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CKE RESTAURANTS™

2024 Open Enrollment Guide

It's time to enroll in STAR BENEFITS!

October 31 - November 14, 2023

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Your 2024 Open Enrollment E-guide

Same Coverage & Providers. 401k Options. Voluntary Benefits. We've got good news! You will find that just about everything that is most important to you about your CKE STAR Benefits—the coverage you expect, the doctors you see, the healthcare facilities you use—are the same or continue to be BETTER in 2024! Cigna will continue to provide you and your families a broad range of medical and dental benefits. You will see a slight increase to your premiums.

VSP will continue to insure your vision benefits with no change and no premium increase.

Your other benefits, also remain unchanged for 2024.

- Principal Financial remains the administrator for The CKE Savings Plan, and CKE continues to match 25 percent of your contributions, up to 6 percent of your annual salary.
- Lincoln Financial continues to provide life, disability, accident and critical illness insurance at rates unchanged from 2023 .

STAR Tip

When you need more details about CKE benefits you can turn to Health Advocate to help you make the right choices.

- Call 866-695-8622
- **HealthAdvocate.com/members** or
- **answers@HealthAdvocate.com**

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Health Advocate

Sometimes the complexities of healthcare can be overwhelming. That's when Health Advocate comes to the rescue. It's a free service for all CKE employees, intended to make healthcare easier. With Health Advocate, you can find the right coverage and the right care and get the right support, all in one place.

The experienced specialists at Health Advocate:

- Know the ins and outs of health plans and other benefits, so you know what's covered and how to get the most cost-effective care
- Can find the right doctors, hospitals and other providers to meet employees' unique care needs, and even help to make an appointment
- Explain diagnoses and treatment options, providing unbiased support when you need it
- Work to untangle claims and billing issues, including reviewing medical bills to uncover costly errors
- Make personalized services available to employees, their spouses and dependents

These services are available to all CKE employees and their family members. You can learn more about Health Advocate at **ckebenefits.com.**

STAR Tip

4 ways to use Health Advocate

Phone: 866-695-8622

Online: HealthAdvocate.com/members

Email: answers@HealthAdvocate.com

Mobile: Download the Health Advocate app at the App Store or Google Play

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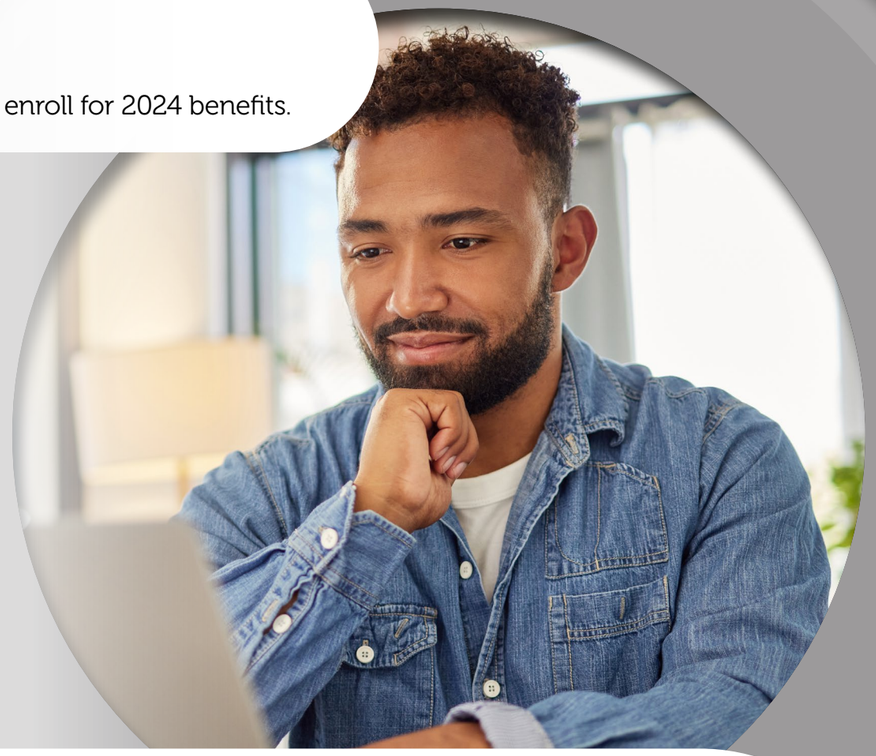
How To Enroll

How to Enroll

- Go to **www.ckebenefits.com**
- Click 2024 Open Enrollment where you will find information on how to enroll for 2024 benefits.



Eligibility

Regular full-time employees are eligible for all of the benefits described in this guide. Benefits begin on the first of the month following your hire date, provided you enroll by the deadline.

Hourly crew members and shift leaders are eligible for Accident and Critical Illness insurance and the Employee Assistance Program. Benefits begin on the first of the month following 90 days of employment.

ACA full-time employees: If you are an hourly crew member or shift leader and have been determined to be full-time, in accordance with Affordable Care Act (ACA) rules, you'll become eligible for medical, dental, and vision coverage . You will receive more details when you become eligible.

Your dependents

If you enroll yourself, you may also enroll your eligible dependents for medical, dental, vision, life/AD&D, and the voluntary insurance plans. Eligible dependents are generally defined as:

- Your legal spouse
- Your child(ren) up to age 26 biological, step, foster, legally adopted or placed for adoption, children for whom you have legal guardianship and children for whom you are required to provide coverage under a Qualified Medical Child Support Order
- Your disabled children age 26 or older who are incapable of self-care

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Making Changes

Open Enrollment is your once-a-year opportunity to change your benefits for the upcoming calendar year. Outside of Open Enrollment, you can generally only change your benefits if you experience a qualifying life event. Examples include:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement for adoption of a child
- Change in work schedule that affects benefits eligibility (e.g., full-time to part-time)
- Gain or loss of coverage through your spouse's employer
- A change in your spouse's or child's eligibility for benefits
- Eligibility for Medicare or Medicaid
- Death of a spouse or covered child

If you have a qualifying life event:

- You must notify the CKE Benefits Department and/or make changes to your coverage within 30 days of the event. The change(s) will be effective on the date of the event.
- The benefit change(s) must be directly related to the life event, and you will be asked to provide documentation, such as a marriage license or birth certificate.
- If you miss the 30-day enrollment window, you must wait until the next Open Enrollment window to change your benefits.
- In the event of birth or adoption of a child, the 30-day deadline applies, even if you have other children covered.

When Coverage Ends

For employees and their dependents, coverage will begin on January 1st and continue through December 31st. If you separate from the company, your Medical/Dental/Vision and Life/AD&D coverage end on the last day of the month in which you are employed by CKE. Disability, FSA and HSA participation ends on your last day of work. Under certain circumstances, you may continue your healthcare coverage for a period of time under COBRA .

STAR Tip

Enrollment is MANDATORY

Your CKE benefits do NOT automatically roll over to 2024. That's why you must make new elections during Open Enrollment. If not, your CKE benefits will end on Dec. 31, 2023.

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Benefit Cost Highlights

Like last year, you will have three plans to choose from. Also like last year, your options include one High-deductible plan with a Health Savings Account (HSA) and two traditional medical plans with different premiums and annual deductibles. Coverages are the same. Shown here are the weekly premium costs to you for each of the plans. The different plans' coverages and deductibles are detailed starting on Page 11.

Your 2024 Medical Benefit Premiums (weekly)

COVERAGE	HDHP WITH HSA	SILVER MEDICAL PLAN	GOLD MEDICAL PLAN
Employee	$19.64	$43.31	$73.30
Employee + Spouse	$51.20	$117.46	$187.21
Employee + Child(ren)	$39.28	$86.61	$146.60
Family	$73.48	$173.40	$276.36

STAR Tip

Take advantage of YOUR coverages!

- Physical/occupational therapy visits (up to 100 per year)
- Chiropractic services
- Gastric bypass procedures
- Gender transition services

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Benefit Cost Highlights

Two dental PPO options are offered through Cigna. Both cover preventive care and restorative services; the High option also covers orthodontia for adults and children. With either option, you can go to any dentist you choose, but you pay less out of pocket when you use Cigna network providers. For more details, see Page 19.

Your 2024 Dental Plan Premiums (weekly)

COVERAGE	DENTAL PPO LOW	DENTAL PPO HIGH
Employee	$2.56	$3.16
Employee + Spouse	$8.96	$12.58
Employee + Child(ren)	$6.99	$11.08
Family	$12.84	$17.05

Cigna.

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Benefit Cost Highlights

We are continuing to partner with VSP as our vision benefit provider. Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings. For more details, see Page 20.

Your 2024 Vision Plan Premiums (weekly)

COVERAGE	VSP VISION
Employee	$2.49
Employee + Spouse	$3.99
Employee + Child(ren)	$4.08
Family	$6.39

vsp℠ Vision care for life

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Additional Coverage

Life and AD&D Coverage

These benefits, provided through Lincoln Financial, are unchanged from 2023. Basic life and Accidental Death & Dismemberment coverage is provided to regular full-time employees by CKE at no cost to you. For more details, including how to add more life insurance for yourself and dependents, see Page 24.

Critical Illness

You can buy coverage that pays when you experience certain severe conditions and injuries. For details see page 26.

Accident

You can't always avoid accidents, but you can protect yourself from costs associated with them. Accident coverage, through Lincoln Financial, pays cash benefits when an accidental injury occurs. You can use the money to pay for expenses not covered by insurance, such as your deductible or coinsurance, and living expenses like mortgage, rent and transportation. For details, see Page 25.

Premiums (Weekly)

COVERAGE	VOLUNTARY ACCIDENT COVERAGE
Employee	$1.93
Employee + Spouse	$3.15
Employee + Child(ren)	$3.38
Family	$4.59

Disability Coverage

Short-term and Basic Long-term disability coverage, also through Lincoln Financial, is provided to regular full-time employees at no cost to you. If you are a regular full-time employee, short-term disability benefits for an approved disability claim begin after a 14 day waiting period and can last up to 26 weeks. Long-term disability coverage picks up where short-term disability coverage leaves off, protecting you financially if your disability prevents you from working for an extended period. You can purchase enhanced long-term disability coverage to increase your income replacement if you choose.

For more details, see Page 23.

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Time for a Closer Look

Same Coverage & Providers. 401(k) Options. Voluntary Benefits.

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Medical Benefit Plans

Comparing the Medical Plans

Deciding which medical plan is right for you and your family can depend on factors such as your ages, health status and other personal circumstances. Just know that all of the plans use the same network of quality healthcare providers and hospitals, covering the same services. All plans have separate deductibles for in-network medical expenses and out-of-network medical expenses. It will usually be less expensive for you to use in-network providers. The biggest differences in the plans are the cost for coverage to you, and how your deductible works.

Let's look at the three options and how they work

- High-Deductible Health Plan with Health Savings Account (HDHP with HSA)
- Silver Medical Plan .
- Gold Medical Plan.

STAR Tip

- Log in to **myCigna.com** or the myCigna® app to search your current plan's network .
- Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.
- You can also contact Health Advocate by visiting **HealthAdvocate.com/members** or by emailing **answers@HealthAdvocate.com**

STAR Tip

The 2024 Cigna Easy Choice Tool

- The 2024 Cigna Easy Choice Tool set up for CKE Restaurants holdings, Inc. is complete. Please use this URL to access the CECT login page: **https://decisionsupport.cigna.com**
- Employee access codes:
  All Employees: YMJDQH96

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High-Deductible Health Plan With Health Savings Account (HDHP WITH HSA)

The HDHP with HSA is a high-deductible health plan. It does not have copays and starts paying benefits only after you meet the deductible. Enrolling in a HDHP offers several advantages:

- Lowest premiums
- A Health Savings Account (HSA) that allows you to set aside tax-free money to pay eligible expenses
- A $500 company HSA matching contribution, if you contribute at least $500 of your own money to the HSA

2024 HDHP with HSA premiums (weekly)

COVERAGE	HDHP WITH HSA PREMIUMS
Employee	$19.64
Employee + Spouse	$51.20
Employee + Child(ren)	$39.28
Family	$73.48

See how your HSA works on the next page.

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Health Savings Accounts

If you enroll in the **High-Deductible Health Plan (HDHP)** you can make pre-tax contributions to a Health Savings Account (HSA). CKE will also match your HSA contributions, up to $500 per year. You can use this money help pay eligible health care expenses, such as deductibles and copays (but not insurance premiums). Any unused money in your account rolls over from year to year.

Here's how it works. Both you and CKE can contribute. Here's how much based on your coverage level:

2024 Health Savings Plan maximum contributions

COVERAGE	EMPLOYEE (WEEKLY)	CKE (WEEKLY)	TOTAL (WEEKLY)	TOTAL (ANNUAL)
Employee	$70.19	$9.62	$79.81	$4,150.00*
Employee + Spouse	$150.00	$9.62	$159.62	$8,300.00*

*Includes CKE's matching contribution (up to $500)

If you are age 55 or older, you may make an additional $1,000 catch-up contribution. You can change how much you contribute at any time.

Using the money

- You can use your HSA for eligible medical, dental and vision expenses for you and your tax dependents
- You can also use your HSA as a retirement savings vehicle. Since this money is 100% yours and grows over time, you can use this for eligible retiree medical expenses down the road
- When you first enroll, you'll receive a debit card that you can use to pay for eligible expenses

STAR Tip

You must be enrolled in the HDHP to contribute to an HSA. If you contribute to an HSA, you cannot contribute to a Healthcare FSA.

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Silver and Gold Medical Plans

The Silver and Gold Medical Plans are traditional medical plans that use copays for office visits and prescription drugs. These plans have lower deductibles than the HDHP plan, but they also have higher employee premiums. The Silver Medical Plan has lower premiums than the Gold Medical Plan, but higher deductibles, while the Gold Medical Plan has higher premiums and lower deductibles than the Silver Medical Plan.

2024 Silver Medical Plan Premiums (weekly)

COVERAGE	
Employee	$43.31
Employee + Spouse	$117.46
Employee + Child(ren)	$86.61
Family	$173.40

2024 Gold Medical Plan Premiums (weekly)

COVERAGE	
Employee	$73.30
Employee + Spouse	$187.21
Employee + Child(ren)	$146.60
Family	$276.36

STAR Tip

- Cigna One Guide is a free service for CKE employees to help understand the basics of health coverage, identify the health plans available to you, help find in-network doctors, and answer any benefit questions you may have.
- Call 888.806.5042 to speak with a Cigna One Guide representative today.

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Medical Plans Highlights

	HDHP WITH HSA		SILVER MEDICAL PLAN		GOLD MEDICAL PLAN	
OPEN ACCESS PLUS PLAN	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CKE HSA CONTRIBUTION	$500 MATCH IF YOU CONTRIBUTE AT LEAST $500		N/A		N/A	
ANNUAL DEDUCTIBLE[2]						
Individual	$3,500	$7,000	$2,000	$4,000	$500	$1,000
Family	$7,000	$14,000	$ 4,000	$ 8,000	$1,000	$2,000
OUT-OF-POCKET MAXIMUM[3]						
Individual	$6,450	$14,000	$ 4,000	$ 8,000	$3,000	$6,000
Family	$12,900	$28,000	$ 8,000	$16.000	$6,000	$12,000

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Medical Plans Highlights

	HDHP WITH HSA		SILVER MEDICAL PLAN		GOLD MEDICAL PLAN	
OPEN ACCESS PLUS PLAN	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CKE HSA CONTRIBUTION	$500 MATCH IF YOU CONTRIBUTE AT LEAST $500		N/A		N/A	
WHAT YOU PAY (AFTER DEDUCTIBLE)						
Preventive Care	$0	50%	$0	50%	$0	50%
PHYSICIAN OFFICE VISITS[4]						
Primary Care	30%	50%	$30 copay	50%	$25 copay	50%
Specialty Care	30%	50%	$60 copay	50%	$50 copay	50%
Cigna Telehealth (Virtual care)	30%	50%	$30 copay	Not covered	$25 copay	Not covered
Outpatient services	30%	50%	20%	50%	20%	50%
Inpatient services	30%	50%	20%	50%	20%	50%
EMERGENCY SERVICES						
Urgent Care Facility	30%	50%	$60 copay	50%	$50 copay	50%
Emergency room	30%	30%	$350 copay	$350	$350 copay	$350
Outpatient therapy[5]	30%	50%	$30 copay	50%	$25 copay	50%
Chiropractic[6]	30%	50%	$30 copay	50%	$25 copay	50%
MENTAL HEALTH AND SUBSTANCE USE DISORDER						
Physician's Office	30%	50%	$60 copay	50%	$25 copay	50%
Inpatient services	30%	50%	20%	50%	20%	50%

[1] Out-of-network services are subject to reasonable and customary (R&C) limits. If you go out-of-network, you will be responsible for paying amounts exceeding R&C limits. Network providers have agreed not to exceed R&C limits.
[2] The deductible must be met before coinsurance applies. If a service is covered with a per-visit copay, the deductible does not apply. All plans have an embedded deductible. This means a covered individual does not have to meet the full family deductible before coinsurance begins. Each individual only has to meet the individual deductible, then the plan begins to pay benefits (per applicable coinsurance).
[3] Once you reach the out-of-pocket maximum, the plan will pay 100% for covered services for the remainder of the calendar year. The out-of-pocket maximum includes copays and amounts paid toward the deductible.
[4] Obstetrician and gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost-share depending on how the provider contracts with Cigna (i.e., as PCP or as Specialist).
[5] Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy; maximum 100 visits per year.
[6] Chiropractic services maximum 20 visits per year.

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Prescription Drug Benefits

Prescription drug benefits, administered by Cigna, are included with all medical plans . Each plan treats copays a little differently. The chart below shows what you pay based on which medical plan you choose.

PRESCRIPTION DRUG BENEFITS	HDHP	SILVER MEDICAL PLAN	GOLD MEDICAL PLAN
IN-NETWORK			
Retail (30-day supply)	After deductible	No deductible	No deductible
Generic	$10	$15	$15
Preferred Brand	$40	$35	$35
Non-Preferred Brand	$70	$75	$60
RETAIL OR HOME DELIVERY (90-DAY SUPPLY)			
Generic	$25	$37	$25
Preferred Brand	$100	$87	$87
Non-Preferred Brand	$175	$187	$150
PREVENTIVE/MAINTENANCE MEDICATIONS[1]			
Preventive Generics	$0		
Preventive Preferred Brand	Deductible does not apply; 30%		
Preventive Non-Preferred Brand	Deductible applies; 30%		
OUT-OF-NETWORK			
Retail (All prescriptions)	50%	50%	50%
Home Delivery	Not Covered	Not Covered	Not Covered

[1] The Preventive drugs include those medications that are taken regularly for chronic conditions, such as high blood pressure, high cholesterol or diabetes. Note that prescriptions for Preventive Generics are free. This could be a big money-saver if it applies to you!

STAR Tip

Understand the formulary tiers. All plans use a formulary (a list of preferred drugs). You pay the least for Generic drugs.

Here's how to save money and time on prescriptions

- Contact Health Advocate for advice on lower-cost medications you take: **HealthAdvocate.com/members** or **answers@HealthAdvocate.com**
- If you regularly take maintenance medications for chronic conditions, you will probably want to get a 90-day supply each time. Just remember that it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- All three plans use a formulary — a list of normally covered drugs. When you receive a new prescription, make sure the medication is on the formulary and look for generic equivalents of brand name drugs, which can cost you much less.

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Cigna Telehealth Connection Virtual Healthcare

Access care from anywhere via video or phone.

- Get minor medical virtual care 24/7/365—even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to your local pharmacy, if appropriate.

	HDHP WITH HSA	SILVER MEDICAL PLAN	GOLD MEDICAL PLAN
What you pay when you use MDLIVE	30%	$30	$25

Virtual care is provided through MDLIVE. You can connect with needed medical advice with just a few easy steps.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

Free Wellness Screenings

You don't have to be sick to take advantage of virtual care. You can also conduct a wellness screening, or check-up, using MDLIVE. Simply make your appointment online, then make a quick visit to a lab for your blood work and vitals. The rest is completed online and via video or phone, whatever's most convenient for you. You'll receive a summary of your screening results for your records. And it's all done at no cost to you as a preventive care benefit when you use in-network providers.

STAR Tip

How can virtual care help if you may have COVID-19?

While a diagnosis of COVID-19 cannot be confirmed through virtual medical care, it is still the most convenient way to get the medical attention you may need without leaving home. There are, however, some restrictions to what a virtual care provider from MDLIVE can and cannot do relative to COVID-19.

A virtual care provider CAN:

- Assess your likelihood of COVID-19 based on symptoms and other risk factors
- Advise you to:
  - » Self-quarantine according to the latest CDC guidelines
  - » Pursue COVID-19 testing via an in-person care setting
  - » Go to an emergency department if symptoms are severe, and help coordinate with your local emergency department if necessary
- Write a note excusing you from school or work for up to 14 days

A virtual care provider CANNOT:

- Order any tests for COVID-19 or advise you where to get a test
- Treat COVID-19 cases with anti-viral medication
- Provide a note that clears you to return to work

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Dental Plans

CKE offers Dental coverage through Cigna. Most in-network diagnostic and preventive care is covered 100%, and you pay either 50 percent or 20 percent of the cost for most other care after you meet your deductible. You can see any dentist you want, but providers in Cigna's Dental PPO network charge a lower, negotiated rate. That means more dental services could be covered before you reach your annual benefit maximum by using in-network dentists.

The big difference in the High Dental Plan and the Low Dental Plan, besides the premiums, is that the High Plan covers orthodontics (braces) and has a much higher annual benefit maximum.

Here's what you pay for dental care:

2024 Cigna Dental Premiums (weekly)

COVERAGE	DENTAL PPO LOW	DENTAL PPO HIGH
Employee	$2.56	$3.16
Employee + Spouse	$8.96	$12.58
Employee + Child(ren)	$6.99	$11.08
Family	$12.84	$17.05

STAR Tip

Is Your Dentist In-Network?

Using in-network providers can save you money because Cigna negotiates special rates for you. To see if your dentist or other dental professional is in-network, go to **www.mycigna.com** or call Cigna Customer Service 24/7 at 1.800.CIGNA24.

Do you or your dependents need braces?

Take a close look at the Dental High Plan. It includes orthodontics and has a much higher annual benefit.

DENTAL BENEFITS	DPPO LOW IN-NETWORK*	DPPO HIGH IN-NETWORK*
Annual deductible	$50/person; $150/family	$50/person; $150/family
Preventive/diagnostic (such as exams, cleanings, bitewing x-rays)	$0; No Deductible	$0; No Deductible
Basic (such as fillings, simple extractions)	20%	20%
Major (such as crowns, bridges, dentures)	50%	50%
Orthodontia for adults and children	Not Covered	50%; No Deductible
Maximum annual benefit	$750	$3,000

* Out-of-network benefits are the same, except in-network dental fees are based on negotiated rates. If out-of-network fees exceed reasonable-and-customary limits, you will be responsible for the difference.

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Vision Plans

CKE and VSP provide you with an affordable vision plan. You can get the most out of your benefits and greater savings by using a VSP network doctor.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility.

Here are some of the most common covered benefits and your costs.

Vision Benefits

BENEFIT DESCRIPTION	COVERAGE	YOU PAY (IN-NETWORK)	FREQUENCY
WELLVISION Exam	Focuses on your eyes and overall wellness	$10 copay	Once a year
Prescription glasses	Eyeglass frames and lenses	$10 copay	Once a year
Frames	$200 featured frame brands allowance 20% savings on the amount over your allowance $80 Walmart®/Sam's Club®/ Costco® frame allowance)	Included in prescription glasses	Once a year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children	Included in prescription glasses	Once a year
Contacts	$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60	Once a year

STAR Tip

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP. No ID cards are issued

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Additional Star Benefits

CKE offers benefits to help you prepare to pay both expected expenses and for life's unexpected events. Take a look at the additional benefits available to you. Some are provided to you at no cost, and some are voluntary and require contributions from you.

Flexible Spending Account (FSA)

CKE offers two different FSAs to help you save tax-free money to pay for eligible expenses. One covers healthcare expenses, like the deductibles and copays (but not the premiums of medical, dental and vision plans). The other covers dependent care expenses, usually child care. In both cases, money you contribute to an FSA is not subject to federal income tax.

Health Care FSA

You can contribute up to $3,200. Remember, you can use this account for:

- Medical care
- Prescriptions
- Dental and vision expenses for yourself and your eligible dependents

A Health Care FSA can also help bridge the gap until you meet your plan deductible.

Dependent Care FSA

You can contribute up to $5,000 ($2,500 if married but filing separately from your spouse) tax-free to pay for:

- Day care fees and associated expenses for your children under age 13
- Dependent care fees for a disabled spouse or child or a tax-dependent parent or elderly person

STAR Tip

Cigna will continue to administer Flexible Spending Accounts in 2024.

STAR Tip

No contribution changes — Once you decide how much to contribute to each FSA account, you can't change it until the next Open Enrollment (unless you experience a qualifying life event).

No transfers — If you participate in both FSAs, you cannot transfer money between your two accounts or use money in one to pay expenses for the other.

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Additional Star Benefits (cont.)

Flexible Spending Account (FSA) Continued

How to manage your FSA

How to Get Started

1. Estimate your health care and dependent care expenses separately for 2024.
2. Decide how much to contribute to each account. Be careful not to overestimate your expenses as unused funds at year-end are forfeited.
3. Your contributions will be deducted from your paycheck before taxes are taken out of your check and deposited into your account(s). (If you contribute to the Health Care FSA, your full annual election amount is available to you at the beginning of the calendar year.)
4. Get reimbursed with the tax-free money in your account(s) using one of the following options:
   - For Healthcare FSA expenses, use the debit card you receive in the mail after enrollment.
   - For both healthcare and dependent care expenses, pay as you normally would, then submit a claim to Cigna. You can even have your claims payment deposited directly into your checking or savings account.

You must re-enroll every year (during Open Enrollment) to keep participating in the FSAs, even if you wish to keep your same contribution. Once you enroll, you will receive a welcome packet from Cigna with complete rules and tips for maximizing your savings with the FSAs.

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Income Protection and Other Insurance

CKE offers additional benefits to help protect your income if you become injured or disabled, or to provide cash payments in the event of your death or the death of a covered dependent. At the same time, you can also insure the life of your spouse or even children. These benefits are provided through Lincoln Financial.

Disability Insurance

Disability coverage, administered by Lincoln Financial, continues a portion of your paycheck if a serious illness or injury keeps you from working.

If you are a regular full-time employee, short-term disability is provided by CKE at no cost to you. Long-term disability coverage generally picks up where short-term disability coverage leaves off to protect you financially if your disability continues for an extended period.

Short-Term Disability (STD) replaces part of your income if you are unable to work due to illness or injury.

Long-Term Disability (LTD) provides income protection if you become disabled and cannot work due to an illness or injury that lasts more than 180 days.

	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits begin:	After 14 days of disability	After 180 consecutive days of disability
Plan pays:[1]	60% of your base pay, up to $1,500/week	40% of your base pay, up to $10,000/month You may purchase buy-up coverage to increase income replacement to 60%
Benefits continue:[1]	Up to 26 weeks	Benefits generally continue until you are no longer disabled or reach normal retirement age

[1] Limits may apply

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

Life Insurance

Life insurance benefits include:

- Basic Life Insurance and Accidental Death and Dismemberment (AD&D) provides coverage of 1 year's salary (up to $500,000) in life insurance benefits and an equal amount of AD&D benefits. These benefits are provided at no cost to Regular Full Time employees.
- Optional Life Insurance for yourself, your spouse/domestic partner and children can be purchased.

NOTE: If you don't enroll when first eligible, you will be required to provide Evidence of Insurability (EOI) and be approved by Lincoln Financial before coverage begins.

STAR Tip

What is Evidence of Insurability?

In certain cases, you (or your spouse) may be required to submit Evidence of Insurability (EOI) and be approved before your life insurance coverage becomes effective. EOI is required if:

- You decline voluntary or spouse life coverage when first eligible but wish to add it at a later date
- You elect to increase your or your spouse's life coverage
- Life coverage elections exceed the following guaranteed issue amounts:
  - Your voluntary life: any amount over $250,000; or
  - Spouse coverage: any amount over $20,000

If EOI is required, you will be advised when you enroll.

	VOLUNTARY LIFE	VOLUNTARY AD&D
For you:	1, 2, 3, 4 or 5x your annual salary, up to $1 million	1, 2, 3, 4 or 5x your annual salary, up to $1 million
For your spouse:	Up to $250,000 (in $10,000 increments)[1]	Up to $250,000 (in $10,000 increments)[1]
For each unmarried dependent child:	$10,000 per child (in $2,000 increments)[1]	$10,000 per child (in $2,000 increments)[1]

[1] Spouse life coverage cannot exceed 50% of your voluntary amount. If you elect child life, coverage includes all your children.

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Accident Insurance

You can't always avoid accidents, but you can protect yourself from costs associated with them. Accident coverage, through Lincoln Financial, pays cash benefits when an accidental injury occurs. You can use the money to pay for expenses not covered by insurance, such as your deductible or coinsurance, and living expenses like mortgage, rent and transportation.

Accident Insurance Premiums (Weekly)

COVERAGE	
Employee	$1.93
Employee + Spouse	$3.15
Employee + Child(ren)	$3.38
Family	$4.59

Below are some examples of covered injuries and benefit amounts: Service Plan pays[1]:

SERVICE	PLAN PAYS[1]
Ambulance (ground)	$225
Ambulance (air)	$1,125
Initial care visit	$75
Emergency room	$150
Hospital admission	$1,000
Hospital stay	$200/day
Intensive care unit	$400/day

[1] Amount paid is based on injury and service required. Limits apply.

The plan also pays cash benefits for x-rays, fractures, dislocations, concussions, burns, traumatic brain injuries, sports injuries, pain management, physical therapy, mobility devices, accidental death and dismemberment, expenses associated with the accidental injury like transportation and lodging, and more.

See the plan brochure on **ckebenefits.com** for a complete benefits list.

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Critical Illness Insurance

When a serious illness strikes, this coverage can provide vital financial help. The plan, provided through Lincoln Financial, pays cash benefits you can use to pay expenses not covered by insurance. You can also use the money for everyday expenses like housekeeping, transportation and day care. Covered critical illnesses include:

Accidental injury (brain injury, severe burns, permanent paralysis)

- Cancer
- Advanced COPD
- Arterial/vascular disease*
- Heart attack
- Kidney or major organ failure
- Stroke

* Covered at 25%-30% of your coverage amount. If child coverage is elected, additional childhood conditions, such as Type 1 diabetes, Down syndrome, spina bifida and others, are covered.

Critical Illness Insurance Coverage Levels

COVERAGE	DEPENDING ON COVERAGE OPTION ELECTED, THE PLAN PAYS THE FOLLOWING UPON DIAGNOSIS*:		
Employee	$10,000	$15,000	$20,000
Spouse	$5,000	$ 7,500	$10,00
Child(ren)	$2,500	$ 5,000	$10,000

*Dependent coverage cannot exceed 50% of employee's coverage election

Pre-existing condition exclusion

Under the critical illness plan, no benefits are payable during your first 12 months of coverage as the result of a pre-existing condition. A pre-existing condition is one for which you received medical advice or treatment from a medical professional in the 12-month period before your coverage begins. However, after you have been covered by the plan(s)) for 12 months, the pre-existing condition limit no longer applies. See the plan brochure on **ckebenefits.com** for more details about this coverage.

Your 2024 Cost

Your cost for critical illness coverage is based on coverage level, tobacco use, and the age of the covered person, and can be viewed when you log onto MyStar to enroll.

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Employee Assistance Program

For Life's Little (and not so little) Detours

You have hopes, dreams, and goals for your future. So, when you encounter bumps along the road, the EmployeeConnect℠ program is on your side. Whether it's a helping hand during tough times or a bit of professional guidance, we're here for you with the support you need to keep moving forward. You can get help with:

- Depression
- Marital or family difficulties
- Managing stress and anxiety
- Substance abuse
- Legal and financial matters
- Locating child or elder care
- Moving and relocation
- Planning for college, events or vacation
- Family planning and pregnancy health

To Find Out More:

1. Visit **GuidanceResources.com**
2. **Username**: LFGSupport; **Password**: LFGSupport1
3. Download the GuidanceNow℠ mobile app
4. Call **888-628-4824**

Scan the QR code to learn more about how EmployeeConnect℠ services can help!

Some matters are best resolved by meeting with a professional in person. With EmployeeConnect℠, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings

Contents

401(k) The CKE Savings Plan

Principal has been a leader in providing retirement solutions for over 75 years. We're excited to share the new features, tools, and resources you can use to help save for, and live in, retirement.

It's never too early to start saving for your future! Principal makes it easy to do it. Since Principal Financial continues as our 401(k) plan administrator, your account access hasn't changed. Here are the highlights of the savings plan.

Eligibility

In order to be eligible to contribute to the CKE Savings Plan, you must be in a designated full-time General Manager or Corporate role. If you have questions about your eligibility, please contact the CKE Benefits Department.

Automatic Enrollment

Enrollment is automatic for newly eligible employees at a rate of 2% of your salary. You can change your contribution amount or start or stop participation at any time by going to the Principal Financial website at **www.principal.com** or by calling **800-547-7754**.

Join Anytime

If you're eligible and not currently participating, you can start any time. It just takes a few clicks at **www.principal.com/welcome** to set up your account, contribution amounts, investment choices and name a beneficiary.

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401(k) The CKE Savings Plan

Open Enrollment is a great time to review your beneficiaries for the Savings Plan and review your other benefits to do some financial planning. You can log on to your account at **www.principal.com** to keep up with your 401(k) portfolio.

The Benefit of Long-Term Saving

Contributing even 1% of your pay today can make a big difference in your savings when you retire. That's because of compounding—the ability for earnings on contributions to your account to be reinvested and earn even more money for you. The earlier you contribute, the more time your earnings have to compound. In the long run, you can also save more money for retirement by gradually increasing your contribution as you are able.

CKE Contributes, Too

The Savings Plan allows both you and the company to contribute money toward your retirement. For every $1 you contribute to your 401(k), CKE matches 25 percent, up to 6 percent* of your salary. You can choose to invest up to 75% of your paycheck (up to IRS limits) as pre-tax contributions.

It's Your Money

Contributions you make to your 401(k) always belong to you. After just three years, the company's contributions to your account are 100 percent yours, too.

Pick Your Investments

If you don't select an investment option, your money will go into an age-appropriate fund. Sign in to your account to see all your investment options, which offer a variety of goals from aggressive growth to capital safety.

Check your account on the go

Download the Principal® App for iPhone® and Android™*. Point your browser to **principal.com/onthego** for the link.

Learn more about saving for retirement

Don't know much about investing? Principal helps you balance your money priorities at **principal.com/Milestones**. You can also watch engaging webinars at **principal.com/LearnNow.**

* Highly Compensated Employees

Highly Compensated Employees (HCEs) are limited to saving 5% of total eligible compensation. CKE identifies an HCE as an employee receiving $130,000.00 or more in eligible compensation during the current Plan year. If you have questions about your classification as an HCE, please contact the CKE Benefits team.

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Important Contacts

BENEFIT	CONTACT	ONLINE	PHONE
General benefits and enrollment questions	Health Advocate	HealthAdvocate.com/members answers@HealthAdvocate.com	866-695-8622
	CKE Benefits	ckebenefits.com benefits@ckr.com	888-253-3115
Claims assistance and care advice	Health Advocate	HealthAdvocate.com/members answers@HealthAdvocate.com	866-695-8622
Enrollment website	MyStar	https://n35.ultipro.com/ RSC Employees: https://ckr.okta.com	866-725-4253
Medical and Dental	Cigna	myCigna.com	800-CIGNA24
Vision	VSP	vsp.com	800-877-7195
Health Savings Account (HSA) Flexible spending accounts	Cigna	myCigna.com	800-CIGNA24
Life/AD&D	Health Advocate	HealthAdvocate.com/members **answers@HealthAdvocate.com**	866-695-8622
	CKE Benefits	ckebenefits.com benefits@ckr.com	888-253-3115
Disability. Accident, Critical Illness	Lincoln Financial	mylincolnportal.com Company code: CKERHINC	888-408-7300 800-423-2765 800-423-2765
401(k) Savings	Principal	principal.com/OnTheGo Principal.com	800-547-7754
Employee Assistance Program (EAP)	ComPsych	guidanceresources.com Username: LFGsupport Password: LFGsupport1	888-628-4824

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Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance apply.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or 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 (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Contact Information

Questions regarding any of this information can be directed to:

CKE Benefits at 888-253-3115 or **benefits@ckr.com**

Contents

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for **questions or complaints is available at the end of the notice.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

- We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

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Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date 01/01/2024
- CKE Benefits at 888-253-3115 or **benefits@ckr.com**

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from CKE Restaurants Holdings, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CKE Restaurants Holdings, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. CKE Restaurants Holdings, Inc. has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC Updated April 1, 2011
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CKE Restaurants Holdings, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current CKE Restaurants Holdings, Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CKE Restaurants Holdings, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CKE Restaurants Holdings, Inc. changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Date: 01/01/2024
Name of Entity/Sender: CKE Restaurants Holdings, Inc.
Contact: CKE Benefits
Address: 6700 Tower Circle, Franklin, TN 37067
Phone Number: 888-253-3115

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Premium Assistance Under MedicAid and The Children's Health Insurance Program(CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

Website: **http://myalhipp.com/**
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – MEDICAID

Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
Website: **http://dhcs.ca.gov/hipp**
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO
(COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991
State Relay 711
Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/**
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1 GA
CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid Website: **https://www.in.gov/medicaid/**
Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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KENTUCKY – MEDICAID	NEW HAMPSHIRE – MEDICAID
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov/agencies/dms**	Website: **www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
LOUISIANA – MEDICAID	**NEW JERSEY – MEDICAID AND CHIP**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: **http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MAINE – MEDICAID	**NEW YORK – MEDICAID**
Enrollment Website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – MEDICAID AND CHIP	**NORTH CAROLINA – MEDICAID**
Website: **https://www.mass.gov/masshealth/pa** Phone: 1-800-862-4840 TTY: 711 Email: **masspremassistance@accenture.com**	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – MEDICAID	**NORTH DAKOTA – MEDICAID**
Website: **https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **https://www.hhs.nd.gov/healthcare** Phone: 1-844-854-4825
MISSOURI – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742
MONTANA – MEDICAID	**OREGON – MEDICAID**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084 Email: **HHSHIPPProgram@mt.gov**	Website: **http://healthcare.oregon.gov/Pages/index.aspx** Phone: 1-800-699-9075
NEBRASKA – MEDICAID	**PENNSYLVANIA – MEDICAID AND CHIP**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx** Phone: 1-800-692-7462 CHIP Website: **Children's Health Insurance Program (CHIP) (pa.gov)** CHIP Phone: 1-800-986-KIDS (5437)
NEVADA – MEDICAID	**RHODE ISLAND – MEDICAID AND CHIP**
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

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SOUTH CAROLINA – MEDICAID	VIRGINIA – MEDICAID AND CHIP
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs** Medicaid/CHIP Phone: 1-800-432-5924
SOUTH DAKOTA - MEDICAID	**WASHINGTON – MEDICAID**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **https://www.hca.wa.gov/** Phone: 1-800-562-3022
TEXAS – MEDICAID	**WEST VIRGINIA – MEDICAID AND CHIP**
Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services** Phone: 1-800-440-0493	Website: **https://dhhr.wv.gov/bms/ http://mywvhipp.com/** Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 1-800-362-3002
VERMONT– MEDICAID	**WYOMING – MEDICAID**
Website: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health** Access Phone: 1-800-250-8427	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Contents

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact .

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name CKE Restaurants Holdings, Inc.		4. Employer Identification Number (EIN) 90-0941003
5. Employer address 6700 Tower Circle		6. Employer phone number 888-253-3115
7. City Franklin	8. State TN	9. ZIP code 37067
10. Who can we contact about employee health coverage at this job? CKE Benefits		
11. Phone number (if different from above) 888-253-3115		12. Email address benefits@ckr.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are: Full-time Employees
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are: Legal Spouse, Child(ren) up to age 26
  - We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.