Ferrara Candy Company, Inc.

Administrative Services for Short Term Disability Plan

Benefit Highlights

SHORT TERM DISABILITY PLAN

This short term disability plan is provided for you by Ferrara Candy Company, Inc..

This plan provides financial protection by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled. Benefits start after the elimination period.

Program Date:	January 1, 2025
Program Number:	71249
Covered Classes:	All Salaried and Hourly Employees other than those classified by the Employer as California Jelly Belly Employees.
Minimum Hours Requirement:	Employees must be working at least 30 hours per week.
Employment Waiting Period:	You may need to work for your Employer for a continuous period before you become eligible for the plan. Your Employer will let you know about this waiting period.
Elimination Period:	7 days for disability due to sickness. There is no elimination period for disability due to accident which begins while you are covered. For all maternity disability claims, there is no elimination period. **Benefits begin the day after the Elimination Period is completed.**
Weekly Benefit:	60% of your weekly earnings for disability claims other than Maternity claims. For Maternity Disability Claims: 100% of your weekly earnings for 8 weeks of post delivery. Your benefit may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.
Maximum Period of Benefits:	For all disability claims other than maternity, 26 weeks of benefits. For all maternity disability claims, 8 weeks of post delivery.
Cost of Coverage:	The short term disability plan is provided to you on a non-contributory basis. The entire cost of your coverage under the plan is being paid by your

Employer.

The above items are only highlights of your coverage. For a full description please read this entire program document.

Table of Contents

General Provisions

General Definitions used throughout this program document include:

You means a person who is eligible for coverage under the Program.

Employee means a person who is in ***active employment*** with the ***Employer*** for the minimum hours requirement.

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least 30 hours per week. If you are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Employer means your Employer, and includes any division, subsidiary or affiliate who is reported for inclusion under the Program.

Insured means any person covered under a coverage.

Plan means a line of coverage under the Program.

When Are You Eligible for Coverage?

If you are working for your Employer in a ***covered class***, the date you are eligible for coverage is the later of:

- the plan's program date; and
- the day after you complete your ***employment waiting period.***

You do not have to complete a new employment waiting period if:

- your coverage ends because you stop working for your Employer for any reason; and

- and you resume working for your Employer in a covered class within 6 months after your coverage ended.

Covered class means your class as determined by the Employer. This will be done under the Employer's rules, on dates the Employer sets. The Employer must not discriminate among persons in like situations. You cannot belong to more than one class for the coverage on each basis, Contributory or Non-contributory coverage, under a plan. "Class" means covered class, benefit class or anything related to work, such as position or earnings, which affects the coverage available. If you are an employee of more than one Employer included under the Program, for the coverage you will be considered an employee of only one of those Employers. Your service with the others will be treated as service with that one.

Employment waiting period means the continuous period of time that you must be in a covered class before you are eligible for coverage under a plan.

When Does Your Coverage Begin?

When your Employer pays the entire cost of your coverage under a plan, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage; and
- the date you are in active employment. If you are not in active employment on the date your coverage would normally begin, it will begin on the date you return to active employment.

When Will Changes to Your Coverage Take Effect?

Once your coverage begins, any increased or additional coverage will take effect on the latest of:

1. the effective date of the change, if you are:
    - in active employment;
    - on a temporary layoff;
    - on leave of absence; or
    - working ***reduced hours***, for reasons other than disability.
2. the date you return to active employment, if you are not in active employment due to injury or sickness.

Any decrease in coverage will take effect immediately upon the effective date of the change. Neither an increase nor a decrease in coverage will affect a ***payable claim*** that occurs prior to the increase or decrease.

Reduced hours means you are working less than the number of hours required to be considered in active employment.

Payable claim means a claim for which Ferrara Candy Company, Inc. is liable under the terms of the Program.

Once Your Coverage Begins, What Happens If You Are Temporarily Not Working Or If You Are Working Reduced Hours?

If you are on a ***temporary layoff***, and if any required contribution is paid, you will be covered to the end of the month following the month in which your temporary layoff begins.

If you are on a ***leave of absence***, and if any required contribution is paid, you will be covered to the end of the month following the month in which your leave of absence begins. But, with respect to leave of absence under the federal Family and Medical Leave Act of 1993 (FMLA) or similar state law, if it is your employer's policy to allow a longer period of continued coverage for FMLA leaves, this policy will be used to determine the period of continued coverage for your FMLA leave.

If you are working reduced hours, for reasons other than disability, and if any required contribution is paid, you will be covered to the end of the month following the month in which your reduced hours begin.

Temporary layoff means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff.

Leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time or any period of disability is not considered a leave of absence.

When Does Your Coverage End?

Your coverage under the Program or a plan ends on the earliest of:

- the date the Program or a plan is canceled;
- the date you are no longer a member of the covered classes;
- the date your covered class is no longer covered;
- the last day you are in active employment except as provided under the Once Your Coverage Begins, What Happens If You Are Temporarily Not Working Or If You Are Working Reduced Hours? section; or
- the date you are no longer in active employment due to a disability that is not covered under the plan. The disabilities that are not covered are shown in the What Disabilities Are Not Covered Under Your Plan? section of the Short Term Disability Coverage Benefit Information pages.

Short Term Disability Coverage

BENEFIT INFORMATION

How Is Disability Defined?

You are disabled when:

- you are unable to perform the ***material and substantial duties*** of your ***regular occupation*** due to your ***sickness*** or ***injury***;
- you are under the ***regular care*** of a ***doctor***; and
- you have a 20% or more loss in ***weekly earnings*** due to the same sickness or injury.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Your ability to work and the extent to which you are able to work will be assessed by considering the facts and opinions from:

- your doctors; and
- specified doctors, other medical practitioners or vocational experts.

When you are required to be examined by specified doctors, other medical practitioners or vocational experts, your Employer will pay for these examinations. Examinations may be required as often as it is reasonable to do so. You may also be required to be interviewed by an authorized representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

Regular occupation means the occupation you are routinely performing when your disability begins. Your occupation will be looked at as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan.

Injury means a bodily injury that:

- is the direct result of an accident;
- is not related to any cause other than the accident; and
- results in immediate disability.

Disability must begin while you are covered under the plan.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Any relative, including but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse will not be recognized as a doctor for a claim that you submit.

Weekly earnings means your gross weekly income from your Employer in effect just prior to your date of disability. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

If you become disabled while you are on a covered layoff or leave of absence, your weekly earnings from your Employer in effect just prior to the date your absence begins will be used.

How Long Must You Be Disabled Before Your Benefits Begin?

You must be continuously disabled through your ***elimination period***. Your disability will be treated as continuous if your disability stops for 5 consecutive days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period for disability due to a sickness which begins while you are covered is 7 days. There is no elimination period for disability due to accident which begins while you are covered. For all maternity disability claims, there is no elimination period.

Elimination period means a period of continuous disability which must be satisfied before you are eligible to receive benefits under the plan. If you become covered under a group short term disability plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Can You Satisfy Your Elimination Period If You Are Working?

Yes, provided you meet the definition of disability.

When Will You Begin to Receive Disability Payments?

You will begin to receive payments when your claim is approved, providing the elimination period has been met. You will be sent a payment weekly for any period for which your Employer is liable.

How Much Will You Be Paid If You Are Disabled and Not Working?

This process will be followed to figure out your ***weekly payment***:

1. Multiply your weekly earnings by 60%. This is considered your ***gross disability payment***.
2. Subtract from your gross disability payment any ***deductible sources of income***.

That amount figured in item 1 is your weekly payment.

After the elimination period, if you are disabled for less than 1 week, you will be sent 1/7 of your payment for each day of disability.

Weekly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

Gross disability payment means the benefit amount before any deductible sources of income and disability earnings are subtracted.

Deductible sources of income means income from deductible sources listed in the plan that you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

How Much Will You Be Paid If You Work While You Are Disabled?

You will be sent the weekly payment if you are disabled and your weekly ***disability earnings***, if any, are less than 20% of your weekly earnings due to the same sickness or injury.

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, due to the same sickness or injury, this process will be followed to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment by the answer in item 2.

This is the amount you will be paid each week.

You may be required to send proof of your weekly disability earnings on a weekly basis. Your payment will be adjusted based on your weekly disability earnings.

As part of your proof of disability earnings, you may be required to send appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which are necessary to substantiate your income.

You will not be paid for any week during which disability earnings exceed 80% of weekly earnings.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to the greatest extent possible. This would be the greatest extent of work, based on your restrictions and limitations, that you are able to do in your regular occupation, that is reasonably available. Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

What Happens If Your Disability Earnings Fluctuate?

If your disability earnings are expected to fluctuate widely from week to week, your disability earnings may be averaged over the most recent 3 weeks to determine if your claim should continue subject to all other terms and conditions in the plan.

If your disability earnings are averaged, your claim will end if the average of your disability earnings from the last 3 weeks exceeds 80% of weekly earnings.

You will not be paid for any week during which disability earnings exceed 80% of weekly earnings.

What Are Deductible Sources of Income?

The following deductible sources of income will be deducted from your gross disability payment:

1. The amount that you receive or are entitled to receive as loss of time disability income payments under any:

   (a) state compulsory benefit ***act*** or ***law***.

2. The amount that you receive, due to your disability, from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount of loss of time benefits that you receive or are entitled to receive under any ***salary continuation or accumulated sick leave*** to the extent that your weekly payment and deductible sources of income, including any other group disability benefits, exceed or would exceed 100% of your weekly earnings.

4. The amount that you receive or are entitled to receive under any unemployment income ***act*** or ***law*** due to the end of employment with your Employer.

Only deductible sources of income which are payable as a result of the same disability will be subtracted.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

Salary continuation or accumulated sick leave means continued payments to you by your

Employer of all or part of your weekly earnings, after you become disabled as defined by the Program. This continued payment must be part of an established plan maintained by your Employer for the benefit of an employee covered under the Program. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your weekly payment.

What Are Not Deductible Sources of Income?

Income you receive from, but not limited to, the following sources, will not be deducted from your gross disability payment:

- 401(k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- military pension and disability income plans;
- credit disability insurance;
- franchise disability income plans;
- automobile liability insurance;
- a retirement plan from another Employer;
- individual retirement accounts (IRA).

What Happens When You Receive a Cost of Living Increase from Deductible Sources of Income?

Once any deductible source of income has been subtracted from your gross disability payment, your payment will not be further reduced due to a cost of living increase from that source.

What If It Is Determined that You May Qualify for Deductible Income Benefits?

If it is determined that you may qualify for benefits under the deductible sources of income section, your entitlement to these benefits will be estimated. Your payment may be reduced by the estimated amount if such benefits have not been awarded.

However, your payment will NOT be reduced by the estimated amount if you:

- apply for the benefits;
- appeal any denial to all necessary administrative levels; and
- sign a reimbursement agreement form. This form states that you promise to pay back any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when proof is received:

- of the amount awarded; or
- that benefits have been denied and all necessary appeals have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If it is determined that you may qualify for benefits under the deductible sources of income section, your entitlement to these benefits will be estimated. Your payment may be reduced by the estimated amount if such benefits have not been awarded.

If your payment has been reduced by an estimated amount, your payment will be adjusted when proof is received:

- of the amount received; or
- that benefits have been denied. In this case, a lump sum refund of the estimated amount will be made to you.

What Happens If You Receive a Lump Sum Payment?

If you receive a lump sum payment from any deductible source of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

How Long Will Payments Continue to Be Sent to You?

A payment will be sent to you weekly up to the ***maximum period of payment***. Your maximum period of payment for all disability claims other than maternity is 26 weeks during a continuous period of disability. Your maximum period of payment for all maternity disability claims is 8 weeks of post delivery.

Payments will no longer be sent to you and your claim will end on the earliest of the following:

1. When you are able to work in your regular occupation on a ***part-time basis*** but you choose not to.
2. The end of the maximum period of payment.
3. The date you are no longer disabled under the terms of the plan.

4. The date you fail to submit satisfactory proof of continuing disability.

5. The date your disability earnings exceed the amount allowable under the plan.

6. The date you die.

Maximum period of payment means the longest period of time payments will be made to you for any one period of disability.

Part-time basis means the ability to work and earn between 20% and 80% of your weekly earnings.

What Disabilities Are Not Covered Under Your Plan?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries;
- active participation in a riot;
- commission of a crime for which you have been convicted under state or federal law; or
- ***occupational sickness or injury*** or any disabilities which begin at the same time or after your occupational sickness or injury. However, disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by workers' compensation law will be covered.

Your plan does not cover a disability due to war, declared or undeclared, or any act of war.

Occupational sickness or injury means an injury arising out of, or in the course of, any work for wage or profit regardless of employer, or a sickness covered, with respect to such work, by any workers' compensation law, occupational disease law or similar law.

What Happens If You Return to Work Full Time and You Become Disabled Again?

1. If your current disability is related or due to the same cause(s) as your prior disability for which you received a payment:

   Your current disability will be treated as part of your prior claim and you will not have to complete another elimination period if you return to active employment for your Employer on a full time basis for 30 consecutive days or less. Your disability will be subject to the same terms of the plan as your prior claim.

2. If your current disability is unrelated to your prior disability for which you received a payment:

   Your current disability will be treated as a new claim and you will have to complete another elimination period. Your disability will be subject to all of the plan provisions.

   If you become covered under any other group short term disability plan, you will not be eligible for payments under this plan.

Short Term Disability Coverage

CLAIM INFORMATION

When Do You Submit a Claim?

You are encouraged to submit your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Employer. If you do not receive the form within 15 days of your request, submit written proof of claim without waiting for the form.

Your Employer will tell you where to send the claim.

How Do You File a Claim?

You and your Employer must fill out your own section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and submit it as directed by your Employer.

What Information Is Needed as Proof of Your Claim?

Your proof of claim, provided at your expense, must show:

- That you are under the ***regular care*** of a ***doctor***.
- Appropriate documentation of your weekly earnings.
- The date your disability began.
- Appropriate documentation of the disabling disorder.
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation.
- The name and address of any hospital or institution where you received treatment, including all attending doctors.
- The name and address of any doctor you have seen.

For your Short Term Disability claim, you may be asked to send satisfactory proof of continuing disability, indicating that you are under the regular care of a doctor. In some cases, you will be required to give authorization to obtain additional medical information, and to provide non-medical information (e.g., copies of your IRS federal income tax return, W-2's and 1099's) as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of the request. Your claim may be denied or

payments may stop if the appropriate information is not submitted.

Regular care means:

- you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Any relative including, but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse will not be recognized as a doctor for a claim that you submit.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Who Will Payments Be Made To?

Payments will be made to you.

What Happens If Your Claim Is Overpaid?

Any overpayments due to any of the following reasons may be recovered:

- fraud;
- any error made in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse the overpayment in full. You will be told the method by which you must repay the overpaid amount.

You will not be required to repay more money than the amount you were overpaid.

Glossary

Active employment means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least 30 hours per week. If you are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

Your worksite must be:

- your Employer's usual place of business;
- an alternate work site at the direction of your Employer other than your home unless clear specific expectations and duties are documented; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.

Individuals whose employment status is being continued under a severance or termination agreement will not be considered in active employment.

Covered class means your class as determined by the Employer. This will be done under the Employer's rules, on dates the Employer sets. The Employer must not discriminate among persons in like situations. You cannot belong to more than one class for the coverage on each basis, Contributory or Non-contributory coverage, under a plan. "Class" means covered class, benefit class or anything related to work, such as position or earnings, which affects the coverage available. If you are an employee of more than one Employer included under the Program, for the coverage you will be considered an employee of only one of those Employers. Your service with the others will be treated as service with that one.

Deductible sources of income means income from deductible sources listed in the plan that you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

Disability earnings means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible as explained in the plan.

Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

Doctor means a person who is performing tasks that are within the limits of his or her medical license; and

- is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- has a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Any relative, including but not limited to, you, your spouse, or a child, brother, sister, or parent of you or your spouse will not be recognized as a doctor for a claim that you submit.

Elimination period (STD) means a period of continuous disability which must be satisfied before you are eligible to receive benefits under the plan. If you become covered under a group short term disability plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Employee means a person who is in active employment with the Employer for the minimum hours requirement.

Employer means your Employer, and includes any division, subsidiary or affiliate who is reported for inclusion under the Program.

Employment waiting period means the continuous period of time that you must be in a covered class before you are eligible for coverage under a plan.

Evidence that you qualify for coverage means a statement of your medical history which will be use to determine if you are approved for coverage.

Gross disability payment means the benefit amount before any deductible sources of income and disability earnings are subtracted.

Hospital or institution means an accredited facility licensed to provide care and treatment for the condition causing one's disability.

Injury means a bodily injury that:

- is the direct result of an accident;
- is not related to any cause other than the accident; and
- results in immediate disability.

Disability must begin while you are covered under the plan.

Law, plan or act means the original enactment of the law, plan or act and all amendments.

Leave of absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time or any period of disability is not considered a leave of absence.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

Maximum period of payment means the longest period of time that payments will be made to you for any one disability.

Occupational sickness or injury means an injury arising out of, or in the course of, any work for wage or profit regardless of employer, or a sickness covered, with respect to such work, by any workers' compensation law, occupational disease law or similar law.

Part-time basis (STD) means the ability to work and earn between 20% and 80% of your weekly earnings.

Payable claim means a claim for which Ferrara Candy Company, Inc. is liable under the terms of the Program.

Plan means a line of coverage under the Program.

Reduced hours means you are working less than the number of hours required to be considered in active employment.

Regular care means:

- one personally visits a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat one's disabling condition(s); and
- one is receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for one's disabling condition(s) by a doctor whose specialty or experience is the most appropriate for one's disabling condition(s), according to generally accepted medical standards.

Regular occupation means the occupation you are routinely performing when your disability begins. Your occupation will be looked at as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Retirement plan means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions.

Salary continuation or accumulated sick leave (STD) means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Program. This continued payment must be part of an established plan maintained by your Employer for the benefit of an employee covered under the Program. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your weekly payment.

Sickness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage or childbirth. Disability must begin while you are covered under the plan.

Temporary layoff means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer, other than for reasons in connection with any severance or termination agreement. Your normal vacation time, any period of disability or FMLA leave is not considered a temporary layoff.

Weekly earnings means your gross weekly income from your Employer as defined in the plan.

Weekly payment means your payment after any deductible sources of income have been subtracted from your gross disability payment.

You means a person who is eligible for coverage under the Program.

SUMMARY PLAN DESCRIPTION

This booklet is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that you be given a "Summary Plan Description" which describes the plan and informs you of your rights under it.

Plan Name

FERRARA CANDY COMPANY, INC. Short Term Disability Plan

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

FERRARA CANDY COMPANY, INC.
404 W Harrison St
Suite 650
Chicago, Illinois 60607

Employer Identification Number

36-3331581

Plan Administrator

FERRARA CANDY COMPANY, INC.
Attention: Human Resources Department
404 W Harrison St
Suite 650
Chicago, Illinois 60607

Agent for Service of Legal Process

FERRARA CANDY COMPANY, INC.
Attention: Human Resources Department
404 W Harrison St
Suite 650
Chicago, Illinois 60607

Service of legal process may also be made upon the plan administrator at the address above.

Plan Year Ends

December 31

Claims Administration provided by

The Prudential Insurance Company of America ("Prudential")
751 Broad Street
Newark, New Jersey 07102

Your Employer retains complete authority and responsibility for your Employer's Plan(s), its operation, and the benefits provided thereunder, including all fiduciary duties under the Employee Retirement Income Security Act of 1974 ("ERISA"). Prudential has been delegated the responsibility to act on behalf of your Employer in connection with the Plan only as expressly stated in the Administrative Services Agreement between your Employer and Prudential (the "ASA") or as agreed to in writing by Prudential and your Employer.

Plan Sponsor and Employer not Agents of Prudential

For all purposes associated with the Plan, the Employer/Plan Sponsor acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Plan Sponsor be deemed the agent of Prudential, absent a written authorization of such status executed between the Employer/Plan Sponsor and Prudential. Nothing in these documents shall, of themselves, be deemed to be such a written authorization.

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this Plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the Plan at any time. This Plan Document elsewhere describes your rights upon termination of the Plan.

Claim Procedures

1. Determination of Benefits

The Plan Administrator shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Plan Administrator will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from the Plan Administrator of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the

Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific Plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to the Plan Administrator within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Plan Administrator does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Plan Administrator, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

The Plan Administrator shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Plan Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Plan Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

The Plan Administrator will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by the Plan Administrator in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Plan Administrator's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from the Plan Administrator of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific Plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of the Plan's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

(g) a statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to the Plan Administrator within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if the Plan Administrator does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

The Plan Administrator shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an

additional 45 days if the Plan Administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which the Plan Administrator expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second 45-day appeal review period.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from the Plan Administrator of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

Rights and Protections

As a participant in this Plan, you are entitled to certain rights and protections under the ERISA, as amended. ERISA provides that all Plan 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, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Enforce Your Rights

If your claim for a welfare 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 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 a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you 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. 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 Plan Administrator. 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 Office of Outreach, Education and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.