Ferrara Candy Company
Comprehensive
Health and Welfare Benefit Plan

Summary Plan Description

Effective January 1, 2024

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Introduction

This summary plan description ("SPD") describes the health and welfare benefits available to Eligible Employees of **Ferrara Candy Company** (the "Company") and their eligible Dependents effective as of January 1, 2024. These benefits are governed by the official plan document: the Ferrara Candy Company Comprehensive Health and Welfare Benefit Plan, including the applicable Cafeteria Plan provisions (the "Plan"). See the *"Administrative Information"* section for Plan document information.

This SPD can help you better understand and use your health and welfare benefits, replaces previous SPDs, and is intended to comply with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). It is to your advantage to read through this SPD, learn how the benefits work, and share this information with your family.

Incorporated Documents

This SPD includes the documents (listed in Appendix A) that describe the health and welfare benefits offered under the Plan, as provided in the *"Your Health and Welfare Benefits"* section. In addition, this SPD incorporates enrollment materials, summaries of benefits and coverage, and other general communications identified by the Plan Administrator that contain information about health and welfare benefits offered under the Plan.

The documents describing the health and welfare benefits are incorporated into this document and serve as the source of specific information relating to these benefits. This document and these incorporated documents function as one SPD to summarize these benefits.

While the SPD describes your health and welfare benefits, if there is any inconsistency or discrepancy among the provisions of the SPD and the official Plan document, your rights and benefits are determined under the official Plan document for the Plan. In addition, if there is any inconsistency or discrepancy among the provisions of this document and the Incorporated Documents, this document will determine your rights and benefits unless otherwise noted (for example, the Incorporated Documents will prevail with respect to Coordination of Benefits and ERISA Claims and Appeals).

Cafeteria Plan Benefits

The Company's benefit program includes a cafeteria plan, referred to as the Ferrara Candy Company Cafeteria Plan ("Cafeteria Plan"), that qualifies under Code Section 125. This allows you to pay your premium contributions for these health and welfare benefits, when applicable, on a pre-tax basis and describes the Health Care Flexible Spending Account ("Health Care FSA"), Dependent Care Flexible Spending Account ("Dependent Care FSA"), and the health savings account ("HSA"). It also requires that the Company adhere to Code Section 125 regulations concerning such terms as when you may make changes to your elections each year. In addition, this means you may have to make new elections every year for the pre-tax benefits. The Cafeteria Plan is part of the Ferrara Candy Company Comprehensive Health and Welfare Benefit Plan with respect to the Health Care FSA since the Health Care FSA is subject to ERISA.

Plan Contacts

For additional information about your health and welfare benefits, you may contact the following:

Contact	Reasons to Access
Plan Administrator Ferrara Candy Company Ferrara Employee Benefits Advisory Committee (EBAC) C/o Director of Total Rewards 404 W. Harrison Street, Suite 650 Chicago, IL 60607 Telephone: 773-243-4300	▪ Verify your eligibility ▪ Review your benefits ▪ Get answers to most questions ▪ Get information about employee and retiree contributions
General Enrollment and Benefits Information **Ferrara Benefits Resource Center** **www.FerraraBenefits.com** Telephone: 888-681-2263	▪ Review information about your benefits ▪ Enroll
Claims Administrators **Eligibility Claims** Ferrara Candy Company Attn: Eligibility Claims Administrator 404 W. Harrison Street, Suite 650 Chicago, IL 60607 Copies of the claim initiation form are available at **HRTotalRewards@ferrara.com**. **Eligibility Appeals** Ferrara Candy Company Attn: Employee Benefits Appeals Committee 404 W. Harrison Street, Suite 650 Chicago, IL 60607 **Medical Benefits/Medical Claims Administrator** Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680 Telephone: 800-828-3116 Website: **www.bcbsil.com** **Prescription Drug Benefits** CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072 Telephone: 866-409-8519 Website: **www.caremark.com** **Dental Benefits** MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 Telephone: 800-GET-MET8 Website: **www.metlife.com** **Vision Benefits** EyeMed Attn: OOC Claims P.O. Box 8504 Mason, OH 45040-7111 Telephone: 866-800-5457 Website: **www.eyemed.com**	▪ Review your benefits ▪ Locate a participating provider ▪ Obtain a predetermination ▪ Review your rights as a patient ▪ Speak with a claims service representative ▪ Request or download a claim form

Contact	Reasons to Access
Basic Life and Accidental Death & Dismemberment ("AD&D"), Supplemental Voluntary Life and AD&D, Dependent Voluntary Life and AD&D, Short-Term Disability ("STD"), Long-Term Disability ("LTD") and LTD "Buy-Up" Insurance Prudential 751 Broad Street Newark, NJ 07102 Telephone: 888-598-5671 Website: **www.prudential.com** **Critical Illness Insurance, Accident Insurance, Hospital Indemnity** Voya P.O. Box 320 Minneapolis, MN 55440 Telephone: 877-236-7564 Website: **https://presents.voya.com/EBRC/Ferrara** **Group Legal Services** Legal ARAG Telephone: 800-247-4184 Website: **www.ARAGLegalCenter.com** **Employee Assistance Program ("EAP") Benefits** SupportLinc CuraLinc Employee Assistance Program 314 W. Superior Street, Suite 601 Chicago, IL 60654 Telephone: 888-881-LINC Website: **supportlinc.com** **Telemedicine Benefits** Teladoc Telephone: 800-835-2362 Website: **www.Teladoc.com** **Health Care FSA, Dependent Care FSA*, and HSA*** Optum Financial 11000 Optum Circle Eden Prairie, MN 55344 Telephone: 877-292-4040 Website: **secure.optumfinancial.com** **Fertility and Family Benefits** Maven Clinic Co. 394 Broadway, 4th Floor New York, NY 10013 Website: **mavenclinic.com/join/Ferrara**	
COBRA Administrator Empyrean Ferrara Benefits Resource Center Billing Center P.O. Box 2617 Omaha, NE 68103 - 2617 Telephone: 833-874-1600 Website: **www.cobraandbillingservices.com**	▪ Get information about an extension of health benefits under COBRA

*Benefit that is not subject to ERISA.

Eligibility

You and your Dependents are eligible for the health and welfare benefits under the Plan as follows. Please contact your local HR representative or the Benefits Team within Total Rewards at **HRTotalRewards@ferrara.com** if you have any questions about your eligibility.

Your Eligibility

You are eligible for the health and welfare benefits under the Plan if you are classified as either a Full-Time Non-Union Employee, Full-Time Union Employee, or a Full-Time META Employee. See Glossary for details. This generally means actively working 30 or more hours per week. However, special rules apply under the "*Continuing Participation, Leave of Absence*" section of this SPD if you are on a leave of absence including STD or LTD.

Please Note: Only common law employees are eligible to participate in the Plan. The following individuals are not eligible to participate in the Plan:

- Leased employees (under Code Section 414(n)).
- Individuals who are classified as special status employees or independent contractors because their employment status is inconsistent with common law employee status.
- Individuals who perform services for the Company whose wages are not initially reported by the Company on IRS Form W-2.
- Interns.
- Temporary employees employed through a temporary or staffing agency.

If you are excluded from the Company's definition of an eligible common law employee you will not be eligible for benefits under the Plan, even if a court, the Internal Revenue Service ("IRS"), or any other enforcement authority finds that you should be considered an Eligible Employee unless approved by the Plan Administrator.

Please Note: Employees acquired by the Company as a result of a merger or acquisition will be eligible to participate in the Plan as outlined and agreed to in the Company's merger or acquisition agreement, except to the extent required by law. Full-Time META Employees are not eligible for the Plan until March 1, 2024. Effective as of January 1, 2025, Jelly Belly Full-Time Non-Union Employees will be eligible to participate in benefits as outlined by this SPD.

Dependent Eligibility

Your Dependents are eligible for the same health benefits under the Plan that you choose for yourself. Your Dependents for purposes of medical, including Rx, dental, vision, EAP and dependent life, and dependent AD&D insurance include your:

- Spouse.
- Domestic Partner.
- Children, including those of a covered Domestic Partner.
- Child(ren) for whom health benefit coverage is required through a qualified medical child support order ("QMCSO") (applicable to group health plan benefits only).

Domestic Partners

You may cover your Domestic Partner (same-gender or opposite-gender) and their Children on your health and welfare benefits for which a Spouse is eligible. You will be required to certify the Domestic Partnership

by completing the Affidavit of Domestic Partnership, which must be approved by the Ferrara Benefits Resource Center prior to enrollment. Please see the definition of *Domestic Partner* in the Glossary.

Under current law, you are required to be taxed on the value of health benefits provided to a Domestic Partner (and their covered Children) who does not qualify as a Dependent for group health plan purposes under the Internal Revenue Code (see the definition of *IRS Tax Dependent* in the Glossary). Any contributions you make towards Domestic Partner coverage will be deducted from your pay on an after-tax basis, and the value of the Company-provided coverage will be taxable to you and treated as "imputed income." See the *"Federal Tax Implications for Dependent Coverage"* section for more information.

General Provisions

Your Dependents are eligible for health and welfare benefits if you are enrolled in the Plan; however, the definition of an eligible Dependent may vary across the Component Benefits. If there is a discrepancy between the definition of Dependent in this SPD and an Incorporated Document, this SPD will prevail for any self-insured benefit.

Please Note: The Plan Administrator has the sole right to determine who is eligible for benefits under the Plan and may require documentation proving a Dependent's status. For example, the Plan Administrator typically will mail information to your home regarding its procedures for confirming your dependent's eligibility for medical benefits. If you are unable to provide the required documentation, your Dependent will not be eligible for benefits under the Plan. In addition, you may be required to reimburse the Plan for any costs associated with covering an individual who is not an eligible Dependent, and your participation in the benefits, as well as that of your Dependents, may be terminated.

State Eligibility Laws and ERISA

States sometimes pass laws that require employee benefit plans to provide benefits to individuals who otherwise are not eligible. For example, a state might require an employer to provide benefits to an ex-spouse or a child who exceeds a plan's age requirements. States also may pass laws that impact the benefits that a Plan covers and/or interferes with nationally uniform plan administration.

ERISA's preemption provision supersedes those state laws, except as they relate to fully insured benefits which are governed by applicable state laws. As a result, the Company and this Plan only provide health and welfare benefits to the individuals outlined in this SPD and its Incorporated Documents, unless otherwise stated by the Plan or the Incorporated Documents for any fully insured benefits.

Enrollment/Cost of Coverage

The Company offers a variety of benefits for you and your Dependents. Some of these benefits are provided automatically to you if you are eligible for the Plan. Other benefits that you are eligible for require you to enroll during the open enrollment period or during a special enrollment period if you have a qualified change in status. See the "*Changing Your Participation and Benefits During the Plan Year*" section.

The Plan Year is the calendar year that runs from January 1 through December 31.

Following is a chart that summarizes the enrollment and cost of coverage requirements for each benefit. The "*Eligibility*" section above includes more details, including the eligibility of Dependents.

Benefit Option	Brief Description	What are the Enrollment Requirements?	What is the Cost of Coverage?
Medical			
BCBS-IL HDHP1 or HDHP2	▪ Medical benefits, including preventive care at 100% ▪ This is a high deductible health plan that will allow you to make tax-favored contributions to a health savings account (HSA) ▪ You cannot enroll in the "general purpose" Health Care FSA; however, the "limited purpose" Health Care FSA that solely reimburses dental and vision expenses is available ▪ When you elect this medical option, you also receive a prescription drug benefit administered by CVS/Caremark	Enrollment required	Company and employee share the cost as communicated as part of annual enrollment in the Open Enrollment Benefits Guide; employee's portion of the cost is paid pre-tax
BCBS-IL PPO	▪ Medical benefits, including preventive care in-network at 100% ▪ This is not a high deductible health plan. You are not eligible to contribute to an HSA if you enroll in this option; however, you will have the option to enroll in the "general-purpose" Health Care FSA ▪ When you elect this medical option, you also receive a prescription drug benefit administered by CVS/Caremark	Enrollment required	Company and employee share the cost as communicated as part of annual enrollment in the Open Enrollment Benefits Guide; employee's portion of the cost is paid pre-tax

Benefit Option	Brief Description	What are the Enrollment Requirements?	What is the Cost of Coverage?
Prescription Drug			
Prescription Drug CVS/Caremark	▪ Prescription drug benefits is included with both medical options ▪ Rx cost sharing differs depending on which medical option you select	Included with medical plan election/enrollment	Company and employee share the cost as communicated as part of annual enrollment in the Open Enrollment Benefits Guide; employee's portion of the cost is paid pre-tax
Dental Benefits			
Dental MetLife	▪ Dental benefits (both in and out-of-network) that covers preventive and diagnostic services (such as cleanings, exams, and x-rays) ▪ Basic restorative services (such as fillings, non-surgical periodontics) ▪ Major services (such as crowns and dentures) ▪ Orthodontia subject to lifetime limits	Enrollment required	Company and employee share the cost as communicated as part of annual enrollment in the Open Enrollment Benefits Guide; employee's portion of the cost is paid pre-tax
Vision Benefits			
Vision EyeMed	▪ Vision benefits (both in and out-of-network) that covers an exam, lenses or contacts, frames and additional discounts for Hearing Health and LASIK	Enrollment required	Employee pays the full cost of coverage pre-tax
Disability			
Short-Term Disability (STD) (See Incorporated Document for details regarding maternity)	▪ Short-term disability benefits that provide you with 60% of your pre-disability earnings for up to 180 days ▪ 7 calendar day waiting period for illnesses, but coverage for an accident and maternity will begin immediately	Coverage is automatic with no action required by you	Company pays the full cost of coverage; you will be taxed on any benefit paid
Basic Long-Term Disability (LTD)	▪ Long-term disability benefits if disability extends beyond 180 days ▪ LTD benefit provides you with a specific percentage of your pre-disability earnings up to a dollar limit per month as explained in your Open Enrollment Benefits Guide	Coverage is automatic with no action required by you	Company pays the full cost of coverage; you will be taxed on any benefit paid

Benefit Option	Brief Description	What are the Enrollment Requirements?	What is the Cost of Coverage?
AD&D and Life Insurance			
Basic Life Insurance	The Company provides you with a life insurance benefit of 2 times your annual salary [up to a dollar maximum specified in your Open Enrollment Benefits Guide]	Coverage is automatic with no action required by you	Company pays the full cost of coverage
Supplemental Voluntary Life Insurance	Supplemental life insurance benefit that may provide you an additional amount up to 4 times your annual salary based on your elected increment amount [up to a dollar maximum specified in your Open Enrollment Benefits Guide]	Enrollment required	Employee pays the full cost of coverage after-tax
Spouse/Domestic Partner and Dependent Voluntary Life Insurance	Life insurance benefit for your Spouse (up to $100,000) and/or Child (up to $20,000) based on your elected coverage level	Enrollment required	Employee pays the full cost of coverage after-tax
Basic accidental death and dismemberment (AD&D)	The Company provides you with an AD&D benefit of 2 times your annual salary [up to a dollar maximum specified in your Open Enrollment Benefits Guide]	Coverage is automatic with no action required by you	Company pays the full cost of coverage
Employee Voluntary AD&D	Voluntary AD&D benefit that may provide you an additional amount up to 4 times your annual salary based on your elected increment amount [up to a dollar maximum specified in your Open Enrollment Benefits Guide]	Enrollment required	Employee pays the full cost of coverage after-tax
Spouse/Domestic Partner and Dependent Voluntary AD&D	AD&D benefit for your Spouse (up to $100,000) and/or Child (up to $20,000) based on your elected coverage level	Enrollment required	Employee pays the full cost of coverage after-tax

Benefit Option	Brief Description	What are the Enrollment Requirements?	What is the Cost of Coverage?
Spending Accounts			
Health Care Flexible Spending Account	Tax favored reimbursement of eligible health care expenses generally for current year	Enrollment is required	▪ Employee contributes on a pre-tax basis ▪ Company may contribute to the Health Care FSA, as communicated as part of annual enrollment in the Open Enrollment Benefits Guide
Dependent Care Flexible Spending Account (not subject to ERISA)	Tax favored reimbursement of eligible dependent care expenses for current year	Enrollment is required	▪ Employee contributes on a pre-tax basis ▪ Company may contribute to the dependent care FSA, as communicated as part of annual enrollment in the Open Enrollment Benefits Guide
Health Savings Account (not sponsored by Ferrara and not subject to ERISA)	Tax favored reimbursement of eligible health care expenses to be used in current year or future years but only available if enrolled in an HDHP and NO disqualifying coverage. Note: Disqualifying coverage includes, but is not limited to, medical coverage received by you through a Spouse's **non-HDHP** medical plan, Medicare, or a general-purpose health care FSA.	Enrollment is required	▪ Employee contributes on a pre-tax basis ▪ Company may contribute to the HSA, as communicated as part of annual enrollment in the Open Enrollment Benefits Guide
Other			
Accident Insurance for HSA/HDHP	The Company provides you with an accident insurance benefit to cover expenses for any accident that occurs to you on or off the job	Coverage is automatic with no action required by you if you enroll in the HDHP1 or HDHP2 medical option	Company pays the full cost of coverage
Accident Insurance	Accident insurance benefit that provides you with an additional amount of money to cover expenses for any accident that occurs to you on or off the job—you may elect to cover your Spouse/Domestic Partner and children as well	Enrollment required	Employee pays the full cost of coverage after-tax
Critical Illness Insurance	Critical illness benefit that provides you with a lump sum benefit if you are diagnosed with a covered disease or condition	Enrollment required	Employee pays the full cost of coverage after-tax

Benefit Option	Brief Description	What are the Enrollment Requirements?	What is the Cost of Coverage?
Hospital Indemnity Insurance	Hospital indemnity benefit that provides you with a lump sum benefit for both accident and sickness upon a hospitalization (includes pregnancy)—you may elect to cover your Spouse/Domestic Partner and children as well	Enrollment required	Employee pays the full cost of coverage after-tax
Group Legal Services	Legal assistance benefit that provides you legal services from network attorneys in a wide variety of legal matters at no additional cost to you	Enrollment required	Employee pays the full cost of coverage after-tax
Employee Assistance Plan (EAP)	The Company provides you with counseling services and additional resources to help you navigate through different life events (e.g., counseling, legal, financial, health and wellness)	Coverage is automatic with no action required by you	Company pays the full cost of coverage
Fertility and Family Benefits (Maven)	Fertility and family benefits program that includes maternity, parenting and pediatrics, and menopause support. On-demand access to family specialists, care advocates, and content library. Also offers reimbursement benefit (up to $10,000) towards family planning services such as IUI/IVF, adoption, or surrogacy.	Coverage is automatic; activate access online	Company pays the full cost of coverage Note: For fertility coverage that does not flow through the Plan and is not considered a "medical benefit" for your IRS Tax Dependent (for example, surrogacy), you will be taxed on the value of the benefit.

The details of each of these health and welfare benefits are described in the incorporated documents, which are listed in Appendix A.

Enrollment Details

Enrollment for Employees

You must enroll in the health and welfare benefits using the appropriate enrollment process established and communicated by the Plan Administrator. You will be given this enrollment information when you are initially eligible and again each year during the annual open enrollment period.

As an employee, if you do not elect to participate in the Plan for benefits for which enrollment is required when you are first eligible, you will not be enrolled in such benefits for the remainder of that Plan Year. You will have to wait to enroll until the next annual open enrollment period unless you experience a qualified change in status. See the "*Changing Your Participation and Benefits During the Plan Year*" section.

During each annual open enrollment period, you will have the opportunity either to enroll in or change your elections for health and welfare benefits for the next Plan Year as described in the annual open enrollment

materials. You will be able to choose from different coverage levels described in the open enrollment materials to enroll yourself and any eligible Dependents. When you enroll your eligible Dependents, you may need to provide relevant documentation as requested by the Plan Administrator.

In addition, as an employee, you may be automatically enrolled in certain benefits that are provided by the Company at no cost to you. If this occurs, you will be notified in your enrollment materials. Elections made in prior years may carry over to the following year as communicated by the Plan Administrator via the open enrollment materials if you do not make an election otherwise. Except for your Dependent Care FSA which will be reset to zero each year.

Note for "Company Couples" General Rule: If you and your Spouse (or Domestic Partner) both work for Ferrara, one of you may enroll the other as a Dependent OR you may each enroll individually. However, you will **not** receive duplicate coverage for benefits that cover "Dependents" such as medical, dental, and vision. Also, your dependent Children can be covered by only one of you, but not both. ***Exception for Kaiser beginning in 2026***: If you and your Spouse (or Domestic Partner) are a Company Couple and both of you enroll in Kaiser then, duplicative coverage will be permitted.

Effective Date of Your Enrollment

If you make an election to participate in the Plan as a newly-hired Full-Time Non-Union Employee or Full-Time Union Employee, you and your Dependents will become enrolled in the Plan as follows:

- Full-Time Non-Union Employee: On the first day of the calendar month following the month of hire.
- Full-Time Union Employee: On the date set forth in the applicable collective bargaining agreement. Enrollment will not occur later than the 91st day following the date of hire.
- Full-Time META Employee: If you were employed by META on February 29, 2024, your coverage is effective as of March 1, 2024. If you are a new Full-Time META Employee then, your coverage begins on the first day of the calendar month following month of hire.

If you make an election to participate in the Plan during the annual open enrollment period, enrollment for benefits under the Plan for you and your Dependents begins effective as of the next January 1.

Social Security Numbers generally required for enrollment

Under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally require Social Security Numbers for employees and dependents to assist with reporting under the Medicare secondary payer requirements. In some instances, the Company may need your Medicare Health Insurance Claim Number (HICN) to comply. Accordingly, the Company may request that you and your dependents provide Social Security Numbers and, potentially, the HICN if applicable, so that the Company can assist its health plan administrator(s) and pharmacy benefit manager to comply with this requirement.

In addition, under the Affordable Care Act, the IRS generally needs Social Security Numbers for you and your eligible dependents for purposes of tax reporting.

Qualified Medical Child Support Orders ("QMCSO")

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefit coverage for a Child (often because of legal separation or divorce). A QMCSO cannot require the Plan to provide any type or form of benefit coverage not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's health benefit coverage.

A QMCSO may require that you enroll your child in health benefits under the Plan even if you are divorced, your ex-spouse has legal custody of the child, and the child is not dependent on you for support. The QMCSO also gives you a special enrollment right to enroll in health benefits outside of any annual open enrollment period restrictions.

If the Company receives a valid QMCSO, you may enroll a Dependent Child in health benefits under the Plan pursuant to the QMCSO's terms; the change you elect takes effect as of the date the QMCSO is processed. If the Company receives a valid QMCSO and you do not enroll the Dependent Child in health benefits under the Plan pursuant to the QMCSO's terms, the Plan will provide health benefit coverage for the child in accordance with the terms of the QMCSO.

Your share of the cost of the health benefit coverage provided pursuant to the QMCSO will be automatically withheld from your pay, subject to any limits set by state or federal law.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The Company follows certain procedures to determine if a medical child support order is "qualified". You may request, without charge, a copy of the Plan's QMCSO administrative procedures from the Plan Administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator. For more information, please contact the Plan Administrator.

Rehired Employees

If you terminate your employment and are rehired by the Company during the same Plan Year and within 30 days of your prior termination of employment, you will continue to be eligible for (and enrolled in) the same pre-tax benefits in which you participated prior to your termination of employment. If you are rehired more than 30 days after your prior termination of employment or during a subsequent Plan Year, you must enroll again in the Plan to participate in pre-tax benefits.

Cost of Health and Welfare Benefits/Funding/Contributions

The Company determines the amount of your employee contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the Plan Administrator to receive information about your employee contributions. The Company reserves the right to change the amount of required employee contributions for the health and welfare benefits at any time, with or without advance notice to participants.

The cost of your health and welfare benefits depends on the level of coverage you choose under the Plan and for certain benefits, the number of Dependents you cover. Your employee contributions may be deducted from your paycheck on a pre-tax basis or paid with after-tax dollars, as specified in this SPD.

The cost of health benefit coverage does not include your payments for any applicable deductibles, copays, coinsurance, out-of-network charges, or non-covered items.

Cafeteria plan requirements and paying for coverage

Because many of your benefits are part of a cafeteria plan, you pay for coverage with dollars deducted from your paycheck before taxes are withheld. The benefits that flow through the cafeteria plan are noted as benefits that are paid for with pre-tax dollars.

Deductions are withheld as soon as administratively possible after you become eligible, and enroll, for coverage. The amount of the salary reduction election available to you to pay for benefits is equal to your share of the premium required to pay for such coverage.

Because the cafeteria and health and welfare plan provisions work together to provide your benefits, Plan rules contained in this SPD pertain to both your cafeteria plan and your health and welfare benefits, as follows:

- Participation, including the requirement that you be an employee to participate in the cafeteria plan, as described in the "*Your Eligibility*" section of this SPD.
- The procedures that pertain to your elections under the Plan, including the period when elections can be made or changed, as described in the "*Enrollment/Cost of Coverage*" and "*Changing Your Participation and Benefits During the Plan Year"* sections of the SPD.

Wellness Program

Wellness Screening Credit

The Company offers a Wellness Screening Credit that rewards you for taking steps to help maintain good health or to achieve better health, and to encourage a relationship with a physician. The Wellness Screening Credit is available to you if you are eligible and are either enrolled or will be enrolled in the Company's medical benefit during the next Plan Year. New hires also are eligible.

The Wellness Screening Credit includes a discount for medical coverage for the next Plan Year if: (1) you are enrolled in the Company's medical benefit; and (2) you visit your primary care doctor for an annual physical. This annual physical is provided free of charge when you are enrolled in the Company's medical benefit and visit an in-network physician. An optional form is available for you to bring to your physician's office to certify you fulfilled this criterion. Please see the Notice Regarding EEOC Wellness Program in your Open Enrollment Benefits Guide for more information on your rights and requirements.

Tobacco-Free Wellness Credit

Your cost for the upcoming year is shown in your Open Enrollment Benefits Guide. The cost shown is a "tobacco-user" rate. If you and your adult Dependents do not use tobacco products, you can receive a credit. You may also qualify for the "non-tobacco user" medical contribution credit if you and/or your adult Dependents who use tobacco complete a tobacco cessation program through Blue Cross Blue Shield (BCBS-IL). Specifically, log into the Blue Access for Members (BAM) account at **www.bcbsil.com/member**. The Well onTarget tobacco cessation program through BCBS-IL is offered at no cost to you. Once you are in the BAM portal, go to the *My Health* tab, and click on *Wellness*. Click on the "Visit Well onTarget" link on the Well onTarget tile, and you will be taken to the portal. From the Well onTarget dashboard, click on "Browse All Activities." The tobacco cessation program is listed under the self-management programs. If a participant completes a tobacco cessation program that is not through BCBS-IL, he or she will need to provide proof or documentation to the Company to be eligible for the credit.

Tobacco-User Status

If you are enrolled in a Ferrara medical plan option and certify as a non-tobacco user during your enrollment period, you may be eligible for a "non-tobacco user" credit. You will have an opportunity each year at annual enrollment to certify your tobacco user status. The "non-tobacco user" credit will reduce your annual medical plan contribution.

To qualify for "non-tobacco user" status, you and your covered dependents must not use tobacco products. If you cannot attest to "non-tobacco user" status, you will be eligible for the non-tobacco user credit if you satisfy a reasonable alternative (e.g., the BCBS-IL tobacco cessation program) and complete an affidavit certifying that you have completed a tobacco cessation program. While the intent is to encourage non-tobacco use, you will be entitled to a credit for ALL months in which you had coverage under the Plan (including retroactive reimbursement) if you complete the tobacco cessation program even if you continue to use tobacco products. For more information on tobacco cessation programs and the certification process, reach out to the Benefits Team at HRTotalRewards@ferrara.com.

- If you **turn in your affidavit to the Benefits Team** within the plan year, in accordance with your certification, you will receive the "non-tobacco" user medical contribution credit for **ALL** months in which you had coverage during the plan year. Your premium will be reduced prospectively and a reimbursement will be paid for any months within the plan year that were impacted by the tobacco user rate.

Federal Tax Implications for Dependent Coverage

Most Dependents are considered IRS Tax Dependents; the value of Dependent coverage is usually exempt from federal income tax.

Generally, if you can claim an individual as a Dependent for federal income tax purposes, then the value of that Dependent's coverage will not be taxable to you as income. For a more complete definition of who sis an IRS Tax Dependent for group health plan purposes, see the "*Glossary*" section of this SPD and of course, consult your own tax adviser. If you enroll an individual in the Plan who is not an IRS Tax Dependent, such as a Domestic Partner, Ferrara Candy Company is required to report income for you that reflects the value of that individual's coverage for tax-reporting purposes; this is referred to as "imputed income." Your IRS Form W-2 will reflect any additional income if you cover an individual who does not meet the definition of an IRS Tax Dependent.

The Company assumes all Dependents except Domestic Partners and their Children are IRS Tax Dependents. You must contact the Ferrara Benefits Resource Center if your Domestic Partner and his or her Children are your IRS Tax Dependents and complete an Affidavit of Tax Status or if you cover other Dependents who are not IRS Tax Dependents.

If you have questions concerning your specific situation, you should consult your own tax advisor or attorney.

Participating Provider Networks and Directories

For health benefits, you may obtain the participating provider directories from the claims administrator for a benefit, free of charge. See the "*Plan Contacts*" section for contact information.

The Plan arranges for health care providers to participate in a network. At your request, you can be sent a directory of network providers free of charge. Keep in mind, a provider's network status may change. Before obtaining services, you should always verify the network status of a provider. To verify a provider's status or request a provider directory, call the Blue Cross Blue Shield of Illinois customer service number on your ID card or log in to www.bsbsil.com. If a provider status is incorrectly listed as in-network in the directory, you may be entitled to protection. See the "*Plan Updates Due to the Consolidated Appropriations Act, 2021*" section for additional information.

Telemedicine Benefits under Medical

If you enroll in a medical benefit option, you and your Dependents may receive on-demand, virtual primary care health services and behavioral therapy services through the Plan with Teladoc. Teladoc is a virtual first health plan administered by Blue Cross and Blue Shield of Illinois. Teladoc allow you to consult an independently contracted, board certified doctor or therapist for non-emergency situations by phone, mobile app or online video anytime, anywhere. You and your Dependents may also use the platform to access non-urgent primary care via the Teladoc website, mobile application, or over the phone. Teladoc doctors can treat a variety of non-emergency conditions: allergies, anxiety, asthma, cold/flu, depression, ear infections (age 12+), fever (age 3+), headache, insect bites, nausea, pink eye, rash, sinus infections, stress management, and more.

The cost of these services will be determined by the medical benefit option you elected but will be significantly less than an in-person office visit. The amount that you pay will depend on which medical plan you choose to enroll in. By being able to access these services through an app on your mobile device, a primary care physician will be able to diagnose, treat and answer any questions about your or your Dependent's illness or condition at your convenience.

You and your Dependents do not have to take any additional steps to ensure that the primary care physician treating you through the virtual primary care health services is in-network. However, if the primary care physician orders lab tests or prescription drugs as part of treatment, you or your Dependents should verify that these additional services are provided in-network.

See the "*Plan Contacts*" section for Teladoc contact information as well as the administrator of your medical benefit option.

Employee Assistance Program (EAP)

The EAP is automatically available to you and your Dependents. You are eligible for the EAP if you are an employee of the Company, even if you are not eligible for or enrolled in other benefits as described in this SPD. The EAP provides you with access to an advocate that can assess your needs and develop a solution for issues ranging from parenting, senior care, childcare, pet care, as well as financial and legal services. The advocate can direct you to community resources and online tools.

With respect to counseling services, you are not required to exhaust these benefits before you use any medical benefits for which you are eligible. The EAP is provided to you at no cost and there is no cost sharing under the EAP. Your counseling services are subject to ERISA and therefore, you are entitled to COBRA and the ERISA claims and appeals rights apply. However, the EAP is an excepted benefit and therefore, not subject to all requirements that apply to group health plans under ERISA.

The EAP includes referrals to a behavioral counselor with coverage for up to eight personal counseling sessions. Discount programs are also available through this program. For more information on or to seek assistance through this program, contact SupportLinc at 1-888-881-LINC.

Fertility and Family Benefits

Fertility and family benefits are supported by Maven. Maven provides free virtual support for a wide variety of family planning topics, including preconception and fertility, pregnancy, postpartum, adoption, surrogacy, parenting, pediatrics, and menopause support. Also included in the Maven suite of services are on-demand virtual appointments with practitioners, personalized support from Care Advocates, and access to an online library of expert family building content.

As part of the Maven benefit, you have access to Maven Wallet, through which Ferrara provides coverage for eligible family building expenses. Ferrara offers a benefit subject to limits outlined in the Company's Benefit Guide that can be used to reimburse certain services related to IUI/IVF treatment, adoption, or surrogacy. This benefit includes coverage of medication prescribed to an egg donor who is not covered by the Plan for fertility services. Submit claims for expense reimbursement through the Maven Clinic app or website, along with any required documentation.

Maven is available to all Eligible Employees. If you have a clinical diagnosis of infertility, any reimbursement from the Maven Wallet is excludable from your taxable income. However, if you do not have a diagnosis of infertility then, any reimbursement from the Maven Wallet will be taxable to you. Surrogacy benefits and medications prescribed to an egg donor who is not a tax dependent that is covered by the Plan also are subject to taxation. Contact Maven at support@mavenclinic.com for additional details on these benefits (an Incorporated Document, i.e., booklet, is available) and talk to your tax advisor for information on how this may affect you.

Health Coverage for Expatriates

If you are a Ferrara employee living abroad, you are provided access to medical care through the AXA International Health Plan. The terms of this international coverage, including information about covered expenses and exclusions, are explained in the AXA Global healthcare handbook. You can request a copy of the AXA handbook by contacting your local HR representative or the Benefits Team within Total Rewards at **HRTotalRewards@ferrara.com**. You can also access information and manage your Plan online at **axaglobalhealthcare.com/customer**.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account ("Health Care FSA") is used for reimbursement of eligible Health Care FSA expenses for you, your Spouse, and your Dependent Children. (A Domestic Partner's or his/her Children's expenses cannot be reimbursed by the Health Care FSA unless s/he also is your IRS Tax Dependent and you have completed an Affidavit of Tax Status for Ferrara.) Please note that you will have either a General-Purpose Health Care FSA or a Limited-Purpose Health Care FSA, but not both. Your Open Enrollment Benefits Guide does not use the term "general-purpose;" instead, references to the Health Care FSA without the description "Limited-Purpose" is the "General Purpose" Health Care FSA.

Each Plan Year, you can contribute to your Health Care FSA and then, during the Plan Year, you can receive reimbursement for eligible Health Care FSA expenses that are not otherwise reimbursed. Contribution levels are set forth below.

Eligibility

To participate in the Health Care FSA, you must be eligible for medical and prescription drug coverage and enroll in the Health Care FSA (see the "*Eligibility*" and "Benefit Overview/*Enrollment and Cost of Coverage*" sections for more information). If you enroll in the high-deductible medical and prescription drug benefit option (i.e., BCBS HDHP1 or HDHP2) and make contributions to a Health Savings Account, then you can also elect to contribute to the Limited-Purpose Health Care FSA but not a General-Purpose Health Care FSA. If you enroll in a non-high-deductible medical and prescription drug plan (i.e., BCBS PPO), then you can contribute to the General-Purpose Health Care FSA.

Contributions

Each year, you must decide on the amount of pre-tax dollars you want to contribute to the Health Care FSA. Please note that this account is merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures. The Health Care FSA does not constitute a separate fund or entity. Rather, the amount you elect to "contribute" remains in the Company's general assets until claims are reimbursed. There is no interest credited to this account.

Note: The Company may, from time to time, make a discretionary contribution to the Health Care FSA, subject to the terms and conditions outlined in your Open Enrollment Benefits Guide.

The IRS sets the maximum amount that you can contribute to the Health Care FSA for each Plan Year, as described in the open enrollment material. For 2025, the maximum annual amount that you may contribute is $3,200, the 2024 IRS limit. If the Company contributes to your Health Care FSA, such amount is applied towards the IRS limit. Generally, the Company uses the IRS indexed amount from the prior Plan Year, since typically, the IRS does not issue the indexed amount for the next Plan Year until after the Company's annual enrollment period. See your Open Enrollment Benefits Guide for indexed amounts in future years.

You cannot change or stop contributions to the Health Care FSA unless you experience a qualified change in status, see the "*Qualified Change in Status*" section. It's important that you carefully estimate the amount that you contribute to the Health Care FSA, since you cannot use amounts in the Health Care FSA to reimburse expenses under the Dependent Care FSA (or vice-versa) and are **not** permitted to receive a refund of such amounts under IRS rules if you do not use the balance of your account—this is often referred to as the "use it or lose it" provision.

You have until March 31st of the next year to request reimbursement for eligible expenses incurred during the Plan Year (the "run-out period"). If any balance remains in your account after the run-out period then, you will forfeit your rights to any remaining balance (but see special carryover rule for the Health Care

FSA below). Forfeitures will first be used to defray the administrative costs of the Plan and if any amounts remain, will then be retained by the Company.

Special Carryover Rule for the Health Care FSA
If any balance remains in your Health Care FSA at the end of the Plan Year, you will be permitted to carry over an amount specified by the IRS to the next Plan Year. For 2023, you can carryover $610 of your remaining balance to 2024. If you do not use your entire balance in 2024, you can carryover $640 to 2025. The carryover does not impact the amount that you may contribute in the next Plan Year. This carryover provision does **not** apply to your Dependent Care FSA.

Example: At the end of the 2024 Plan Year, your unused Health Care FSA amount is $700. You may carry over up to $640 to reimburse 2025 eligible Health Care FSA expenses. However, the entire $700 is also available to reimburse 2024 Plan Year expenses during the 2024 run-out period (January 1, 2025 to March 31, 2025). If you submit, for example, $450 during the run-out period, you will have $250 that carries over and can be used for expenses incurred during 2025. In contrast, if you do not submit any claims for reimbursement during the runout period then, you can carryover $640 to be used for new claims incurred during 2025.

In addition:

- **Carryover Eligibility Details**. You must be a participant in the Health Care FSA as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.
- **Ordering Rules**. Eligible Health Care FSA expenses incurred in the current Plan Year will be reimbursed first from your unused amounts credited for that Plan Year and then from amounts carried over from the preceding Plan Year.
- **Cannot Convert the Carryover to Cash**. The carryover cannot be converted to cash or transferred to the Dependent Care FSA.
- **Health Savings Account Eligibility.** If you carry over any unused General-Purpose Health Care FSA amounts to the next Plan Year, you (and any other individual whose expenses can be reimbursed by your Health Care FSA) cannot contribute to an HSA during the entire next Plan Year. Therefore, if you enroll in an HDHP, the amounts available for carryover under a General-Purpose Health Care FSA will automatically be carried over to the Limited-Purpose Health Care FSA. Conversely, if you maintain a Limited-Purpose Health Care FSA and have an unused amount to carry over at the end of the year but enroll in a non-HDHP medical option and discontinue your contributions to an HSA, Optum Financial will automatically rollover such amounts to a General-Purpose Health Care FSA.

Midyear Termination
If your coverage terminates due to you ceasing to be an Eligible Employee, requests for reimbursement must be filed by March 31 after the Plan Year in which you cease to be an Eligible Employee. Claims must be incurred on or before your termination date unless you elect COBRA continuation coverage (see "*COBRA Continuation Rights*" section).

If your coverage under your Health Care FSA ends due to your death, then your beneficiary or the representative of your estate may submit claims for expenses incurred prior to your death by the earlier of the remainder of the Plan Year or until amounts remaining in your account is exhausted. If no such beneficiary is specified, the Plan Administrator may designate your Spouse, one of your Dependents, or the representative of your estate for this purpose.

Eligible Expenses
To be eligible for reimbursement from your Health Care FSA, the medical expenses must be incurred (i.e., medical care or service is provided and giving rise to the expense) while you are participating in the Health Care FSA. Any reimbursement you receive through your Health Care FSA cannot be reimbursed under any other plan covering health benefits, including a Spouse's or Dependent's plan. At any time

during the Plan Year, you may seek reimbursement for eligible Health Care FSA expenses up to the amount you have elected to contribute for the Plan Year, less prior reimbursements for that Plan Year.

An eligible Health Care FSA expense differs depending on whether you have a General-Purpose Health Care FSA or Limited-Purpose Health Care FSA.

For purposes of the General-Purpose Health FSA, an eligible Health Care FSA expense includes medical, dental, and vision expenses incurred for "medical care" as described under Code Section 213(d) and the IRS Regulations issued under that Code Section for your Spouse or Dependents. Examples of these expenses include deductibles and copayments as well as physicals, well care and vision-related expenses. "Medical care" includes over-the-counter medicines and drugs sold lawfully without a prescription or menstrual care products as permitted by the IRS following the passage of the "CARES" Act.

For purposes of the Limited-Purpose Health Care FSA, eligible Health Care FSA expenses are limited to dental and vision care expenses incurred by you, your Spouse or Dependents, as described under Code Section 213(d) and the IRS Regulations issued under that Code Section. Over-the-counter medicines and menstrual products are **not** reimbursable by the Limited-Purpose Health Care FSA.

Eligible Health Care FSA expenses do **not** include expenses incurred for the payment of premiums under a health plan, expenses which are reimbursable through insurance or otherwise (other than this Plan) or expenses for which you are not obligated to pay. Other exclusions include (but are not limited to) long-term care services, cosmetic surgery (unless medically necessary), funeral and burial expenses, and custodial care.

A full list of eligible medical expenses under the General-Purpose Health Care FSA or the Limited-Purpose Health Care FSA can be found at: **secure.optumfinancial.com**. Please contact Optum Financial to request a list of eligible medical expense in paper, free of charge, at 877-292-4040.

Please keep receipts and other supporting documentation related to your expenses and reimbursement requests. The IRS may request itemized receipts to verify select expenses. Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.

If you are divorced or separated, you can submit eligible expenses for your Child(ren) even if you do not claim him or her as an IRS Tax Dependent.

Claims Reimbursement

When you incur an eligible Health Care FSA expense, you have the choice as to how to submit your eligible claims. You can either use a debit card or file a claim with Optum Financial by submitting the claim through the Optum Financial online portal or by completing and submitting the "Health Care FSA Claim Form."

Filing Electronic or Paper Claims for the Health Care FSA

You may access the online portal and/or obtain a copy of the claim forms online by logging into your Optum Financial account at **secure.optumfinancial.com**. You may also contact Optum Financial for a paper copy.

Generally, you must include documentation from the service provider (e.g., a receipt, Explanation of Benefits "EOB", etc.) associated with each expense that indicates the following:

- The nature of the expense (e.g., what type of item, service or treatment was provided).
- The date the expense was incurred.

- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. You may also be able to use a debit card to pay for eligible medical expenses at the time they are incurred. More information about debit cards and reimbursements can be found on the Optum Financial website at **secure.optumfinancial.com**. You must submit all claims for reimbursement prior to March 31st of the following year.

Reimbursement for expenses that are determined to be eligible Health Care FSA expenses will be made as soon as possible after receiving and processing the claim. In most cases, claims will be processed and reimbursements made within 30 days (unless extended as explained in the *Claims and Appeals Procedures* section) after the claim is received by Optum Financial. You will be notified of all payments and will receive an explanation of how the payments were calculated. If the expense is determined to not be eligible, then you will receive notification of this determination.

If you have a question or concern about a benefit determination, you may informally contact Optum Financial before requesting a formal appeal but are not required to do so. If Optum Financial cannot resolve the issue to your satisfaction over the phone, you may submit your question or concern in writing through the formal appeal process. If you first informally contact Optum Financial and later wish to request a formal appeal in writing, you should contact Optum Financial and request an appeal in writing. A written appeal must be received by Optum Financial within 180 days after you receive written notification of the benefit determination with respect to your claim. See the "*Claims and Appeals Procedures*" section of this SPD for details.

Debit Card for Health Care FSA

The Company may provide you with a debit card to use under the Health Care FSA. You may use this debit card to pay for Health Care FSA expenses instead of filing an electronic or paper claim, as outlined below. In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the debit card program and the cardholder agreement, including: any fees applicable to participate, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc.

The debit card allows you to pay for eligible medical expenses at the time that you incur the expense. You must agree to abide by the terms of the debit card program and cardholder agreement both during your initial and each annual open enrollment period. Failure to abide by the cardholder agreement will result in termination of debit card use privileges. The cardholder agreement is part of the terms and conditions of your Plan and this SPD. You should contact Optum Financial with any questions or if you wish to obtain a copy of the cardholder agreement.

Use of the card for Health Care FSA reimbursement is limited to merchants who are health care providers (doctors, pharmacies, etc.). When you incur an eligible expense, you swipe the card much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount at that time you swipe the card. Every time you swipe the card; you certify to the Plan that the expense for which payment is being made is an eligible medical expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

You must obtain and retain documentation (e.g., receipt, invoice, etc.) from the provider each time you swipe the card. If you are enrolled in both the Health Care FSA and an HSA, the debit card will deduct from the Health Care FSA before the HSA.

You may be required to submit documentation after using your debit card if Optum Financial is not able to automatically verify the transaction was for an eligible medical expense. The information that you may need to provide to Optum Financial includes:

- The name of the person who received the service or for whom the item was purchased. For retail store purchases, this information may be excluded.
- The provider that delivered the service or the merchant where the item was purchased.
- The date when services were provided, or the item was purchased.
- A detailed description of the service provided, or item purchased. A bag tag is sufficient for prescriptions.
- The amount paid for the service or product and/or the portion that is not reimbursed through your insurance carrier.

You will be notified if the documentation is needed and provided a time frame for which to submit the documentation to Optum Financial.

If you are unable to provide adequate or timely substantiation as requested by Optum Financial, you must repay the Plan for the unsubstantiated expense. If you do not repay the Plan within the applicable time period, the card will be suspended and an amount equal to the unsubstantiated expense will be offset against future eligible medical expenses.

If no claims are submitted prior to the date, you terminate coverage in the Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay or the remaining unpaid amount may be treated by the Company as any other collectible debt, which will result in additional gross income for you.

Nondiscrimination Testing

Under the Code and related federal regulations, Health Care FSAs are subject to nondiscrimination testing each year to ensure the Plan does not provide an unfair advantage to highly compensated employees.

You will be notified if this affects you.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account ("Dependent Care FSA") is used for reimbursement of eligible dependent care expenses such as daycare.

Each Plan Year, you can contribute to your Dependent Care FSA, and then, during the Plan Year, you can receive reimbursement for eligible dependent care expenses that are not otherwise reimbursed. Contribution levels are set forth below.

The Dependent Care FSA is not subject to ERISA.

Eligibility

To participate in the Dependent Care FSA, you must be eligible for and enroll in the Dependent Care FSA (see the "*Eligibility*" and "Overview of Benefits/*Enrollment and Cost of Coverage*" sections for more information).

Contributions

Each year, you must decide on the amount of pre-tax dollars you want to contribute to the Dependent Care FSA. Please note that this account is merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures. The Dependent Care FSA does not constitute a separate fund or entity. Rather, the amount you elect to "contribute" remains in the Company's general assets until claims are reimbursed. There is no interest credited to this account.

For the Dependent Care FSA, you may elect to contribute up to $5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 per Plan Year. If you or your Spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your Spouse's earned income (whichever is lower). Any change in the maximum amount will be communicated to you, as described in the open enrollment materials.

If you are a Full-Time Non-Union Employee, you may be eligible for a Company contribution towards your Dependent Care FSA depending on your income. If an employer contribution is available, it will be communicated as part of your Open Enrollment Benefits Guide. Any employer contribution will count against the amount of contribution that you are able to make to the account. For example, if you are eligible for a $600 employer contribution and are otherwise eligible to contribute up to $5,000, you may contribute no more than $4,400 towards the Dependent Care FSA.

Note: Your exclusion from income under a Dependent Care FSA cannot exceed your earned income or, if married, the earned income of the lesser earning Spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your Spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your Spouse to have a monthly income of $250 (as adjusted from time to time) if you have one Dependent, or $500 (as adjusted from time to time) if you have two or more Dependents, for each month that your Spouse is incapable of caring for himself or herself or is a full-time student. If your Spouse has no earned income, you cannot use the Dependent Care FSA unless your Spouse is physically or mentally incapable of caring for himself/herself, is looking for work, or is a full-time student for at least five months during the Plan Year.

You cannot change or stop contributions to the Dependent Care FSA unless you experience a qualified change in status, see the "*Qualified Change in Status*" section. It's important that you carefully estimate the amount that you contribute to the Dependent Care FSA, since you cannot use amounts in the Dependent Care FSA to reimburse expenses under the Health Care FSA (or vice-versa) and are not

permitted to receive a refund of such amounts under IRS rules if you do not use the balance of your account—this is often referred to as the "use it or lose it" provision.

You have until March 31st of the next year to request reimbursement for eligible expenses incurred during the Plan Year (the "run-out period"). If any balance remains in your account after the run-out period then, you will forfeit your rights to any remaining balance. Forfeitures will first be used to defray the administrative costs of the Plan and if any amounts remain, will then be retained by the Company.

Midyear Termination

If your coverage terminates due to you ceasing to be an Eligible Employee, requests for reimbursement must be filed on or before the date your eligibility ceased by the earlier of March 31st of the following calendar year or until amounts remaining in your Dependent Care FSA are exhausted. However, if you terminate employment but if you otherwise meet the requirements under the law to obtain reimbursement under a Dependent Care FSA (for example, you are working at another employer and the expenses are incurred to care for an eligible dependent in order to allow you to be gainfully employed as explained below) then, you are eligible to continue to incur claims and "Spend Down" your Dependent Care FSA through the end of the Plan Year.

If your coverage under your Dependent Care FSA ends due to your death, then your beneficiary or the representative of your estate may submit claims for expenses incurred prior to your death by the earlier of the remainder of the Plan Year or until amounts remaining in your account is exhausted. If no such beneficiary is specified, the Plan Administrator may designate your Spouse, one of your Dependents, or the representative of your estate for this purpose.

Eligible Expenses

Eligible expenses that can be reimbursed from your Dependent Care FSA are expenses incurred to care for an eligible dependent to enable you and (if married) your Spouse to be gainfully employed, which generally means working or actively looking for work, or a full-time student.

Eligible Dependent for Purposes of the Dependent Care FSA

An eligible dependent for purposes of the Dependent Care FSA ("DC FSA Dependent") is:

- A Qualifying Child (see definition of *IRS Tax Dependent* in Glossary) who has **not** attained age 13;
- An IRS Tax Dependent of any age who is physically or mentally incapable of caring for himself or herself; or
- Your Spouse if he or she is physically or mentally incapable of caring for himself or herself and he or she has the same principal place of abode with you for more than one-half of the tax year.

A special rule applies for children of divorced or separated parents. Specifically, a child is a DC FSA Dependent only with respect to the custodial parent, but the noncustodial parent is entitled to claim the child as a tax dependent. See your tax advisor for more details.

Eligible Expenses for Purposes of the Dependent Care FSA

For purposes of the Dependent Care FSA, an eligible expense must be for the care of a DC FSA Dependent (either inside or outside your home) or for household services that are attributable to that care. Expenses paid for food, lodging, clothing, or education are generally not for the care of a DC FSA Dependent. However, if the care is provided in such a manner that the expenses cover other goods or services that are incidental to and inseparably a part of the care, the full amount may be reimbursed for the care.

Other considerations:

- In the case of dependent care provided outside your home, the following requirements apply:
  - If the person or facility providing the care cares for more than six individuals, expenses will be considered eligible only if the person or facility complies with all applicable state and local laws.
  - If the expenses relate to an individual who is not your Qualifying Child under the age of 13 then, the DC FSA Dependent must regularly spend at least 8 hours per day in your household.
- While day camp expenses for the care of a DC FSA Dependent may be eligible for reimbursement if all other requirements are met, expenses for overnight camp are not eligible.
- Example of expenses that are eligible for reimbursement if all requirements are met:
  - Expenses for care at a daycare center and daycare transportation that complies with all applicable state and local regulations.
  - Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for an eligible DC FSA Dependent.
  - Expenses for care provided by a relative who cares for your DC FSA Dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- No reimbursements will be paid to an individual:
  - With respect to whom, for such taxable year, you or your Spouse is entitled to a personal tax exemption as a dependent; or
  - Who is your Child under age 19 or your Spouse.

A list of eligible dependent care expenses under the Dependent Care FSA can be found at: **secure.optumfinancial.com**. Please contact Optum Financial to request a paper copy and for any questions on eligible Dependent Care Expenses at 877-292-4040.

Please keep receipts and other supporting documentation related to your expenses and reimbursement requests. The IRS requires appropriate documentation for all Dependent Care FSAs. Reimbursement requests must include an itemized statement from the dependent care provider that includes service dates, Dependent's name, type of service, amount billed, and provider's name and address. Credit card receipts, canceled checks and balance forward statements do not meet the requirements for acceptable documentation.

You will be reimbursed for eligible dependent care expenses incurred while you are enrolled in the Dependent Care FSA for the Plan Year. Dependent care expenses will be considered incurred when the dependent care is provided and not when you are formally billed, charged for or pay the dependent care expenses. Again, reimbursement from your Dependent Care FSA for eligible dependent care expenses may never exceed the amount then remaining in your account.

Dependent Care Tax Credit vs. Dependent Care FSA

You may be eligible to claim a dependent care tax credit on your federal income tax return. This credit is available for the same types of expenses as the Dependent Care FSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under the Dependent Care FSA. In other words, you cannot use expenses reimbursed through the Dependent Care FSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the Dependent Care FSA.

Claims Reimbursement

When you incur a dependent care expense, you file a claim with Optum Financial by submitting the claim through Optum Financial's online portal or by completing and submitting the "Dependent Care FSA Form." Under the Dependent Care FSA, you are not entitled to reimbursement for an amount that exceeds the balance in your account.

Filing Electronic or Paper Claims for the Dependent Care FSA

You may access the online portal and/or obtain a copy of the claim forms online by logging into your Optum Financial account at **secure.optumfinancial.com**. You may also contact Optum Financial for a paper copy.

Generally, you must include documentation from the service provider associated with each expense that indicates the following:

- The nature of the expense (e.g., what type of service or treatment was provided).
- The date the expense was incurred.
- The amount of the expense.

You may be required to provide additional substantiation to the extent determined necessary to support your claim. You must submit all claims for reimbursement prior to March 31st of the following year.

Reimbursement for expenses that are determined to be eligible dependent care expenses will be made as soon as possible after receiving and processing the claim. You will be notified of all payments and will receive an explanation of how the payments were calculated. If the expense is determined to not be eligible, then you will receive notification of this determination.

If you have a question or concern about a benefit determination, you may informally contact Optum Financial before requesting a formal appeal but are not required to do so. If Optum Financial cannot resolve the issue to your satisfaction over the phone, you may submit your question or concern in writing through the formal appeal process. If you first informally contact Optum Financial and later wish to request a formal appeal in writing, you should contact Optum Financial and request an appeal in writing. A written appeal must be received by Optum Financial within 180 days after you receive written notification of the benefit determination with respect to your claim. See the "*Claims and Appeals*" section of this SPD for details.

Nondiscrimination Testing

Under the Code and related federal regulations, the Dependent Care FSA is subject to nondiscrimination testing each year to ensure the Plan does not provide an unfair advantage to highly compensated employees. The Dependent Care FSA is also subject to an average benefits test.

Depending on the results of the annual tests, contributions of certain colleagues may be reduced or returned. You will be notified if this affects you.

Health Savings Account (HSA)

An HSA is an individual account used in conjunction with an HSA-eligible, high-deductible health plan to cover out-of-pocket Qualified Medical Expenses on a tax-advantaged basis. Your HSA belongs entirely to you, is not sponsored by the Company, and can be used to pay for both current and future HSA Qualified Medical Expenses for you and your eligible IRS Tax Dependents. (A Domestic Partner's or his/her Children's expenses cannot be reimbursed by your HSA unless s/he also is your IRS Tax Dependent.) You can contribute to your account, withdraw contributions to pay for current Qualified Medical Expenses, and potentially grow your account on a tax-free basis by investing your savings in a wide array of investment options.

Any unused balance in your account will automatically carry over from year to year so you can begin to build your savings for future Qualified Medical Expenses. Your HSA always belongs to you, even if you change jobs or become unemployed, change your medical coverage, move to another state, or change your marital status.

Eligibility

You must meet several IRS eligibility requirements in order to establish and contribute to an HSA. **It is your responsibility to determine if you are eligible**. To be an "eligible individual" for this purpose, you must meet the following criteria.

- You must be enrolled in an HSA-eligible, high-deductible health plan (for example, BCBS-IL HDHP1 or HDHP2) on the first day of the month. For example, if your coverage is effective on May 15, you are not eligible to contribute to or take a distribution from your HSA until June 1.
- You cannot be covered by any other health plan that is not an HSA-eligible health plan; otherwise, it will disqualify your ability to contribute to the HSA on a tax-favored basis). This is why you can only contribute to the Limited Purpose Health Care FSA; the General-Purpose Health Care FSA will disqualify your ability to contribute to an HSA.
- You cannot currently be enrolled in Medicare.
- You cannot be claimed as a dependent on another person's tax return.

Additionally, in order to open and contribute to an HSA, you must have a valid U.S. address.

If you open an HSA and do not meet the above criteria, your contributions, any investment earnings, and distributions may be subject to income taxes, penalties, and/or excise taxes.

Enrollment in Medicare

If you are enrolled in Medicare, you cannot contribute to an HSA. This means that some individuals upon reaching age 65 will no longer be eligible to contribute to an HSA. When you sign-up for Social Security benefits you are automatically enrolled in Medicare Part A and Part B, so if you start receiving these benefits, you will not be eligible to contribute to an HSA. You cannot opt-out of Medicare if you begin receiving Social Security benefits. Please consult a tax advisor about tax consequences if you apply for Social Security benefits or are beyond your full Social Security retirement age.

Contributions

The maximum annual contribution limit is set by federal regulations and is based on your age and coverage tier, as well as on when you become enrolled in an HSA-eligible, high deductible health plan. If Ferrara contributes to your HSA, those contributions, combined with any contributions that you make, count towards the IRS contribution limit.

The Company may make a discretionary contribution and/or a match as explained in and subject to conditions specified in the Open Enrollment Benefits Guide. If you receive a Company contribution towards your HSA, it will lower the maximum amount that you can contribute to the HSA.

For 2024, the maximum annual amount that you may contribute, including any contributions made by the Company, is $4,150 for individuals with employee only coverage and $8,300 for other-than-self-only coverage (e.g., family). If you are age 55 or older, you can contribute up to an additional $1,000 each year as a catch-up contribution. This also applies to your Spouse if he or she is age 55 or older. All contributions are handled by Optum Financial; however, it is your responsibility to monitor your HSA and ensure contributions are correct. **Note,** however, that your Spouse must open an HSA for his or her own catch-up contribution. For future Plan Years, the Plan will follow IRS indexing for HSA contribution maximums as communicated in the annual open enrollment materials.

If you enroll in an HSA-eligible, high-deductible health plan (i.e., BCBS-IL HDHP1 or HDHP2) as of the first of the Plan Year, the HSA contribution (your contribution and the Company's) is prorated based on the number of months during the year a person is covered by an HSA-eligible plan as of the first day of the month.

If you enroll in an HSA-eligible, high-deductible health plan (i.e., BCBS-IL HDHP1 or HDHP2) after the beginning of the Plan Year, then you may contribute up to the statutory maximum annual contribution amount as long as you are an eligible individual in December of that tax year and remain eligible for a full 12-month period following such month. If you fail to meet these criteria, the maximum annual contribution amount must be prorated based on the number of months you are an eligible individual, and any amount above such prorated amount is includible in your gross income and will be subject to an excise tax. If this occurs, you should talk to your tax advisor about your options.

Qualified Medical Expenses

You can use your HSA to help pay for your out-of-pocket Qualified Medical Expenses. You can also use your HSA to pay for Qualified Medical Expenses incurred by your eligible Dependents, who satisfy the definition of IRS Tax Dependent.

You may also use your HSA to pay for medical care that is not covered under the Plan but is considered a deductible medical expense for federal income tax purposes under Code Section 213(d). Qualified Medical Expenses shall be defined as those expenses described under Code Section 213(d) and the IRS Regulations issued under that Code section. Distributions from an HSA used to pay for Qualified Medical Expenses for you, your Spouse, and eligible Dependents are tax free provided they meet the IRS definition of a Qualified Medical Expense, such as:

- Health plan deductibles and coinsurance;
- Most medical care and services;
- Dental and vision care;
- Prescription drugs and insulin; and
- Over-the-counter drugs and menstrual products.

Note that these expenses must not already be covered by insurance and that health insurance premiums generally do not qualify. For more information about HSAs and Qualified Medical Expenses, refer to IRS Publications 969 and 502 at **www.irs.gov** or consult a tax professional.

Any distribution taken from your HSA to pay for a nonqualified medical expense must be included in your gross income for tax purposes and may be subject to an additional 20% penalty.

The recordkeeping of your HSA is up to you, and it is important to hold on to all receipts, records, and other documentation as proof that the expenses you pay from your HSA are for Qualified Medical Expenses.

How to Open Your HSA with Optum Financial

You can open your HSA online, if you have not already done so. To open it online, log in to Optum Financial at **secure.optumfinancial.com**. If you previously opened your HSA with Optum Financial, there is no need to so again.

If you do not have online access or wish to open the account using a paper application, call 1-877-292-4040 or your plan's toll-free number and a Optum Financial Representative will mail you an application. Representatives are available 24 hours a day, seven days a week.

Optum Financial HSA Debit Card

The Optum Financial HSA debit card, issued through Optum Financial, can be used to pay for known Qualified Medical Expenses at the point of sale (such as pharmacy prescriptions). Many providers will also accept your Optum Financial HSA debit card for payment of an invoice you received in the mail. For convenience, you can request debit card(s) for your Spouse and eligible Dependents, too.

Management of Your Optum Financial HSA and Additional Information

To view your HSA balance and/or access Optum Financial's online information and resources log in to your account at **secure.optumfinancial.com** using your existing username and password.

Through your Optum Financial account, you can:

- Access tools and resources;
- Access forms and application;
- Perform ongoing account maintenance and management tasks, such as:
  - Account statements, confirmations, and tax forms;
  - Beneficiary information; and
  - Address changes.

Questions and Further Information

For questions and further information about your HSA, you can contact a Optum Financial Representative at 1-877-292-4040 or online at **secure.optumfinancial.com**, or your plan's toll-free number. Representatives are available 24 hours a day, seven days a week.

Changing Your Participation and Benefits During the Plan Year

Once you enroll in or decline pre-tax health and welfare benefits under the Plan, your election generally stays in effect for the Plan Year. However, you can make changes to your election during the Plan Year if:

- You experience a qualified change in status, have a special enrollment right, or experience another change in circumstance.
- That event or other change affects the eligibility for benefits under the Plan for either you or your Dependents, as determined by the Plan Administrator.
- The modification in your election is due to and consistent with the event or other change, as determined by the Plan Administrator.

Note that the Plan Administrator has determined that it will also administer election changes for post-tax benefits following these same rules. **Timing and procedures for mid-year changes are explained at the end of this section of the SPD.**

Note: While your contributions to the HSA are made on a pre-tax basis, the IRS has made an exception and you can typically change your HSA elections at any time during the year as long as it is on a prospective basis. The Company generally allows you to change your HSA, as needed, subject to reasonable administrative limitations. Contact **HRTotalRewards@ferrara.com** for details.

Qualified Change in Status

A qualified change in status is a specific change in circumstance ***that affects your eligibility for benefits,*** including the Health Care FSA and Dependent Care FSA, under the Plan for either you or your Dependents, which is any of the following:

- You get married, divorced, or legally separated or your marriage is annulled.
- You have a baby, adopt a Child, or have a Child placed in your care (or in the care of your Spouse) for adoption or legal guardianship.
- Your Dependent dies.
- Your Dependent gains or loses eligibility status.
- You or your Dependent moves to a new place of residence resulting in eligibility or loss of eligibility into or out of a benefit option.
- You or your Dependent has a change in employment status, such as:
  - Beginning or ending employment (this provision does not apply if rehired within 30 days).
  - Experiencing a strike or a lockout.
  - Commencing or returning from an unpaid leave of absence. [Note: This change is only permitted if there is a change in eligibility; eligibility generally remains in effect for 90 days. So, an unpaid LOA will not allow for a change to the Health Care FSA, because you remain eligible.]
  - Experiencing any other change in employment status that affects eligibility for benefits.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you certain other rights to change health coverage for you or your eligible Dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the Plan. If any of these conditions apply to you, you should contact the Plan Administrator.

Cost or Coverage Changes

If the cost of a benefit provided under the Plan increases or decreases during a Plan Year, then the Company will automatically increase or decrease your salary reduction election as an employee. If the cost increases significantly, as determined by the Plan Administrator, you will be permitted to either make corresponding changes in your payments or revoke your election and obtain coverage under another benefit package option with similar coverage or revoke your election entirely if no other similar coverage is available.

If the coverage under a benefit is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive on prospective basis coverage under another plan with similar coverage. In addition, if the Company adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. Upon notification to you by the Plan Administrator, if coverage under an existing benefit package option or other coverage is significantly improved during a Plan Year, the Plan **may** permit a midyear enrollment. There are also certain situations when you may be able to change your elections on account of a change under the plan of your Spouse, former Spouse, or Dependent's employer.

The IRS allows you to make a change to the Dependent Care FSA if you have a cost change imposed by your dependent care provider who is not a relative or if you make a change in your dependent care provider. For example, if your Child attends a child care center at an annual cost of $3,000 (and you make your election before the beginning of the Plan Year under this assumption), but later want to revoke, because you locate a different health care provider with a different cost (whether the new provider is a household employee, family member, or a person who is independent of you such as a day care center), this will be permitted on a prospective basis.

The IRS does **not** allow you to make a change to your Health Care FSA as a result of a significant cost or coverage change.

HIPAA Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") gives you additional flexibility in whom you can enroll in medical, including prescription drug, benefits under the Plan, due to certain events:

- Marriage: If you are eligible but not enrolled under the Plan, you can enroll in medical benefits as a result of your marriage **within 30 days.** You can also enroll your Spouse and eligible Dependent Child(ren). However, you must enroll under the Plan in order to enroll your Spouse and eligible Dependent Child(ren).
- Birth, Adoption, or Placement for Adoption: If you are eligible but not enrolled under the Plan, you can enroll in medical benefits if you acquire a Child through birth, adoption, or placement for adoption **within 60 days**. You can also enroll your Spouse and your eligible Dependent Child(ren). However, you must enroll under the Plan in order to enroll your Spouse and eligible Dependent Child(ren).
- Under HIPAA's special enrollment rules, you also can make a change during the Plan Year if you elect "no coverage" because you have coverage elsewhere (for example, under a Spouse's medical plan) and that other coverage later ends. These loss-of-coverage rules also apply to a Spouse or other Dependent.

- The coverage must end because of a loss of eligibility, such as a divorce, termination of employment or the other employer not making contributions to the Plan. You cannot make a change during the Plan Year if your "other coverage" is lost because of something you do or do not do, such as not making your required contributions.

- You must request enrollment within **30 days** after your or your Dependents' other coverage ends or after the other coverage stops contributing toward the other coverage.

If you or your Dependent is eligible, but not enrolled, for health benefits, you also are eligible to enroll if you meet either of the following conditions and you request enrollment no later than **60 days** after the date of the event:

- You or your Dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage.
- You or your Dependent becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

Revocation of Election due to Enrollment in Qualified Health Plan

You can revoke a coverage election with respect to coverage under the Plan's medical benefits due to enrollment in a Qualified Health Plan through an Affordable Care Act government exchange if you satisfy the following conditions:

- You are eligible for a Special Enrollment Period, as defined by the Department of Health and Human Services (HHS), to enroll in a Qualified Health Plan through a government exchange pursuant to guidance issued by HHS and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a government exchange during the exchange's annual open enrollment period; and
- The revocation of the election of coverage under the Plan's medical benefits corresponds to your intended enrollment for yourself and your Dependents who cease coverage due to the revocation in a Qualified Health Plan through a government exchange for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked under the Plan.

Other Changes in Circumstance

Certain other events also permit you to change your elections during the Plan Year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health benefit coverage for a Dependent.
- You or your Dependent either becomes enrolled in or loses eligibility for Medicare or Medicaid coverage.
- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage from another employer for you or your Dependent is exhausted.
- If your Dependent is employed and his employer's plan allows for an election change in your Dependent's benefits (either during that employer's open enrollment period or due to a Midyear election change), you may be able to make a corresponding election change under the Plan that is on account of and corresponds with a change made under that other employer plan, but only if (i) the other employer plan permits its participants to make an election change that would be permitted under the Code (disregarding this provision); or (ii) the other employer plan permits its participants to make an election for a period of coverage that is different from the Plan Year for this Plan.
- You experience a change permitted under the Family and Medical Leave Act of 1993, as amended.

How to Make Changes During the Plan Year

You can report your mid-Plan Year change to the Plan Administrator. **However, you must complete the appropriate election change process within the earlier of (i) 30 days after the date of the event, or (ii) the date required by the applicable incorporated document (or 60 days if due to birth, adoption, or placement for adoption, CHIP, or Medicaid eligibility) in order to make the election change effective**. If you do not report your mid-Plan Year change and complete the required process within the required period, you will not be able to make any election changes until the next annual open enrollment period, unless you again meet one of the conditions for a change during the Plan Year.

As long as you notify the Plan Administrator within the required time period, election changes will be effective either (a) on the date of the birth, adoption, or placement for adoption; or (b) for all other events, on the first day of the calendar month following your request for the election change.

Important Medical Plan Notices and Protections

Consumer Protections Under the Affordable Care Act

The Company's medical and prescription drug plan benefits provide you with certain protections—sometimes referred to as "group market reforms" or "consumer protections" under the Affordable Care Act, including:

- Prohibition of preexisting condition exclusions
  - The Company does not impose any preexisting condition exclusions.
- Prohibiting discrimination against participants and beneficiaries based on a health factor
  - The Company does not discriminate against participants and beneficiaries based on a health factor.
- Prohibition on waiting periods that exceed 90 days
  - For Non-Union Employees coverage will begin on the first day of the month following the month of hire.
  - For Union Employees, the Company's waiting period for medical and prescription drug coverage is as provided by the applicable collective bargaining agreement (generally on the first day of the month following 90 days of service). See the "*Eligibility*" section of this SPD for more details.
- Prohibition on lifetime or annual dollar limits on essential health benefits
  - The Company does not impose any lifetime or annual dollar limit on essential health benefits. For purposes of determining what is an essential health benefit, the Company uses Utah as its "benchmark state."
- Prohibition on rescissions
  - The Plan will not retroactively rescind your coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. If coverage is cancelled or discontinued prospectively, that is not considered a rescission. It is also not a rescission if you do not pay your required premium and your coverage is cancelled or discontinued back to the date that the premium was not paid. The Plan will provide you with at least 30 calendar days' advance notice before your coverage is rescinded. If your coverage is or will be rescinded, you have the right to file an appeal.
- Eligibility of Children until at least age 26
  - The Company extends coverage to adult Children until the end of the month in which a Child attains age 26.
- Summary of benefits and coverage and uniform glossary
  - Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. SBCs are available by contacting Ferrara's Human Resources Department at 773-243-4300. You may request a paper copy free of charge.
- Solely with respect to insured medical benefit options, the medical loss ratio requirements
  - At this time, this provision does not apply to the Company's medical benefit options.
- Accommodations in connection with coverage of preventive health services
  - The Company's medical and prescription drug plan options provide preventive care benefits in-network without cost-sharing. See the summary of your medical plan benefits for more details on what constitutes preventive care for this purpose; the list changes periodically. Preventive care generally includes items and services with a rating of "A" or "B" under the United States Preventive

Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC; and with respect to children and women, certain preventive care and screenings based on guidelines supported by the Health Resources and Services Administration.

- General information pertaining to other preventive services and a prescription drug list is available at **www.healthcare.gov/coverage/preventive-care-benefits/**. The list of in-network preventive care items and services with no cost sharing includes: A number of screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations (including COVID-19 immunizations), counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as specialist consultation, bowel preparation medications, anesthesia, polyp testing, and certain follow-up procedures[1]) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.
- For women, the medical and prescription drug options also will cover an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; FDA-approved contraceptive methods (including but not limited to medications, items and services, as well as surgical implants and tubal ligation for elective female sterilization[2]) and counseling as prescribed for women; breastfeeding support, supplies and counseling (including lactation counseling services); and screening and counseling for interpersonal and domestic violence. In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact your medical claims administrator, to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.
- The Plan will cover at no cost, in-network HIV pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for prevention of HIV infection for high risk individuals, HIV screening for adolescents and adults age 15 to 65 years (or other ages if increased risk of HIV infection), HIV screening for all pregnant women, and counseling interventions or referrals by clinicians for pregnant and postpartum women at increased risk for perinatal depression.

Note: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. The federal government has clarified that with respect to contraception, it will scrutinize medical management techniques such as denial of coverage of all or a particular brand name contraceptive, fail-first policies, or age-based restrictions. The Plan will defer to a medical necessity determination given by your physician for contraception. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

- Internal claims and appeals and external review process
  - See the "*Claims and Appeals Procedures*" section of this SPD for more information.
- Consumer patient protections (choice of health care professional and coverage of emergency services)
  - If you need "emergency services," the medical options offered by the Company will provide you with coverage regardless of whether the provider for such "emergency" services is in-network or out-of-network. Also, "emergency services" are subject to special cost-sharing rules that require non-grandfathered group health plans (like the Company's) to not impose a higher copayment or coinsurance, for example, for out-of-network emergency services than for in-network emergencies

[1] This includes coverage for a follow-up colonoscopy after a patient has received a positive screening test or direct visualization test.
[2] As clarified in July 2022, this includes items and services that are integral to the furnishing of birth control, regardless of whether the item or services are billed separately, such as coverage for anesthesia for a tubal ligation procedure. Male condoms must also be covered at no cost in-network with a prescription.

services, but in certain circumstances you may be “balance billed.” For details on this requirement, including what constitutes an emergency service, contact your medical claims administrator.

- Provider nondiscrimination
  - The medical and prescription drug options offered to you will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.
- Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements)
  - As required by the Affordable Care Act, your total in-network out-of-pocket costs in 2025, including copayments and prescription drug expenses under the medical options available to you, will not exceed $9,200 for individual coverage and $18,400 for all other coverage tiers (family). The Affordable Care Act’s individual out-of-pocket expense maximum applies to each covered individual, whether the individual has self-only, family, or another coverage tier. So, it’s possible that this limit will result in payment for an individual before the family out-of-pocket expense maximum is hit for an HDHP if the HDHP has a family out-of-pocket that is more than the self-only limit under the Affordable Care Act ($9,200 for 2025).
    - Note for HDHP: With respect to an HSA-compatible HDHP, your total in-network, out-of-pocket costs in 2025 will not exceed $8,300 for individual coverage and $16,600 for all other coverage tiers (family). These amounts may be adjusted each year by the government.
  - The maximum imposed by the Affordable Care Act creates a separate, legally required limit on in-network out-of-pocket costs, which requires that additional costs count toward these limits even if they do not apply toward your medical option’s out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copayments, coinsurance, and eligible prescription drug expenses. Out-of-pocket expenses that do not apply toward your in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician.
  - For details on the impact of coupons on the deductible or out-of-pocket maximum, contact CVS/Caremark. At the time of the preparation of this SPD, a conflict in the law exists regarding the application of the value of coupons towards the deductible and out-of-pocket maximum and may depend on whether or not there is a generic equivalent prescription available.
  - The actual out-of-pocket expense maximums under the medical/Rx option that you elect may be lower than the legal maximums. Please contact your medical claims administrator for more details.
- Coverage for individuals participating in approved clinical trials
  - You are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact the medical claims administrator for details.
- Transparency and Internet-Based Self-Service Tool
  - Beginning in 2023, the Affordable Care Act transparency provisions will give you access to an internet-based price comparison tool to compare prices for up to 500 items and services designated by the federal government that can be found: **500 Items and Services | CMS**. In 2024, this requirement will apply to all medical and prescription drug items and services covered by the Plan. Upon request, this information may be provided in paper without a fee, subject to certain limits.

Standards for Mothers and Newborns

The Plan 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, the Plan may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights Following a Mastectomy

The Plan includes health benefits for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered Dependent who is receiving mastectomy-related benefits, benefits 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.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

These benefits will be subject to the same annual deductibles, copays, and coinsurance provisions that apply for all other medically necessary procedures under the Plan.

Plan Updates Due to Consolidated Appropriations Act, 2021

Provider Directory Information

A directory of providers is available online at www.bcbsil.com or at your request, Blue Cross Blue Shield of Illinois will send you a directory of network providers free of charge. If you need information regarding which pharmacies are in-network, you should contact CVS. BCBS-IL and CVS strive to keep this information as current as possible; however, a provider's network status may change. If you receive a covered service from a non-network provider and were informed incorrectly prior to receipt of the service that the provider was a network provider, either through a database, provider directory, or in response to your request for such information (via telephone, electronic, web-based or internet-based means), you will not be responsible for paying a cost sharing amount that is higher than the amount that would have applied if you had seen an in-network provider/pharmacy. Further, any cost-sharing amounts paid by you will count towards your in-network deductible and out-of-pocket maximum.

Continuity of Care Benefits

If you are currently receiving treatment for covered health services from a network provider whose network status changes from in-network to out-of-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the in-network benefit level for specified conditions (for example, undergoing a course of treatment for a serious and complex condition, in institutional or inpatient care, scheduled for non-elective surgery, pregnant, or terminally ill) and may last up to the earlier of 90 days or until you are no longer a continuing care patient. (This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud.) If you would like to learn more about eligibility for continuity of care benefits, please call the BCBS-IL customer service telephone number on your ID card.

No Surprises Act and Balance Billing

When you receive emergency care or are treated by an out-of-network provider or nonparticipating provider at a network hospital or ambulatory surgery center, you are protected from balance billing by federal law – the No Surprises Act.

For designated network benefits and network benefits for covered services provided by a network provider, you are not responsible for any difference between the Allowed Amount and the amount the provider bills (other than your usual cost-sharing obligations). There are certain situations where you may consent to be balance billed, but such consent must be in writing and obtained in advance of services performed.

You are not responsible, and the out-of-network provider or nonparticipating provider may not bill you, for amounts in excess of your copayment, coinsurance, or deductible, which is based on the allowed amount, for the following:

- For covered services that are Ancillary Services received at certain network facilities on a non-emergency basis from out-of-network or nonparticipating providers;
- For covered services that are Non-Ancillary Services received at certain network facilities on a non-emergency basis from out-of-network or nonparticipating providers who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a Non-Ancillary Service is provided for which notice and consent have been satisfied;
- For covered services that are Emergency Services provided by an out-of-network or nonparticipating provider; and
- For covered services that are Air Ambulance services provided by an out-of-network or nonparticipating provider.

Please call BCBS-IL at the number on your ID card for assistance if you are billed for amounts in excess of your applicable cost sharing. For more information on these balance billing protections, please visit **www.cms.gov/nosurprises**.

Coordination of Benefits

Coordination of benefits procedures will be as described in the Incorporated Documents. To the extent that the Incorporated Documents do not have any provisions for coordination of benefits, the procedures described below shall govern.

If you or your Dependent(s) is covered by more than one health plan (for example, this Plan and your Spouse's plan), you should understand how the plans work together to pay for covered expenses. The coordination of benefits provision is designed to prevent duplicate payments for the same covered expenses and to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

You should file all health claims with each plan. However, a claim will not be paid twice if the expense is covered by both plans. Claims are coordinated so that you or your providers will receive no more than the benefit payments allowable under this Plan.

Order of Payment Determination Rules

The primary plan is the plan that determines and provides health benefits or makes payments without taking into consideration the existence of any other plan. The secondary plan is the plan that can reduce its payments after taking into consideration the health benefits and payments provided by the primary plan.

A plan that does not have a coordination of benefits rule consistent with this section will always be the primary plan. If the other plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation shall be followed:

- The plan that covers a person as an employee shall be the primary plan and the plan that covers that person as a Dependent will be the secondary plan.
- For a Dependent Child whose parents are not divorced or legally separated and both parents have group health plan coverage that covers the Dependent Child, the primary plan will be the plan that covers the parent whose birthday falls first in the calendar year:
  - This Plan pays first if your birthday (month/day) comes before your Spouse's/Domestic Partner's birthday in the calendar year (for example, if your birthday is March 1 and your Spouse's birthday is June 1).
  - If you and your Spouse/Domestic Partner have the same birthday, the plan covering you or your Spouse/Domestic Partner longer pays first.
  - If your Spouse's/Domestic Partner's plan does not use the birthday rule, the rules of that plan determine which plan pays first.
- For the Dependent Child of divorced or separated parents, the coordination of benefits for the Dependent will be determined in the following order:
  - First, according to the provisions of a qualified medical child support order ("QMCSO") or other court decree, if the court decree states that one parent is responsible for the Dependent child's health benefit coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge.
  - Then, the plan of the parent with custody of the Child.
  - Then, the plan of the noncustodial parent of the Child.

- If none of the above rules determines the order of benefit payments, the plan that has covered you for the longer period of time will be the primary plan.

Benefits and payments under this Plan will be secondary to benefits and payments provided or required by any group or individual automobile, homeowner's, or premises insurance, including medical payments, personal injury protection, or no-fault coverage, regardless of any provision to the contrary in any other policy of insurance.

Effect on Payments by This Plan

If this Plan is the secondary plan, it will pay the difference between what it normally would pay if there were no coordination (after any deductible or copayment) and what the primary plan pays.

Recovery of Excess Payments

If this Plan pays for covered expenses that should have been paid by the primary plan, this Plan will have the right to recover such payments.

This Plan will have sole discretion to seek such recovery from any person to whom, or for whom, or with respect to whom, such benefits were provided, or such payments were made by any other plan. If the Plan Administrator requests, you must execute and deliver such instruments and documents as the Plan Administrator determines are necessary to secure the right of recovery for this Plan.

Right to Receive and Release Information

Unless prohibited under HIPAA, the Plan Administrator, without consent or notice to you, may obtain information from and release information to any other plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide the Plan Administrator with any information it requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information (including an Explanation of Benefits ("EOB") paid under the primary plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits for Medicare Eligible Individuals

An overview of Medicare

Medicare is a government program administered by the Centers for Medicare and Medicaid Services (CMS) that provides basic medical coverage. It has several parts:

- Medicare Part A helps pay for medically necessary inpatient hospital care, post-hospital skilled nursing facility stays, home health care and hospice care. A monthly contribution, or premium, generally is not required to participate in Medicare Part A.
- Medicare Part B helps pay for medically necessary physicians' services, outpatient medical and surgical services, diagnostic X-rays and laboratory tests, and other outpatient services. A monthly premium is required to receive coverage.
- Medicare Part C provides Medicare Advantage plans (such as an HMO or PPO), which are alternative systems of health care that combine delivery of care and payment to promote cost-effective health care.
- Medicare Part D provides prescription drug coverage. It is offered through Medicare-approved private insurers who contract with CMS to offer Part D. At least annually and upon request, you will receive a Medicare Part D Notice of Creditable or Non-Creditable coverage. Please read this notice carefully. It explains that if you do not enroll in Medicare Part D when first eligible, you may be entitled to a late enrollment penalty if you do not have "creditable coverage" elsewhere. Due to improvements under the Inflation Reduction Act, it's possible that certain prescription drug options that were creditable will not be in the future. If you only have non-creditable coverage and are Medicare eligible, you may be subject to a late enrollment penalty if you later enroll in Medicare Part D. Please watch for the applicable notice which should help you decide whether or not to enroll in Part D when first eligible.

For more information about Medicare, contact the Social Security Administration at www.medicare.gov or the Ferrara Benefits Resource Center.

Medicare eligibility:

You generally become eligible for Medicare at these times:

- When you reach age 65;
- If you become disabled and have received Social Security disability benefits for 24 months; or
- If you have end stage renal disease (ESRD).

Which plan is primary, your Ferrara medical Plan or Medicare?

If you continue to be actively employed by the Company after you reach age 65, your health benefits remain in effect even though you are eligible for Medicare. Your Spouse may also continue to be covered under this Plan if he reaches age 65 and is eligible for Medicare.

If you or your Spouse is enrolled in Medicare because of your age, this Plan pays first, and Medicare pays second, as long as you remain actively employed by the Company.

If you, your Spouse, or your Dependent Child is enrolled in Medicare because of a disability, this Plan pays first, and Medicare pays second, as long as you remain actively employed by the Company and have "current employment status" as that term is defined by Medicare. However, if you no longer continue to work, this Plan will pay second (and Medicare will be the primary payer) after the first 24 months of Social Security disability entitlement if you receive disability benefits and are taxed for 6 months.

If you, your Spouse, or your Dependent Child is enrolled in Medicare because of end stage renal disease ("ESRD"), this Plan pays first for the first 30 months that Medicare benefits are available because of ESRD, and Medicare pays second for that 30-month period. However, after the end of the 30-month ESRD coordination period, Medicare will pay first, and this Plan will pay second.

Note: Even if you have "current employment status" with the Company, Medicare is assumed to be the primary payer when your Domestic Partner is eligible for Medicare due to attainment of age 65.

Contact BCBS-IL if you have questions regarding Medicare coordination or you or your Dependent(s) are eligible for Medicare for more than one reason.

When Medicare pays primary (for example, after 30-month ESRD period or perhaps, if you are eligible for Company provided disability benefits and Medicare due to disability and no longer maintain "current employment status," or your Domestic Partner is Medicare eligible due to age), the Plan Administrator will give consideration to the benefits available under Medicare when determining this Plan's payments for your covered expenses. As a result, it's important to enroll in Medicare Part A **and** Part B, if you and/or your Dependent(s) are eligible and Medicare pays primary, because the Company pays benefits "as if" you are enrolled in Part A **and** Part B when the Company pays second, even if you are not enrolled in Medicare Part A and Part B. This rule applies even if you are required to pay a premium for Medicare benefits. The process used in determining payments under this Plan for your covered expenses is as follows:

- This Plan will determine what the payment for a covered expense would be without regard to the coordination of benefits provisions of this Plan.

- This Plan will deduct from this amount the amount paid or payable by Medicare. The amount payable by Medicare will be deducted whether or not you have enrolled in and/or received payment from Medicare.
- The difference, if any, is the amount that will be paid under this Plan.

Leaves of Absence

Generally, participation in the Plan's health and welfare benefits continues while you are on a paid leave of absence, but you must continue to make employee contributions for your participation to continue. Contact the Plan Administrator for additional payment details. Details regarding leaves of absences can be found in the Leave of Absence Policy Summary and the incorporated documents that it references.

Participation in the Plan's health and welfare benefits might also continue while you are on an unpaid leave of absence if you make employee contributions, as applicable. For more information, please contact the Plan Administrator.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), sets requirements for the continuation of health benefit coverage under the Plan in the event of an employee's leave of absence to perform service in the uniformed services ("military"). For this purpose, military service means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission. These requirements apply to health benefit coverage (medical, dental, vision and the Health FSA) for you and your Dependents. It important that you notify **HRTotalRewards@ferrara.com** or your local HR manager in advance of going on military leave so that you receive the full benefits of this law. If you are unable to notify the Company, please have a family member or personal representative provide such an election.

Additional details regarding the Company's procedures for military leave can be found in the **Military Leave Policy**.

Continuation of Health Benefit Coverage

You may elect to continue your health plan coverage for yourself and your Dependents for up to 24 months. You must notify **HRTotalRewards@ferrara.com** before your military leave begins. Once the Company is notified of the leave, you will be given the opportunity to elect continued coverage. Your election generally will align with the COBRA rules and such election typically will last from 60 days from the date that your COBRA letter (election notice) is received and your coverage will be retroactive to the date that coverage was lost. If you do not make an election, your coverage under the Plan will end (unless there was an extenuating circumstance such as the inability to notify the Company or elect coverage related to your service (e.g., you are involved in a military conflict overseas).If you are unable to make an election due to extenuating circumstances related to your military leave, once you make the election, coverage will be retroactive as long as you pay all unpaid amounts due. Health plan coverage that you maintained on the day before the military leave may continue for up to 24 months.

For military leaves of less than 90 days, you will make employee contributions for your health benefit coverage as if you were still an active employee—in other words, you will continue to receive the Company subsidy towards your medical, dental, and vision coverage that you had elected. While the Company will not take deductions for these contributions, once you return to work, your contribution towards this coverage will be taken at 150% of the normal rate until the amount in arrears has been repaid.

For military leaves of 91 days or more, the following applies:

- Your health benefit coverage will last up to the earliest of the following:
  - 24 months from the last day of employment with the Company.
  - The day after you fail to return to work following the end of your military leave of absence as required by USERRA.
  - The day after your grace periods for non-payment as provided for under the COBRA rules unless you are unable to make a payment due to military necessity or such payment is otherwise impossible or unreasonable due to your military service (e.g., you are involved in a military conflict overseas).
  - The day the Plan terminates.
- The Company may charge you and your Dependents up to 102% of the full cost of the health benefit coverage. Your USERRA continuation coverage will run concurrently with COBRA.

Reinstatement of Health Benefit Coverage
If your health benefit coverage ends during the military leave because you do not elect coverage under USERRA and you are reemployed by the Company, the health benefit coverage for you and your Dependents may be reinstated if:

- You gave the Company advanced written or verbal notice of your military leave.
- The duration of all military leaves while you are employed with the Company does not exceed five (5) years.

You and your Dependents will be subject to only the balance of a waiting period, if appropriate, that was not yet satisfied before the military leave began. However, if an injury or illness occurs or is aggravated during the military leave, full Plan and USERRA limitations will apply.

If your health benefit coverage under the Plan terminates as a result of your eligibility for military health benefits and your order to active duty is canceled before your active-duty service commences, these reinstatement rights will continue to apply.

Family and Medical Leave Act

Your health benefit coverage will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended ("FMLA"). The Plan Administrator will give you more detailed information about the FMLA, including if you are eligible. (See the Leave of Absence Policy Summary for details.) The FMLA allows eligible employees to take an unpaid leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your Child and to care for the newborn Child.
- The placement of a Child with you for adoption or foster care.
- To care for a family member (Child, Spouse, or parent) with a serious health condition.
- Your own serious health condition that makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that your Spouse, Child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation in accordance with the FMLA.

If eligible, you may also take a leave for up to a total of 26 work weeks in a single 12-month period to care for a family member who is a covered member of the Armed Forces with a serious injury or illness if you are the Spouse, son, daughter, parent or next of kin of the covered service member.

Benefit Coverage While on FMLA Leave
The Company will continue your benefit coverage under the Plan during your FMLA leave just as if you were still employed. The cost of your benefit coverage during an FMLA leave must be paid, and you must make all required employee contributions in accordance with the agreement reached between you and the Plan Administrator prior to your FMLA leave becoming effective. However, you are required to continue to pay for such benefits during your leave for coverage to remain in effect.

If your pay continues during your FMLA leave, then deductions for benefit coverage will be continued in the ordinary course. However, if you are on an unpaid FMLA leave, the Company uses the "catch-up" payment option permitted by the IRS. Under the "catch-up" option, the Company will continue to provide you with coverage during the period of unpaid leave, the Company will advance any contributions, including insurance payments, on your behalf during this period, and once you return to work, your contribution towards this coverage will be taken at 150% of the normal rate until the amount in arrears has been repaid.

A newly acquired Dependent is eligible for benefit coverage while your participation in the Plan is continued during an FMLA leave.

Continued benefit coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required employee contributions.
- Exhaust your approved period of FMLA leave and do not return to work from your FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue your health benefit coverage under the COBRA rules at the end of your FMLA leave. See the "*COBRA Continuation Rights*" section for more details.

Reinstatement of Canceled Health Benefit Coverage Following FMLA Leave
Upon your return to your employment following an FMLA leave, any terminated benefit coverage will be reinstated as of the date of your return. You will not be required to satisfy any waiting period, if appropriate, to the extent that it had been satisfied prior to the start of the FMLA leave.

State or Municipality Family and Medical Leave Laws
The Company's FMLA policy also complies with any state or municipality law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state or municipal law, you will receive the greater benefit if it is required by that law and if federal law does not preempt such state or municipal law's benefit continuation requirements. Contact Prudential for details.

If Company Changes Benefits
If the Company offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but your required employee contributions for the new benefit coverage may increase.

Short-Term Disability
The Ferrara Short-Term Disability (STD) Program is designed to provide you with continuing income if a sickness or non-work-related accident that results in an injury prevents you from working. If your disability is due to sickness, there is a seven (7) calendar day waiting period. However, if your disability is due to an accident or maternity, your STD benefits may start effective as of the date of that event. The STD wage replacement benefits may last up to 180 days. (For maternity leave, paid leave generally continues for up to eight (8) weeks post-delivery.)

If you are absent from work due to sickness for seven (7) or fewer days, you may be eligible for paid time off (PTO) or if you do not have a balance in your PTO bank then, such time will be unpaid.

The Company complies with the FMLA. Any leave taken under the FMLA will run concurrently with any Ferrara PTO or STD benefits.

The STD Program does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Applying for a Benefit
To apply for STD benefits, call Prudential at 1-888-598-5671 and inform your HR manager as soon as possible (or upon the occurrence of an accident or need for maternity leave) and follow the instructions to certify your disability. In addition, your claim for STD benefits must be submitted within 30 days after the date your disability begins on account of the sickness, accident, or maternity leave to which your disability pertains.

When Benefits Begin
You may be eligible to receive STD benefits after you have been unable to work for more than seven (7) consecutive calendar days due to sickness or upon the occurrence of an accident or maternity leave. Detailed eligibility requirements pertaining to when (and if) benefits will begin, including the definitions of disabled or disability, sickness or injury, are included in the Incorporated Document pertaining to STD benefits.

How Your Benefit Is Determined
If you are approved by Prudential for STD benefits according to the terms of the STD Program, you will be eligible to receive 60% of your weekly pre-disability earnings for up to 26 weeks, or 100% of your weekly pre-disability earnings for maternity disability for up to 8 weeks. Pre-Disability Earnings is defined in the STD Program Incorporated Document and as follows: Your gross salary or wages that you were earning as of your last day actively at work before disability began. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 Cafeteria Plan, or flexible spending account. It does not include income actually received from commissions and bonuses including renewal commissions, overtime pay, any other extra compensation (including any stipends or wellness credits), or income received from sources other than your Employer.

In the unlikely event of a benefit overpayment, you will be given the opportunity to repay such amounts to the Plan. The Plan has the right to recover any overpayments.

Benefits Continuation
All benefits described in this SPD (e.g., medical, dental, vision, life, AD&D) that you have in effect for you and your eligible Dependents when you become entitled to STD benefits will continue as long as you are an active Eligible Employee. You will be responsible for any required contributions. If your STD benefit payments are sufficient to pay for your benefits in effect on the day before your STD benefits commence, then deductions will continue to be taken from your STD benefit payments, similar to your pre-disability pay. However, if such amount is not sufficient to pay for your other covered benefits, then, benefit coverage will continue (the Company will pay any required contributions on your behalf), but once you return to work, your contribution towards this coverage will be taken at 150% of the normal rate until the amount in arrears has been repaid.

Independent Medical Examination
If you are receiving Plan benefits and there is a difference of opinion between the claim's administrator and your physician regarding your sickness or injury, the claims administrator may schedule an independent medical examination for you. If required, you must attend this examination for your benefits to continue until

the time of the examination. However, in no case will your benefits continue for more than 180 days or past the date on which you would otherwise be ineligible for benefits.

In addition, if you are able to work and there is a difference of opinion between the claims administrator and your physician regarding medical restrictions (such as the number of hours you can work or the weight you can lift), or the duration of such restrictions on your work, the claims administrator may schedule an independent medical examination for you. If required, you must attend this examination. The independent medical examiner's determination as to your functional capacity to perform your work duties will be binding on all parties.

When Benefits End

You will continue to receive STD benefits for as long as you are "disabled" as defined by the STD benefits booklet, up to 26 weeks. For maternity leave, your STD benefits will continue generally for up to eight (8) weeks (2 weeks before delivery if medically necessary and then, 6 weeks after delivery), provided you do not qualify for further benefits as provided in the STD benefits booklet. In addition, you will continue to receive health care and life insurance coverage for as long as you are eligible for STD benefits. If you do not return to work after your STD benefits end, your employment may be terminated. Upon termination of employment, you will be given an opportunity to elect COBRA with respect to your group health plan benefits (i.e., medical, dental, vision, Health FSA and EAP). The offer of COBRA coverage will begin regardless of whether or not you are eligible for LTD benefits, assuming that you were not terminated for gross misconduct.

You may be eligible for Long-Term Disability (LTD) benefits after your STD benefits end. LTD insurance covers 40% of your pre-disability monthly earnings (you are eligible to purchase buy-up LTD coverage for an additional 20% of coverage). The maximum benefit of base LTD coverage is $5,000 monthly; the maximum benefit of buy-up LTD coverage is $15,000 monthly. If you are on an approved STD leave and must transition to LTD, that process will be managed by Prudential. Again, upon termination of employment, group health plan benefits will end, and COBRA continuation coverage will be offered. If you are disabled for more than 9 months, you may be eligible for a life insurance premium waiver. For more details on LTD coverage, please refer to the LTD certificate which is an Incorporated Document and part of this SPD.

If you do not return to work at the end of your STD benefit period, your employment may be terminated as of the last day of your approved disability, unless you are eligible and approved for FMLA leave or an authorized leave of absence, including a leave of absence under the Americans with Disabilities Act ("ADA").

If you die while receiving STD benefits, any benefits owed to you but not yet paid at the time of your death may be paid to your Spouse or other appropriate individual. For example, if you died on a Thursday, your family would receive the payments owed you for the four days of that week (if you already would have been paid for the previous weeks). The Plan Administrator (i.e., the Ferrara Employee Benefits Advisory Committee) or its delegate determines who will receive the payments for the balance owed as of the date of your death.

If you separate from service for any reason while receiving STD benefits, you will continue to receive disability benefits until you are no longer disabled or the end of the 26-week benefit period, whichever occurs first. For maternity leave, you will continue to receive disability benefits generally for up to eight (8) weeks, unless employee continues to meet the definition of disability.

Please see additional details in the STD and LTD benefits booklet, which is part of this SPD.

Other Approved Leaves of Absence

If you are approved for a leave of absence and it is paid (for example, bereavement leave), the Company will continue your benefit coverage and deductions will be taken. For approved leaves of absence that are unpaid and not subject to the FMLA or USERRA (for example, parental leaves that are not covered by the FMLA) or perhaps, a temporary layoff, coverage generally may continue for up to an additional 90 days dependent upon your type of absence. Upon expiration of your approved leave not to exceed 90 days, coverage will end and for group health plan benefits, you will be offered COBRA. Additionally, in limited instances, the Company may continue benefit coverage due to a particular temporary layoff or unpaid leave of absence on a nondiscriminatory basis, but you will receive information at that time about how to continue your coverage and information related to payment. **Upon return from such unpaid leave, contributions owed toward elected coverages will be collected at 150% of the normal amount until the arrears have been repaid.**

Termination of Plan Participation

Employees

If you lose eligibility under the Plan, your coverage ends as of the last day of the calendar month in which you:

- You no longer meet the eligibility requirements (see the "*Eligibility*" section).
- You stop making required payments.
- Your employment terminates.
- The Plan is terminated.
- You die.

When coverage ends, you may be eligible to continue health care coverage under COBRA (see the "*COBRA Continuation Rights*" section). You also may be eligible to convert a particular benefit when coverage ends. You should review the Incorporated Documents and/or contact the administrator in the *Plan Contacts* section for more details.

Dependents of Employees

Participation in the Plan for all of your Dependents will cease on the earliest date below:

- The day your coverage ends.
- The day on which the Dependent ceases to qualify as a Dependent, as outlined in the "Eligibility" section.
  - If your Child who is not disabled attains age 26, his or her medical, dental, vision and EAP coverage will automatically end on the last day of the month in which he or she attains age 26.
- The day Dependent coverage under the Plan is terminated.
- The day the Plan is terminated.

When coverage ends, your Dependents may be eligible to continue health care coverage under COBRA. You also may be eligible to convert a particular benefit when coverage ends. You should contact the Plan Administrator in the "*Plan Contacts"* section for more details.

COBRA Continuation Rights

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), offers you and your qualified beneficiaries the opportunity to continue health benefit coverage under the Plan in certain circumstances. **This section of the SPD is a notice that explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your rights to get it.** For additional information about your rights and obligations under the Plan and under federal law, contact the Plan Administrator.

COBRA continuation coverage is a temporary continuation of health benefit coverage (i.e., medical and prescription drug, dental, vision, Health FSA, and the EAP) under the Plan when it otherwise would end because of a COBRA "qualifying event." After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your Spouse, and/or your Dependent Children could become qualified beneficiaries if you, your Spouse, or your Dependent Child is enrolled in health benefits under the Plan on the day before a qualifying event occurs and that health benefit coverage is terminated because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period. While Domestic Partners are not "qualified beneficiaries" under COBRA, the Plan offers continuation coverage to eligible Domestic Partners as if they were qualified beneficiaries.

Please Note: Qualified beneficiaries may have other options available when they lose Plan coverage. For example, they may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, they may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, they may qualify for a 30-day special enrollment period for another group health plan for which they are eligible (such as a Spouse's plan), even if that plan generally does not accept late enrollees. They may also have other coverage options through Medicare, Medicaid, and the Children's Health Insurance Program ("CHIP"). Some of these options may cost less than COBRA continuation coverage.

Qualified Beneficiaries and Qualifying Events

Covered Employee
You'll become a qualified beneficiary and eligible for COBRA continuation coverage if you lose your health benefit coverage under the Plan because of one of the following qualifying events:

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

Spouse or Domestic Partner of Covered Employee
Your Spouse will become (or in the case of a Domestic Partner will be considered for purposes of the Plan) a qualified beneficiary and eligible for COBRA continuation coverage if he/she loses health benefit coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- You die.
- You become divorced or legally separated from your Spouse.
- You and your Domestic Partner cease to have a Domestic Partnership.

Note: While Medicare entitlement can be a qualifying event, it does not apply to this Plan because the Plan does not terminate coverage of a Spouse or Child of an active employee who becomes entitled to Medicare.

Dependent Children

Your Dependent Children will become qualified beneficiaries and eligible for COBRA continuation coverage if they lose health benefit coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- You die.
- You become divorced or legally separated from your Spouse.
- Your Child loses eligibility as a "Dependent Child" under the Plan.

A Child born to, or adopted by, or placed for adoption with you during a period of COBRA continuation coverage is considered to be a qualified beneficiary, but only if you timely elected COBRA continuation coverage for yourself. The new Child's COBRA continuation coverage begins when the Child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA continuation coverage lasts for your other family members who are qualified beneficiaries. To be enrolled in the Plan, the new Child must satisfy the otherwise applicable Plan eligibility requirements.

Notification of Qualifying Events

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. See the *"Plan Contacts"* section for contact information.

When the qualifying event is the end of your employment, the reduction in your work hours, or your death, the Company will notify the Plan Administrator of the qualifying event.

For other qualifying events (your divorce or legal separation, termination of a Domestic Partnership, or a Dependent Child losing eligibility as a Dependent Child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs or the day the qualified beneficiary loses health benefit coverage under the Plan because of the qualifying event. **If you or your qualified beneficiary fails to notify the Plan Administrator within this 60-day period, your Dependent will not be entitled to elect COBRA continuation coverage**. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

How COBRA Continuation Coverage is Offered

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment form by mail within 14 days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their Children. It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Plan Administrator to ensure that you receive a COBRA enrollment form following a qualifying event.

Qualified beneficiaries have 60 days from the date health benefit coverage under the Plan ends due to a qualifying event or from the date of the COBRA notice, whichever is later, to elect COBRA continuation coverage. If the qualified beneficiary fails to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

Effective Date of COBRA Continuation Coverage

If elected within the period allowed for the election, COBRA continuation coverage is effective retroactively to the date health benefit coverage under the Plan would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for COBRA continuation coverage in this retroactive period. However, if the qualified beneficiary waives COBRA continuation coverage and then revokes the waiver within the 60-day election period, elected COBRA continuation coverage begins on the date the waiver is revoked.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of health benefit coverage under the Plan. COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of your work hours. Certain qualifying events may permit coverage to last for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- Your Dependent Child losing eligibility as a Dependent Child.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or a qualified beneficiary in your family is determined by the Social Security Administration to be disabled, and you notify the Plan Administrator in a timely fashion, you and all other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

- The COBRA qualifying event was your termination of employment or reduction in work hours.
- The qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA continuation coverage, and the disability lasts at least until the end of the 18-month period of COBRA continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage.
- An increased premium of 150% of the monthly cost of health benefit coverage is paid, beginning with the 19th month of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your Spouse and Dependent Children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your Spouse and any Dependent Children receiving COBRA continuation coverage if you die, you become entitled to Medicare benefits (under Part A, Part B, or both), get divorced or legally separated, or your Dependent Child is no longer eligible under the Plan as a Dependent Child, but only if the event would have caused your Spouse or Dependent Child to lose health benefit coverage under the Plan had the first qualifying event not occurred.

Medicare Extension for Your Dependents
If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last until the later of: (1) 36 months after the date you became enrolled in Medicare or (2) 18 months (29 if disability extension) after the date of your termination of employment. Your COBRA continuation coverage will last for 18 months from the date of your termination of employment or reduction in work hours. For example, if you become entitled to Medicare eight months before your employment terminates, COBRA continuation coverage for your Spouse and Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Special Rule for the Health Care FSA
You may be eligible to continue participation in your Health Care FSA for the remainder of the calendar year in which participation otherwise would end due to a COBRA qualifying event. You will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA coverage will be available to you only if you have a positive Health Care FSA balance at the time you become eligible for COBRA (considering all claims submitted by you before the date of the qualifying event). Coverage will cease at the end of the calendar year and will not be continued thereafter. However, you will be permitted to request reimbursement for Eligible Expenses incurred during the calendar year as provided by the "run-out period." Any Health Care FSA amounts left over after the calendar year will be forfeited.

Enrolling in Medicare Instead of COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you**.

What COBRA Continuation Coverage Costs

Qualified beneficiaries must pay monthly premiums for COBRA continuation coverage. Premiums are based on the full cost of health benefit coverage under the Plan for a covered person set at the beginning of

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

the Plan Year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee. An increased premium of 150% of the full cost of health benefit coverage under the Plan must be paid in the case of a disability extension, beginning with the 19th month of COBRA continuation coverage.

Payment is due at enrollment, but there is a 45-day grace period from the date the qualified beneficiary mails his COBRA enrollment form to make the initial payment. The initial payment includes COBRA continuation coverage for the current month, plus any previous month(s). Note that COBRA continuation coverage will not be effective until the COBRA premium is actually paid; if payment is not made with enrollment, COBRA continuation coverage will be retroactively activated back to the date of enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

General Provisions

If you, your Spouse/Domestic Partner, and/or Dependent Child(ren) elect COBRA continuation coverage:

- You or your Dependent can keep the same health benefit coverage under the Plan that you had as an active employee or choose a lower level of coverage.
- You or your Dependent may change health benefit coverage:
  - During the annual open enrollment period.
  - Upon a qualified change in status.
  - For any change in circumstance recognized by the Internal Revenue Service (“IRS”).
- You may enroll any newly-eligible Spouse or Dependent Child under Plan rules.

When COBRA Continuation Coverage Ends

COBRA continuation coverage ends when the first of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period. COBRA continuation coverage for a newly-acquired Dependent who has been added for the balance of a COBRA continuation period would end at the same time that your COBRA continuation period ends.
- The qualified beneficiary becomes covered under another group health plan not offered by the Company.
- The qualified beneficiary fails to pay the COBRA premiums by the due date as required.
- The Company stops offering any health benefit coverage to any employee.
- The qualified beneficiary dies.
- Any reason the Plan would terminate the health benefit coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (such as fraud).
- The Social Security Administration determines that the qualified beneficiary is no longer disabled (if entitled to 29 months of COBRA continuation coverage under the special disability rule), in which case the extended portion of the COBRA continuation coverage will end with the month that begins more than 30 days after the Social Security Administration’s determination.

If You Have Questions

See the “*Your Rights Under ERISA*” section for contact information if you have questions about your rights under COBRA.

Filing an ERISA Claim or Appeal

Disagreements about benefit eligibility or benefit amounts can arise. If the Claims Administrator is unable to resolve the disagreement, there is a formal appeals procedure in place for ERISA-covered benefits, such as medical. This section explains the steps you or your authorized representative is required to take to file an ERISA claim or appeal. You must request your benefits or file a claim within one year (or as such shorter time specified in the applicable Incorporated Document) of the receipt of service or onset of illness or injury, whichever is later, or your claim will be denied. If you intend to file a civil action under Section 502(a) of ERISA, it must be filed within one year after completing the ERISA claims and appeals process unless specified otherwise in the Incorporated Documents.

The claims and appeals procedures are slightly different, depending on whether you have an "eligibility" claim or a "benefit" claim. An eligibility claim is a claim to participate in the Plan or Plan option / Component Benefit or to change an election to participate during the year. A benefit claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

ELIGIBILITY

Procedures for Claims & Appeals Involving "Eligibility" for Coverage

An eligibility claim is a claim to participate in a Component Benefit offered under the Plan or to change an election to participate during the year. Examples of eligibility claims include claims regarding whether you are enrolled in the correct benefit option, or claims related to whether you properly enrolled a Dependent. Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

For initial eligibility claims for all Component Benefits subject to ERISA, the Claims Administrator is Ferrara Candy Company's Eligibility Claims Administrator. To file an eligibility claim, you must request a Claim Initiation Form at **HRTotalRewards@ferrara.com**. You must return the form to the Eligibility Claims Administrator.

You will be notified of the decision within the time periods below:

- For medical (including prescription drug), Health Care FSA, dental, vision, and EAP within 30 days or within 72 hours (if you specify that it is an urgent care claim) of the Eligibility Claims Administrator's receipt of your Claim Initiation Form;
- For disability benefits, within 45 days of the Eligibility Claims Administrator's receipt of your Claim Initiation Form; or
- For all other ERISA benefits, within 90 days of the Eligibility Claims Administrator's receipt of your Claim Initiation Form.

If additional information is needed to process your eligibility claim, you will be notified within that initial period. The Plan may request an extension, not longer than:

- For medical (including prescription drug), Health Care FSA, dental, vision, and EAP benefits, an additional 15 days;
- For disability benefits, up to two additional 30-day periods; or
- For all other claims (e.g., life), 90 days.

The Company's Eligibility Claims Administrator will notify you of the deadline to submit additional information, if applicable. If your claim is **approved**, the Company will notify you in writing.

If your claim is **denied**, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary.
- 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 appeal.
- With respect to medical including prescription drug and disability.
  - Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request).
  - Information sufficient to identify the claim involved.

Depending on where you live, you may be able to receive a medical, prescription drug or disability denial notice in Spanish, Tagalog, Chinese, or Navajo.

Before you can bring any legal action to recover Plan benefits, you **must** exhaust this process. Specifically, you must file an appeal as explained in this section and your appeal must be finally decided by the Claims Administrator. For eligibility claims for all Component Benefits, the Claims Administrator fiduciary (appeals) is Ferrara Candy Company's Employee Benefits Appeals Committee. All decisions by the Employee Benefits Appeals Committee are final and binding on all parties.

If your claim is denied and you want to appeal it, you must file your appeal within 180 days (for medical [including prescription drug], Health Care FSA, dental, vision, and disability) or otherwise 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to Ferrara Candy Company's Employee Benefits Appeals Committee for the Plan (see "*Plan Contacts*" section) and include:

- A copy of your claim denial notice.
- The reason(s) for the appeal.
- Relevant documentation.

You will be notified of the decision within 60 days for medical (including prescription drug), Health Care FSA, dental, vision, and EAP (unless it is an urgent care claim, in which case you will be notified within 72 hours) of the Employee Benefits Appeals Committee's receipt of your appeal, 45 days for disability (90 days when special circumstances apply), or 60 days (120 days when special circumstances apply) for all other ERISA-covered Component Benefits.

BENEFITS
Procedures for Claims & Appeals Involving a Benefit

The following is a summary of the benefits claims and appeals procedure.

The Claims Administrator/fiduciary must comply with this process or you must verify that the process has been exhausted. If you believe that the Claims Administrator/fiduciary has violated this process, you may write to the Plan Administrator.

References to "you" refer to the claimant, including his or her authorized representative.

Benefit claims and appeals are divided into four categories.

- Post-service: A claim for reimbursement of services already received. This is the most common type of claim.
- Pre-service: A claim for a benefit for which prior authorization is required by the Plan.
- Concurrent care: A claim for ongoing treatment over a period of time or a number of additional treatments that have been approved.
- Urgent care: A claim for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

Fully Insured Benefits. For purposes of determining the amount of, and entitlement to, benefits of the Component Benefits provided under insurance or contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Component Benefit, you must follow the claims procedures under the applicable insurance contract (Incorporated Document), which may require that a written claim be completed, signed and submitted on the insurer's form. Please contact the Claims Administrator/insurer for details.

The insurance company will decide claims in accordance with its reasonable claims procedures, as required by ERISA. The procedures outlined here align with ERISA. The insurer, as the Claims Fiduciary may have slightly different procedures. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide submitted claims. If the insurance company denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. Failure to timely file a claim may cause you to lose your right to file suit in a state or federal court, based on a failure to exhaust internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

See the Component Benefit's claims filing instructions for more information about how to file a claim and for details regarding each insurance company's claims procedures.

Self-Funded Benefits (i.e., medical and prescription drug, dental and Health Care FSA). For purposes of determining the amount of, and entitlement to, benefits under the Component Benefits provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement. The Plan Administrator has delegated its authority to finally determine claims to the Claims Administrator.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Claims Administrator a written claim as directed by the Claims Administrator. The Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide the claim.

The Claims Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Claims Administrator denies a claim in whole or in part, then the Eligible Employee will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the denial may be appealed to the benefit's Claims Fiduciary. The Claims Fiduciary will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the appeal is untimely, the right to file suit in a state or federal court may be lost, because internal administrative appeal rights have not been exhausted (which generally is a prerequisite to bringing a suit in state or federal court).

If there is a conflict between the claims and appeals procedures outlined in this SPD or in the Claims Administrator's benefits booklet, the Claim's Administrator's procedures apply. The following chart provides a guideline of the timing and response requirements under ERISA.

Medical and Prescription Drug Benefit Claims and Appeals for Benefits

To file a benefit claim, write to the medical and prescription drug Claims Administrator (e.g., BCBS-IL or CVS). For eligibility claims and appeals, please refer above to the "*Eligibility Claims and Appeals for All Component Benefits*" section.

	Post-Service Claim	**Pre-Service Claim**	**Concurrent Care Claim**	**Urgent Care Claim**
	Internal Claims (Internal Benefit Determination)			
Misdirected Claim	Not applicable. Response time frame does not begin until claim is properly filed.	5 days.	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.	24 hours.
When You Will Be Notified of Claim Decision Within the time frame indicated in the columns to the right after receipt	30 days. This period may be extended for 15 days. Claimant must be notified within the initial 30-day period.	15 days. This period may be extended for an additional 15 days. Claimant must be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow appeal and obtain a response to that appeal before coverage is reduced or terminated. For concurrent care that is urgent, within 24 hours (provided that claim is submitted at least 24 hours in advance of reduction or termination of coverage); otherwise, within 72 hours.	72 hours.
Failure to Provide Sufficient Information Procedure Claim ***may*** be decided based on the information provided if Claims Administrator decides to request additional information before deciding claim, you will be notified within time frames provided in the columns to the right.	30 days.	15 days.	Decision will be based on information provided unless the concurrent care claim involved urgent care; see urgent care time frame.	24 hours.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
You must provide additional information within the time frames provided in the columns to the right. Otherwise, the claim will be decided based on information originally provided.	45 days.	45 days.		48 hours.
If claimant provides additional information, notification of the decision must be sent within the time frames provided in the columns to the right.	The time period remaining for the initial claim.	The time period remaining for the initial claim.		48 hours.
How You Will Be Notified of the Claim Decision	If the claim (benefit determination) is approved, you will be notified in writing; commonly referred to as an explanation of benefits ("EOB"). If claim is denied (adverse benefit determination), in whole or in part, the denial notice must contain: ▪ The specific reason(s) for the denial. ▪ The Plan provisions on which the denial was based. ▪ Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and upon request the availability of the diagnosis and treatment codes and their corresponding meanings). ▪ Any additional material or information you may need to submit to complete the claim. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge upon request). If based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination (or a statement that such explanation will be provided free of charge upon request). ▪ The Plan's appeal procedures. ▪ The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process. If the Claims Administrator relies on new evidence to deny your claim, you will be notified in advance, free of charge, of the rationale so that you can respond in advance of the final internal adverse benefit determination. ▪ You have a right to review your claim file.			If your claim is denied, claimant will be notified by phone. Within 3 days of the oral denial, claimant must receive a written denial notice, as explained under the general procedure. The denial notice must explain the expedited review process.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Internal Appeals (Benefit Determinations on Review)—Step 2: Before you can bring any action at law or in equity to recover Plan benefits, you must exhaust this process. Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the Claims Fiduciary. The Plan Administrator or its delegate has delegated its authority to finally determine claims to the Claims Administrators for benefit claims. The Claims Fiduciary is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. All decisions by the Claims Fiduciary are final and binding on all parties.				
How to File an Appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim (adverse benefit determination). You may request access, free of charge, to all documents relating to your appeal. You should write to the party identified in your claim denial notice (adverse benefit determination) and include: ▪ A copy of your claim denial notice. ▪ The reason(s) for the appeal. ▪ Relevant documentation.	180 days.	180 days.	180 days.	180 days. You may orally file your appeal with the Claims Fiduciary for urgent care claims. At the time your claim is denied, the Claims Administrator will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.
The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your initial claim. In addition, if your appeal involves a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.				
When You Will Be Notified of Appeal Decision *(Can require one or two level(s) of appeal(s))*	One level of appeal: within 60 days. Two levels of appeals: within 30 days at each appeal level.	One level of appeal: within 30 days. Two levels of appeals: within 15 days at each appeal level.	Before a reduction or termination of benefits occurs. If involves urgent care, 72 hours.	Within 72 hours.
If Appeal is Denied in Whole or in Part, the Adverse Benefit Determination on Review Must Contain	▪ The specific reason(s) for the denial. ▪ The Plan provisions on which the denial was based. ▪ A description of any additional information or material needed from the claimant to "perfect the claim" and an explanation of why such additional information or material is necessary. ▪ A statement regarding the documents to which the claimant is entitled. ▪ An explanation of the voluntary or mandatory appeal procedures, if any. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).			

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
	▪ If based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination (or a statement that such explanation will be provided free of charge upon request). ▪ The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency." – **Note**: In lieu of including the above statement regarding "voluntary alternative dispute resolution options" in the appeal denial letter, the plan or insurer may include any specific voluntary appeal procedures offered by the plan along with a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA. ▪ Sufficient information to identify the claim involved (e.g., date of the service, the health care provider, claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning). ▪ The reason(s) for an adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. ▪ A description of available internal appeals and external review processes. ▪ The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.			
External Appeals (IRO)—Step 3 Under the Affordable Care Act, medical benefit claims (not eligibility claims) and rescissions under a non-grandfathered health plan are eligible for an external review (Step 3 of the claims and appeals process) by an independent review organization (IRO). To be eligible for the external review, the medical benefit claim must involve medical judgment, excluding claims that involve only contractual or legal interpretation without any use of medical judgment as determined by the external reviewer. You will be provided with information regarding this new external review if you receive a final internal adverse benefit determination (i.e., your claim is denied after completing Step 2 of the claims and appeals process). You cannot request an external review unless you have exhausted the internal claims and appeals process and receive a final adverse benefit determination.				
Filing an Appeal	4 months after date of receipt of notice final adverse benefit determination.	4 months after date of receipt of notice final adverse benefit determination.	4 months after date of receipt of notice final adverse benefit determination. Expedited appeal can be requested: (1) if the time frame for completion of a standard external review would seriously jeopardize life or health or ability to regain maximum function; or (2) if it concerns an admission, availability of care, continued stay, or health care item or service for emergency services, but have not been discharged from a facility.	4 months after date of receipt of notice final adverse benefit determination. Expedited appeal can be requested: (1) if the time frame for completion of a standard external review would seriously jeopardize life or health or ability to regain maximum function; or (2) if it concerns an admission, availability of care, continued stay, or health care item or service for emergency services, but have not been discharged from a facility.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Claims Administrator's Preliminary Review	5 business days.	5 business days.	5 business days. If involves urgent care, immediately.	Immediately.
Time to Notify Claimant of Preliminary Review ▪ If request is incomplete, claimant must provide required information.	1 business day. Within the 4-month appeal filing deadline or 48 hours (whichever is later).	1 business day. Within the 4-month appeal filing deadline or 48 hours (whichever is later).	1 business day. If involves urgent care, immediately. Immediately if the concurrent care claim involves urgent care.	Immediately.
Claims Administrator Provides IRO with Documentation	5 business days.	5 business days.	5 business days.	Immediately.
IRO Notifies Claimant of Acceptance of External Review Request	Timely.	Timely.	Timely, expedited if it involves urgent care.	N/A.
Claims Administrator's Notice of Reversal of Adverse Benefit Determination (if applicable)	1 business day following decision.	1 business day following decision.	1 business day following decision.	N/A.
When You Will Be Notified of External Appeal Decision	Within 45 days.	Within 45 days.	Within 45 days. If involves urgent care, oral notice within 72 hours. IRO must provide written confirmation of decision to the claimant and the Claims Administrator within 48 hours.	Oral notice within 72 hours. IRO must provide written confirmation of decision to the claimant and the Claims Administrator within 48 hours.
IRO external review decision notice content	▪ General description of the reason for the request for external review, including information to identify claim (i.e., date[s] of service, health care provider, claim amount [if applicable], diagnosis, and treatment codes and their meaning, and the reason for the previous denial); ▪ Date IRO received the assignment to conduct the external review and date of IRO decision; ▪ References to evidence or documentation, including specific coverage provisions and evidence-based standards considered; ▪ Discussion of the principal reason(s) for its decision, including rationale and any evidence-based standards relied upon; ▪ Statement that the determination is binding except to the extent other remedies may be available under state or federal law to either the medical plan or to the claimant; ▪ Statement that judicial review may be available to the claimant; and ▪ Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman. If IRO reverses Claims Administrator's decision, the Claims Administrator must provide coverage or payment for the claim immediately.			

Health Care FSA, Dental, Vision, and EAP Benefits Claims and Appeals

To file a **benefit** claim, write to the applicable Claims Administrator. Generally, these types of claims are post-service.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
	Internal Claims (Internal Benefit Determination)			
Misdirected Claim	Not applicable. Response time frame does not begin until claim is properly filed.	5 days.	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, 24 hours.	24 hours.
When You Will Be Notified of Claim Decision Within the time frame indicated in the columns to the right after receipt	30 days. This period may be extended for 15 days. Claimant must be notified within the initial 30-day period.	15 days. This period may be extended for an additional 15 days. Claimant must be notified within the initial 15-day period.	A time period sufficiently in advance of the reduction or termination of coverage to allow appeal and obtain a response to that appeal before coverage is reduced or terminated. For concurrent care that is urgent, within 24 hours (provided that claim is submitted at least 24 hours in advance of reduction or termination of coverage); otherwise, within 72 hours.	72 hours.
Failure to Provide Sufficient Information Procedure Claim ***may*** be decided based on the information provided if Claims Administrator decides to request additional information before deciding claim, you will be notified within time frames provided in the columns to the right.	30 days.	15 days.	Decision will be based on information provided, unless the concurrent care claim involved urgent care; see urgent care time frame.	24 hours.
You must provide additional information within the time frames provided in the columns to the right. Otherwise, the claim will be decided based on information originally provided. If claimant provides additional information,	45 days.	45 days.		48 hours.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
notification of the decision must be sent within the time frames provided in the columns to the right.	The time period remaining for the initial claim.	The time period remaining for the initial claim.		48 hours.
How to Notify Claimants of Decision	If the claim (benefit determination) is approved notification is provided in writing; commonly referred to as an explanation of benefits or EOB. If claim is denied (adverse benefit determination), in whole or in part, the denial notice must contain: ▪ The specific reason(s) for the denial. ▪ The Plan provisions on which the denial was based. ▪ Any additional material or information you may need to submit to complete the claim. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). ▪ If based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination (or a statement that such explanation will be provided free of charge upon request). ▪ The Plan's appeal procedures.			If your claim is denied, you will be notified by phone. Within 3 days of the oral denial, claimant must receive a written denial notice, as explained under the general procedure. The denial notice must explain the expedited review process.
Internal Appeals (Benefit Determinations on Review)—Step 2:				
About the Claims Fiduciary Before you can bring any action at law or in equity to recover Plan benefits, you must exhaust this process. Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the Claims Fiduciary. The Plan Administrator or its delegate has delegated its authority to finally determine claims to the Claims Administrators for benefit claims. The Claims Fiduciary is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. All decisions by the Claims Fiduciary are final and binding on all parties.				
	Post-Service Claim	**Pre-Service Claim**	**Concurrent Care Claim**	**Urgent Care Claim**
How to File an Appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim (adverse benefit determination). You may request access, free of charge, to all documents relating to your appeal. You should write to the party identified in your claim denial notice (adverse benefit determination) and include:	180 days.	180 days.	180 days.	180 days. You may orally file your appeal with the Claims Fiduciary for urgent care claims. At the time your claim is denied, the Claims Administrator, as applicable, will give you instructions about how to file your appeal. You must identify that you are appealing an urgent care claim.

	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
▪ A copy of your claim denial notice. ▪ The reason(s) for the appeal. ▪ Relevant documentation.				
The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your initial claim. In addition, if your appeal involves a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.				
When You Will Be Notified of Appeal Decision *(Can require one or two level(s) of appeal(s))*	One level of appeal: within 60 days. Two levels of appeals: within 30 days at each appeal level.	One level of appeal: within 30 days. Two levels of appeals: within 15 days at each appeal level.	Before a reduction or termination of benefits occurs. If involves urgent care, 72 hours.	Within 72 hours.
If appeal is denied in whole or in part, the adverse benefit determination on review must contain	▪ The specific reason(s) for the denial. ▪ The plan provisions on which the denial was based. ▪ A statement regarding the documents to which the claimant is entitled. ▪ An explanation of the voluntary or mandatory appeal procedures, if any. ▪ Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). ▪ If based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination (or a statement that such explanation will be provided free of charge upon request). ▪ The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency." – **Note**: In lieu of including the above statement regarding "voluntary alternative dispute resolution options" in the appeal denial letter, the plan or insurer may include any specific voluntary appeal procedures offered by the plan along with a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA.			

Disability, AD&D, Life, and Other ERISA-Covered Insurance Claims and Appeals

To file a **benefit** claim, write to the applicable Claims Administrator.

	Disability Insurance Subject to ERISA *	AD&D, Life, and Other ERISA Insurance Subject to ERISA
Misdirected Claim	Response time frame begins even if claim is not properly filed.	Response time frame begins even if claim is not properly filed.
When You Will Be Notified of Claim Decision Within the time frame indicated in the columns to the right after receipt	Within 45 days of receipt. Two 30-day extensions are available. Claimant must be notified within the initial 45-day period, and if extended for a second time, within the first 30-day extension period.	Within 90 days of receipt. This period may be extended for an additional 90 days. Claimant must be notified within the initial 90-day period.
Failure to provide sufficient information procedure Claim ***may*** be decided based on the information provided if Claims Administrator decides to request additional information before deciding claim, you will be notified within time frames provided in the columns to the right.	Within 45 days of receipt. (If the original 45-day period is extended due to a request for additional information, the deadline time frame is tolled or suspended.)	Within 90 days of receipt.
You must provide additional information within the time frames provided in the columns to the right. Otherwise, the claim will be decided based on information originally provided.	Within 45 days.	N/A
If claimant provides additional information, notification of the decision must be sent within the time frames provided in the columns to the right.	Within 30 days after receipt of additional information.	N/A
How You Will Be Notified of Decision	If your claim is approved, you generally will be notified in writing. If your claim is denied, in whole or in part, you will be notified in writing. Your denial notice will contain: ▪ Specific reason for denial; ▪ Reference to specific plan provisions on which the decision is based; ▪ Description of any additional information needed to perfect the claim and why such information is necessary; ▪ Describe appeal procedures (e.g., time limits); ▪ Specific rule, guideline, protocol relied upon in making the determination and that a copy is available free of charge; and ▪ An explanation of the scientific or clinical judgments for the determination, applying the terms of the plan (or that the explanation will be provided free of charge).	If your claim is approved, you generally will be notified in writing. If your claim is denied, in whole or in part, you will be notified in writing. Your denial notice will contain: ▪ Specific reason for denial; ▪ Reference to specific plan provisions on which the decision is based; ▪ Description of any additional information needed to perfect the claim and why such information is necessary; and ▪ Describe appeal procedures (e.g., time limits).

	Disability Insurance Subject to ERISA *	AD&D, Life, and Other ERISA Insurance Subject to ERISA
Internal Appeals (Benefit Determinations on Review) *Claimant must exhaust this process before bringing any action at law or in equity*		
How to File an Appeal If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim (adverse benefit determination). You may request access, free of charge, to all documents relating to your appeal. Write to the party identified in your claim denial notice (adverse benefit determination) and include: ▪ A copy of your claim denial notice. ▪ The reason(s) for the appeal. ▪ Relevant documentation.	Within 180 days.	Within 60 days.
When You Will Be Notified of Appeal Decision *(Can require one or two level(s) of appeal(s))*	Within 45 days. This period may be extended for an additional 45 days. Claimant must be notified within the initial 45-day period.	Within 60 days. This period may be extended for an additional 60 days. Claimant must be notified within the initial 60-day period.

In addition, the following provisions apply to disability claims and appeals:

- Disclosure requirements: Disability denial notices will need a more complete discussion of why the Plan denied a clam and the standards it used to make the decision (e.g., explain why a denial occurred if it disagreed with a disability determination made by the Social Security Administration).
- Claim file and internal protocols: Disability claim file must offer that the claimant is entitled to receive the claim file and other relevant documents as part of the claim (not just the appeal).
- Review and respond to new information: Plans may not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage unless the claimant is given a fair opportunity to respond.
- Conflicts of interest: For example, a claims adjudicator or medical expert cannot be hired, promoted or compensated based on the likelihood of such individual denying benefit claims.
- Coverage rescissions: Certain rescissions (retroactive termination) of disability benefits due to alleged misrepresentation of fact (e.g., errors in the application for coverage) must be treated as an adverse benefit determination (i.e., claim denial) which would trigger the Plan's appeal procedures.
- Communication requirements in non-English languages: Adverse benefit determinations of disability benefits must be provided in a "culturally and linguistically appropriate manner." Depending on what county you live in, you may be able to receive such information in Spanish, Chinese, Tagalog, and Navajo.

FERRARA CANDY COMPANY
HIPAA Privacy Notice
Effective 1/1/2021

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.

The group health plan options offered under the Ferrara Candy Company Comprehensive Health and Welfare Benefit Plan, including the Health Flexible Spending Account provisions of the Ferrara Candy Company Cafeteria Plan (referred to in this Notice as the "Health Plan") may use or disclose health information about participants (employees and their covered Dependents) as required for purposes of administering the Health Plan, such as for reviewing and paying claims and conducting a utilization review.

This notice does not apply to the Ferrara Candy Company as the plan sponsor of the Health Plan or to the non-health care component(s) of the Health Plan. If you participate in a fully insured health care coverage option offered under the Health Plan, the applicable insurer will provide you with a separate HIPAA notice of privacy practices which will describe how the insurer will protect the health information it creates or receives in providing coverage to you. This notice will apply to any individually-identifiable health information received by the Health Plan from the applicable insurer, as well as the individually-identifiable health information created or received by the Health Plan in providing the self-insured coverages to you.

If you have a question, concern, complaint, or request regarding your protected health information (PHI) held by a business associate of the Health Plan, contact the business associate directly using the contact information contained in the summary plan description or on your insurance cards. If you have a question, concern, complaint, or request regarding your PHI held internally at Ferrara Candy Company by the Health Plan's workforce members, please contact 1-773-243-4300.

Please note that the rest of this notice uses the capitalized word, **"Health Plan"** to refer to Health Plan described above, including the Health Plan's workforce members, as well as any business associates who handle health information under contract with the Health Plan.

As required by federal law, this notice is being provided to you to describe the Health Plan's HIPAA Administrative Simplification Policies and Procedures. It also provides details regarding certain rights you may have under federal (and state) law regarding medical information about you that is maintained by the Plan.

You should review this notice carefully and keep it with other records relating to your health coverage. The Health Plan is required by law to abide by the terms of this notice while it is in effect. **This notice is effective beginning 1/1/2021** and will remain in effect until it is revised.

If the Health Plan's HIPAA Administrative Simplification Policies and Procedures are changed so that any part of this notice is no longer accurate, the Health Plan will provide a new updated privacy notice. The Health Plan reserves the right to apply any changes in its health information policies retroactively to all health information maintained by the Health Plan, including information that the Health Plan received or created before those policies were revised.

This notice describes how Health Plan information about you may be used and disclosed and how you can get access to this information:

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 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, and we may say “no” if it would affect your care.

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 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 on first page 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., Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/hipaa/filing-a-complaint/index.html**.
- We will not retaliate against you for filing a complaint.

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.

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.

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: Ferrara Candy Company contracts with us to provide a health plan, and we provide your Company with certain statistics to explain the premiums.

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/hipaa/for-individuals/guidance-materials-for-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/hipaa/for-individuals/guidance-materials-for-consumers/index.html**.

Changes to the Terms of this Notice
Again, 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, and we will mail a copy to you.

Administrative Information

This section contains important information about how your health and welfare benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

Plan Name/Identification

The benefits described in this SPD are governed by the following Plan documents, which are governed by the Employee Retirement Income Security Act of 1974 (ERISA) and subject to the reporting and disclosure requirements of this law:

- The official Plan document for the Component Benefits governed by ERISA and described in this Summary Plan Description (SPD) is the **Ferrara Candy Company Comprehensive Health and Welfare Benefit Plan**. The Component Benefits governed by ERISA and covered by this SPD are medical, including prescription drug, dental, vision, STD, LTD, life insurance, AD&D, Health Care FSA, accident insurance, critical illness insurance, hospital indemnity insurance, group legal services, and the EAP.
- The official Plan document for the "cafeteria" plan provisions described in this SPD is the **Ferrara Candy Company Cafeteria Plan** which is incorporated into the **Ferrara Candy Company Comprehensive Health and Welfare Benefit Plan** as applicable. The "cafeteria" plan document applies to your ability to pay for these benefits on a pre-tax basis, including the ability to contribute to a Health Care FSA, Dependent Care FSA, and I on a pre-tax basis, and the requirements that apply to that ability, such as the Midyear change in status rules. The Health Care FSA is subject to ERISA and the Dependent Care FSA and I are not subject to ERISA.

The Ferrara Candy company Comprehensive Health and Welfare Benefit Plan, including the Health Care FSA component of the Ferrara Candy Company Cafeteria Plan, is listed with the U.S. Department of Labor under the Company's employer identification number 36-3331581 and the Plan number 501.

History

The Ferrara Candy Company Comprehensive Health and Welfare Plan was previously identified as the Ferrara Candy Company, Inc. Group Insurance Plan (which included the Health Care FSA). As of January 1, 2021, the Ferrara Candy Company, Inc. Group Insurance Plan was amended and restated as the Ferrara Candy Company Comprehensive Health and Welfare Plan.

Plan Information

The Plan documents consist of:

- The official Plan documents referenced above.
- This document, which is the Summary Plan Description (SPD) for the ERISA-governed plans, including the Incorporated Documents (See Appendix A).
- Applicable Summaries of Material Modifications (SMMs), including annual enrollment materials (often referred to as the Open Enrollment Benefits Guide) identified as SMMs.
- "Plan materials," which means updates to a Component Benefit issued by a third-party administrator or insurer, for example, through an online benefit description or booklet, to the extent that such update is approved by the Plan Administrator or a delegate of the Plan Administrator.
- Insurance contract(s).

Plan Administration Information

Plan Sponsor/Employer	Ferrara Candy Company 404 W. Harrison Street, Suite 650 Chicago, IL 60607
Plan Administrator	Ferrara Employee Benefits Advisory Committee (EBAC) C/o Director of Total Rewards 404 W. Harrison Street, Suite 650 Chicago, IL 60607 Telephone: 773-243-4300
Claims Administrators	See "*Plan Contacts*" section of this SPD
Agent for Service of Legal Process	The Plan Administrator Ferrara Candy Company 404 W. Harrison Street, Suite 650 Chicago, IL 60607 ATTN: Legal Department
Plan Year	January 1–December 31

Funding and Source of Contributions

Benefit Option (Component Benefit)	**Funding information and source of contributions**
Medical and Prescription Drug	Self-insured Employer and employee contributions (pre-tax); after-tax when aligned with Domestic Partner coverage
Dental	Self-insured Employer and employee contributions (pre-tax)
Vision	Fully insured Employee contributions (pre-tax)
STD Insurance	Self-insured Employer contributions
Basic LTD Insurance	Fully insured Employer contributions
LTD "Buy-Up" Insurance	Fully insured Employee contributions (after-tax)
Basic Life Insurance	Fully insured Employer contributions (after-tax)
Supplemental Voluntary Life Insurance	Fully insured Employee contributions (after-tax)
Dependent Voluntary Life Insurance	Fully insured Employee contributions (after-tax)
Basic AD&D Insurance	Fully insured Employer contributions
Voluntary AD&D Insurance	Fully insured Employee contributions (after-tax)
Dependent Voluntary AD&D Insurance	Fully insured Employee contributions (after-tax)
Health Care FSA	Self-insured Employee contributions (pre-tax)
Dependent Care FSA (not subject to ERISA)	Employee contributions (pre-tax) Employer *may* make contributions, as communicated as part of annual enrollment in the Open Enrollment Benefits Guide
HSA (not subject to ERISA)	Employee contributions (pre-tax) and employer contributions Employer *may* make contributions, as communicated as part of annual enrollment in the Open Enrollment Benefits Guide

Benefit Option (Component Benefit)	Funding information and source of contributions
Accident Insurance	Fully insured Employer contributions for HDHP/I option Employee contributions for all other medical options (after-tax)
Critical Illness Insurance	Fully insured Employee contributions (after-tax)
Hospital Indemnity Insurance	Fully insured Employee contributions (after-tax)
Group Legal Services	Fully insured Employee contributions (after-tax)
Employee Assistance Plan	Fully insured Employer contributions

Self-Insured Plans
The Company pays a fee to an outside organization to process claims for the self-insured plans (i.e., contract administration). The fees and all benefit payments are paid from company revenues. None of the self-insured benefit plans guarantee benefits under a contract or policy of insurance. The administrators of self-insured options (e.g., BCBS-IL, MetLife, and Optum Financial) administer the benefits under the options.

Fully Insured Plans
The Company pays an insurance company or other provider a premium—from company revenues—for providing coverage under the fully insured plans (i.e., insurer administration). The insurance company or other provider processes claims and makes all benefit payments from a policy of insurance.

The Claims Administrator and its Authority to Review Claims

The Plan Administrator has delegated its authority to finally determine claims and appeals to the Claims Administrators. In some cases, the Plan Administrator delegates the authority to finally determine claims to certain other organizations on behalf of Company; the organizations listed as the Claims Administrators are the claims and appeals fiduciaries with respect to ERISA-covered benefits, as noted. Benefits under the Plan are paid only if the Plan Administrator, or its delegate, decides in its discretion that the applicant is entitled to them.

The Claims Administrators have:

- The authority to make final determinations regarding eligibility and benefit claims under the Plan.
- Discretionary authority to:
  - Interpret the Plan based on provisions and applicable law and make factual determinations about claims arising under the Plan.
  - Determine whether a claimant is eligible for benefits.
  - Decide the amount, form and timing of benefits.
  - Resolve any other matter under the Plan that is raised by a participant or a beneficiary or that is identified by the Claims Administrator.

In case of an appeal, the Claims Administrator's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the participant or beneficiary later proves that a Claims Administrator's decision was an abuse of administrator discretion.

No Employment Rights or Guarantee of Benefits

All terms of the Plan are legally enforceable. However, neither the Plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

Misrepresentation or Fraud

If you or your Dependent makes a false or misleading statement that is material to your claim for benefits, you must repay all amounts paid by the Plan and will be liable for all costs of collection, including attorneys' fees. Alternatively, the Plan Administrator may offset against future benefit payments any amount paid to you to which you were not entitled. It is the Plan Administrator's sole decision on whether to demand repayment or offset future payments, and you agree to abide by that decision. The Plan Administrator has the authority to take any additional action as may be deemed necessary to make the Plan whole, in accordance with the law. The Plan Administrator reserves the right to rescind your participation in the Plan if you or your Dependent performs an act, practice, or omission that constitutes fraud or if you or your Dependent makes an intentional misrepresentation of material fact. However, any retroactive cancellation of group health benefits subject to the ACA will comply with the ACA's limitations and requirements for rescission of coverage.

Amendment/Termination

Although the Company presently intends to continue the Plan, it reserves the right to, at any time, amend or terminate any and all health and welfare benefits under the Plan, to amend or terminate the eligibility of classes of employees, Eligible Retirees, and/or Dependents to be covered by the Plan, to amend or eliminate any other term or condition of the Plan, and to terminate the entire Plan, or any part, subject to applicable law. The procedures by which these actions may be taken are contained in the legal Plan document, which is available for inspection and copying from the Plan Administrator.

No consent of any participant is required to amend or terminate the Plan.

Termination of the Plan will have no adverse effect on any benefit payments to be made under the Plan for any covered expenses incurred prior to the date that the Plan terminates. Likewise, any extension of benefits under the Plan due to your or your Dependent's total disability which began prior to and has continued beyond the date the Plan terminates will not be affected by the Plan's termination. No extension of benefits or rights will be available solely because the Plan terminates.

Outcome of Covered Services and Supplies

The Company is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies for which you receive benefit payments under the Plan.

You are solely responsible for your choice of health care providers, services, and/or supplies. Obtaining health care and determining which provider, service, and/or supply to use shall not be construed, interpreted, or deemed as resulting from the Plan or any Incorporated Document.

You must decide as to your health care independent of any determinations to whether benefit payments will or will not be made under the Plan for that health care. The determination of whether or not health care is medically necessary is made solely for purposes of determining whether benefit payments will be made under the Plan and is not intended to be advice to you about your health care.

Unclaimed Funds

If you fail to file a claim using the Plan's procedures, or you fail to accept or cash a claim reimbursement check within 120 days after the reimbursement check has been issued, and the Plan Administrator has made a reasonable attempt to reimburse you, the funds will be considered unclaimed and will be treated as Plan forfeitures. However, if you should later renew your written claim for reimbursement of the forfeited amount, the Company will reimburse that amount to you within 90 days of the renewed claim.

However, for an insured benefit, the applicable Incorporated Document will govern the handling of any unclaimed funds.

Non-Assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payment provided by the Plan before receipt of that benefit payment. However, benefits will be provided to your Child if required by a Qualified Medical Child Support Order. In addition, subject to your written direction, all or a portion of benefit payments provided by the Plan may, at the option of the Plan, and unless you request otherwise in writing, be paid directly to the provider rendering a service to you. Any benefit payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Company to the extent of such payment.

In addition, you may not assign your rights to bring a lawsuit under the Plan to any providers or other persons who may provide or render any treatment or services to you or your Dependents.

Right of Recovery

If, for some reason, a benefit payment is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency that received or holds this benefit payment. This excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding benefit payments must produce any instruments or papers necessary to ensure this right of recovery.

Reimbursement

This section applies when you recover damages (by settlement, verdict, or otherwise) for an injury, illness, or other condition, including death. If you have received, or in the future may receive, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat the injury or illness or the treatment of the injury or illness. These benefits are specifically excluded.

If the Plan does advance moneys or provide care for the injury, illness, or other condition, you must promptly send to the Plan the moneys or other property that you receive from any settlement, arbitration award, verdict, insurance proceeds, or monetary recovery from any party for the reasonable value of the health benefits advanced or provided to you by the Plan, regardless of whether or not:

- You have been fully compensated or made whole for your loss.
- You or any other party admits to liability.
- The recovery is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan has first priority to receive reimbursement for any payments made on your behalf, before payment is made to you or any other party. This reimbursement is required from any recovery you make, including uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners, or otherwise); workers' compensation settlements, compromises, or awards; other group insurance (including student plans); and direct recoveries from liable parties.

In order to secure the Plan's rights when it makes benefit payments in these situations, you must acknowledge and agree to the following when you accept benefit payments from the Plan:

- Acknowledge that the Plan has first priority against the proceeds of any such settlement, arbitration award, verdict, or other amounts you receive.
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by you or any other person, are being held for the benefit of the Plan.
- Assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement.

- Cooperate with the Plan and its agents, provide relevant information, and take actions that the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of benefit payments made.
- Consent to the Plan's right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section.
- Consent to the Plan's right to deduct from any future benefit amounts otherwise payable under the Plan the value of benefit payments advanced under this section to the extent not recovered by the Plan.
- Agree to not take any action that prejudices the Plan's rights of reimbursement.

The Plan is responsible only for those legal fees and expenses to which it agrees in writing. You cannot incur any expenses on behalf of the Plan in pursuit of the Plan's rights under this Section. Specifically, no court costs or attorney's fees can be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

If you retain an attorney, you are wholly responsible for all attorney's fees or other expenses incurred to obtain a recovery. If the attorney(s) you retain in relation to an injury, illness, or other condition brings a separate claim or lawsuit against the Plan to recover his/her attorney's fees under the "Common Fund Doctrine", quantum meruit, unjust enrichment or other similar state laws, you will be required to reimburse the Plan from the money you received as part of your recovery as a result of your injury, illness, or other condition for: 1) any money judgment entered against the Plan in the lawsuit brought by the attorney; and 2) the Plan's attorney's fees and costs defending the lawsuit, regardless of whether the Plan prevails or loses. You shall fully indemnify, hold harmless and defend the Plan from and against any such claims or lawsuits.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest, and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefit payments advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary or covered person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party (including insurance carriers who are financially liable) is, or may be considered, liable for your injury, illness, or other condition, including death, and the Plan has advanced benefit payments. Subrogation is similar to reimbursement but allows the Plan to "step into your shoes" and obtain a payment from a third party who was negligent or responsible for your injury or illness. This occurs when the Plan has to make a benefit payment due to your injury, illness, or other condition, but would not have owed the payment if the third party had not caused the problem.

In consideration for the advancement of benefit payments, the Plan is subrogated to all of your rights against any party liable for your injury, illness, or other condition, including death, or which is or may be liable for the payment for the medical treatment of the injury or occupational illness (including any insurance carrier), to the extent of the value of the health benefit payments advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, the covered person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not

obligated in any way to pursue this right independently or on your behalf but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that you fail to cooperate with this provision, including executing any documents required herein, the Plan will, in addition to remedies provided elsewhere in the Plan and/or under the law, offset from any future benefit payments otherwise payable under the Plan the value of benefit payments advanced under this section to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation are borne solely by you.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts 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, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- 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 or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

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 up to $110 a day (as indexed) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the internal claims and appeals procedures available under the Plan, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the 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 write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Glossary

Affidavit of Tax Status
An Affidavit in which you attest that your Domestic Partner (and if applicable, his/her Children) are IRS Tax Dependents for group health plan purposes. If you cover a Domestic Partner (and his/her Children) and do not complete an Affidavit of Tax Status, you will be taxed on the value of the coverage provided to such individuals.

Air Ambulance
Medical transport by rotary wing (helicopter) or fixed wing (airplane) air ambulance as defined by federal law.

Ancillary Services
Items and services provided by out-of-network providers or nonparticipating providers at a network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary of Health and Human Services;
- Provided by such other specialty practitioners as determined by the Secretary of Health and Human Services; and
- Provided by an out-of-network physician when no other network physician is available.

Cafeteria Plan
Ferrara Candy Company Cafeteria Plan.

Company
The employer/plan sponsor, Ferrara Candy Company

Child(ren)
- Your child(ren) under age 26, including your:
  - Natural child(ren),
  - Legally-adopted child(ren),
  - Child(ren) placed for adoption,
  - Stepchild(ren),
  - Child(ren) for whom you or your Spouse have legal guardianship,
  - Child(ren) for whom you or your Spouse have legal responsibility, and
  - Foster child(ren) that live with you and for whom you are the primary source of financial support.

  Coverage ends on the last day of the month following attainment of age 26. Your child(ren) is/are not subject to restrictions such as residency, marriage, financial dependency, or student status that would run afoul of the Affordable Care Act.

- Your child(ren), as defined above, age 26 and older who have a physical or mental disability which began ***prior to*** attaining age 26 who are unable to support themselves and are chiefly dependent on you for support and maintenance. The Plan Administrator has the right to require proof of continuing disability.

Note: The definition of a Dependent may be different for purposes of life insurance coverage. Please see the applicable certificate of insurance for more information. Contact the Claims Administrator for questions or to request such detail, free of charge.

Code
The Internal Revenue Code.

Component Benefits
The benefits described in this SPD including the applicable Incorporated Documents.

Dependents
- Spouse.
- Domestic Partner.
- Child(ren), including those of a covered Domestic Partner.
- Child(ren) for whom health benefit coverage is required through a qualified medical child support order ("QMCSO").

Note: An eligible dependent for Dependent Care Spending Account purposes is addressed in the Dependent Care Spending Account section of this SPD.

Domestic Partner (or Domestic Partnership)
Domestic partnership by government registration. You and your partner have registered as domestic partners under the laws of any state or local (e.g., county or municipality) government domestic partner registry.

Domestic partnership by "Company registry." In order to qualify as a Domestic Partnership without a government registration, you and your partner must satisfy all of the following and complete an affidavit certifying compliance with these requirements:

1. Share the same principal residence for at least six months and intend to do so indefinitely;

2. Have an exclusive and committed relationship of mutual caring of at least six months and intend to remain domestic partners indefinitely;

3. Are not related by blood closer than would prohibit marriage in your state of residence;

4. Are jointly responsible for each other's common welfare and shared financial obligations;

5. Are both 18 years of age or older and competent to contract; and,

6. Neither have another Spouse or domestic partner or civil union partner or spouse equivalent of the same or opposite sex.

7. Neither of us has been in a domestic partnership, civil union, or marriage with any other person within six months prior to designating each other as domestic partners in the Affidavit of Domestic Partnership provided to the Company.

Eligible Employee
A common law employee of the Company that meets the definition of a Full-Time Non-Union Employee, a Full-Time Union Employee, or a Full-Time META Employee.

Emergency Medical Care (Emergency Services)
Services that a medical provider, exercising prudent clinical judgment, would provide to an individual experiencing an emergency medical condition, including:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as appliable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as appliable, such further medical examination and treatment as required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished.

Emergency Medical Condition
A medical condition (including a mental health condition or substance use disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

Full-Time META Employee
A common law, U.S. based employee of Michel et Augustin ("META") who is on the permanent payroll of META and is expected to work and actively working a minimum of 30 hours per week. Full-Time META Employees are eligible for coverage under the Plan as described in this SPD as of March 1, 2024. META is a participating company within the Company's controlled group as that term is defined by the Code.

Full-Time Non-Union Employee
A common law employee of the Company who:

- Is not a member of a union.
- Is not seasonal.
- Is on the permanent payroll of the company, and
- Is expected to work and actively working a minimum of 30 hours per week.

Full-Time Union Employee
A common law employee of the Company who:

- Is a member of a collective bargaining agreement listed in Appendix B.
- Is not seasonal.
- Is on the permanent payroll of the Company, and
- Is expected to work and actively working a minimum of 30 hours per week.

Incorporated Documents
The supplemental descriptions of the Component Benefits listed in Appendix A to this "wrap" SPD; the Incorporated Documents are a part of the SPD.

IRS Tax Dependent

An IRS Tax Dependent for medical, prescription drug, dental, vision, and Health Care FSA purposes is an individual whose coverage under the Plan does not result in additional income to you. It does not reflect who is eligible under the Plan, which is a separate requirement outlined in the Eligibility section of this SPD. While the Company always recommends that you consult with a tax adviser, the definition provided here is a summary of these complex rules.

General Rule

Your Spouse is an IRS Tax Dependent, as defined by IRS (federal) rules. In addition, your Child (meaning your son, daughter, stepson, stepdaughter, or eligible foster child placed with you by an authorized placement agency or by order of a court of competent jurisdiction) who has not attained the age of 27 as of the end of the taxable year is an IRS Tax Dependent. A son or daughter includes your legally adopted Child or a Child who is lawfully placed with you for adoption. A domestic partner's child generally will not be your (the employee's) IRS Tax Dependent unless he/she meets the definition of a "qualifying relative"; that generally will not be the case unless your domestic partner also is your IRS Tax Dependent.

Other Categories

Otherwise, an individual may be your IRS Tax Dependent if he or she is a U.S. citizen or resident who is a "qualifying child" or a "qualifying relative."

A "qualifying child" generally is a person who meets the following criteria:

- Is younger than you.
- Is unmarried (i.e., has not filed a joint tax return during the calendar year at issue).
- Is under the age of 19 (or 24 in the case of a student) or is permanently and totally disabled.
- Is your Child, grandchild, brother, sister, stepbrother or stepsister or niece or nephew.
- Does not provide over one half of his or her own support for the calendar year.
- Lives with you for more than one-half of the calendar year.

A "qualifying relative" generally is a person who meets the following criteria:

- Is not your qualifying child or any other taxpayer's qualifying child during the calendar year.
- Receives over one-half of his or her financial support from you for the calendar year.
- Is "related to you" or "lives with you for the entire calendar year as a member of your household."

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a Dependent Child under the Company's health care (medical, prescription drug, dental, and/or vision) plans.

You may obtain a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator (see the "*Administration Information*" section). To be qualified, the medical child support order must meet the requirements of section 609 of ERISA, including:

- The name and last known mailing address of the participant and the name and mailing address of each alternate recipient (Dependent Child subject to the order);

- A description of the coverage type to be provided by the Plan to each alternate recipient (e.g., medical, prescription drug, dental, and/or vision etc.);

- The period to which the order applies; and
- Each Plan to which the order applies.

In any case, if subject to an order, you and each Child will be notified about further procedures.

Spouse

A person of the opposite or same sex who is a husband or wife, pursuant to a legal union defined as a "marriage" conducted by any domestic or foreign jurisdiction having the legal authority to sanction marriages, which are recognized by any state, possession, or territory of the United States.

Incorporated Documents

- Blue Cross and Blue Shield of Illinois
  - Medical PPO, # P68379
  - Medical HDHP1, # P41003
  - Medical HDHP2, # PL3171
- CVS/Caremark
  - Prescription Drug, # 3650
- MetLife Dental
  - Dental, # 0235830
- EyeMed
  - Vision, Policy # 9920745
- Prudential
  - Short-Term Disability, # 71249
  - Long-Term Disability, Policy # 71249
  - Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, Policy # 71249
  - Supplemental Voluntary Life and AD&D Insurance, Policy # 71249
  - Dependent Voluntary Life Insurance and AD&D, Policy # 71249
- Voya
  - Critical Illness Insurance, Policy # 00702994
  - Accident Insurance, Policy # 00702994 or 70299-4CAC (if enrolled in HDHP)
  - Hospital Indemnity, Policy # 00702994
- Legal ARAG
  - Group Legal Services, Policy # 18466
- Allstate Identity Protection (formerly InfoArmor)
  - Group Identity Theft Services, Policy # 2823
- Optum Financial
  - Health Care FSA and Dependent Care FSA, # 156499 (Dependent Care FSA is not subject to ERISA)
  - Health Savings Account, # 156499 (HSA is not subject to ERISA)
- CuraLinc
  - Employee Assistance Program (EAP), Policy # 04139
- Maven
  - Maven Wallet for Ferrara Candy Company

Appendix B

- As of January 1, 2024, no Collective Bargaining Units participate in the Plan.