dependent Care FSA, you have until April 15 of the following year to submit your claims for expenses incurred during the calendar year. 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.
- **Terminations.** If your employment is terminated, voluntarily or involuntarily, you may file claims against your account as long as the expenses were incurred before your termination date. You may continue submitting claims until April 15 following the plan year in which you incurred the expenses. Under certain circumstances, 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 Healthcare FSA, a dependent is someone who is eligible for tax-free health benefits. For the Dependent Care FSA, a dependent is a qualifying individual.

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's Flexible Spending Accounts.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Healthcare FSA and Dependent Care FSA plans indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

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

At-a-Glance

Life insurance provides financial protection for your family or beneficiary when you die. Here are the highlights of Denny's Life Insurance and Basic Accidental Death and Dismemberment (AD&D) benefits:

- Denny's provides Basic Life Insurance coverage to eligible salaried employees, at no cost to the employee, equal to one times annual base salary.
- You can also purchase Supplemental Life Insurance coverage for yourself and your dependents.

Supplemental Coverage for:	Coverage Amounts Available
You	Additional one, two, three or four times annual base salary
Your spouse/ domestic partner	$20,000, $40,000, $60,000, $80,000 or $100,000
Your dependent child(ren)	Each eligible child six months or older: $5,000 or $10,000 Each child under six months: $2,500

- 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 — as long as you have not reached age 70. In some cases, you may convert your group life insurance to an individual policy. Details on this conversion provision can be found on page 50.

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

Denny's provides Basic Life Insurance coverage equal to one times your annual base salary, rounded up to the nearest $1,000, up to a maximum of $1,500,000 (combined with Supplemental Life amounts). Denny's also provides Basic Accidental Death and Dismemberment (AD&D) coverage equal to one times annual base salary.

Supplemental Accident Insurance

Denny's also offers supplemental accident insurance. See *Personal Accident Insurance (PAI)*, beginning on page 53, for details.

Annual Base Salary and Coverage Amounts

Your life insurance and AD&D benefits are based on your annual base salary. Your annual base salary each year is your base salary as of October 1 of the previous year. For instance, your annual base salary for determining your coverage in 2008 is based on your base salary as of October 1, 2007.

If you are a new hire, your life and AD&D benefits are based on your annual base salary as of your date of hire. If you are promoted to a salaried position from an hourly position, your life and AD&D coverage amounts will be based on your annual base salary as of the day you become a salaried employee.

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

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 salary, 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.

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%
Child Education	Lesser of 2% or $2,000 each year for four years (per child)
Coma Benefit	1% of benefit amount payable monthly for up to 100 months
Child Care	Up to the lesser of 3% or $3,000 (per child)
Exposure and Disappearance	Benefit paid
Paralysis	Benefits paid according to set schedule
Repatriation	Lesser of actual cost or $5,000
Seatbelt	Lesser of $25,000 or 10%
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 combined coverage for Basic and Supplemental Life Insurance may not exceed $1,500,000.

For You

You can purchase Supplemental Life Insurance coverage for yourself in any of the following amounts, rounded up to the nearest $1,000:

- One times your annual base salary
- Two times your annual base salary
- Three times your annual base salary
- Four times your annual base salary

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

Example

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

For Your Spouse/Domestic Partner

You can purchase Supplemental Life Insurance coverage for your spouse or domestic partner in any of the following amounts:

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

For Your Children

You can purchase Supplemental Life Insurance coverage for your children in the amount of:

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

Important Note About Spouse Coverage

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

Unmarried 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.

When Evidence of Insurability (EOI)/Proof of Good Health Is Required

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

- You enroll in any of the supplemental coverage options after your initial enrollment period — or 31 days after your date of hire
- You move from "hourly" to "salaried" status and you do not enroll within 31 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 annual base salary 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, the 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

You will be taxed on the value of Basic and Supplemental Life Insurance coverage over $50,000. Any taxable life insurance will be reported on your W-2 at year end.

Naming a Beneficiary

For Your Coverage

It is important to name a beneficiary who will receive benefits from the plan if you die. Your beneficiary for Basic Life Insurance can be different from your beneficiary for Supplemental Life Insurance. To name a beneficiary, you must complete the beneficiary section at the time you enroll in the plan. 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.

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 executor or administrator 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.

Extended Coverage During Disability

If you stop working at Denny's because you are totally disabled, you may be eligible to receive extended Basic and Supplemental Life Insurance (employee life insurance) coverage during your period of disability. You are considered totally disabled when you are completely unable to perform any occupation for wage or profit because of injury or sickness as determined by Minnesota Life Insurance Company.

Minnesota Life has the right to require proof of your continuing total disability and have a designated physician examine you at any time while your coverage is being extended.

If Disabled Before Age 60

If you stop working for Denny's before age 60 because you are totally disabled, your Basic Life Insurance will continue — if approved by Minnesota Life — at no cost to you as long as you have been totally disabled for at least six months and have provided acceptable proof of your disability. Such proof must be submitted no later than one year after you stop working due to the disability. Coverage will be extended as long as you remain totally disabled and submit proof of the continuation of your total disability when requested.

Extended coverage will end as described under *When Extended Coverage Ends* on this page.

If You Die While Disabled

If you die during the period of extended coverage, written notice of your death must be provided to Minnesota Life within one year of your death or no benefits will be paid. The benefit will be the amount of coverage you had as of the day you stopped working due to your disability — or your last day of active service at Denny's.

When Extended Coverage Ends

Extension of your Basic Life Insurance coverage resulting from a disability will end:

- When you are no longer totally disabled
- If you do not submit to a physical exam when required by Minnesota Life
- If you fail to provide proof of continuous total disability
- When you reach age 65

If you return to work at Denny's after your disability ends and become eligible under the group policy, your Basic Life Insurance coverage will continue at no cost to you. If you have Supplemental Life Insurance coverage, it will continue as long as you continue to make the required contributions. If you are not eligible for benefits under the group policy after your disability ends, you may convert your coverage to an individual policy.

Coverage Reductions as You Get Older

As you get older, your Basic and Supplemental Life Insurance coverage will be reduced as shown here.

When You Reach This Age …	Your Coverage Will Be Reduced to This Level …
Age 65	65%
Age 70	50%
Age 75	25%

For example, if your coverage is $84,000 when you reach age 65, it will be reduced to 65% of that amount, or $55,000 (65% of $84,000 is $54,600 rounded up to the nearest $1,000 is $55,000).

Reductions take effect immediately on the date you reach any of the ages noted in the previous chart. Your Accidental Death and Dismemberment Insurance ends when you reach age 70.

Changing Supplemental Coverage Amounts

For You

You can change your Supplemental Life Insurance coverage amount each year during the annual benefits enrollment period. You can increase your coverage by one level each year. For example, if you have coverage equal to two times your pay this year, you can increase your coverage by one level during annual enrollment. This will mean that you have coverage equal to three times your pay next year. If, however, you increase your coverage by more than one level during annual enrollment or your total amount of life insurance (Basic and Supplemental coverage combined) is more than $500,000, you will need to provide Evidence of Insurability (EOI).

For Your Spouse/Domestic Partner

You may change your spousal coverage amount each year during the annual benefits enrollment period. You can increase your spouse/domestic partner's coverage by one level each year. For example, if you have spousal coverage of $20,000 this year, you can choose to increase coverage to

$40,000 for next year. You will need to provide satisfactory EOI for any coverage level greater than $40,000.

When Coverage Ends

Your Basic and Supplemental Life Insurance coverage will end:

- The day you leave employment with Denny's for any reason, including retirement
- The date you retire or terminate your employment (your last day of active service)
- The date you no longer meet the eligibility rules
- The date your Basic coverage ends, at which time your Supplemental coverage, if any, ends too
- The date the group plan ends
- When you stop making the required contribution for Supplemental Life Insurance coverage
- The date you enter the armed forces of any country, excluding service in the reserves or a call of duty for two months or less

In addition, dependent coverage will end in any of the following situations:

- Spouse/domestic partner coverage will end on the date:
  - Your basic coverage ends
  - Your spouse/domestic partner is no longer eligible for coverage
- Dependent child coverage will end on the date:
  - Your basic coverage ends
  - Your child is no longer an eligible dependent; for example, because she/he reaches the eligibility age limit or gets married

If you stop working for Denny's because of injury or sickness, coverage will continue while you remain totally and continuously disabled. See *Extended Coverage During Disability*, beginning on page 47 for details. If your situation is not addressed in this section, your insurance coverage will end on the date Denny's stops paying for your coverage or cancels your insurance.

If you continue to work for Denny's until you reach age 70, your Basic AD&D coverage will end at that time.

When your or your dependent's coverage ends, you may be eligible to convert this coverage to an individual policy. See the next page for more information on conversion.

Living Benefit (Accelerated Benefits)

A living benefit option can provide financial assistance if you become terminally ill. If your doctor determines you are terminally ill and have 12 or fewer months to live, you may apply to receive a living benefit — or a smaller part of your life insurance benefit — while you are living.

A living benefit is a percentage of your combined Basic and Supplemental Life Insurance benefits, up to a maximum of $1,000,000. The benefit payable upon death will be reduced by any benefits paid under the living benefit option. For more information, contact Minnesota Life at 1-800-872-2214.

Portability

You can take your Supplemental Life Insurance coverage with you (also known as "porting" your coverage) if your Denny's employment ends for any reason other than illness or injury. You can port the amount of your supplemental coverage, up to a maximum of $750,000 within 31 days of the date your Denny's coverage ends. If you are age 65 or older when you port, you may take a maximum of $487,500. In either case, you do not need to provide Evidence of Insurability (EOI). When you port your coverage, you may also port your dependent coverage. You cannot port coverage if you are age 70 or older.

When your ported coverage ends, you may convert the amount of your coverage to an individual conversion policy. Contact Minnesota Life or the Total Rewards Department for the necessary forms.

Converting to an Individual Policy

You have the option to convert the full amount of your Basic and Supplemental Life Insurance, as well as your Dependent Life Insurance, to an individual policy if your Denny's coverage ends because:

- You are no longer eligible for life insurance
- You stop working for Denny's
- You die, in which case your dependents can convert coverage
- Your spouse/domestic partner is no longer an eligible dependent
- Your child is no longer an eligible dependent; for example, because she/he reaches the eligibility age limit or gets married
- You retire or your coverage amount is reduced because of a change in eligibility class; for example, because you go from full-time to part-time employment

You must submit a written application to Minnesota Life and pay the first premium within 31 days of the date your coverage under the group policy ends. Provided you meet these requirements within the 31-day time period, the individual policy becomes effective 31 days after your Denny's coverage ends. When you apply for individual coverage, you will not need to provide EOI.

You may also convert a limited amount of life insurance coverage if the Denny's group policy terminates or is changed to reduce or terminate your coverage. However, in order to do so, you need to have been covered for at least five years under the Denny's group policy prior to one of those events occurring. If you qualify, you may convert the full amount of your group life insurance, up to a maximum amount of either:

- $10,000, or
- The amount of your coverage under the terminated Denny's plan *minus* the total amount of any other group life insurance for which you become eligible under any group policy issued or reinstated by Minnesota Life or any other insurer within 31 days of the date your coverage under the Denny's policy ended

… whichever is less.

If You or Your Dependent Dies During the 31-Day Conversion Period

Your beneficiary, or you in case your spouse/domestic partner dies, will receive the amount of insurance coverage that the beneficiary would have received under the group policy, whether or not you applied for an individual policy or paid the first premium before your or your dependent's death.

To convert your group coverage to an individual policy:

- Request an application from the Denny's Total Rewards Department
- Return the written application
- Pay the first premium to Minnesota Life within 31 days after your group coverage ends

Remember, it's *your* responsibility to apply for coverage. You will not receive a conversion application from Denny's unless you request it.

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.

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's Life Insurance coverage.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Life Insurance Plan indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

Personal Accident Insurance (PAI)

At-A-Glance

Denny's offers Personal Accident Insurance (PAI) as a way to provide financial support in the event of an accidental death or physical loss. Here are the highlights of the PAI Plan:

- You can purchase coverage of $25,000, $50,000, $100,000, $150,000, $250,000 or $500,000 for yourself only or for yourself and covered dependents.
- Coverage is provided for family members, including your spouse/domestic partner and children, at a percentage of your coverage amount.
- When you select family coverage, you may also be eligible for additional benefits.

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

How PAI Works

PAI is Accidental Death and Dismemberment (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, in one of the following amounts:

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

You can also choose coverage for you and your family. When you choose family coverage, your spouse/domestic partner and eligible dependent children are automatically covered and receive a percentage of your coverage amount. The benefit you, or your family members, 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

Maximum PAI Benefits

Your PAI coverage cannot be more than ten times your annual base salary. If, for instance, your base annual salary is $26,000, you could select the $250,000 coverage level but you could not choose the $500,000 coverage.

Your PAI benefit is based on your annual base salary. Your annual base salary each year is your base salary as of October 1 of the previous year. For instance, your annual base salary for determining your coverage in 2008 is based on your base salary as of October 1, 2007.

If you are a new hire, your PAI benefit is based on your annual base salary as of your date of hire. If you are promoted to a salaried position from an hourly position, your PAI coverage amount will be based on your annual base salary as of the day you become a salaried employee.

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

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 100% of the 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 as shown in the chart above.

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	Percentage of Benefit Payable*
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
Either hand or foot and sight of one eye	100%
Movement of both upper and lower limbs (quadriplegia)	100%
Movement of any three limbs (triplegia)	75%
Movement of both lower limbs (paraplegia)	75%
Movement of both upper and lower limbs of one side of the body (hemiplegia)	67%
Movement of one limb (uniplegia)	50%
Both speech and hearing	100%
One hand or one foot	50%
Sight of one eye	50%
Speech or hearing	50%
Thumb and index finger of either hand	25%

* 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

Naming a Beneficiary

For Your Coverage

It is important to name a beneficiary who will receive benefits from the plan if you die.
To name a beneficiary, you must complete the beneficiary section at the time of your enrollment in the plan. You may change your beneficiary designation at any time. To request a change form, call the Denny's Total Rewards 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:

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 executor or administrator 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.

Coverage Reductions as You Get Older

The amount of your Personal Accident Insurance coverage will be reduced on the January 1 following the year you reach age 70. As you grow older, it will be further reduced as shown in the following chart.

At This Age …	Your Coverage Amount Is Reduced to …
70-74	65% of benefit
75-79	45% of benefit
80-84	30% of benefit
85 and older	15% of benefit

As an example, if you choose the $150,000 coverage option, your coverage amount would be reduced to $97,500 (65% of $150,000) on the January 1 following the year you reach age 70. It would be further reduced to $67,500 (45% of $150,000) on the January 1 following the year you reach age 75.

Other Benefits Provided by Personal Accident Insurance

If you select family coverage, 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.

Education Benefit

If you die because of an accident covered by this plan, your covered dependent child may receive either an annual or one-time education benefit, depending on your child's age at the time of your accident.

An annual education benefit is payable if, on the date of your accident, your dependent child is:

- In the 12th grade and enrolled in an institution of higher learning within 365 days following the date of your accident
- Enrolled as a full-time student in an institution of higher learning beyond the 12th grade

The annual education benefit is 5% of your coverage amount — up to $5,000. There is a $2,500 minimum benefit. The benefit will be paid each year for up to four consecutive years, as long as your child is enrolled as a full-time student in an institution of higher learning.

Your surviving spouse covered by this plan may also receive an education benefit if you die because of an accident covered by this plan. Your spouse must enroll in an occupational training program within one year of your death.

Additional Benefit for Covered Losses of Dependent Children

If your dependent child suffers a covered physical loss, other than loss of life, the plan will pay two times the amount payable for the loss.

Survivor's Benefit

If you or your spouse/domestic partner dies in an accident, the plan will pay a survivor's benefit to the surviving spouse/domestic partner or dependent. The monthly survivor's benefit is 1% of the coverage amount payable. The survivor's benefit is paid each month for up to six months.

Rehabilitation Physical Therapy for Accidental Dismemberment Benefit

If you have a covered loss because of an accidental injury within 365 days of the date of the accident, the plan will pay 5% of your coverage amount, up to $5,000, for rehabilitative physical therapy prescribed by your attending physician or surgeon.

Monthly Coma Benefit

If you or another covered person has a loss because of a covered injury within 365 days of the date of the accident, which results in your being in a coma for at least 30 consecutive days, the plan will pay a monthly coma benefit. The benefit will be paid each month for up to 100 months of a continuous coma. No benefit will be paid after the comatose condition has ended.

The monthly coma benefit will be the lesser of:

- 1% of the covered individual's coverage amount
- 1% of the difference between the full coverage amount and the amount of any benefit paid for loss arising out of the same accident

In no case will the total amount paid for all benefits exceed the total coverage amount. The coma must be verified by competent medical authority.

Day Care Benefit

If you select family coverage and either you or your spouse/domestic partner dies in a covered accident, the plan will pay a day care benefit. The benefit will be equal to 5% of your or your spouse/domestic partner's coverage amount, but cannot exceed the actual cost of child care, up to $5,000 a year. There is a $2,500 minimum benefit. Your dependent child must have been enrolled in an accredited child care facility on the date of the accident — or be enrolled within 90 days from the date of loss.

If both you and your covered spouse/domestic partner die, the day care benefit will be based on your coverage amount.

The day care benefit will be paid annually for a maximum of four consecutive annual payments, but only if the dependent child is under age 13 and remains enrolled in an accredited licensed child care facility. The benefit will be paid to the surviving spouse/domestic partner. If there is no surviving spouse/domestic partner then the benefit will be paid to the child's legally appointed guardian.

An accredited child care facility is any facility:

- Operating according to state and local laws
- Licensed by the state for such child care purposes
- Having an IRS provider tax identification number

The plan does not cover a hospital, the child's home, a nursing home, convalescent home, a facility for the treatment of mental disorders, an orphanage or a treatment center for drug and alcohol abuse.

Seatbelt Benefit

The plan may provide an additional accidental death benefit to your beneficiary if you die in an automobile accident while wearing a seat belt as verified by the police report.

The plan will pay up to 10% of your benefit. The maximum seat belt benefit is $25,000.

The plan will not pay a benefit if the accident occurs while you are under the influence of an abusive substance.

What's Not Covered by PAI

No benefits will be paid for a loss resulting in any way from:

- Bodily or mental infirmity
- Disease or bacterial infection, except as the result of an accidental cut or wound
- An intentionally self-inflicted injury
- Suicide (in Missouri, while sane), or any suicide attempt
- Service in the armed forces of any country (the premium you paid the year you went into the armed forces will be returned to you)
- War or any act of war, whether declared or undeclared
- Operating or learning to operate an aircraft, serving as a member of the crew of an aircraft or while riding in any aircraft operated by or under any military authority, except a transport aircraft of the armed forces of a country or an aircraft used for testing or experimental purposes

When Coverage Ends

Personal Accident Insurance coverage ends on the earliest of:

- The date you stop working for Denny's for any reason or retire
- The date you choose to stop coverage during the annual enrollment period; coverage will end on the last day of that calendar year
- The date you no longer meet the eligibility rules
- The date the group plan ends

If PAI coverage through Denny's ends, or you are no longer eligible for coverage, you may convert this coverage to an individual policy.

Converting to an Individual Policy

You can convert your group PAI to an individual policy if your coverage ends because:

- You are no longer eligible for PAI
- The group plan ends

You may convert to an individual policy for Personal Accident Insurance coverage of up to $100,000. You pay the full cost of coverage under your individual policy. The cost of the insurance will be based on the amount of coverage you select and your age. You may renew your individual policy each year, with The Hartford's approval, until you reach the maximum age under the policy.

When you apply for individual coverage, you do not have to provide Evidence of Insurability (EOI). You will have to:

- Request an application from the Denny's Total Rewards Department
- Return the completed application
- Pay the first premium to the plan administrator within 31 days after your Denny's coverage ends

It is *your* responsibility to apply for this coverage. You will not receive a conversion application from Denny's unless you request it.

The converted policy becomes effective on the date your Denny's coverage ends or on the date you apply for an individual policy, whichever happens later. Your individual policy may contain any exclusion contained in the policy and this group policy. Benefits payable under the individual policy will be reduced by the amount of any benefit payable under the Denny's coverage after the Denny's coverage ends.

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's Personal Accident Insurance coverage.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Personal Accident Insurance plan indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

Disability Coverage

At-A-Glance

Short- and Long-Term Disability coverage provides income in the event you are unable to work due to an approved disability resulting from an illness or injury. Here are the highlights:

Short-Term Disability (STD)

- Denny's provides STD benefits at no cost to you.
- You are eligible for STD benefits after you complete six months of service.
- STD benefits give you replacement income equal to either 100% or 50% of your base weekly salary, depending on your length of service.
- STD benefits are payable for up to:
  - 13 weeks if you have six months to one year of Denny's service
  - 26 weeks if you have one or more years of Denny's service
- STD benefits coordinate with other disability benefits you receive, such as Social Security or state disability.

Long-Term Disability (LTD)

- You are eligible for LTD coverage immediately on your date of hire.
- Basic LTD coverage replaces 50% of your base monthly salary, up to $15,000 a month. The minimum monthly benefit is $50.
- You can choose to purchase additional coverage equal to 10% of your base monthly salary, to replace a total of 60% of your base monthly salary, up to $15,000 a month.
- LTD benefits begin after 180 days of approved disability and coordinate with other disability benefits you receive.

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 an approved disability resulting from an injury or illness. To be eligible for benefits:

- You must complete six months of service
- You must be unable to do all material duties of your regular occupation because of sickness or injury.
- Your disability must begin while you are covered under this plan.
- Your disability must be approved by Denny's disability administrator. To begin STD benefits, call The Hartford at 1-800-741-4306.

STD benefits are payable for up to:

- 13 weeks, if you have six months to one year of Denny's service
- 26 weeks, if you have one or more years of Denny's service

STD Benefit Amounts

The benefit you receive under the STD plan depends on your length of service. You receive 50% or 100% of your base weekly salary as of the date you became disabled. Your base weekly salary 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 the first …**	50% of your base weekly pay will be paid for the next …**	Payment begins …
6 months to 1 year	1 week	12 weeks	Day One of your approved 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 benefits if you have less than six months of service with Denny's.

** Length of disability must be approved by Denny's disability administrator.

How STD Affects Other Benefits

Your other Denny's benefits, including medical and prescription drug, 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 STD period.

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

Returning to Work

If you return from STD leave within a reasonable period of time, you may return to your former job with no break in service. If your job has been filled, Denny's will attempt to find you a similar position with similar pay. If eligible under the Family and Medical Leave Act, you are entitled to be returned to your same or comparable position if you return to work within twelve (12) weeks of the date your disability began. If you return to your job after twelve (12) weeks and your job has been filled, Denny's 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 removed from the active payroll. At that time, you may be eligible to receive LTD benefits.

How STD Payments Coordinate with Other Disability Benefits

STD benefits coordinate with any other agency-provided disability benefits you receive. This means that any disability benefit payments you may receive from other sources, such as Social Security and federal, state and local government disability programs, will be subtracted from your Denny's STD benefit; the benefit you receive from this plan will be reduced by any other benefit amounts.

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 disability administrator when you become disabled since these states have mandatory disability benefit programs. If your disability is approved, you will receive a disability check from the state. Your Denny's benefit will be equal to 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.

Verifying Your Disability

You may be required to periodically submit a doctor's verification of your disability. You must pay any charges associated with this verification.

You also may be required to be examined by a doctor selected by the disability administrator. You will not be charged for this examination.

Failure to provide verification of your disability may cause STD benefits to end.

If Your Disability Recurs

If you are receiving disability benefits, recover and return to work, but are then disabled again for the same or related cause within two weeks of your return to work, you will be considered in the same period of disability.

For example:

- If you have four years of service, you are eligible to receive 100% of your base salary for up to the first eight weeks of your disability.
- Suppose you receive disability pay for three weeks and then return to work.
- Then, you become disabled again due to the same condition within 10 days of returning to work.
- You are still eligible for an additional five weeks of benefits at 100% of your base weekly salary and 18 weeks at 50% of your base weekly salary.

You are eligible for a new maximum benefit period if your disability is unrelated to or begins at least two weeks after any previous disability.

When you return to work after a disability, you must give your supervisor or the Total Rewards Department a doctor's statement approving your return to work, including a release date.

When Short-Term Disability Benefits End

Short-Term Disability benefits will end on the earliest of the date:

- You are no longer disabled
- You reach the maximum benefit period in the benefit schedule
- You fail to provide the required proof of total disability or to take a required medical exam
- Coverage under this program ends for you or for your class of employees
- You begin an absence other than a disability absence

If you are disabled and cannot work when your STD benefits end, you may be eligible for continued benefits under the Long-Term Disability Plan.

What's Not Covered by the Short-Term Disability Plan

Benefits will not be paid if you are disabled because of:

- Injury received while working for pay for another employer
- Sickness or injury that occurred before you became eligible for coverage under this plan
- Sickness or injury that begins after your employment has been terminated
- Sickness or injury resulting from war, or any action of war or aggression, or from active participation in a riot
- Suicide attempt or other intentionally self-inflicted injury
- Participation in a felony
- Sickness or injury that begins after your eligibility for STD coverage ends
- A condition that begins while you are not under the regular and continuing care of a doctor (other than yourself or a member of your immediate family) or are not following a prescribed course of treatment for the sickness or injury causing your disability

Short-Term Disability benefits paid, payable, or for which there is a right under any Workers' Compensation or occupational disease act or law, or any other law which provides compensation for an occupational injury or sickness, are not covered under the STD Plan. If a Workers' Compensation claim is denied, The Hartford will consider the claim under this plan after receiving a denial letter from Workers' Compensation.

Long-Term Disability (LTD) Insurance

How the LTD Plan Works

Basic LTD coverage replaces 50% of your monthly base salary if you become totally disabled. Monthly base salary is your monthly salary, excluding commissions, overtime earnings, incentive pay, bonuses, or other compensation. Your monthly base salary is determined by your rate of pay at the time your disability occurs.

You can also choose to purchase additional coverage, equal to 10% of your monthly base salary, so that your total LTD coverage replaces 60% of your monthly base salary.

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

- The minimum monthly benefit is $50 and the maximum is $15,000.
- LTD benefits begin after 180 days of approved total disability.
- The LTD benefit you receive from Denny's 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 The Hartford — 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 10% additional (for a total of 60%) LTD coverage.

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 following chart

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 you are not gainfully employed. Gainful employment means that you 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 considered totally disabled if you are unable to perform the duties of *any* occupation for which you are or become qualified by education, training, or experience and are otherwise not gainfully employed. The skills, responsibilities, income, and degree of social acceptance of your job prior to your disability are considered when evaluating your prospects for employment.

Disabilities can include those caused by pregnancy, prolonged illness or injury.

You may be considered totally disabled — even if you are gainfully employed — if your injury or sickness is causing physical or mental impairment to such a degree that you are unable to earn more than 80% of your monthly salary in any occupation for which you are qualified by education, training or experience. You are not considered disabled, on the other hand, if you are able to earn more than 80% of your monthly salary. Your monthly salary does not include sick pay or any salary continuance payments you receive.

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 disabled because of a mental or emotional disease or disorder of any type (as defined by The Hartford), LTD benefits will continue for a maximum of 24 months. After 24 months, benefits will end unless you qualify under the continuing benefit provision. 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.

Pre-Existing Conditions

Pre-existing conditions apply if you enroll for additional LTD benefits (additional 10% coverage to bring total LTD coverage to 60% of your base monthly salary). A pre-existing condition is any condition, advice or treatment received, prescribed or recommended within 12 months before the date your coverage under the Denny's plan began.

Benefits for a disability resulting from a pre-existing 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

Filing LTD Claims

See *General Information About Your Benefits Program*, beginning on page 76, for information on how to file an LTD claim or appeal a decision.

Coordinating with Other Disability Benefits

Denny's LTD benefits are coordinated with other disability benefits you may receive to provide replacement income to 50% or 60% of the base monthly salary you were receiving before LTD benefits began. This means that LTD benefits are offset by any other disability benefits you may be receiving. Other benefit amounts are considered in determining the amount of your LTD benefit to bring your total replacement income to 50% or 60% of your base monthly salary. If, for instance, you become disabled and receive Social Security disability benefits that replace 30% of your base monthly salary, the LTD benefit you receive from your Denny's coverage will equal either 20% or 30% of your base monthly salary — the amount needed to bring your total replacement income to 50% or 60%, depending on your coverage level.

Other sources of disability benefits include:

- Social Security retirement or disability benefits payable to you and your dependents
- Workers' Compensation, occupational disease laws or other disability legislation
- Any state disability benefit law
- Disability pay from any group insurance plan
- Pay from sick leave plans
- Half of any pay you earn through rehabilitative employment
- Occupational accident coverage provided by your employer
- Any statutory disability benefit law
- The Railroad Retirement Act
- The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act
- The Canada Old Age Security Act
- Any public employee retirement system plan, or any state teacher's retirement system plan, or any plan provided as an alternative to any of the above acts or plans

- Retirement and disability benefits paid under a retirement plan provided by Denny's except for amounts attributed to your contributions
- Disability benefits paid under any no fault automotive vehicle coverage

Your plan benefit will not be affected by:

- Cost-of-living increases you may receive for any other source of disability benefits
- Benefits you receive from a private disability policy you purchased on your own

Regardless of the age at which you become disabled, if you remain disabled you will receive at least 12 monthly payments.

Benefits During Rehabilitative Employment

During your disability, you may be able to take a paying job and continue to receive LTD benefits. Rehabilitative employment benefits will be paid for each month of rehabilitative employment following the 180-day waiting period — or for a period during which you receive total disability benefits.

Rehabilitative employment means that, because of injury or illness, you are:

- Continuously unable to perform the substantial and material duties of your regular occupation
- Under the regular care of a licensed physician other than yourself or a member of your immediate family
- Gainfully employed in any occupation, on a full-time or part-time basis, for which you are or become qualified by education, training or experience

If you are receiving rehabilitative employment pay, your monthly LTD benefit — 50% or 60% of your base monthly pay — will be offset by 50% of your rehabilitative employment earnings.

Rehabilitative employment benefits end on the date your earnings from rehabilitative employment exceed 80% of your pre-disability pay or when your benefits end as shown in this section.

If Your Disability Recurs

If you are receiving disability benefits, recover and return to work — but are disabled again for the same or related cause less than six months after your return to work, you are considered to be in the same period of disability. Benefits will be paid according to the plan in effect at the time the initial disability period began.

If your disability recurs more than six months after you return to work, a new 180-day waiting period will apply and benefits will be paid based on the plan in effect on the day the disability began again.

When Long-Term Disability Coverage Ends

LTD coverage will end on the earliest of:

- The date you are no longer disabled
- The date you reach the maximum benefit period in the benefit schedule
- The date you fail to provide the required proof of total disability or take a required medical exam
- The date the policy ends
- The date coverage under this program ends for you or your class of employees
- The date you retire or terminate your employment (your last day of active service)

Long-Term Disability Continuing Benefit Provision

The LTD Continuing Benefit Provision is designed to provide additional incentives for you to actively pursue return-to-work opportunities if you are capable of working in some capacity. Under this provision, during the first 24 months of LTD, benefit payments are calculated normally. After 24 months, benefits may be reduced to 20% of pre-disability earnings if you are not receiving Social Security Disability Insurance (SSDI) benefits or comparable offsets, not actively involved in the SSDI appeals process, or not working in some capacity.

What's Not Covered by the Long-Term Disability Plan

LTD benefits will not be paid if you are disabled because of:

- Sickness or injury, resulting from declared or undeclared war or any action of war or aggression, or active participation in a riot
- Mental or emotional disorders of any type lasting more than 24 months after the 180-day waiting period, unless you are confined to a hospital or other institution
- Sickness or injury resulting from a pre-existing condition — unless you have been covered under the Denny's plan for 12 months before the disability began
- Injury received while working for pay for another employer
- Sickness or injury that occurred within 12 months before you became eligible for coverage under this plan
- Sickness or injury that begins after your employment has been terminated
- Suicide attempt, while sane or insane, or other intentionally self-inflicted injury or sickness
- Commission of or attempt to commit an act which is a felony
- Sickness or injury that begins after your eligibility for disability coverage ends
- A condition you have for which you have not sought the regular and continuing care of a doctor (other than yourself or a member of your immediate family) — or are not following a prescribed course of treatment for the sickness or injury causing your disability
- Any period during which you are confined to a penal or correctional institution, if the confinement exceeds 30 days

Other Important Information

This section of your SPD — along with the information in the *Participating In Denny's Benefits* and *General Information About Your Benefits Program* sections — is the summary plan description for Denny's disability coverage.

The *Participating In Denny's Benefits* section:

- Includes information about eligibility
- Describes when coverage begins and ends and the process for changing coverage during the year and continuing coverage
- Outlines the process for enrolling and paying for benefits

The *General Information About Your Benefits Program* section:

- Includes information about the plan sponsor and administrator
- Describes the process for filing a claim and for filing an appeal if your claim is denied
- Outlines your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Denny's expects to continue the Disability Plans indefinitely. It reserves the right, however, to change or terminate the plans at any time. The *General Information About Your Benefits Program* section includes more information about what would happen if Denny's were to terminate all or part of these plans. The terms of these plans are determined by official plan documents and insurance contracts. If there is any discrepancy between this SPD and the plan documents or insurance contracts, the documents and contracts will govern.

General Information About Your Benefits Program

Basic Administrative Information

Plan Name	Denny's, Inc. Welfare Benefit Plan for Salaried Employees
Plan Sponsor and Plan Administrator	Denny's, Inc. Total Rewards Department 203 East Main Street Spartanburg, SC 29319 1-800-859-2244
Agent for Service of Legal Process	General Counsel Denny's, Inc. 203 East Main Street Spartanburg, SC 29319 1-864-597-8000
Plan Year	January 1 to December 31
Plan Number	511
Employer Identification Number	The federal employer identification number assigned to Denny's, Inc. is 95-2023160.
Type of Plan	Welfare benefit plan including medical and prescription drug, dental, vision, flexible spending accounts, life insurance, AD&D, personal accident insurance and disability benefits
Plan Documents and Contracts	The descriptions contained in this booklet are intended to provide a summary explanation of your benefits. Easy-to-read language has been used as much as possible to help you understand the plan provisions. Official plan documents govern the operation of the Plan and are the legally governing instruments in determining all rights and obligations under the plan. Your rights to inspect or obtain copies of these documents are described under *Your Rights Under ERISA*, beginning on page 81. In case of any discrepancies between this SPD and the official plan documents, the plan documents will control.
Rights to Employment	This SPD is for your information only; it is not a binding contract, nor does it impose any legal obligation upon Denny's. No information in this SPD says or implies that participation in the benefit plans is a guarantee of continued employment with Denny's.
Right to Amend or Terminate Plans	Denny's, Inc. in its sole discretion, reserves the right to amend, modify, suspend or terminate the benefit plan, in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason. A decision to terminate, amend or replace the benefit plan may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service or ERISA, or for any other reason. This may include the elimination of or decreases in benefits, changes in plan networks, and increases in your required contributions for coverage.

Subrogation and Reimbursement

Right of Subrogation

If you or your covered dependent has a claim to recover money from a third party arising out of or relating to an injury for which the medical plan provides benefits, the medical plan will be subrogated to your rights, and to the rights of your legal representative, to recover from the third party as a condition to your receipt of medical plan benefits. If the medical plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the plan nonetheless may choose in its discretion to pay benefits. Also, the plan may choose in its discretion to exercise only the right of reimbursement.

Right of Reimbursement

If you or your covered dependent is injured as a result of the act of a third party, and you or your legal representative files a claim for medical benefits, then you or your legal representative must, as a condition of receiving benefits, reimburse the plan in full from any money received from the third party or its insurer to the extent of the amount paid by the plan.

Procedures for Subrogation and Reimbursement

You or your covered dependent or legal representative must cooperate with the plan administrator with respect to the exercise of the subrogation and reimbursement rights of the medical plan and shall do nothing to prejudice those rights. In addition, you or your legal representative must, at the time of making a claim for medical plan benefits, inform the plan administrator in writing whether you were injured by a third party and must provide information relevant to recovery from the third party as a condition to receiving medical plan benefits. By accepting benefits from the plan, you agree that the plan has the right to "first dollar" recovery; that is, the plan's claim for subrogation and/or reimbursement has priority over any other claim to the funds paid by the third party and takes precedence over the claims of any other entity, including any claims you may have for pain and suffering, other non-medical or dental charges, claims for attorneys' fees, or other costs and expenses, regardless of whether you have made a full or partial recovery from the third party. The "make whole" rule is inapplicable to the plan, so that the plan's rights override any interest you may have to be made whole before reimbursing the plan for amounts that it paid.

The plan has a right to recover its payments from any available source, including but not limited to, any recovery from another party or any amount payable under any liability, auto or vehicle insurance coverage. The plan also may recover its payments by other means, including offsetting future benefits paid by the plan.

In its discretion, the plan administrator may, as a condition precedent to paying medical benefits, require you or your legal representative to sign and return a written agreement to subrogate or reimburse the plan, and may condition any future or continuing benefit payments on compliance with these provisions. The plan will have the right both to discontinue payments and to bring legal action against you or your heirs, guardians, executors or other representatives to recover benefits already paid. In the case of a covered dependent who is a minor, any settlement or award received by the minor or his trustee, guardian, parent or other representative will be subject to this provision regardless of state or federal law and/or whether his representative has access to or control over any recovered funds.

You or your covered dependent is not entitled to recover from a third party or his insurer by settlement, judgment or otherwise until the medical plan has been paid in accordance with these provisions. Before disbursement of any money pursuant to settlement, judgment or otherwise, the plan must be paid or alternatively, given the opportunity to adjudicate its right to share in the money with prior notice by registered mail to the plan administrator. If you recover from a third party or his insurer before payment to the plan, then any money that you or your legal representative recovers must and is deemed to be held in trust for the benefit of the medical plan to the extent of the amount of plan benefits provided until reimbursement, with you or your legal representative as trustee and fiduciary.

The plan will be entitled to apply for and receive an injunction to restrain any violation of these provisions of its right to collect the money and will have the right to recover from you or your legal representative an amount equal to the amount paid by the plan with interest at 5% per annum, or whatever smaller amount is recovered by you.

Neither you nor your legal representative may retain an attorney with respect to the third party without the plan administrator's prior written consent. As a condition of receiving benefits under the plan, you and your legal representative hereby agree that the plan may assume at its discretion the defense of any action that has been or could be brought against the third party by you or your legal representative, and the plan must be provided the opportunity to approve any settlement with the third party before it is made. Neither the plan nor Denny's will be responsible for any attorneys' fees or expenses incurred in connection with any amount recovered by you or your legal representative from the third party. The plan's right of recovery will not be defeated or reduced by the so-called "fund doctrine," "common fund doctrine," or "attorney's fund doctrine."

Claim and Appeal Procedures

Denny's uses claim administrators to process claims under most of its benefit plans. Each claim administrator has the authority to review specific claims and, in doing so, to interpret the plan provisions and decide claim-related questions. Questions regarding eligibility, however, are determined by Denny's, Inc. as the plan administrator.

See the following chart for the names and addresses of Denny's claim administrators for each plan. Following the chart, you'll find instructions for:

- Filing benefit claims under the Denny's Benefits Plans
- Submitting an appeal if you believe that a benefit is due under a plan and it is not paid

Your authorized representative may act on your behalf at any stage of the claims and appeal procedures.

Claim Administrators for Denny's Healthcare, FSA, Life and Basic AD&D, PAI and Disability Plans

Plan	Claim Administrator	Contact Information
PPO Medical Plans	Aetna	P.O. Box 14079 Lexington, KY 40512-4079 1-888-522-3862
Prescription Drug Plan	Medco	P.O. Box 14711 Lexington, KY 40512 1-800-396-0376
Dental Plans	Aetna	P.O. Box 14094 Lexington, KY 40512-4094 1-877-238-6200
Vision Plan	VSP	3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195
Flexible Spending Accounts	Aetna	P. O. Box 4000 Richmond, KY 40476-4000 1-888-238-6226
Life Insurance and Basic Accidental Death and Dismemberment	Minnesota Life Insurance Company	400 Robert Street North St. Paul, MN 55101-2098 1-800-872-2214
Personal Accident Insurance	The Hartford Life Insurance Company	P. O. Box 101007 Atlanta, GA 30392-1007 1-800-572-9047
Short-Term Disability Plan	The Hartford — Comprehensive Employee Benefits Services Company	P. O. Box 946710 Maitland, FL 32794-8710 1-800-741-4306
Long-Term Disability Plan	The Hartford Life and Accident Insurance Company	P. O. Box 946710 Maitland, FL 32794-8710 1-800-303-9744

If you participate in an HMO, refer to your HMO booklet for addresses and telephone numbers.

Medical, Dental and Vision Claims

The following provides general guidelines for processing medical and dental claims. Your plan may have slightly different rules or processes. See any certificates of coverage received from administrators for more specifics.

Pre-Service Medical, Dental and Vision Claims

In general, under federal law, when you submit a request for precertification or pre-approval of services under the Medical, Dental or Vision Plan, the claim administrator will inform you of its decision — whether approval or denial — within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after it receives your claim. The claim administrator may extend this period for up to 15 days if the extension is needed due to matters beyond its control. If this happens, you will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the claim administrator expects to make a decision. If additional information is needed, you will have 45 days to provide it to the claim administrator, and the extension period will not begin until you have submitted that information.

If your pre-service claim is denied, you have up to 180 days to file an appeal.

Urgent Care Medical, Dental or Vision Claims

An urgent care claim involves medical, dental or vision care where a delay could:

- Seriously jeopardize the life or health of you or your dependent or the ability to regain maximum function or
- In the opinion of a physician with knowledge of the medical condition of you or your dependent, could cause severe pain that could not be adequately managed without the care or treatment requested in the claim

By applying the judgment of a prudent layperson who possesses average knowledge of health and medicine, the claim administrator will determine whether a claim involves urgent care. When a physician who has knowledge of your (or your dependent's) medical condition determines there is a claim involving urgent care, however, the claim administrator will treat it as a claim involving urgent care.

In general, federal law requires the claim administrator to notify you of the determination on your claim as soon as possible, but not later than 72 hours after receipt of your claim. If you do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan, the administrator will inform you as soon as possible — but no later than 24 hours after it receives your claim — of the additional information it needs to complete your claim. You have 48 hours to provide missing information. Notification may be written or electronic and will include the information described below for other claim denials. Appeals of a denied urgent care claim will also be processed as soon as possible — but not later than 72 hours after receipt of your appeal.

You have up to 180 days to file an appeal for an urgent care claim.

Concurrent Care Decisions

If the medical, dental or vision plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any request to extend the course of treatment will be decided as soon as possible. If the request is made at least 24 hours before the end of the prescribed course of treatment, the claim administrator will notify you within 24 hours after your request.

Any reduction or termination by the plan of a course of treatment will be treated as an adverse benefit determination.

If a claim concerning a concurrent care decision is denied, you have up to 180 days to file an appeal.

All Other Claims

If a claim is not described above, including a claim made after services are provided, the claim administrator will notify you of its decision within 30 days after receiving the claim. The claim administrator may extend this period for up to 15 days if the extension is needed due to matters beyond its control. If this happens, you will be

notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the claim administrator expects to make a decision. If additional information is needed, you will have 45 days to provide it to the claim administrator, and the extension period will not begin until you have submitted that information.

If your claim is denied, you have up to 180 days to file an appeal.

Coordination of Benefits

Denny's Medical Plan and Dental Plan coordinate benefits with other medical or dental plans that may cover you. This means you may not collect more than 100% of the total covered charges from both plans.

How to File a PPO Medical Plan Claim

For care received from network providers: You do not have to submit a claim form. Network providers will submit claims directly to the claim administrator.

For care received from non-network providers: You or your provider will have to submit a claim to Aetna Benefits Services. Claim forms are available from the Denny's Total Rewards Department or the Aetna Benefits Services website.

Supporting information such as bills must be attached to the completed claim. All completed claim forms and bills should then be submitted directly to:

Aetna
P.O. Box 14079
Lexington, KY 40512-4079
1-888-522-3862

Any claim for medical benefits should be filed as soon as possible after you receive treatment or services — generally within 90 days. Late claims that are filed more than one year after the normal deadline generally will not be paid, unless the charges relate to a previous claim already on file or the delay was due to your legal incapacity.

Each claim form must include:

- Employee name, address and Social Security number
- Patient name, age, and relationship to employee
- The member and group number, if applicable, listed on your Medical Plan ID card
- The date the injury or sickness began
- A statement indicating whether you are covered under any other health insurance plan. If you have other coverage, you must provide the name of the other carrier.

You must also submit an itemized bill from your provider that includes the following:

- The diagnosis
- The date(s) of service
- The procedure code(s) and description of the service(s) provided
- The charge for each service
- The provider's name, address, and tax identification number

If you participate in an HMO, contact the HMO for information on how to file an HMO Medical Plan claim, if required.

How to File a Dental Plan Claim

You and your dentist are responsible for completing and sending in claim forms. Supporting information such as bills must be attached to the completed claim. All completed claim forms and bills should then be submitted directly to the claim administrator's claim office at this address:

Aetna Benefits Services
P.O. Box 14094
Lexington, KY 40512-4094
1-877-238-6200

How to File a Vision Plan Claim

If you use a VSP provider, the provider calls VSP to confirm coverage and will submit the claim for you. If you use a provider outside the VSP network, you need to send in a claim form. Supporting information such as bills must be attached to the completed claim. All completed claim forms and bills should then be submitted directly to the claim administrator's claim office at this address:

VSP
333 Quality Drive
Rancho Cordova, CA 85670
1-800-877-7195

Notice of Denied Claim

If part or all of a medical, dental or vision plan claim is denied, the applicable claim administrator will provide you a written notice. This notice will include the following:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed to perfect your claim and an explanation of why it is necessary
- A description of the plan's review procedures and the applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA
- Either a copy of any internal rule, guideline, protocol or similar criterion relied on in making the decision, or a statement that you may obtain a copy upon request and free of charge
- If applicable, an explanation of any limit or exclusion based on medical necessity, experimental treatment, or a similar exclusion or limit, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided upon request and free of charge
- In the case of an urgent care claim, an explanation of the applicable expedited review process

Coordination of Medical and Dental Plan Benefit Payments

Benefits provided by the Medical and Dental Plans are coordinated with benefits available from or provided by Medicare or any other group health plan that covers the same person for the same service. The combined benefits will not be more than 100% of the reasonable and customary (R&C) cost for a covered service for which you are claiming benefits under the plan.

The term "allowable expenses" means any necessary, reasonable and customary item of expense that is covered at least in part by at least one (1) of the plans covering the person for whom a claim is made. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid. "Allowable expense" does not include charges specifically excluded under this plan that may be covered under other plans.

If you are enrolled in medical or dental coverage and have other coverage, the coordination of benefits depends on who in your family has a claim and whether or not anyone is eligible for Medicare. There are rules that determine which plan pays benefits first:

- The plan without a coordination of benefits provision pays benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If that person is eligible for Medicare and not actively working, the Medicare Secondary Payor rules do not apply, so that Denny's plan would pay benefits for that person as if Medicare paid benefits first. The Denny's plan is always primary for an active employee or covered family member who is Medicare-eligible (although special timing rules apply to individuals with Medicare because of end-stage renal disease).
- Except in the case of divorce or legal separation, if both you and your spouse/domestic partner cover your dependent children, the plan of the parent whose birthday comes first during the calendar year will pay first for the dependent child. When both parent's birthdays are on the same day, the plan covering the parent longest pays first. If the other plan doesn't have a birthday rule, its coordination of benefits rule applies.
- If you are divorced or legally separated and have a dependent child and:
  - You have legal responsibility for your child's healthcare expenses, then your plan will pay first
  - The court decree states both parents will share joint custody without stating responsibility for healthcare expenses, then the birthday rule will apply
  - There is no court decree that sets primary responsibility for your child's healthcare expenses:

- If the parent with custody has not remarried, the plan of the parent with custody will pay first.
- If the parent with custody has remarried, the plan that pays first will be determined in the following order:
- Plan covering the parent who has custody
- Plan covering the spouse/domestic partner of the parent who has custody
- Plan covering the parent without custody

- The benefits of the plan which covers the person as an employee who is neither laid off nor retired, or his dependent, will be determined before the plan which covers the person as a laid off or retired employee or his dependent.
- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

Requesting a Reimbursement from Your Flexible Spending Accounts

You will have to complete and submit a Flexible Spending Account (FSA) request for reimbursement form to receive money from your flexible spending accounts, unless you use your FSA Debit Card for eligible healthcare expenses.

How to File a Claim

- Provide employee name, address, Social Security number, work and telephone contact information at the top of the form.
- For healthcare expenses, list eligible expenses, including the date the expense was incurred and for whom, name of provider and description of expense and amount of reimbursement requested. If you have more than six expenses, use additional reimbursement forms. You will need to attach an explanation of benefits (EOB) form, original bill or receipt to the claim form before submitting.
- For dependent day care expenses, provide names of dependents and ages, the period service was provided, the name, address and Social Security number or tax ID number of the service provider and the amount of reimbursement requested.
- Sign and date the form.
- Mail or fax the completed form and receipts to Aetna.
  - By mail: P.O. Box 4000, Richmond, KY 40476-4000 (address is shown on reimbursement form)
  - By fax: (888) 238-3539

You may submit your claims each time you have a qualifying expense or file them periodically or annually. The Request for Reimbursement form, when signed, provides your acknowledgement that you have not been reimbursed by any other insurance or benefit plan.

How to Appeal a Denied Medical, Dental, Vision or Healthcare FSA Claim

If you disagree with a medical, dental, vision or Healthcare FSA benefit determination, you may contact the appropriate claim administrator in writing to formally request an appeal. You generally have 180 days from receipt of the notice of denial to file an appeal. Except for appeals involving urgent care (see *Urgent Care Medical, Dental or Vision Claims* on page 71), all appeals must be in writing. You may submit comments, documents and other information in support of your appeal. The review on appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination. Upon request and free of charge, you will also be provided reasonable access to and copies of all documents, records and information relevant to your claim.

Any appeal should include your name, the reason you believe the claim should be paid, and any documentation or other written information to support your request for claim payment. If the appeal relates to a claim for payment of medical or dental benefits, your request for appeal also must include:

- The patient's name and identification number (for medical, it will be shown on the Medical Plan ID card)
- The date of the service
- The provider's name

If you are appealing an urgent care claim denial, refer to *Urgent Care Medical, Dental or Vision Claims* on page 71 and call the customer service number

on your Medical Plan ID card immediately. All other appeals will be processed as explained in the following sections.

Who to Call With Questions about an Appeal

Call the claim administrator or the Denny's Total Rewards Department if you have questions about the appeal process. You can find phone numbers for either resource under *Basic Administrative Information* on page 67.

First Level Appeals

The claim administrator is responsible for reviewing first level appeals. The review of the first level appeal will not be based on the initial benefit determination. Someone other than an individual involved in the initial benefit determination or a subordinate of such individual will be appointed to decide the first level appeal.

If your claim was denied based on a medical judgment (such as whether a service or supply is experimental or medically necessary), the claim administrator will consult with a health professional with appropriate training and experience. The healthcare professional consulted for the first level appeal will not be the professional (if any) consulted during the prior determination or a subordinate of such professional. The claim administrator also will identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

The claim administrator will provide you written or electronic notification of the determination, as follows:

- For first level appeals of pre-service and other medical claims, not later than 15 days after receipt of your request for a first level appeal
- For first level appeals of post-service medical or dental claims, not later than 30 days after receipt of your request for a first level appeal. The claim administrator may extend that review process by 60 days if it is unable to complete the review in the first 60 days because of extenuating circumstances. You will be notified of any delay before the end of the first 60-day review period.

If your first level appeal is denied, the notification from the claim administrator will include:

- The specific reasons for the denial
- Reference to the specific plan provisions on which the determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, or other information relevant to the claim
- A description of any voluntary appeal procedures offered by the plan and statement of your right to bring a civil action under Section 502(a) of ERISA
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- If the denial on appeal is based on a medical necessity, experimental treatment, or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefit determination (or a statement that such explanation will be provided free of charge upon request)

Second Level Appeals

If you are not satisfied with the determination of the claim administrator on your first level appeal, you can submit a second level appeal to the claim administrator. All second level appeals (except those involving urgent care) should be submitted in writing within 180 days after you receive the notice of determination on your first level appeal.

Like first level appeals, the review of a second level appeal will not be based on prior determinations and will be conducted by someone other than individuals involved in the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the claim administrator will consult a health professional other than the professional consulted for the first level appeal.

The claim administrator will provide you written or electronic notification of the determination, as follows:

- For appeals of pre-service claims, not later than 15 days after receipt of your request for a second level appeal
- For second level appeals of post-service medical or dental claims, not later than 30 days after receipt of your request for a second level appeal

Denial notifications of second level appeals will include the information listed above for first level appeal denials.

How to File a Disability Claim

Short-Term Disability

The claim administrator for the Denny's Short-Term Disability (STD) Plan is The Hartford.

When applying for Short-Term Disability benefits, it is your responsibility to contact The Hartford to start the notification and claim process. Call the toll free number 1-800-741-4306 to begin your claim. Provide your name, department and the last day of full-time work, as well as your manager's name and phone number and necessary medical information. Be prepared to give your physician's name, address and phone number. A Hartford representative will call your physician for treatment details.

If you become totally disabled, you must notify your supervisor immediately. It is important to provide documentation of the disability within two weeks of your first day away from work due to the disability. If you fail to provide this documentation, your absence may be considered unauthorized and corrective action may be taken.

Short-Term Disability benefits will not be paid until all required information is submitted to, reviewed by and approved by The Hartford. You will be notified of the approved timing for the leave by telephone or by mail.

If you cannot return to work within the approved time period and need to extend your return-to-work date, you must contact The Hartford and provide them with all requested information. The Hartford will review the information, which must be approved before any extension will be granted.

While on disability leave, make sure to keep your supervisor advised of the status of your absence.

If your STD claim is denied, you will be informed in writing that you have a right to appeal the denial. You must submit your appeal in writing to The Hartford within 180 days after receipt of the written notice of denial of a claim. The Hartford will review any information received and evaluate it according to the terms of the STD plan. If the appeal requires additional information, medical information or specialty review, The Hartford will make reasonable and good faith attempts to obtain that information. The Hartford will then make a recommendation to Denny's. Denny's makes the final claim determination and will notify you of the results of the appeal in writing, generally within 45 days, but not later than 90 days, after receipt of the request for review.

Long-Term Disability

The claim administrator for the Denny's Long-Term Disability (LTD) Plan, The Hartford, makes all decisions about benefit claims. If your STD is going to exceed 180 days, your claim is forwarded automatically to the LTD group.

An Income Benefits Questionnaire is mailed to you to obtain additional information unique to LTD claims. Once this questionnaire is returned to The Hartford, a representative will obtain the necessary medical information from your physician.

Claims filed later than one year after the filing deadline will not be accepted unless you are legally incapacitated. The claim administrator has the right to have a doctor examine you as often as reasonably necessary while your claim is being processed. These exams will be paid for by the claim administrator.

Appeal

Within 180 days after receiving a notice explaining the denial of any part of your LTD claim, you may appeal the decision to the claim administrator. Your request must be submitted in writing and must include:

- The reasons why you feel your claim is valid
- The reasons why you think your claim should not be denied

You may appeal any denial of a claim for benefits by filing a written request for a full and fair review to The Hartford. In connection with such a request, documents pertinent to the administration of the plan may be reviewed and comments and issues outlining the basis of the appeal may be submitted in writing. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision provided by Hartford no longer than 45 days after receipt of the request for review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for the review. If an extension is needed, you will be notified in writing before the beginning of the extension period. The decision after your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

Denial of Appeal

You will be notified in writing or electronically if any part of your appeal is denied. The notification will include:

- Specific reasons for the denial of your claim
- References to the pertinent LTD Plan provisions on which the denial is based
- A description of any material or information needed to pursue the claim and an explanation of why it is needed
- A description statement of your right to bring a civil action under Section 502(a) of ERISA
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- If the denial on appeal is based on a medical necessity, experimental treatment, or similar exclusion, an explanation of the scientific or clinical judgment for the adverse benefit determination (or a statement that such explanation will be provided free of charge upon request)

How to File a Life Insurance or Basic AD&D Claim

Minnesota Life Insurance Company, the claim administrator for the Life Insurance Plan, will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate and a fully completed claim form, which can be obtained from the Denny's Total Rewards Department.

How to File a Personal Accident Insurance Claim

The Hartford, the claim administrator for Personal Accident Insurance, will pay benefits within 60 days of receiving proof of death while insured, such as a certified death certificate, or proof of your or a covered dependent's loss such as a physician's statement, and a fully completed claim form, which can be obtained from the Denny's Total Rewards Department.

How to Appeal a Denied Life Insurance, Basic AD&D or Personal Accident Insurance Claim

The claim administrator will review your claim and inform you in writing or electronically of its decision within a reasonable period of time, but no later than 90 days after it receives your claim. Under special circumstances, the claim administrator may take up to an additional 90 days to review your claim, if extra time is needed due to circumstances beyond its control. If this happens, you will be notified of the extended review time before the initial 90-day period ends.

The claim administrator again may extend by an additional 90 days if claim review is delayed due to circumstances beyond its control, with notification to you before the end of the first 90-day extension. Any notice of extension will include:

- An explanation of the standards on which entitlement to benefits is based
- The unresolved issues that prevent a decision on your claim
- Any additional information needed to resolve those issues

The claim administrator will let you know how much time you have to provide any additional information needed. The extension for reviewing the claim will not start until you have provided that information.

If your claim is denied, the claim administrator will provide written notice within 180 days after your claim is received that includes:

- The specific reason(s) for the claim denial
- Reference to the specific plan provisions on which the determination is based
- A description of any additional material or information needed from you and why that information is necessary
- A description of the plan's review procedures and time limits
- A statement of your right to bring a civil action under section 502(a) of ERISA following review of the claim denial
- A statement that the administrator will, at your request, provide you with a copy of any internal rule, guideline, protocol or other similar criteria relied on in denying your claim

You may request access to and copies of all documents, records and other information relevant to your denied claim. Information will be provided free of charge.

You have 60 days from the time you receive the notice of a denied claim to file an appeal. You may submit written comments, documents, records and other information related to the claim. The reviewer will take all that information into account — even if it was not submitted or considered in the initial decision.

The claim administrator will review your claim without granting any deference to the initial decision about your claim. In addition, no reviewer may be a person who was involved in making the initial claim decision or a subordinate of that person. And, if your claim was denied based in whole or in part on a medical judgment, the administrator will consult with a health professional who:

- Has appropriate training and experience in the field of medicine involved
- Was not the person or subordinate of the person consulted by the administrator in the original claim decision

The claim administrator will review your appeal and inform you in writing or electronically of its decision generally within 60 days. When special circumstances require additional time for processing the review, the administrator may take up to an additional 60 days and is responsible for notifying you in writing of those circumstances before the end of the original 60-day period. That notice will include:

- The date by which the plan expects to make a decision
- An explanation of the standards on which entitlement to benefits is based
- The unresolved issues that prevent a decision on your claim
- Any additional information needed to resolve those issues

Again, the claim administrator will advise you of the time you have to provide any additional information needed. The extension for reviewing the appeal will not start until you have provided that information.

If your appeal is denied, the claim administrator will provide written or electronic notice that includes:

- The specific reason(s) for the claim denial
- Reference to the specific plan provisions on which the determination is based
- A statement of your right to bring a civil action under section 502(a) of ERISA
- A statement that the claim administrator will, at your request, provide you with a copy of any internal rule, guideline, protocol or other similar criteria relied on in denying your claim

Also, at your written request, the administrator will provide you with a statement identifying those medical or vocational experts whose advice was obtained on behalf of the plan in connection with your appeal.

Legal Action

You may have a right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of an appeals procedure. In most instances, you may not initiate a legal action against the claim administrator until you have completed the first and second level of appeal. If your appeal is expedited because it involves an urgent care medical or dental claim, there is no need to complete the appeal process for the second level of appeal before bringing legal action.

Your Rights Under ERISA

As a participant in the Denny's, Inc. Welfare Benefit Plan for Salaried Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are outlined in this section.

Information About Your Plan and Benefits

You can review all documents governing the plan at the plan administrator's office. These documents include insurance contracts and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

With written request to the Denny's Total Rewards Department, you can obtain copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

You can also 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 the summary annual report (SAR).

Continued Group Health Plan Coverage

You can continue healthcare (medical, dental, vision, FSA) coverage for yourself, your spouse/domestic partner, or your dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

ERISA allows for reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases — if you request it before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision 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 a copy of plan documents or the latest annual report (if any) from the plan 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. 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, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Denny's Total Rewards Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration at 1-202-219-8776.

SALARIED

BENEFITS CHANGE FORM

Reason for Change (check below)

- ☐ Marriage
- ☐ Domestic Partner Relationship
- ☐ Divorce/Legal Separation
- ☐ Birth or Adoption
- ☐ Death
- ☐ Beneficiary Change
- ☐ Loss of Employment
- ☐ Gain of Employment
- ☐ Employment Status (part-time to/from full-time)
- ☐ Other _____

Date Change Occurred (Month/Day/Year) _____/_____/_____

Part A: Employee Information

Name (Please Print)		Social Security #		
Address	City	State	Zip	Daytime Phone # ( )

For each benefit, place an "X" in the box for the NEW _____ benefit level and coverage you want

Part B: Change your Benefit Plan or Coverage

MEDICAL PLAN

Option:
- ☐ $500 Deductible
- ☐ $1500 Deductible
- ☐ $150 Deductible (limited coverage plan)
- ☐ HMO (if you elect an HMO you must also complete an HMO application)
- ☐ No Medical Coverage

Coverage:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + 2 or More Dependents

DENTAL PLAN

Option:
- ☐ $25 Deductible (Full coverage)
- ☐ $50 Deductible (Basic coverage)
- ☐ No Dental Coverage

Coverage:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + 2 or More Dependents

VISION PLAN

Option:
- ☐ Vision Coverage
- ☐ No Vision Coverage

Coverage:
- ☐ Employee Only
- ☐ Employee + One Dependent
- ☐ Employee + 2 or More Dependents

EMPLOYEE LIFE INSURANCE PLAN

Option:
- ☐ Additional 1 x Base Pay
- ☐ Additional 2 x Base Pay
- ☐ Additional 3 x Base Pay
- ☐ Additional 4 x Base Pay
- ☐ No Additional Coverage

Please note: Evidence of Insurability may be required!

SPOUSAL LIFE INSURANCE PLAN

- ☐ $20,000 of coverage
- ☐ $40, 000 of coverage
- ☐ $60, 000 of coverage
- ☐ $80,000 of coverage
- ☐ $100,000 of coverage

Please note: Evidence of Insurability may be required!

CHILDREN'S LIFE INSURANCE PLAN

Option:
- ☐ $5,000 Each Child
- ☐ $10,000 Each Child
- ☐ No Children Life Coverage

LONG TERM DISABILITY PLAN

- ☐ Basic Coverage (50% of Base Pay)
- ☐ Supplemental Coverage (60% of Base Pay)

PERSONAL ACCIDENT INSURANCE PLAN

Option:
- ☐ $25,000
- ☐ $50,000
- ☐ $100,000
- ☐ $150,000
- ☐ $250,000
- ☐ $500,000
- ☐ No Personal Accident Coverage

Coverage:
- ☐ Employee Only
- ☐ Employee & Family

FLEXIBLE SPENDING ACCOUNT

- ☐ ERHC - I elect to contribute $_____ per paycheck ($_____ annually) for the plan year to a Healthcare Reimbursement Account on a pretax basis.
- ☐ ERDC - I elect to contribute $_____ per paycheck ($_____annually) for the plan year to a Dependent Care Reimbursement Account on a pretax basis.

Return COMPLETED FORM and REQUIRED DOCUMENTS to the Denny's Total Rewards Department.
This form cannot be processed until all required documentation is received.

EMPLOYEE SIGNATURE: _____ DATE: _____

SALARIED
BENEFITS CHANGE FORM

- To make a family or employment status change, you must complete and return this form to:

  Denny's, Inc.
  Total Rewards Department P-5-10
  203 East Main Street
  Spartanburg, SC 29319

  You also may fax this form and documentation to (864) 597-8888.

- This form must be received by the Total Rewards Department within 30 calendar days of the event for which you seek a chang
- The benefit change must be consistent with your family or employment event. For example, if you get married, you may add your new spouse to your medical coverage upon your marriage.
- You must be able to verify the family or employment change. To do this, you will need to send photocopies (DO NOT SEND ORIGINALS) of the following documents (as they apply):

EVENT	DOCUMENTATION
• Marriage	Marriage License
• Domestic Partnership Relationship	Domestic Partner Affidavit
• Birth of Child	Proof of Birth
• Adoption of Child	Court Order
• Death	Death Certificate
• Employment Change	Letter from Employer (HIPAA - proof of other coverage)
• Divorce/Legal Separation	Court Order granting Divorce/Legal Separation

- If you are adding or dropping dependents from your medical, dental, vision, or life insurance coverage, you must also complete the Dependent/Beneficiary Change sections below.

Part C Add/Drop Dependents

Add Dependent(s): This section must be completed if adding dependent(s)						Check Coverage(s) Requested for Dependents					
Dependent(s)	Relationship			Social Security Number	Date of Birth	* F/T Student	Medical	Dental	Vision	** Life	Personal Accident
LAST NAME, FIRST NAME	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	(√)	(√)	(√)	(√)	(√)	(√)
				- -	- -						
				- -	- -						
				- -	- -						
				- -	- -						
				- -	- -						

Please attach a copy of the marriage license, birth certificate or court documentation for any dependent(s) listed with a different last name. * The age limit for f/t students is 23 (otherwise, the age limit is 19). ** Spousal or Children Life Insurance

Drop Dependent(s): (This section must be completed if dropping dependent(s)						
Dependent(s)	Relationship			Social Security Number	Date of Birth	Address
LAST NAME, FIRST NAME	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	
				- -	- -	
				- -	- -	
				- -	- -	

IF NOT RECEIVED WITHIN 30 DAYS OF THE EVENT, YOU MUST WAIT FOR THE NEXT ANNUAL ENROLLMENT PERIOD.

Part D Name a New Beneficiary

Employee Life & Accidental Death & Dismemberment				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)
Personal Accident				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)

I name the above beneficiary(ies) to receive any benefits from the corresponding benefit plans that may be payable in the event of my death. I understand that this designation supersedes any prior beneficiary designation. **Forms that are not fully completed will be returned.**

Employee Signature: _____ Date: _____

YOU MAY COPY OR REMOVE THIS FORM