



# **EMPLOYEE BENEFITS PLANS**

**Provided Under  
Collective Bargaining Agreement  
Between  
ITG Brands  
And  
Bakery, Confectionery, Tobacco Workers, and  
Grain Millers International Union  
(AFL-CIO-CLC)**

**Greensboro, N.C. • Local No. 317-T  
October 1, 2023 – September 30, 2027**

## INTRODUCTION

As an hourly-rated employee of ITG Brands, covered under the collective bargaining agreement mentioned below, you are eligible to participate in the benefits plans described in this booklet.

Some of the benefits are provided at no cost to you; others provide coverage for you and your dependents on a cost-sharing basis, if you elect to have the coverage.

This summary contains the basic terms of the plans and answers some of the most frequently asked questions. If you have any questions not answered here, please contact your local Benefits Department.

The descriptions that follow merely summarize the plans provided. This booklet, together with any separate booklet or contract more particularly describing the terms of any benefit listed in this booklet, together constitute the Summary Plan Description for each welfare benefit unless a separate Summary Plan Description is provided. Unless the summary description states that it is the plan document, the full details are contained in the Plan Documents and insurance contracts which provide the welfare benefits, or in the Plan and Trust documents which provide the Retirement, Profit Sharing and 401(k) Plan benefits.

Benefits provided under  
Collective Bargaining Agreements  
Negotiated with  
Local 317-T Greensboro

Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC)  
Agreement effective October 1, 2023 to September 30, 2027

**Life, AD&D, A&H,  
Healthcare**

# LIFE, AD&D, A&H, HEALTHCARE

## LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, ACCIDENT AND HEALTH, HEALTH CARE PLANS

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## **GROUP TERM LIFE INSURANCE**

### **As amended**

On effective date of December 1, 2023.

### **You are eligible for Group Term Life Insurance**

on your 91st day of employment. Coverage is automatic on that day.

### **The cost of your life insurance**

is paid entirely by the Company.

### **The amount of life insurance you have**

Effective December 1, 2023 is \$150,000 while you are actively employed. If you are eligible for the Company's Retirement Allowance Plan and retire from active service under the Plan, your insurance will continue but the amount is reduced to \$55,000.

If you are eligible for the Company's Retirement Allowance Plan and retire on disability, your coverage will be \$150,000 until you reach age 65, when it will be reduced to \$55,000.

### **If the life insurance should become payable**

the benefit will be paid to the person you have named as your beneficiary. You can also name a second beneficiary to receive the benefit, in case your first beneficiary does not survive you. You can also name more than one beneficiary to share in the benefit. If you do name more than one person, you must state what part (50%, 30%, etc.) each person should receive and the total should equal 100%.

### **You can name or change your beneficiary**

at any time. Complete a new beneficiary form, found in your local P&C office, giving the name of your new beneficiary(is) and their relationship to you. You must *sign and date* the beneficiary form and it must be received by the Company prior to your death in order for it to be valid. If the insurance benefit becomes payable, your beneficiary will be advised to submit whatever documents are necessary to have the claim paid.

### **If your family status should change**

because of marriage, divorce, or death, you should review your beneficiary choice to be sure that you have named the person (or persons) you wish to receive the life insurance benefit.

### **Your life insurance will remain in force**

for as long as you are employed by the Company. If you are eligible for the Company's Retirement Allowance Plan, and retire on a Disability pension before age 60, coverage will remain in force to age 65. If you are laid off, or are on an authorized leave of absence, other than pregnancy or illness leave, your life insurance will be continued for 3 months after the end of the month in which you leave; then it is terminated.

If you are recalled after your layoff, your coverage will start as soon as you return to work, if you had been covered when layoff occurred. If you were not covered when layoff occurred, your coverage would start on the 91<sup>st</sup> day of employment.

### **After your insurance has been terminated**

there is a 31 day “grace period” during which you can apply to the insurance company to purchase a personal life insurance policy.

Should your employment end for any reason other than retirement, you can buy any amount of insurance up to \$150,000. Consult your local P&C team for details.

If your employment ends due to retirement under the Company’s Retirement Allowance Plan, you may purchase any amount of insurance up to \$55,000 offered to eligible retirees. Consult your local P&C team for details.

If your death should occur during the grace period, your beneficiary would receive payment of the full benefit amount.

### **During a pregnancy leave**

your life insurance is continued for the full period of your authorized leave.

### **During an illness leave**

your life insurance will continue for the full period of your authorized leave (up to 24 months). Then, if you are eligible for the Company’s Retirement Allowance Plan and retire on disability before age 60, your insurance will continue in full to age 65, and be reduced at that time to \$55,000.

If you are *not* eligible for Retirement under the Company’s Retirement Allowance Plan, your insurance is terminated at the end of your leave, and you may purchase a personal policy.

### **The premium rate**

under the conversion privilege will depend upon actuarial factors in use by the insurance company at the time of your application. When you convert to a private policy from Group Term Life Insurance, no physical examination is required to prove that you are insurable.

### **Application for conversion**

must be made within the 31 day grace period. You will receive information from the insurance company regarding conversion options.

## OPTIONAL GROUP TERM LIFE INSURANCE

### As amended

On effective date of December 1, 2023.

### You are eligible to elect Optional Group Term Life Insurance

on your 91st day of employment or if you experience Qualifying Life Event or during annual Open Enrollment period.

### The cost of your life insurance

is paid entirely by you.

### The optional life insurance you can elect is as follows:

- Dependent Life Spouse  
Increments of \$10,000 up to \$250,000
  - Newly hired employees can elect up to \$50,000 without submitting information to insurance company to satisfy Evidence of Insurability (EOI). Any amount over \$50,000 will require approval from insurance company.
  - All other elections will require EOI/approval from the insurance company.
- Dependent Life Child(ren)
- \$5,000 or \$10,000 in coverage (regardless of number of dependent children up to age 26)
  - No EOI required.

### If the life insurance should become payable

the benefit will be paid to you.

### Your life insurance will remain in force

for as long as you remain enrolled in the coverage and continue to pay premiums.

### After your insurance has been terminated

there is a 31 day "grace period" during which you can apply to the insurance company to purchase a personal life insurance policy.

## ACCIDENTAL DEATH & DISMEMBERMENT

### Continued

On effective date of December 1, 2023.

### Accidental Death and Dismemberment insurance (AD&D)

is provided at no cost to you, and is in addition to the term life insurance just described.

### You are eligible for AD&D coverage

when you become eligible for group term life insurance coverage on your 91<sup>st</sup> day of employment. Coverage is automatic on that day.

### Benefits will be payable under this plan

if, as a direct and exclusive result of an accidental injury, you

- lose your life;
- suffer dismemberment (lose a hand, foot, eye).

### One-half the full value (\$20,000)

will be paid to you if, within 90 days following an accidental injury you lose

- one hand, or
- one foot, or
- one eye

### The full value (\$40,000)

will be paid to you if, within 90 days following an accidental injury you lose

- sight in both eyes;
- both hands, or both feet;
- one hand and one foot;
- one foot and sight in one eye;
- one hand and sight in one eye

### In the event of your death

within 90 days following an accident, and resulting directly and exclusively from such accident, payment of \$50,000 will be made to your beneficiary. Unless you elect, in writing, a different beneficiary, payment will be made to the person(s) you named as beneficiary under the term life insurance plan.

### Limitations under the AD&D Plan are:

- your death or dismemberment must be caused directly and exclusively by the accident;
- no benefits will be paid if the injury or loss of life are the result of
  - intentionally self-inflicted injury;

- suicide or attempted suicide, whether sane or insane;
- war or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while Intoxicated.

**Intoxicated** means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances; that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

**Your AD&D insurance will terminate**

on the date your employment terminates for any reason (including retirement) or whenever your life insurance is not in effect. There is no grace period and no conversion privilege to a personal policy from the Group coverage.

## ACCIDENT AND HEALTH BENEFIT (A&H)

### As amended

On effective date of contract as shown in the introduction.

### The Accident and Health benefit plan (A&H)

is meant to provide you with income when you cannot work because of injury or illness. The Company pays the full cost of the plan.

### Your coverage begins

on the first of the month following 6 months of employment.

### The benefit amount payable

is 50 % of base pay to a maximum of \$550 per week. Partial weeks are paid proportionately on the basis of 7 calendar days per week.

### The waiting period

before benefits begin is 7 consecutive calendar days. Benefits will start on the 8th day of disability. You must be under the care of a qualified physician (see Definitions, page 26).

### The length of time

you may draw benefits depends on your particular illness.

Generally, you may receive up to 26 weeks of A&H benefits. However, if your absence is due to any of the following, you may receive benefits for up to 39 weeks:

Cancer	Polio
Heart Attack	Typhoid
Stroke	Hepatitis
Coma	Diphtheria
Rabies	Kidney disease requiring dialysis
Spinal or Viral Meningitis	Acquired Immune Deficiency Syndrome
Brain Tumor	Multiple Sclerosis
Joint Replacement	Bypass Surgery
Rotator Cuff Surgery	Organ Transplant Recipient
Alzheimer's Disease	ALS

The Company doctor will determine on a non-discriminatory basis if any illness, in addition to those listed above is considered catastrophic, and qualifies for 39 weeks of benefits.

### If you are on a 26 week A&H leave

and contract one of the above diseases, you will be entitled to the difference between the time used and 39 weeks, without returning to work.

### **If you return to work**

- for less than 14 calendar days and are again disabled from the same (or a related) cause, the periods of disability absence are counted together as one disability period.

You need not satisfy another 7-day waiting period, but benefits will be paid only for the remaining number of weeks in the 26 (or 39) week benefit period.

- for 10 or more working days and are disabled again from the same or related cause, you will be eligible for another benefit period. However, you must satisfy another 7-day waiting period before benefits begin.
- for any length of time and are disabled for a cause unrelated to your previous disability, you will have a new benefit period, after you satisfy a new 7-day waiting period.

### **If you experience another disability while on approved A&H leave from a cause unrelated to your previous disability**

the periods of disability absence are counted together as one disability period. Your benefit period will continue, but benefits will be paid only for the remaining number of weeks in the 26 or 39 week benefit period.

### **If you become disabled while on vacation**

and are under the care of a qualified physician, those vacation days when you are disabled will count toward the 7-day period. However, you will not receive an A&H benefit for vacation days.

### **If your disability is work-related**

the A&H benefit will not be payable. However, if benefits received under Workers' Compensation laws are less than your A&H benefit would be, this plan will pay the difference between the Workers' Compensation benefit and the A&H benefit amount.

### **If you are disabled when you are due to return from a personal leave of absence**

you will be eligible for A&H benefits after the 7-day waiting period, counted from the day you were due to return to work from your leave.

### **To file a claim for A&H benefits**

notify the Medical Department as soon as possible, but *not later than 7 days* from your last day of work. You will be given the necessary forms and instructions.

### **Your benefit payments stop**

when you leave the Company, are on a personal leave, or are laid off. However, if you are on A&H leave and eligible to receive benefit payments at the time of termination or layoff, you will continue to receive benefit payments for the balance of your approved disability period.

### **Benefit payments will not be paid**

- for any period of disability during which you
  - are *not* under the direct care of a licensed physician;
  - performed any work for remuneration or profit;
  - received, or are entitled to receive benefits under any unemployment compensation law of any state or federal government;
- for disability due to intentional self-inflicted injuries;

- for disability which started before the effective date of your coverage;
- unless you worked (or were on vacation) during the payroll week immediately *before*, or in the payroll week in which the disability began.

**There is no conversion**

to a personal policy when your coverage under this plan ends. This plan is self-insured by the Company.

## HEALTH PLANS — IN GENERAL

### As Amended

Effective September 1, 2017, unless specifically noted otherwise.

#### **(NOTE:**

The items in this section which have an asterisk (\*) also apply to the Dental and Vision Care Plans described starting on page 17.)

\*The Health Care coverage benefits described in this section provide protection for you and your eligible covered dependents when you are faced with medical expenses due to illness or accident. However, no benefits will be paid if injury or illness are

- job related. You (or your eligible dependent) will receive whatever benefit is payable under applicable Workers' Compensation laws;
- a result of participation in, or as a result of, commission of a felony;
- a result of actions or situations where legal authorities have determined that you (or your eligible dependent) were the aggressor.

#### **\*Your coverage begins**

automatically on the 91st day of employment.

#### **\*Your coverage levels available are**

##### **Employees hired prior to September 1, 2017:**

- Employee Only
- Employee Plus One Dependent
- Full Family
- Both Spouses ITG Brands Hourly Employees
- Both Spouses ITG Brands Hourly Employees (One Pre 9/1/11 and One Post 9/1/11)

##### **Employees hired September 1, 2017 and later:**

- Employee Only
- Employee Plus Spouse
- Employee Plus Child(ren)
- Family

#### **\*Your eligible dependents are:**

- your spouse, unless legally separated;
- your children from birth to end of month in which they reach age 26;
- your mentally or physically handicapped child over age 26, if the disability occurred before age 26, and if the child is incapable of self-sustaining employment; (Contact

your local P&C team about this continued coverage);

- a legally adopted child, or a child placed for adoption, or a child for whom legal guardianship has been awarded to the employee or employee's spouse up to end of the month in which they reach age 26.

### **\*Your eligible dependents' coverage begins**

when yours does, if you have chosen to cover them.

Note:

If an eligible dependent under age 26 works either part or full-time, he or she can continue to be insured under our plan. However, if the dependent's employer provides health benefits that covers the dependent, the Coordination of Benefits provision discussed later in this booklet will apply, with the dependent's employer's plan being the primary plan.

### **\*If you don't enroll your eligible dependents**

when you are first eligible to do so, and later decide that you want your eligible dependents to be covered and there has been no status change (described below), coverage will begin on January 1st following the annual open enrollment period. Appropriate forms to add a dependent must be completed during the open enrollment period.

### **\*Your Contributions**

to the cost of your coverage will be deducted from your weekly paycheck on a pretax or after tax basis. You make an election at your original enrollment in the plan to contribute pretax or after tax. You may change this election, effective at the beginning of the next year, only during the annual open enrollment period. Because pretax contributions reduce your taxable wages and Social Security taxes are not withheld on these contributions, your future Social Security benefit may be reduced.

Your contribution will increase in the future if the cost to the company increases.

### **\*Refund of Contributions**

due as a result of status changes will not be retroactive past the date the Benefits Department is notified.

### **\*If your status changes**

because of any of the circumstances listed below, you may want to change the type of coverage you have. If you request the coverage change within 31 days of the date your status changes, the new coverage will start on the day of the change.

Circumstances that Qualify as a Change in Status

- Change in legal marital status, defined as marriage, death of a spouse, divorce, legal separation, or annulment.
- Change in number of dependents, defined as the birth, death, adoption, or placement for adoption of a dependent.
- Change in employment status, defined as a termination or commencement of employment or a change in work site of the employee, spouse, or dependent, or any other change in employment that leads to a loss or gain of eligibility under a plan.

- Eligible dependent satisfies or ceases to satisfy the requirements for eligible dependents, defined as an event that causes an employee's eligible dependent to satisfy/cease to satisfy the requirements for coverage due to attainment of age, or other circumstances as provided by the plan.
- Change in residence of the employee, or eligible dependent that affects participation in certain health care plans.

If your coverage change is not requested within the 31-day period of the status change, your new coverage will begin on January 1st following the next annual open enrollment period. Appropriate forms to add an eligible dependent must be completed during the open enrollment period.

**\*To request a change**

fill out a new Health enrollment form in your local P&C team.

**Coverage will stop for you and your eligible dependents**

- on the last day of your employment unless you are eligible for the Company's Retirement Allowance Plan and retire under the Retirement Allowance Plan and were enrolled in coverage for yourself and dependents, if applicable, as an active employee immediately prior to your retirement date,(see the Retirement Allowance Plan section for details.)
- 30 days after you are laid off. Cost will be the same as for active employees. However, at the end of the 30 day period, you may temporarily continue coverage by paying the full premium (see Continuation Coverage Rights Under COBRA section for details).

**\*Coverage will stop for any employee or eligible dependent who**

no longer qualifies as eligible. However, coverage may be continued temporarily by paying the full premium. (see Continuation Coverage Rights Under COBRA section for details).

**\*If you are eligible for the Company's Retirement Allowance Plan and retire from active service**

your coverage may be continued (see the Retirement Allowance Plan section for details).

**\*In case of your death**

while actively employed, your eligible dependents (if you had them enrolled) can continue their coverage. To continue coverage, your dependents must pay the same amount an active employee pays for dependent coverage. Your spouse may continue coverage until they become eligible for Medicare and eligible dependent children may continue coverage as long as they meet the eligibility requirements under Health Plans-General section (generally until age 26).

If your spouse is receiving a retirement benefit from the Retirement Allowance Plan, he or she may continue coverage until they become eligible for Medicare, and any eligible dependent children may continue health coverage up to age 26 by continuing to pay the same amount an active employee pays for dependent coverage.

**\*Coordination of Benefits (COB)**

Health benefit plans are meant to help you pay the covered expenses you and your family

may have. Sometimes, because employees may have protection under more than one Group plan (because both spouses work, and each covers the other under the employer's Family plan), the total benefit could be more than the actual expenses. Our plan has a Coordination of Benefits (COB) provision to guard against duplication of coverage. The Coordination of Benefits (COB) provision also applies to dependents under age 26, covered by the plan.

When you are covered by more than one Group Plan, you should follow these "rules of thumb" when filing claims:

- if the claim is on the employee, *our* Group policy will be primary-will pay first;
- if the claim is on the spouse, *their* Group policy will be primary-will pay first;
- if the claim is on a dependent child, the parent whose birthday falls earlier in the year will be primary unless divorce or legal separation is involved. In this case, contact your local Benefits team.
- if a claim is on a dependent under age 26, who is insured for benefits by his or her employer, then the dependent's Group policy will be primary — will pay first.

If your spouse has Group coverage which does not have a similar COB provision, then the *other policy*, not ours, will be primary in all cases.

Your claims should be sent first to the primary coverage, then, the same bills, plus a copy of the summary of benefits from the primary coverage, should be submitted to the second company. The second company will adjust any benefits payable by the amount already received from the first company.

Your coverage also coordinates with Medicare under certain circumstances.

While you are actively employed by the Company, you (and your eligible dependents) will continue to be primarily covered under the Company's plans, even if you are also eligible for Medicare. If you are eligible for Company's Retirement Allowance Plan and retire from active service with health plan coverage as active employee, Medicare coverage, if you are eligible for it, would become your primary coverage and your eligibility to participate in the Company plan will end. Your eligible dependents may continue to be covered by paying the active rate as long as they were covered under the health plan at the time of your retirement as an active employee.

Coordination of benefits does not apply to any personal health insurance policy you might have.

**\*If you are on an approved leave of absence,**

your coverage will be continued. You can continue your coverage by making direct payment of the same premium paid by active employees, to the Company.

**Right of Subrogation/Right to Reimbursement**

**\*Right of Subrogation**

Subrogation means to substitute one for another. ITG Brands' Health Plan may act as your substitute in the event of any payment made by this plan for medical, dental or vision benefits.

For example, ITG Brands' 3rd Party Health Plan Administrator may file a claim, on your behalf, against the insurance carrier of someone who is liable for expenses incurred in an automobile accident.

ITG Brands' Health Plan will be subrogated to all rights of recovery of the individual who received such benefits under the Plan against any insurance carrier(s) or any third party(ies). All rights of recovery will be limited to the amount of any payments made under this plan.

Any Covered Person claiming benefits under the Plan shall execute and deliver such documents as may be required and do whatever else is necessary to secure such rights to the plan.

### **Right to Reimbursement**

The Plan is also granted the right of first reimbursement from any settlement proceeds, even if the Covered Person is not made whole, i.e., compensated in full. Any Covered Person claiming benefits under the Plan shall execute and deliver such documents as may be required, and do whatever else is necessary to secure such rights to the Plan.

### **General Provisions**

The subrogation and reimbursement rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

- Any no-fault insurance;
- Medical benefits coverage under any automobile liability plan. This includes the Covered Person's plan or any third party's policy under which the Covered Person is entitled to benefits;
- Under-insured and uninsured motorist coverage;
- Any automobile Medical Payments and Personal Injury Protection benefits; and
- Any third party's liability insurance.

The Plan may make total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan. In the event of such payments the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing by the Plan Administrator in the exercise of its sole discretion.

# **MEDICAL COVERAGE**

## **For employees hired prior to September 1, 2017**

Medical coverage is available for all eligible employees. You may elect or decline medical coverage each year during the annual open enrollment period. No plan design changes were made to the Choice, Choice Plus, and Choice Value plans for the effective date of September 1, 2017.

### **CHOICE OF COVERAGE**

For employees hired prior to September 1, 2017, the Company offers three (3) medical plans. Effective each January 1st, you elect one of the following plans to cover you for the coming year:

#### **CHOICE PLUS**

- This is a Preferred Provider Organization (PPO) plan with in- and out-of-network benefits. This plan offers a comprehensive set of benefits, which include preventive care. There is a schedule of copayments/coinsurance for various services for this plan. The plan allows you to see non-network physicians but this will result in more out-of-pocket expense to you.

A more detailed explanation of coverage is contained in the separate booklet describing the Choice Plus plan, which is distributed to participants in that plan and is also available upon request from your local P&C team.

#### **CHOICE**

- This is a PPO plan with only in-network benefits. This plan offers a comprehensive set of benefits, which include preventive care. There is a schedule of copayments/coinsurance for various services in this plan. You must go to a network provider for treatment. Expenses incurred with a non-network physician or Hospital is not covered unless you have a true medical emergency or the service is approved in advance.

A more detailed explanation of coverage is contained in the separate booklet describing the Choice plan, which is distributed to participants in that plan and is also available upon request from your local P&C team.

#### **CHOICE VALUE**

- This is a PPO with both in- and out-of-network benefits. This plan offers a comprehensive set of benefits, which include preventive care. There is a schedule of copayments/coinsurance for various services for this plan. The plan allows you to see non-network physicians but this will result in more out-of-pocket expense to you.

A more detailed explanation of coverage is contained in the separate booklet describing the Choice Value plan, which is distributed to participants in that plan, and is also available upon request from your local P&C team.

Please see your local P&C team for current costs of the various plans.

## **MEDICAL COVERAGE**

### **For employees hired September 1, 2017 and later)**

Medical coverage is available for all eligible employees. You may elect or decline medical coverage at hire or each year during the annual open enrollment period.

**For employees hired September 1, 2017 and later**, the Company offers three (3) Company medical plans. Effective each January 1st, you elect one of the following plans to cover you for the coming year:

#### **BASIC PLAN WITH A HEALTH REIMBURSEMENT ACCOUNT (HRA)**

- This is a PPO plan with in- and out-of-network benefits. This plan offers a comprehensive set of benefits, which includes preventive care. For all claims other than in-network preventive care, you must first meet a deductible before the plan will pay coinsurance. The coinsurance will be based on in- or out-of-network claims. Also, there are separate deductibles for in- or out-of-network claims. An HRA will be established for you with Company contributions if you complete certain wellness incentives prescribed each year.

A more detailed explanation of coverage is contained in the separate booklet describing the Basic Plan with HRA, which is distributed to participants in that plan and is also upon request from your local P&C team.

#### **COPAY PLAN WITH AN HRA**

- This is a PPO plan with in- and out-of-network benefits. This plan offers a comprehensive set of benefits, which includes preventive care. Office visits have a copay schedule while other claims, except in-network preventive care, require you to first meet a deductible before the plan will pay coinsurance. The coinsurance will be based on in- or out-of-network claims. Also, there are separate deductibles for in- or out-of-network claims. An HRA will be established for you with Company contributions if you complete certain wellness incentives prescribed each year.

A more detailed explanation of coverage is contained in the separate booklet describing the Copay Plan with HRA, which is distributed to participants in that plan and is available upon request from your local P&C team.

#### **HEALTH SAVINGS PLAN WITH A HEALTH SAVINGS ACCOUNT (HSA)**

- This is a PPO plan with in- and out-of-network benefits. This plan offers a comprehensive set of benefits, which include preventive care. For all claims other than in-network preventive care, you must first meet a deductible before the plan will pay coinsurance. The coinsurance will be based on in- or out-of-network claims. Also, there are separate deductibles for in- or out-of-network claims. An HSA will be established for you with Company contributions if you complete certain wellness incentives prescribed each year. You can also elect to contribute to the HSA from your weekly pay.

A more detailed explanation of coverage is contained in the separate booklet describing the Health Savings Plan with HSA, which is distributed to participants in that plan and is also available upon request from your local P&C team.

Please see your local P&C team for current costs of the various plans.

## **PRESCRIPTION DRUG BENEFITS**

If you participate in any of the medical plans, your prescription drug benefits are automatically provided by CVS Caremark. Caremark will provide you with an identification card to purchase your prescription drugs at your retail pharmacy with co-payments.

You may also purchase prescription drugs by mail order from CVS Caremark through their website.

More details about the prescription drug benefits can be found at [www.caremark.com](http://www.caremark.com).

Please see your P&C team for information regarding prescription copay(s) as they vary based on the medical plan for which you are enrolled.

# DENTAL PLAN

## The Dental Plan General Information

**As amended; Effective September 1, 2017, unless specifically noted otherwise. the General Information for the Dental Plan is generally the same as for the Health Plan, and is** outlined in the Health Plan section of this booklet. See the (\*) asterisked items of that section. There are some differences, however, and they are contained in the following paragraphs.

Dental PPO Coverage is available for all eligible employees and their eligible dependents. You may elect or decline coverage at hire or each year during the annual open enrollment period. The dental coverage provides for preventive care, basic and major services. When you (or a covered dependent) are going to have extensive work done, a pretreatment plan must be submitted to the insurance company before any work is done. Actual treatment should begin within 60 days after the pre-treatment plan is approved. Dental plans provide coordination of benefits with other dental insurance coverage.

You'll receive discounts on services when you see a participating network provider, and you won't have any claims to file. To find a participating Cigna Dental PPO network dentist, go to [www.cigna.com](http://www.cigna.com) or [www.mycigna.com](http://www.mycigna.com). To check on the status of your claim, go to [www.cigna.com](http://www.cigna.com) or call Cigna toll-free at **800-244-6224**.

## Your contribution will increase

in the future if the cost to the Company increases.

## An eligible dependent

Under the Dental plan is the same as under the Health plan.

## Coverage will stop for you and your eligible dependents

- on the last day of your employment unless you are eligible for the Company's Retirement Allowance Plan and retire under the Retirement Allowance Plan and were enrolled in coverage for yourself and dependents, if applicable, as an active employee immediately prior to your retirement date, (see the Retirement Allowance Plan section for details.)

## Coverage will stop for any employee or dependent who

- no longer qualifies as eligible. However, coverage may be continued temporarily by paying the full premium (see Continuation Coverage Rights Under COBRA section for details).

**Note:** If you are eligible for the Company's Retirement Allowance Plan and retire prior to your 65th birthday, your coverage will be **continued** (if you were enrolled as an active employee immediately prior to your retirement date) until you reach age 65 by paying the same amount an active employee pays (if applicable). You may elect to continue coverage for your eligible dependent spouse that is under age 65 or eligible dependent child(ren) under age 26 (if they were covered immediately prior

to your retirement while you were an active employee) by paying the same amount an active employee pays for dependent coverage.

Plan provision details and your cost share will vary, depending on if you were hired PRIOR to September 1, 2017 or on or after September 1, 2017. Please see your P&C team for more details.

A more detailed explanation of benefits is available in a separate booklet describing the Dental Plan, which is distributed to participants in that plan and is also available upon request from your local P&C team.

## **VISION CARE PLAN**

**As amended; Effective September 1, 2017, unless specifically noted otherwise.**

### **The Vision Care Plan General Information**

is **generally the same as for the Health Plan, and is** outlined in the Health Plan section of this booklet. See the (\*) asterisked items in that section. There are some differences, however, and they are contained in the following paragraphs.

Vision benefits are available for all eligible employees and their eligible dependents. You may elect or decline vision coverage at hire and during the annual open enrollment period. The vision coverage provides for comprehensive eye examination (in- and out-of-network benefits are available), frames and lenses, contact lenses and laser vision correction.

Plan details and your cost share will vary, depending if you were hired PRIOR to September 1, 2017 or on or after September 1, 2017. Please see your local P&C team for specific details.

Your contribution will increase  
in the future if the cost to the Company increases.

### **An eligible dependent**

Under the Vision Care plan is the same as under the Health plan.

### **Coverage will stop for you and your eligible dependents**

- on the last day of your employment unless you are eligible for and retire under the Company's Retirement Allowance Plan and were enrolled in coverage for yourself and dependents, if applicable, as an active employee immediately prior to your retirement date,(see the Retirement Allowance Plan section for details.)

### **Coverage will stop for any employee or eligible dependent who**

- no longer qualifies as eligible. However, coverage may be continued temporarily by paying the full premium (see Continuation Coverage Rights Under COBRA section for details)

**Note:** If you are eligible for the Company's Retirement Allowance Plan and retire prior to your 65th birthday, your coverage will be **continued** (if you were enrolled as an active employee immediately prior to your retirement date) until you reach age 65 by paying the same amount an active employee pays (if applicable). You may elect to continue coverage for your eligible dependent spouse that is under age 65 or eligible

dependent child(ren) under age 26 (if they were covered immediately prior to your retirement date while you were an active employee) by paying the same amount an active employee pays for dependent coverage.

Plan provision details and your cost share will vary, depending if you were hired PRIOR to September 1, 2017 or on or after September 1, 2017.

A more detailed explanation of benefits is available in a separate booklet describing the Vision Plan, which is distributed to participants in that plan and is also available upon request from your local P&C team.

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

## Introduction

You are receiving this notice because you are covered or have recently become covered under the ITG Brands, LLC Employee Benefits Plan for Hourly Employees (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical, dental, and vision coverage under the Plan. The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is ITG Brands, LLC, 628 Green Valley Road, Suite 500, Greensboro, NC 27408, (336) 335-7000. The Plan Administrator is responsible for administering COBRA continuation coverage.

## COBRA Continuation Coverage

COBRA continuation coverage is a continuation of medical, dental and vision Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to ITG Brands, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Sr. Benefits Administrator, ITG Brands LLC, PO Box 21688, Greensboro, NC 27420.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. The qualified beneficiary must elect COBRA continuation coverage in writing, and must pay for that coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension of 18-Month period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security

Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Sr, Benefits Administrator, ITG Brands, LLC, PO Box 21688, Greensboro, NC 27420.

### **Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Sr. Benefits Administrator, ITG Brands, LLC, PO Box 21688, Greensboro, NC 27420.

### **COBRA Premium Payments**

#### **First payment for continuation coverage.**

If you elect continuation coverage, you must make your first payment for continuation coverage not later than 45 days after the date of your election. If you do not make your first payment for continuation coverage within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

#### **Periodic payments for continuation coverage.**

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis, and the Plan Administrator or its designee will inform you of the payment due dates. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. Payments for COBRA coverage under your Health Care Flexible Spending Account, if applicable and elected, may be pre-paid in one lump sum.

#### **Grace periods for periodic payments.**

Although periodic payments are due on the dates you are told, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

## **If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact Sr. Benefits Administrator, ITG Brands, LLC, PO Box 21688, Greensboro, NC 27420 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

### **Women's Health and Cancer Rights Act**

As required by the *Women's Health and Cancer Rights Act of 1998*, benefits are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending physician:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments, coinsurance and any annual deductible) and the benefit coverage limitations are the same as are required for any other covered health service as described in your COC or SPD.

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### **Newborns' and Mothers' Health Protection Act**

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, call the member phone number on your health plan ID card.

# Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
<p>Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  Health First Colorado Member Contact Center:  1-800-221-3943/State Relay 711  CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a>  CHP+ Customer Service: 1-800-359-1991/State Relay 711  Health Insurance Buy-In Program  (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a>  HIBI Customer Service: 1-855-692-6442</p>	<p>Website:  <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a>  Phone: 1-877-357-3268</p>

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162, Press 1  GA CHIPRA Website:  <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>  Phone: 678-564-1162, Press 2</p>	<p>Healthy Indiana Plan for low-income adults 19-64  Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a>  Phone: 1-877-438-4479  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  Phone: 1-800-457-4584</p>

IOWA – Medicaid and CHIP (Hawke)	KANSAS – Medicaid
<p>Medicaid Website:  <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a>  Hawki Phone: 1-800-257-8563  HIPP Website:  <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a>  HIPP Phone: 1-888-346-9562</p>	<p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660</p>

KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIP.PROGRAM@ky.gov">KIHIP.PROGRAM@ky.gov</a>  KCHIP Website:  <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website:  <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>

<p align="center"><b>MAINE – Medicaid</b></p> <p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>            Phone: 1-800-442-6003            TTY: Maine relay 711            Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>            Phone: 1-800-977-6740            TTY: Maine relay 711</p>	<p align="center"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>            Phone: 1-800-862-4840            TTY: 711            Email: <a href="mailto:masspreassistance@accenture.com">masspreassistance@accenture.com</a></p>
<p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website:  <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a>            Phone: 1-800-657-3739</p>	<p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>            Phone: 573-751-2005</p>
<p align="center"><b>MONTANA – Medicaid</b></p> <p>Website:  <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>            Phone: 1-800-694-3084            Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>	<p align="center"><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>            Phone: 1-855-632-7633            Lincoln: 402-473-7000            Omaha: 402-595-1178</p>
<p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>            Medicaid Phone: 1-800-992-0900</p>	<p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>            Phone: 603-271-5218            Toll free number for the HIPP program: 1-800-852-3345, ext. 5218</p>
<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>            Medicaid Phone: 609-631-2392            CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>            CHIP Phone: 1-800-701-0710</p>	<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website:  <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>            Phone: 1-800-541-2831</p>
<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>            Phone: 919-855-4100</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>            Phone: 1-844-854-4825</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>            Phone: 1-888-365-3742</p>	<p align="center"><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>            Phone: 1-800-699-9075</p>

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: <a href="https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx">https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx</a> Phone: 1-800-692-7462 CHIP Website: <a href="http://www.dhs.pa.gov/CHIP/Program.aspx">Children's Health Insurance Program (CHIP) (pa.gov)</a> CHIP Phone: 1-800-986-KIDS (5437)	Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: <a href="http://www.dhs.texas.gov/HealthInsurance/PremiumPayment/HIPP-Program">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a> Phone: 1-800-440-0493	Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: <a href="http://www.dhs.vermont.gov/HealthInsurance/PremiumPayment/HIPP-Program">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427	Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a>  <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022	Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhpp.com/">http://mywvhpp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

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

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

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

## Paperwork Reduction Act Statement

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

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

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## HIPAA Notice of Privacy Practices

**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.**

**ITG Brands, LLC** (“**ITG Brands**”) sponsors the **ITG Brands, LLC Employee Benefits Plan for Hourly Employees** (the “**Plan**”) to provide health care and other welfare benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the “**Notice**”) describes the legal obligations of the health care components of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. When we say “we”, that means the health care components of the Plan.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

your past, present or future physical or mental health or condition;  
the provision of health care to you; or  
the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by **ITG Brands**, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance

carrier.

### **Contact Information**

If you have any questions about this Notice or about our privacy practices, please contact the **ITG Brands** HIPAA Privacy Officer:

ITG Brands, LLC  
Attention: HIPAA Privacy Officer  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408  
(888) 278-1133

### **Effective Date**

This Notice as revised is effective October 13, 2023.

### **Our Responsibilities**

We are required by law to:

maintain the privacy of your protected health information;  
provide you with certain rights with respect to your protected health information;  
provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and  
follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

### **How We May Use and Disclose Your Protected Health Information**

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

#### **For Treatment**

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

### **For Payment**

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

### **For Health Care Operations**

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

### **To Business Associates**

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

### **As Required by Law**

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

### **To Avert a Serious Threat to Health or Safety**

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

### **To Plan Sponsors**

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

### **Special Situations**

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

#### **Organ and Tissue Donation**

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

#### **Military and Veterans**

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

#### **Workers' Compensation**

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

#### **Public Health Risks**

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;

to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;  
to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

### **Health Oversight Activities**

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

### **Lawsuits and Disputes**

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

### **Law Enforcement**

We may disclose your protected health information if asked to do so by a law enforcement official—

in response to a court order, subpoena, warrant, summons or similar process;  
to identify or locate a suspect, fugitive, material witness, or missing person;  
about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;  
about a death that we believe may be the result of criminal conduct;  
about criminal conduct; and  
in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

### **Coroners, Medical Examiners and Funeral Directors**

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

### **National Security and Intelligence Activities**

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

### **Inmates**

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## **Research**

We may disclose your protected health information to researchers when:

the individual identifiers have been removed; or  
when an institutional review board or privacy board has (a) reviewed the research proposal; and  
(b) established protocols to ensure the privacy of the requested information, and approves the research.

## **Required Disclosures**

The following is a description of disclosures of your protected health information we are required to make.

### **Government Audits**

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

### **Disclosures to You**

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

### **Notification of a Breach.**

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

## **Other Disclosures**

### **Personal Representatives**

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

you have been, or may be, subjected to domestic violence, abuse or neglect by such person; treating such person as your personal representative could endanger you; or  
in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

### **Spouses and Other Family Members**

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential

Communications (see below under “Your Rights”), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

### **Authorizations**

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes, the use or disclosure of protected health information for fundraising or marketing purposes, and disclosures which constitute a sale of protected health information, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

### **Your Rights**

You have the following rights with respect to your protected health information:

#### **Right to Inspect and Copy**

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

#### **Right to Amend**

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

is not part of the medical information kept by or for the Plan;  
was not created by us, unless the person or entity that created the information is no longer available to make the amendment;  
is not part of the information that you would be permitted to inspect and copy; or  
is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

#### **Right to an Accounting of Disclosures**

You have the right to request an “accounting” of certain disclosures of your protected health

information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of not longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

### **Right to Request Restrictions**

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

### **Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

## **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

## **Complaints**

If you believe that your privacy rights have been violated, or that the privacy or security of your unsecured protected health information has been compromised, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, telephone or write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records

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## **Medicare Creditable Coverage Notice**

As part of Medicare Part D, we are required by the Center for Medicare and Medicaid Services to provide you with the following notice about your prescription drug coverage and Medicare. It explains that ITG Brands' health care plans provide "creditable coverage" through the prescription drug benefit that is on average at least as good as the standard prescription drug coverage provided under the Medicare Part D prescription drug benefit. This information is especially important to know if you, your spouse, or your child(ren) are currently Medicare participants.

### **Important Notice from ITG Brands, LLC About Your Prescription Drug Coverage and Medicare**

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- 2. ITG Brands, LLC has determined that the prescription drug coverage offered by the ITG Brands, LLC Employee Benefits Plan for Hourly Employees is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15<sup>th</sup> through December 7<sup>th</sup>.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

For *participants in plans offered to active employees*, if you decide to join a Medicare drug plan, you may continue your current coverage with ITG Brands, LLC and the plan will coordinate with Medicare Part D coverage.

For *participants in Medicare Supplement plans offered to retired employees*, if you decide to join a Medicare drug plan, your current Medicare Supplement coverage with ITG Brands, LLC will end. The ITG Brands Medicare Supplement Plan does not allow you to cancel only your prescription drug coverage. You would be canceling both your medical and prescription drug coverage. You should compare the cost and benefit provisions of your current coverage with available Medicare drug plans in your area.

If you decide to enroll in a Medicare drug plan and drop your ITG Brands, LLC coverage, you and/or your dependents will not be able to get this coverage back.

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

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

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

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

Contact 888-278-1133 ext. 7427 for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ITG Brands, LLC changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date:	October 13, 2023
Name of Entity/Sender:	ITG Brands, LLC
Contact Position/Office:	Andrea Earles, Sr. Benefits Administrator
Address:	714 Green Valley Road, Greensboro, NC 27408
Phone Number:	(888) 278-1133 ext. 7427

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**THE INFORMATION BELOW IS REQUIRED TO BE PROVIDED TO YOU UNDER HEALTHCARE REFORM LAW. THIS DOES NOT IMPACT NOR TAKE THE PLACE OF YOUR ITG BRANDS COMPANY-PROVIDED BENEFITS PLANS. IT IS BEING PROVIDED FOR YOUR INFORMATION ONLY AS REQUIRED BY LAW.**

### **New Health Insurance Marketplace Coverage Options and Your Health Coverage**

Dear ITG Brands, LLC employee:

The information below is required to be provided to you under Health Care Reform law. It is separate coverage from the Company-provided healthcare benefits offered through ITG Brands.

Key parts of the Affordable Care Act, also known as the health care reform law, went into effect January 1, 2014. As a result, there is a new way to buy health insurance: the Health Insurance Marketplace (the “Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by ITG Brands, LLC.

#### **What Is the Health Insurance Marketplace?**

The Marketplace is designed to help individuals find health insurance that meets their needs and fits their budget. It offers “one-stop shopping” to find and compare private health insurance options. All U.S. citizens and legal residents have access to individual health insurance policies through the Marketplace in their state.

Individuals may also be eligible for a new kind of tax credit that lowers their monthly premium right away.

### **Can Individuals Save Money on Health Insurance Premiums in the Marketplace?**

Some people who do not have access to affordable, minimum value health care coverage through their employer may be eligible for a federal subsidy in order to make buying insurance through the Marketplace more affordable. The savings these individuals would be eligible for depends on household income.

**It’s important to note that because ITG Brands, LLC’s health plans meet the government’s standards for minimum value and affordability, you likely will not qualify for a federal subsidy if you are eligible for ITG Brands’ benefits.** You will likely find more affordable coverage through our health plans, or if available, through your spouse’s employer plan or through your parent’s employer plan (if you are under the age of 26).

### **Does Employer Health Coverage Affect Eligibility for Tax Credits through the Marketplace?**

Yes. Individuals who have an offer of health coverage from their employer that meets certain standards (as does ITG Brands, LLC’s health coverage) are likely not eligible for a tax credit through the Marketplace and may wish to enroll in their company’s health plan. Some people may be eligible for a tax credit that lowers their monthly premiums or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer *for employee-only coverage in the lowest cost option* is more than 9.5% of an employee’s household income for the year, or if the coverage the employer provides does not meet a “minimum value” standard set by the health care reform law, an employee may be eligible for a tax credit.

### **What if I’m Not Eligible for ITG Brands, LLC’s Health Plans?**

If you are not eligible for ITG Brands, LLC’s health plans, or those plans are unaffordable, you should consider other options available to you, such as coverage through your spouse’s employer plan, your parent’s employer plan (if you are under age 26), Medicaid, Medicare or your state’s Marketplace. Enrollment in the Marketplace will begin in October. If you decide to enroll through the Marketplace, you will need to provide the Marketplace with the following information about ITG Brands, LLC and our plans:

<p><b>Employer name: ITG Brands, LLC</b> <b>Employer Identification Number EIN: 94-2994213</b> <b>Employer address: 714 Green Valley Road, Greensboro, NC 27408</b> <b>Employer telephone number: 888-278-1133</b> <b>Name of contact for employee health coverage: Andrea Earles</b> <b>Phone number of contact (if different from above):</b> <b>Email address of contact: Andrea.Earles@itgbrands.com</b></p>
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**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by ITG Brands, LLC, then you may lose ITG Brands, LLC’s contribution (if any) to the Company-offered coverage. Also, this contribution – as well as your employee contribution to employer-offered coverage – is often excluded from

income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**Why is ITG Brands, LLC Sending This Information?**

Most U.S. employers are required to send this notice to employees to raise awareness of the new Marketplace and to help them understand how having access to their employer's health care plan may limit their eligibility for tax credits in the Marketplace.

**How Can I Get More Information?**

Remember, the health care reform law requires most Americans to have health care coverage or be subject to a penalty tax. If you have questions about coverage offered by your employer, please review education materials sent during Open Enrollment or contact the ITG Brands Benefits Department at 888-278-1133.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. If you'd like to learn more about the Health Insurance Marketplace in your state, please visit [www.healthcare.gov](http://www.healthcare.gov), the website sponsored by the Department of Health and Human Services for more information.

## OTHER PLAN INFORMATION

Under the Employee Retirement Income Security Act of 1974 (ERISA), employees are to be provided with the following information about the Welfare Benefits plans described in this booklet. If you need more information, contact your local P&C team, or your local office of the U.S. Department of Labor.

### **Name of Plan**

ITG Brands, LLC Employee Benefits Plan for Hourly Employees

### **Plan Number**

502

### **Plan Type**

1. Life and Accidental Death & Dismemberment benefits are provided by insurance contracts with insurance carriers.
2. Health, Dental, and Vision benefits are self-insured by the Company.
3. Benefits for absence due to injury or illness are self-insured by the Company.

### **Plan Year**

January 1 through December 31

### **Plan Sponsor**

ITG Brands, LLC  
628 Green Valley Road,  
Suite 500 Greensboro, NC  
27408  
336-335-7000  
EIN: 94-2994213

### **Plan Administrator**

ITG Brands, LLC  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408  
336-335-7000

The Plan Administrator has delegated its duties to a Benefits Committee selected by the Company. Subject to the Plan, the Committee shall from time to time establish rules, forms and procedures for the administration of the Plan and the transaction of its business. Except as herein or otherwise expressly provided, the Committee shall have the exclusive right to interpret the Plan and to decide any matters arising thereunder in connection with the administration of the Plan. Such decisions, actions and records of the Committee shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the Plan.

**Agent for Service of Legal Process**  
**The Benefits Committee**  
ITG Brands, LLC  
628 Green Valley Road, Suite  
500 Greensboro, NC 27408

Service may also be made on the Plan Administrator.

**Benefits Provided through and Administered by:**

Life Insurance contract # 681488, Hartford, Administrative services contract #904616 UnitedHealthcare, Account #3338745 CIGNA Dental, Account #1571 Caremark, and Account 9954777 EyemedVision

**Plan Documents**

This booklet summarizes the key features of the plans. Complete details for life insurance benefits and accidental death and dismemberment benefits can be found only in the official insurance contract which is the governing document in all cases. Copies of all plan documents, as well as the annual report of the plan operations, are available for review by the plan participants or their beneficiaries during normal working hours in your P&C Department. Upon written request to the Plan Administrator, a copy of these documents will be furnished to a plan member or beneficiary within 30 days. The law permits the Company to charge up to 25¢ a page to cover the actual cost of reproducing these documents.

**Collective Bargaining Agreement**

This plan is maintained pursuant to a collective bargaining agreement. A copy of any such agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and beneficiaries during regular business hours at 2525 E. Market Street, Greensboro, NC 27401.

**Claims and Appeal Procedure**

Refer to the individual benefits booklet or certificate for the applicable claims procedure for your life, AD&D, accident, medical, dental and vision benefits. To the extent a benefit does not have a stated claims procedure, the following procedure will apply.

**A. Claims**

**1. Claims Procedures**

A plan participant or beneficiary may make a claim for benefits under the Plan. Any such claim you file must be submitted to the Plan Administrator in a form and manner acceptable to the Plan Administrator. Contact the Plan Administrator for more information. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim within 90 days after receipt of your claim. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of the initial period the Plan

Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, a description of additional material or information necessary for the claimant to perfect the claim and an explanation of why it is required, and information about the steps that must be taken to submit a timely request for review, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review.

## **2. Review Procedures (For Appeal of an Adverse Benefit Determination)**

You may appeal the denial of your claim made under the procedures described above within 60 days after the date following your receipt of notification of the denied claim by filing a written request for review with the Plan Administrator. This written request may include comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim on review within 60 days after receipt of your appeal. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period the Plan Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim on review is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The Plan Administrator shall provide you with written notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by you – the specific reason or reasons for the adverse determinations, reference to the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

## **Your Rights Under ERISA**

As a participant in the Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security 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 plan documents governing the plan, including

insurance contract and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 Medical And/Or Dental And/Or Vision Plan Coverage**

- Continue medical and/or dental and/or vision care coverage for yourself, spouse or dependents if there is loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plans or health insurer when you lose coverage under the plan when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. (Certificates of creditable coverage are no longer required beginning December 31, 2014, because plans are not permitted to impose preexisting condition exclusions for any plan year beginning on or after January 1, 2014).

### **Prudent Action 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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have the duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer 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 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. If you request material from the plan and do not receive them within 30 days, you may require the Plan Administrator to

provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 the plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

# Retirement Allowance Plan

# **RETIREMENT ALLOWANCE PLAN**

**For employees hired prior to September 1, 2017**

FOR HOURLY RATED AND/OR PIECEWORK EMPLOYEES

As amended on effective date of contract as shown in the Introduction

# RETIREMENT ALLOWANCE PLAN

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## **BECOMING A PLAN MEMBER**

### **You become a member of the Retirement Allowance Plan**

If you were hired prior to September 1, 2017, you became eligible on your first day of work. Employees hired September 1, 2017 and later are not eligible to participate in the Retirement Allowance Plan.

### **Once you are in the Plan**

you continue as a member for as long as you are an hourly employee of the Company. This includes any period of Company-approved absence. If you leave the Company, your Plan membership stops. If you return to the Company, your Plan membership will begin again. (Under certain circumstances, your past service may be restored to you (see Other Important Facts section for details.)

### **Plan membership is free.**

The Company pays the entire cost of providing Retirement Plan benefits. How much the Company contributes depends on yearly calculations made by independent actuaries. All Company contributions go into a separate trust fund to be used only for benefit payments as provided under the Plan.

## SERVICE

### **Your Service with the Company**

counts in two ways:

- to determine when you have earned a right to a pension from the Plan (called “Continuous Service”);
- to determine how much your pension will be (called “Credited Service”).

For full-time employees, Continuous Service and Credited Service are usually the same. (see Other Important Facts section for details.) Your service equals all years of unbroken service with the Company, from your date of hire to the end of your employment, whether you leave for retirement, or for any other reason.

### **If you had a break in Service before January 1, 1976**

the service before the break will be counted at the time of retirement from active service if you had at least 10 years of Continuous Service in the period immediately prior to retirement.

### **If you had a break in Service after December 31, 1975,**

ERISA Regulations apply (see Other Important Facts section for details.).

### **Service under the Plan includes**

- military duty, if you return to work within the time limit provided by law;
- a Retirement Board approved leave of absence of up to 24 months;
- time on layoff (up to 36 months for each layoff) if you return to work within the time limits established under the Seniority Article of the collective bargaining agreement.

### **The amount of Continuous Service you need**

to earn the right to receive a pension is 5 years. If you leave the Company before you have 5 years of Continuous Service, you will not be entitled to a retirement allowance from this Plan. (see Other Important Facts section for details.)

### **When you attain age 65, you are entitled to a Normal Retirement Allowance.**

### **When you have 10 years of Continuous Service and are not age 65**

you will have earned the right to

- an Early Retirement Allowance at any age between 55 and 64;
- a Special Early Retirement Allowance if you have at least 30 years of Service;
- a Disability Retirement Allowance if you become totally disabled before age 60;

### **When you have 5 years of Continuous Service**

you will have earned the right to

- a Vested Retirement Allowance if you leave the Company before the earliest retirement age.

## FIGURING YOUR RETIREMENT ALLOWANCE

### The amount of your Retirement Allowance

depends on the Basic Amounts agreed to under the current collective bargaining agreement, and the years and months of your Credited Service. To figure how much your Retirement Allowance will be, if you retire effective January 1, 2018 through the current contract period, or if you leave the Company with vested rights during this period, multiply your Credited Service by the Basic Amount in one of the following tables. The Basic Amount you use will depend on your age when retirement allowance payments begin.

### This table will be used

if you retire from active service on normal or early retirement:

Retirement Age	
60 and above	\$86.00
55 – 59	\$63.00

### If you take Disability or Special Early Retirement,

your pension amount will be figured by using the Basic Amount of \$86.00 times your Credited Service.

### The following table will be used

if you leave the Company during this contract period with 5 or more years of Continuous Service, but before age 55, or after age 55 if you have more than 5 and less than 10 years of Continuous Service. When you apply for your Vested Retirement Allowance, the Basic Amount used will depend on your age when your retirement payments begin. If you have 10 or more years of continuous service, you can retire on the first of any month after age 55. If you have fewer than 10 years of continuous service, your pension will start at age 65.

Retirement Age	Basic Amount
65 and above	\$ 86.00
64	\$ 80.20
63	\$ 74.60
62	\$ 68.80
61	\$ 63.00
60	\$ 57.40
59	\$ 54.40
58	\$ 51.60
57	\$ 48.80
56	\$ 45.80
55	\$ 43.00

**The easiest way to figure your pension amount**

is to multiply the Basic Amount times the number of years and months of your Credited Service. The following chart shows the number to use for various numbers of months of service.

1 month equals .083333 of a year	7 months equals .583333 of a year
2 months equals .166667 of a year	8 months equals .666667 of a year
3 months equals .25 of a year	9 months equals .75 of a year
4 months equals .333333 of a year	10 months equals .833333 of a year
5 months equals .416667 of a year	11 months equals .916667 of a year
6 months equals .50 of a year	12 months equals 1 Year

**For example**

if you retire from active service with 22 years, 5 months of service, at age 62:  
 $\$86.00 \times 22.41667$  years equals \$1,927.83 per month pension.

if you retire from active service with 18 years, 10 months of service, at age 58:  
 $\$63.00$  times 18.833333 equals \$1,186. 50 per month pension.

**This computation**

will give you your Basic Pension amount.

## NORMAL RETIREMENT

### Your Normal Retirement Date

is the first of the month following your 65th birthday. If your 65th birthday is the first of the month, then your 65th birthday is also your Normal Retirement date.

### You have seen how your pension amount

is figured, based on your Credited Service and on the Basic Amount. If, at Normal Retirement age, you are not married, the pension amount computed under the formula is the monthly amount you will receive for your lifetime. At your death, the pension payments will stop.

### If you are married

at retirement, the Plan *automatically* provides that you share your pension with your spouse. You receive a monthly pension and, if you die first, your spouse will receive half (50%) of the monthly payment which you had been receiving. The benefit payable to you and your spouse will not be reduced for this form of payment.

### When you retire from active service at age 65 or older,

you will receive other benefits from the Company (see the Life Insurance, AD&D, A&H, Health Care Plans section for complete details):

- **Effective January 1, 2018 Life insurance** in the amount of \$55,000 payable at your death to the beneficiary you name,
- **Effective January 1, 2018 A cash payment** in the amount of \$2,500 (taxable as ordinary income in the year received),
- **Your Company health coverage** is cancelled. You will be reimbursed for the standard Medicare Part B premium plus \$5.85.
- **If you retire prior to January 1, 2026, continued Health, Dental and/or Vision Care coverage for your eligible dependents**, if you had them covered as an active employee at the time of your retirement. If you choose to continue any of these coverages for your eligible dependents, your pension amount will be reduced by the same amount an active employee will pay for eligible dependent coverage. In the event of your death, your eligible dependents may continue coverage by paying the same cost as active employees pay for eligible dependent coverage.

If any eligible dependent becomes covered by Medicare, notify the local P&C team immediately. Eligible dependents covered by Medicare are not eligible to be covered by the health care plan. Under age 65 Medicare eligible dependents may continue to be covered by the dental and vision plans if they were covered immediately prior to your retirement while you were an active employee.

- **If you retire January 1, 2026 or later, coverage is not continued for eligible dependents.**

**Where the health care coverage options are involved,**

if you decline any coverage when you are first eligible as a retiree, you may elect coverage in the future.

If you elect any of the health options, you may cancel them at any time. However, if you do cancel an option, you may not have the coverage reinstated in the future.

## EARLY RETIREMENT

### **You may choose to retire early**

as of the first of any month after your 55th birthday or after you have 30 years of Credited Service. If your 55<sup>th</sup> birthday or later falls on the first of the month, this could be your early retirement date. You must apply for Early Retirement, since the choice is yours. See your local P&C team for details.

### **You should apply**

for Early Retirement before the first of the month in which you want your benefits to begin. The time needed to process your retirement application is between 30 and 60 days.

### **The method of payment**

at Early Retirement is the same as with a Normal Retirement:

- if you are single, you receive your full monthly amount as computed under the formula, for your lifetime;
- if you are married, you receive your full monthly amount as computed under the formula and upon your death your spouse will receive 50% of the amount you were receiving.

### **When you Early Retire from active service**

you have the same additional benefits from the Company *EXCEPT*

- Effective January 1, 2018 the cash payment of \$2,500 is paid *only* to those retiring at age 60 or older, or those retiring under the Special 30 and Out Retirement.

### **If you retire prior to January 1, 2026, Your Health, Dental and Vision coverages**

will be continued until you become eligible for Medicare. At that time, your Company coverages will be cancelled. Your eligible dependents' coverage can be continued as when you were an active employee (if they were covered immediately prior to your retirement as an active employee). In the event of your death, dependents' coverage can be continued on the same basis as described under Normal Retirement section.

If you retire January 1, 2026 or later, you will be eligible for up to \$1,500 retirement stipend per month until Medicare eligible. A three-month notice of retirement is required. Retiree life insurance will continue.

### **The Special Early 30 and Out Retirement:**

is available to any employee who has at least 30 years of Credited Service. If you qualify for a 30 and Out Retirement, your pension amount is figured using the Basic Amount for retirement at age 65.

### **You have the same additional benefits**

under a 30 and Out Retirement as under a Normal Retirement.

## **DISABILITY RETIREMENT**

### **If you become totally and permanently disabled,**

before age 60, and have 10 or more years of Continuous Service, you will be eligible for a Disability Retirement Allowance under this Plan.

### **The amount of your benefit**

will be computed based on your Credited Service and on the Basic Amount of \$86 times your Credited Service.

### **You must apply**

for Disability Retirement, through your local P&C team. Your Disability Retirement will begin on the first of the month following approval from the Company physician and will continue for as long as you remain totally disabled.

When you apply for Disability Retirement, if you are married, you will receive a Disability Retirement allowance which will provide a 50% retirement allowance for your spouse, in the event of your death.

### **The Retirement Board**

reserves the right to ask that you be examined by another physician in order to make a determination of your disability status. If there is difference of opinion between your own physician and the physician retained by the Retirement Board, then a third physician will be designated to examine you. Both you and the Retirement Board will agree to accept the opinion of the third physician as to your disability status.

### **Your additional Company benefits**

as a Disability Retiree are different than those under a Normal or Early retirement.

- Effective January 1, 2018, your life insurance amount will remain in force at \$150,000 until you reach age 65. Then, at age 65, the amount will be reduced to \$55,000.
- You are NOT eligible to receive a cash payment under a Disability Retirement.
- Your health care coverage is continued until you become eligible for Medicare. If you become eligible for Medicare prior to age 65 due to disability, your health insurance will terminate.
- If you are NOT eligible for Medicare, your health insurance can be continued until the first day of the month in which you turn age 65 by paying the same cost as active employees.

If you receive a Social Security Disability award and are subsequently denied benefits and Medicare coverage, you may continue to be covered by the Company's Health Care plan by paying the same cost as active employees.

- You may still cover your eligible dependents if you had them covered when your disability began, on the same basis as described under Normal Retirement section.

### Medicare Eligibility

- If you or your eligible dependent becomes eligible for Medicare, your health insurance coverage will be terminated. You will no longer be eligible to participate in an ITG Brands, LLC sponsored health plan. In the event that you or your eligible dependent is awarded Medicare, you must provide a copy of your award letter and Medicare ID card. Your health insurance coverage will terminate; however, your dental and vision coverage will continue until the first day of the month in which you turn 65.

If you eventually receive a Social Security Disability award and become eligible for Medicare, notify ITG Brands' local P&C team.

## **HEALTH COVERAGE WHEN YOU ARE DISABLED (UNDER AGE 65 RETIREES)**

### **If you become totally and permanently disabled**

and retire under the Retirement Allowance Plan your health coverage will be continued until you become eligible for Medicare. Your dental and vision coverage will continue until you are age 65.

You may continue as a participant under your current health plan at no cost for individual coverage until you become eligible for Medicare. Once you are eligible for Medicare, your health insurance will end. If you are awarded Medicare and your Medicare coverage is later discontinued, you can return to the Company plan at no cost for individual coverage. If you are determined to be not eligible for Medicare or your Medicare coverage is discontinued, you must furnish a copy of the Social Security disability denial letter to the Retirement Plan Administrator.

When you are eligible for Medicare, your Company health coverage will be cancelled. You will be reimbursed for the Medicare Part B standard premium plus \$5.85. Contact the Retirement team immediately when you are approved for Social Security Disability benefits and Medicare. The reimbursement will be included in your pension check. The \$5.85 monthly payment is considered taxable income to you.

You may continue to cover your under age 65 otherwise eligible dependents, if you had them covered when your disability began. You must pay the same amount paid by active employees for dependent coverage.

If you are not eligible for a benefit under the Retirement Allowance Plan (see the separate description of that Plan), your employment is considered terminated at the end of the 24-month illness leave of absence provided for in the collective bargaining agreement. The extension of benefits provision will apply to your disabling illness only.

**Note:** If you reject any of the health insurance options when you are first eligible to elect them, you may not take them in the future.

## **RETIREE HEALTH CARE COVERAGE**

If you are under age 65 when you retire, your medical, dental, and vision coverage that you had as an active employee will continue until you become eligible for Medicare or attain age 65; whichever occurs first. If you relocate outside of North Carolina and were covered as an active employee, you may be covered by one of the plans offered by the Company until you become eligible for Medicare.

When you become eligible for Medicare, you will receive Medicare Part B premium reimbursement plus \$5.85. The reimbursement will be included in your pension check. The \$5.85 monthly payment is considered taxable income to you.

Medicare benefits do not begin automatically. You must apply to your Social Security office to enroll for Medicare. Medicare Part A is hospital insurance which is financed by a separate payroll tax paid equally by you and the Company, while you are working. Medicare Part B is medical (physician's) insurance, financed through monthly cost payments by those who enroll for the coverage — it is optional.

## **VESTED RETIREMENT**

### **If you leave the Company**

and you have at least 5 years of Continuous Service, you will be entitled to a Vested Retirement Allowance from this Plan. The table on page R-3 will be used when you retire, if you leave during this contract period with vested rights to a pension.

### **If you are entitled to a Vested Retirement Allowance,**

you may choose to retire on the first of any month following your 55th birthday if you have 10 years of continuous service, otherwise your retirement date will be age 65. The amount of the Allowance will be based on your Credited Service at the date you leave the Company for any reason, and on a Basic Amount under Figuring Your Retirement Allowance section, depending on your age when payments begin.

### **When you retire,**

if you are married, your pension amount will automatically provide that you share your pension with your spouse, unless you reject that option and your spouse gives written notarized consent.

### **You are NOT entitled to**

any of the additional benefits provided by the Company to employees retiring from active service. The pension you receive from this Plan is the only benefit available to you.

### **When you leave the Company**

with Vested rights, you will know exactly how much you will get at age 65. Within a few weeks of your leaving the Company, we will send you a written statement of the vested benefit you are entitled to. This information also goes to the federal government. Then, when you apply for your Social Security benefit, you will be reminded by the Social Security Administration to apply for your pension from this Retirement Allowance Plan.

### **In the event of your death before your actual retirement,**

your spouse is automatically protected by pre-commencement survivor coverage, unless you waive this coverage. At the time your employment ends, an election form will be supplied to you, on which you must indicate whether you want the coverage or waive it. To cover the cost of this protection, the pension payable to you (and your spouse) is reduced by  $\frac{1}{120}$  of 1% for each month that coverage is in effect prior to age 55 ( $\frac{1}{10}$  of 1% per year) and  $\frac{1}{24}$  of 1% for each month that coverage is in effect after age 55 ( $\frac{1}{2}$  of 1% per year). The period of coverage starts at your date of termination of employment. If you waive the coverage, your spouse must also sign the election form, and the form must be notarized.

## **DELAYING RETIREMENT**

“Normal” Retirement is at age 65. However, you may continue to work past age 65. If you do continue working past age 65, your service will continue to be counted as long as you continue to work.

## **SPOUSE’S BENEFIT BEFORE RETIREMENT**

### **In addition to the survivor protection**

available at retirement for your spouse, there is also an automatic spouse’s protection under the Plan for a period of time before you retire, while you are still working for the Company.

### **This pre-retirement spouse’s protection**

will provide a pension for your husband or wife if you die in active service (or during an absence on disability) before retirement, if you have at least 5 years of service.

### **In the event of your death,**

beginning the first of the month following death, or any month from there to what would have been your normal retirement date (at the election of your spouse), your spouse would begin to receive a pension equal to 50% of the reduced Early or Special Early pension, you would have received, if you had retired on the date of death.

If you had 10 years of continuous service but would not have been eligible for an immediate pension at your date of death, your spouse can elect to receive the benefit starting at any date between the date you would have been age 55 and your normal retirement date. Otherwise your spouse will receive a benefit on your normal retirement date.

This coverage is provided at no cost to you during your employment.

## OTHER IMPORTANT FACTS

### **If you leave the Company after December 31, 1975,**

and are later rehired, you may have your first period of service restored to you under certain circumstances.

### **If you do NOT have a Break in Service**

when you return to the Company, the period of time while you were gone will count as Continuous Service but not for Credited Service. If your return was related to a medical leave for up to 24 months or a period of layoff up to 36 months, the time you were gone will count as Continuous and Credited Service.

### **A Break in Service will occur if you**

- terminate your employment and are not rehired within 12 months after you leave;
- are laid off for more than 36 months;
- don't return to work within 12 months after the end of an approved leave of absence of less than 12 months;
- don't return to work within 12 months of the first anniversary of an approved leave of absence of more than 12 but less than 24 months
- don't return to work after an approved leave of absence of 24 months.

An absence for maternity or paternity reasons which lasts less than 2 years will not be considered a break in service.

### **If you DO have a Break in Service**

and return to the Company, your two periods of service (before and after the break) will be combined IF

- you were eligible for a Vested Retirement Allowance when you left; or
- your break period was shorter than your Continuous Service before the Break, or
- your break period was less than 5 years.

For example, if you had three years of Service before the Break, and were gone for two years before returning, your first three years of service will be restored to you after you return to work.

If you had two years of Service before the Break, and were gone for six years before returning, you will not receive any credit for the years of service before the break.

### **If you transfer from Hourly to Salaried status,**

your years of Service under the Salaried Plan will count as Continuous Service under the Hourly Plan. When you retire, your Hourly Plan pension will be computed based on your Service as an Hourly Plan employee and Continuous Service based on from your time in both the Hourly and Salaried positions.

### **If you transfer back to Hourly status**

from Salaried status, you would again become a member of the Hourly plan, and your Continuous Service under the Salaried plan will count under the Hourly plan. At retirement, your Credited Service will be computed as if you were always an

Hourly employee, reduced by the Credited Service earned when you were not an Hourly employee. Your Continuous Service will be computed as if you were always an Hourly employee, unless any type of Break occurred that would state otherwise.

**See examples below:**

If employee had 20 years as hourly employee and 10 years as salaried employee, how would pension benefit be calculated? On 20 years or 30 years?

If an employee was accruing Credited Service and Continuous Service in the Hourly Plan for 20 years and then transferred to the Salaried Plan and was accruing Credited Service and Continuous Service in the Salaried Plan for 10 years, when computing their Hourly Plan benefit, they would get 20 years of Credited Service and 30 years of Continuous Service, if no applicable breaks occurred.

If said employee above had 20 years as hourly employee, transferred to salaried for 10 years and then back to hourly for 5 years, how would benefit be calculated....25 years or 35 years?

If an employee was accruing Credited Service and Continuous Service in the Hourly Plan for 20 years and then transferred to the Salaried Plan and was accruing Credited Service and Continuous Service in the Salaried Plan for 10 years, then transferred back to the Hourly Plan and accrued 5 additional years of Credited Service and Continuous Service, when computing their Hourly Plan benefit, they would get 25 years of Credited Service and 35 years of Continuous Service, if no applicable breaks occurred.

**In the case of a transfer**

to Salaried status, the amount of pension you might be entitled to from this plan will be computed on the Basic Amount tables in effect at the time you make the transfer to salaried status.

to another union local, the amount of the pension you are entitled to as a member of Local 317-T based on the Basic Amount in effect at the time of transfer and your age at retirement, will be combined with the pension you earn as a member of another local and paid as a single pension from this plan at the time of retirement.

from Local 317-T Danville Tobacco Workers or Local 317-T Danville Craft Workers, the amount of pension you are entitled to as a member of Local 317-T Greensboro will be based on the Basic Amount and age at date of termination reflecting all service including service with the other union local. If, however, you transfer from Local 317-T Danville Craft Workers or Local 317-T Danville Tobacco Workers and are not employed by Greensboro for at least 24 months prior to termination of employment, your benefit as a member of Local 317-T Greensboro will only reflect service as a Local 317-T Greensboro employee. In addition, you will receive a benefit for service with the other union based upon the applicable benefit level in effect at your date of transfer from the other union and your age at termination of employment.

**Your Retirement Allowance**

is taxable as ordinary income in the year received. You will be sent a tax statement each January, to report the amount you got in the previous calendar year.

**Cashout of Small Benefits**

If the total value of your pension is \$1,000 or less, you will receive one lump sum payment of the total value of your pension instead of receiving monthly payments.

**Plan Limitations**

Being a member in the plan does not give an employee the right to remain employed with the Company. Also, you cannot sell, transfer, or assign either voluntarily or involuntarily, the value of any plan account. However, under certain conditions, a court may award all or part of your benefits to a present or former spouse, child or other dependent through a Qualified Domestic Relations Order.

You may obtain information from the Plan Administrator regarding procedures governing Qualified Domestic Relations Order determinations.

## OTHER PLAN INFORMATION

Under the Employee Retirement Income Security Act of 1974 (ERISA), employees are to be provided with the following information about the Retirement Plan described here. If you need more information, contact your local P&C team, or your local office of the U.S. Department of Labor.

**Name of Plan**

ITG Brands Retirement Allowance Plan for Hourly Rated and/or Piece Work Employees  
(Retirement Allowance Plan)

**Plan Type**

Defined Benefit Plan

**Plan Year**

January 1 through December 31

**Plan Number**

004

**Plan Sponsor**

ITG Brands, LLC  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408  
336-335-7000  
EIN: 94-2994213

**Plan Administrator**

ITG Brands, LLC  
628 Green Valley Road,  
Suite 500 Greensboro, NC  
27408  
336-335-7000

The Plan is administered by a Retirement Board appointed by the Board of Directors of ITG Brands, LLC. The Retirement Board generally supervises the operation of the Plan, interpreting its provisions, arranging for retirements, and authorizing benefit payments. Subject to the Plan, the Board shall from time to time establish rules, forms and procedures for the administration of the Plan and the transaction of its business. Except as herein otherwise expressly provided, the Board shall have the exclusive right to interpret the Plan and to decide any matters arising thereunder in connection with the administration of the Plan. Such decisions, actions, and records of the Board shall be conclusive and binding upon the Company and all persons having or claiming to have any right or interest in or under the Plan.

You can contact the Retirement Board by writing to:

The Retirement Board  
c/o Benefits Committee  
ITG Brands, LLC  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408  
336-335-7000

**Agent for Service of Legal Process**

ITG Brands, LLC  
**Benefits Committee**  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408

Legal process may also be served on the Plan Administrator or the Plan Trustee.

**Plan Trustee Information and Plan Funding Medium**

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan assets (unless the investment of assets is subject to Participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed.

The Plan's Trustee is:

J.P. Morgan Chase Bank N.A.  
500 Stanton Christiana Road  
NCC5/Floor 2, Mail Code DE3-4382  
Newark, DE 19713-3159

**Collective Bargaining Agreement**

This plan is maintained pursuant to a collective bargaining agreement. A copy of any such agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and beneficiaries during regular business hours at 2525 E. Market Street, Greensboro, NC 27401.

**Pension Benefit Guaranty Corporation**

Your retirement plan is a defined benefit plan, which means that benefits are figured using a specific formula. Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step into pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough with the Company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you may still receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator, or contact PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, DC. 20005-4026, or call (202) 326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <http://www.pbgc.gov>.

## **Appealing a Claim**

If you feel an error occurred in your records or in processing your request for benefits under the Plan, you should be aware that an appeals procedure is available to every Plan participant.

If your request for benefits is denied in whole or in part, the Retirement Board or one of its agents, such as an insurance company in the case of an insured Plan, will notify you or your authorized representative within 90 days of receiving your request. If special circumstances require an extension of time for processing your claim, you will receive written notice of the extension and the reasons for it before the end of the initial 90 days. The extension will not exceed a period of 90 days from the end of the initial 90-day period. If you do not receive a response to your request within this time limit, you should assume that the request has been denied, and you can begin your appeal.

If you are denied a claim for benefits, you will receive in writing:

- an explanation of the specific reason(s) for denial
- specific references to pertinent Plan provisions on which the denial is based
- a description of any additional material or information necessary for you to properly establish the claim and an explanation of why such material or information is necessary
- an explanation of the steps you or your beneficiary can take to submit the claim for review, the time limits applicable to those procedures and a statement of your right to bring a civil action under ERISA Section 502(a) following the denial of your claim on appeal.

In the case of any denial of a claim for disability retirement benefits, the following additional information shall be provided:

- If the adverse benefit determination was based on an internal rule, guideline, protocol or similar criterion, you will be advised of your right to receive a free copy of such material;
- If the adverse determination was based on a scientific or clinical judgment, you will be advised of your right to receive a free explanation of such judgment; and
- If the Retirement Board obtained the advice of medical or vocational experts in connection with the determination, you will be notified of the identity of such experts, even if the advice was not relied upon by the Retirement Board in rendering its decision.

In the case of any claim for disability retirement benefits, you will be notified within 45 days after the Retirement Board receives the application, unless special circumstances that are beyond the control of the Plan require an extension of time of up to an additional 30 days for processing the application. If such an extension of time for processing is required, you will receive written notice of the extension prior to the termination of the initial 45-day period. This notice of extension shall indicate the special circumstances requiring the extension of time and the date by which the Retirement Board expects to render its decision on the application for benefits. However, if the Retirement Board determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that you are notified by the Retirement Board prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. The notice of any extension shall explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed. You will be afforded a period of 45 days within which to provide the additional specified information.

To appeal a denied claim, you or your authorized representative must, within 60 days of receiving the notice of denial (180 days, in the case of the denial of a claim for disability retirement benefits), submit a written request to the Retirement Board (or its agent) asking that your request be reconsidered. At this time, you or your authorized representative will have the right to review all pertinent Plan documents and submit issues and comments in writing. Also whenever possible, you should send copies of any document or records that support your appeal.

In considering an appeal from the denial of a claim for disability retirement benefits that was based in whole or in part on a medical judgment, the Retirement Board shall consult with a health care professional who has appropriate training and experience in the field of medicine relevant to the claim. Any health care professional retained for this purpose must not have been consulted in connection with the adverse benefit determination that is the subject of the appeal, nor may he be the subordinate of a health care professional who was so consulted. Additionally, the person conducting the review of the adverse benefit determination will not be the person who made the original adverse benefit determination, nor a subordinate of such person. In conducting the review, no deference will be given to the original adverse benefit determination.

A decision regarding your appeal will be made within 60 days (45 days, in the case of the denial of a claim for disability retirement benefits) after receipt of your appeal, unless special circumstances require further time for processing and the applicant is advised of the extension.

In no event shall the decision on review be rendered more than 120 days (or 90 days, in the case of a claim for disability retirement benefits) after the Retirement Board received the request for a review.

The Retirement Board shall give prompt written notice of its decision to the applicant and the Committee. In the event that the Retirement Board confirms the denial of the application for benefits in whole or in part, the notice shall set forth, in a manner calculated to be understood by the applicant, the specific reasons for the decision and specific references to the provisions of the Plan on which the decision is based. In addition, in the case of the Retirement Board's affirmation of the denial of disability retirement benefits, the notice shall set forth:

- The claimant's right to receive, upon request and free of charge, copies of all documents and records relevant to the claim, including any guidelines, protocols or similar criteria that was relied upon by the Retirement Board;
- If relevant, an explanation of any scientific or clinical judgment that was the basis of the determination; and
- The following statement: "You and the 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."

The decision of the Retirement Board on appeal is final and binding on all individuals dealing with or claiming benefits under the Plan.

### **Future of the Plan**

The Company expects to continue the Plan indefinitely. However, since future conditions cannot be foreseen, the Company reserves the right to amend the Plan if required. If the Plan is amended, benefits you have earned prior to the amendment will be protected. The Company agrees not to voluntarily discontinue the Plan, as to eligible employees as defined in the Plan, during the term of present collective bargaining agreements which expire in 2027. If the Plan were ever terminated, its funds would be used for the benefit of members and their beneficiaries, as prescribed by law. Also you will immediately become fully vested in your accrued benefit, to the extent it is funded by the trust.

This booklet only summarizes the main features of your Retirement Allowance Plan. The official Plan and trust agreement govern the actual operation and payment of all benefits.

### **Plan Documents**

This booklet summarizes the key features of the plan. Complete details can be found only in the official plan document which is the governing document in all cases. Copies of this document, as well as the annual report of the plan operations and plan descriptions are available for review by the plan participants or their beneficiaries during normal working hours in your local P&C department. Upon written request to the Plan Administrator, a copy of these documents will be furnished to a plan member or beneficiary within 30 days. The law permits the Company to charge up to 25¢ a page to cover the actual cost of reproducing these documents.

## **Collective Bargaining Agreement**

This plan is maintained pursuant to a collective bargaining agreement. A copy of any such agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.

## **Your Rights Under ERISA**

As a participant in the ITG Brands Retirement Allowance Plan for Hourly Rated and/or Piece Work Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. 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 plan documents governing the plan, including insurance contract and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- 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.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

### **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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have the 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 pension benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

If your claim for a pension benefit is denied or ignored in whole or in part, you have the 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US 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 the plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

# Retirement Stipend

# RETIREMENT STIPEND

## FOR HOURLY RATED EMPLOYEES

For Retirements Effective on or after January 1, 2026

This stipend payment provided is strictly for qualified healthcare expenses and is nontaxable. This stipend is available for eligible medical, dental, and vision insurance premiums paid on a post-tax basis and other health-related costs incurred for medical care as defined in Internal Revenue Code Section 213(d).

This stipend can be used to pay for post-tax medical, dental, and vision insurance premiums for you, your spouse, and for any of your eligible dependents (such as a child or stepchild). You can also use it to pay for other health-related costs incurred for medical care as defined in Internal Revenue Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder (such as hearing aids and blood sugar test kits, for example). The funds can be used to pay for eligible expenses incurred by you as the retiree, your spouse, or an eligible dependent. Your eligible dependents include your spouse and/or any dependent children who you claim as a dependent on your Federal income tax return. If you file your Federal income tax return as Married Filing Separately, that will not impact your spouse's eligibility to use the retirement stipend for covered expenses.

A 3-month notice of retirement is required. Please reach out to the P&C department to provide the notice required. This 3-month requirement does not supersede the General Provision 14 in the Master Agreement.

Your retirement stipend begins on your retirement date that is January 1, 2026 or later and ends when you become eligible for Medicare. The stipend will continue through and including the month prior to Medicare eligibility and then will be discontinued. Medicare coverage will begin the first day of a month.

This stipend will be provided through a Retiree Reimbursement Account (RRA). The full details of the RRA are contained in a plan document for the RRA.

Stipend payments will be front-loaded at the beginning of each year in an amount equal to the total monthly stipends for the year. If your retirement date is other than January 1 of any given year, your front-loaded stipend amount for the year of retirement will include a prorated stipend amount equal to the total monthly stipends for the partial year.

Eligibility for the Retirement Stipend is based on original hire date at the Greensboro factory (years of service from the Reidsville factory do not apply) and service thereafter and as follows:

- If you are hired on or after October 1, 2023, you are ineligible for the Retirement Stipend.
- If you were hired at the Greensboro factory on or after September 1, 2017 and before October 1, 2023, and are age 55 with 10 years of service or have 30 years of service at any age you are eligible for a \$750 Retirement Stipend per month.
- If you were hired at the Greensboro factory prior to September 1, 2017 and are age 55 with 10 years of eligible service or have 30 years of service at any age (where service definitions are meant to mirror the Retirement Allowance Plan), you are eligible for a \$1,500 Retirement Stipend per month.
- If you leave the company for any reason (including layoff) and you are later rehired, your original hire date at the Greensboro factory and subsequent rehire date will be used for purposes of determining years of service for your monthly Retirement Stipend eligibility and amount.

# Profit Sharing Plan

# **PROFIT SHARING PLAN**

**FOR ITG BRANDS HOURLY PAID EMPLOYEES**

# PROFIT SHARING PLAN

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## **BECOMING A PLAN MEMBER**

### **To be eligible**

for membership in the Profit Sharing Plan, you must be an hourly employee hired prior to September 1, 2017, and have had one year of service with the Company.

The measuring period is the year beginning with the date you were hired. If you do not qualify during that first period, subsequent periods will be measured on a calendar year basis.

### **If your employment terminated,**

and you were re-employed within the 12 month period after your original date of hire, see page PS-9.

### **You will actually become a Plan Member**

as of the first pay period nearest the first of the month after you complete the year of service. You must, of course, be working at that time, and not on layoff or on leave of absence. (If you are on leave or layoff, you'll become a member the month after you return to work.)

### **Once you become a Member**

you will remain a Member until

- your termination of employment with the Company;
- your retirement;
- your death. (see "When Accounts are Payable section for details".)

## **COMPANY CONTRIBUTIONS**

### **All Company contributions to the Plan**

have been discontinued effective September 30, 2017. The final Company contribution was made in November 2017.

## **VOLUNTARY CONTRIBUTIONS TO THE PLAN**

### **You can contribute your own money**

to the Plan on a pretax or after-tax basis, under the 401(k) portion of the Plan.

If you make contributions to the Plan on a pretax basis, federal, state and any local taxes will be calculated after your money goes into the Plan. FICA is calculated on your pay before your money goes into the Plan.

If you contribute on an after-tax basis, federal, state, FICA and any local taxes will be calculated before your money goes into the Plan.

Contributions will be made by payroll deduction and deposited directly into the investment options you have selected. (Contributions cannot be deposited directly into the brokerage option. They must first be invested in the plan's primary investment options and moved to the brokerage option later.) Any earnings on your money will accrue tax-free while they remain in the Plan. You'll pay taxes on your pre-tax contributions and on any earnings on your contributions when you terminate from the Plan and receive payment. If you want to defer the taxes, you can roll over the taxable part of your payment into an Individual Retirement Account (IRA) or another employer's savings or retirement plan. Your own after-tax contributions won't be taxed when you receive them from the Plan, because you paid taxes on that money before it went into the Plan.

### **Withdrawals**

You are not permitted to make withdrawals of voluntary or Company contributions from the Plan while you are employed by ITG Brands, LLC.

### **How much you can contribute**

The IRS limits the amount that can be contributed annually to plans like the Profit Sharing Plan. These limits can and often do change annually. The current limits can be obtained by contacting your local P&C team. There are other limits that may also apply to these types of plans. If you are affected by these limits, you will be notified by your local P&C Department.

Subject to the limits discussed above, you can choose to deposit on a weekly basis 1% to 50% of your weekly gross pay based upon a 37 1/2 hour work week at your assigned rate of pay.(including bonus pay and shift differential, but excluding any miscellaneous stimulus payments or other regular or non-regular or one-time payments from the Company). The amount you wish to contribute will be deducted from every paycheck. You'll be able to invest this money in any of the funds offered by the Plan based on your current investment selections (except the brokerage option).

If you want to contribute to the plan, you can do so by calling Empower Retirement at 844-465-4455 or by using Internet access at [www.EmpowerMyRetirement.com](http://www.EmpowerMyRetirement.com)

In the future, if you want to change the amount you are contributing, you can do so by contacting Empower Retirement at 844-465-4455, or by using Internet access at [EmpowerMyRetirement.com](http://EmpowerMyRetirement.com). Requests to change contributions will be processed as soon as administratively possible.

## **VESTING**

You are 100% vested in your accounts under the Plan.

## **INVESTMENT CHOICES**

### **Once you are a Plan member**

the Plan gives you investment choices – and the flexibility to change your investments. You received information about the investment choices in the Plan at an orientation meeting when you were eligible to become a Plan member, as explained on page PS-1. You may also request current fund prospectuses from Empower Retirement by calling 844-465-4455, or using Internet access at [EmpowerMyRetirement.com](http://EmpowerMyRetirement.com). For those desiring the most investment flexibility and choice, the Plan offers a self-directed brokerage option, which gives you access to individual stocks and bonds as well as many other mutual funds.

### **How to Divide Your Investments**

When you invest your plan account, it must be in whole percent, not fractions. You may invest your account in several ways. Investment elections must be made for both your current account balances and your future contributions, and each must add up to 100%.

You may invest your current account balance(s) and your future contributions the same way. Or, you may invest your current account balance one way and future contributions another way. For example, you can put 20% of your current account balance in each of five funds and put 20% of future contributions in the same five funds. Or, you can put 50% of your current account balance in two funds, and 10% of future contributions in one fund and 90% in another fund. Later, you may decide to invest 25% of your current account balance in four funds, and continue to invest 10% of future contributions in one fund and 90% in another fund.

### **Making or Changing Your Investment Elections**

You may make or change your investments by calling Empower Retirement at 844-465-4455 or by using Internet access at [EmpowerMyRetirement.com](http://EmpowerMyRetirement.com)

### **Trading Control Policy**

If you exchange any amount out of certain investment options, you will not be permitted to purchase shares of the same investment through investment transfer activity for 30 days. If an investment is subject to a trading control policy, you will be notified when you make the investment.

## LOANS

Following are the rules that apply to the Profit Sharing Plan loan program.

### Eligibility

All regular active hourly employees with a Profit-Sharing Plan account balance, valued at \$2,000 or more, are eligible to apply for a loan from their Profit-Sharing account. To apply for a loan, contact Empower Retirement at 844-465-4455.

### Types of Loans

There are two types of loans available: General Purpose and Home Purchase.

- General Purpose Loan may be used for any purpose.
- Home Purchase Loan must be used for the purchase of the primary residence of the employee. Documentation must be submitted.

A Plan member may have up to, but no more than, three loans outstanding at any time: two General Purpose loans and one Home Purchase loan. Only one loan may be taken in each calendar year, with at least a six month time period between each loan.

If you have an active loan that is not current and have an arrears balance, you are not eligible to request a new loan or refinance an existing loan until the outstanding, arrears balance has been paid and satisfied.

### Loan Amount

**Minimum:** For either type of loan, the minimum you may borrow is \$1,000.

**Maximum:** The maximum you may borrow, whether you have one to three loans, is the lesser of 50% of your account balance or \$50,000, minus your highest outstanding loan balances in the prior 12 months. Please contact Empower Retirement for the maximum amount available for your particular situation.

- Loan amounts must be in whole increments of \$100.
- Maximum amount available for a loan will be estimated based on the most current account balance available at the time your loan is applied for.
- Final approval of your loan application is contingent upon your eligibility under Plan rules and the actual availability of funds in your account at the time the loan is granted.

### Interest Rate

The interest you pay on your loan goes into your account in the Profit Sharing Plan. The interest payments you make will be taxable income when they are paid out in the future. The interest rate will be competitive, and is set by the Plan Administrator.

### Loan Repayment Terms

- General Purpose Loan — Must be repaid over a period of 1 to 5 years.
- Home Purchase Loan — May be repaid from 1 to 15 years, in whole year increments only.

- Repayment — Will be made through automatic payroll deductions from every paycheck based on a schedule provided to you with the Promissory Note/Disclosure Statement. The repaid principal and interest will go into your account in the Plan in accordance with your investment fund selections.
- Prepayment — You may repay your loan in full if approved by the Plan Administrator. Partial prepayments are not permitted.
- Loan repayments cannot be more than 30% of your weekly net pay based on a 37 1/2 hour week at your assigned rate of pay, excluding shift differential.
- Loans not repaid within the maximum term will be treated as taxable distributions in accordance with IRS regulations.

## **Refinancing**

General Purpose Loan-You can increase your general purpose loan amount by refinancing. To refinance your existing loan, you must apply for and be approved for a new loan. Proceeds from the new loan are first used to pay off the existing balance on the old loan; then you receive the remaining loan amount. The maximum term of five years from the date of the original loan cannot be exceeded.

Home Purchase Loan-You can extend your home purchase loan repayment period or possibly secure a lower interest rate by refinancing. Home purchase loans can only be refinanced after five years, but the maximum term of 15 years cannot be exceeded. You cannot increase the amount of a home purchase loan by refinancing.

All refinanced loans will be issued at rates in effect on the date the loan is applied for.

## **Defaults**

A loan payment will be considered to be delinquent if it is not made within 90 days of its due date. You may cure a delinquent loan payment by making the payment by the last day of the calendar quarter following the calendar quarter in which the payment was due. If you do not cure the delinquent loan payment by the last day of the calendar quarter following the calendar quarter in which the loan payment was initially due, the loan will be considered in default on that date. If you default on a loan, the entire amount of the unpaid principal, plus interest, will become immediately due. You may also owe taxes and IRS penalties on the unpaid portion of your loan(s). When you leave the Company, all loan balances must be paid in full within 30 days. If you do not repay the entire amount at that time, the unpaid balance will become taxable income and subject to any IRS penalties applicable at that time.

## **Processing Schedule**

Allow 30 days from the date your application is received by Empower Retirement for receipt of your loan proceeds.

## **Termination or Transfer**

If you retire or leave the Company for any reason other than layoff (including death), you or your beneficiary must repay the loan in full or the remaining balance will be considered a taxable distribution. The unpaid balance of the loan is due and payable within 30 days of termination, retirement or death. Any repayment should be made by certified or cashier's check, and if not paid by the end of the month following the month of termination, retirement or death, it will be treated as a taxable distribution. Please contact Empower for the

repayment amount.

If you are laid off, you have the option to reamortize your loan over the existing loan term, and have monthly payments drafted directly from your bank account by Empower. If you do not elect this option, then your loan will become due and payable within 30 days of your layoff, and you must repay the loan in full or the remaining balance will be considered a taxable distribution. Any repayment should be made by certified or cashier's check, and if not paid by the end of the month following the month of layoff, it will be treated as a taxable distribution. Please contact Empower for the repayment amount.

## **FUND VALUATION**

Money collected through voluntary payroll contributions is transferred to the Trustee weekly. Contributions are invested in accordance with your investment elections.

### **The Trust Fund**

is valued daily. This means that each day after the financial markets close, the day's market activity for each fund will be reflected in your account the next day. If the investment funds that you invested in appreciated (went up) in value, your individual account will share in the increase. If the investment funds you invested in depreciated (went down), your Account will decrease in value.

### **Statements**

Quarterly statements are issued reflecting your total account balance including any Company contributions, employee contributions, and investment gains or losses.

### **Telephone and Internet Access**

By calling the Empower Retirement at 844-465-4455 you can:

- receive information on your account balance
- transfer account balances between investment funds
- receive investment performance information
- change your Personal Identification Number (PIN)
- apply for a loan
- receive information on prepaying your loan

Or, by using Internet access at you can:

- receive information on your account balance
- transfer account balances between investment funds
- receive investment performance information
- change your Personal Identification Number (PIN)

## WHEN ACCOUNTS ARE PAYABLE

### Once you become a Plan Member

you remain a Member for as long as you have some “relationship” with the Company. As long as there is a relationship, there can be no payment from the Trust Fund of Profit Sharing accounts. However, you must begin to receive distributions as of the later of the date you reach age 73 or retire.

#### A “relationship” with the Company includes

- time on approved absence, up to 24 months;
- absence during a period of military service;
- employment by ITG Brands, LLC as a salaried employee, or employment in any capacity by a related company of ITG Brands, LLC.

### You will become a “Former Member”

and your Account will be paid out if

- you terminate your employment with the Company;
- you are laid off from the Company;
- you retire under the Company’s Retirement Allowance Plan;
- you do not return to work after military service within the time limits prescribed by law;
- you do not return to work after leave of absence, within the time limits prescribed in the Seniority Article of the collective bargaining agreement;
- your death occurs.

### If your Account becomes payable

for any of the above reasons, you or your beneficiary may elect to receive your Account value as soon as practicable. The following distribution options are available to you if your Account balance is greater than \$1,000:

- Lump sum payment
- Monthly payments not to exceed a period of 20 years
- Quarterly payments not to exceed a period of 20 years
- Leave the money in your Account until you are age 73.

OR

- If your Account balance is \$1,000 or less, you will receive a lump sum payment of your Account balance.

In the event of your death with an account balance under the Plan, your beneficiary will have the following options:

Lump sum payment and the choice to roll the distribution over into an IRA

If your Account balance is greater than \$1,000 and your beneficiary is your spouse, electing to leave the money in the account until she or he is age 73.

## **Beneficiary Designations**

When you first become a Plan Member, you will be asked to fill out a beneficiary form, naming the person(s) you wish to receive your Profit Sharing account in the event of your death.

**If you are not married**, you can name anyone as your beneficiary or name more than one person if you wish. (You must state each person's share if you have more than one beneficiary.)

**If you are married**, you cannot name anyone other than your spouse as beneficiary unless the beneficiary designation form has been signed by your spouse and notarized. This applies even if you want to name someone other than your spouse as a partial beneficiary.

Remember that, if your personal situation should change, you should check to make sure that your beneficiary card lists the person or persons you wish to receive this benefit.

## **It is very important**

if you leave the Company, to make sure that we have your correct mailing address, so that your Account payment can be sent to you when payable. If the Company cannot locate you or your Beneficiary at the time a benefit becomes payable under the Plan, or if a check is issued to you or your Beneficiary and remains uncashed, your Account under the Plan may be forfeited. If you later make a claim for your benefit under the Plan and the Plan has not been terminated, your Account will be restored to you, without interest. If the Plan is terminated and you or your Beneficiary cannot be located, the Company may set up an individual retirement account or interest bearing bank account in your name and transfer your Account there, or it may deliver your Account to the unclaimed property fund of the state where you last resided, based on Company records.

## **Taxes on Distributions**

When you receive a distribution from the Plan, you will be responsible for paying income taxes on:

- Pretax contributions,
- Company contributions,
- Investment earnings on the Company contributions, pretax and after tax contributions, if applicable.

Generally, taxable income that is not directly rolled over into an IRA or other qualified plan will be subject to 20% federal income tax withholding. Be sure to read the Special Tax Notice that is included in your distribution packet.

If you receive a distribution prior to age 59 1/2, you will generally pay an additional 10% tax on the taxable portion of your distribution. However, the additional tax does not apply if the distribution is:

- Made because of death or total disability,
- Paid out under a court-ordered qualified domestic relations order,
- Directly rolled over into another qualified plan or Individual Retirement Account (IRA),

- Used for certain deductible medical expenses,
- Made due to termination of employment/retirement after age 55.

Depending on your age and years of Plan Participation, you may be eligible for favorable treatment of your distribution, such as five-year or 10-year averaging. Because tax laws can be complicated, you may want to consult a financial advisor before you receive a distribution from the Plan.

## **OTHER IMPORTANT FACTS**

### **Re-Employment**

#### **If your employment terminates**

and you are later rehired, your Plan membership will depend on your status when you left.

- If you were a Plan Member when you left, you will again become a Member as of the pay period nearest the first of the month following your re-employment date.
- If you were not a Plan member when you left, you will become a Plan member only when and if you meet the eligibility requirements (see Becoming a Plan Member section for details). Your service will be measured from your original date of hire.

#### **Check with your local P&C team**

for your own status if this re-employment situation should occur.

### **Claims for Benefits**

#### **Claims Procedures**

A plan participant or beneficiary may make a claim for benefits under the Plan. Any such claim you file must be submitted to the Plan Administrator in a form and manner acceptable to the Plan Administrator. Contact the Plan Administrator for more information. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim within 90 days after receipt of your claim. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of the initial period the Plan Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, a description of additional material or information necessary for the claimant to perfect the claim and an explanation of why it is required, and information about the steps that must be taken to submit a timely request for review, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review.

#### **Review Procedures (For Appeal of an Adverse Benefit Determination)**

You may appeal the denial of your claim made under the procedures described above within 60 days after the date following your receipt of notification of the denied claim by

filing a written request for review with the Plan Administrator. This written request may include comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim on review within 60 days after receipt of your appeal. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period the Plan Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim on review is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The Plan Administrator shall provide you with written notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by you – the specific reason or reasons for the adverse determinations, reference to the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

### **Plan Costs**

Some fees, such as administrative fees, plan loan fees, etc. are charged directly to the account of an affected Participant. A complete list of plan fees chargeable to your account under the Plan is available from your local P&C team and in the annual fee disclosure statement you receive from the Plan Administrator.

### **Participation in the Plan**

does not give an employee the right to keep his or her job. Your Account in the Plan may not be sold or transferred, except as provided by law. Assignment is permitted only to the extent of 10% of any benefit payable, and any assignment made may be revoked by you. However, under certain circumstances, a court may award all or part of your benefits to a present or former spouse, child or other dependent through a Qualified Domestic Relations Order.

You may obtain information from the Plan Administrator regarding procedures governing Qualified Domestic Relations Order determinations.

## OTHER PLAN INFORMATION

Under the Employee Retirement Income Security Act of 1974 (ERISA), employees are to be provided with the following information about the Profit Sharing Plan described in this booklet. If you need more information, contact your People & Culture Department or your local U.S. Department of Labor office.

### **Name of Plan**

Profit Sharing Plan for ITG Brands, LLC Hourly Paid Employees

### **Plan Type**

Defined Contribution Plan

### **Plan Year**

October 1 through September 30

### **Plan Number**

003

### **Plan Sponsor**

ITG Brands, LLC  
628 Green Valley Road, Suite  
500 Greensboro, NC 27408  
336-335-7000  
EIN: 94-2994213

### **Plan Administrator**

ITG Brands, LLC  
628 Green Valley Road, Suite  
500 Greensboro, NC 27408  
336-335-7000

The Plan Administrator has delegated its duties to a Benefits Committee selected by the Company. Subject to the Plan, the Committee shall from time to time establish rules, forms and procedures for the administration of the Plan and the transaction of its business. Except as herein or otherwise expressly provided, the Committee shall have the exclusive right to interpret the Plan and to decide any matters arising thereunder in connection with the administration of the Plan. Such decisions, actions, and records of the Committee shall be conclusive and binding upon the Company and all persons having or claiming to have any right or interest in or under the Plan.

### **Plan Trustee Information and Plan Funding Medium**

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan assets (unless the investment of assets is subject to Participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed.

The Plan's Trustee is:

Great-West Trust Company, LLC  
8525 E Orchard Rd  
Greenwood Village, CO 80111

**Agent for Service of Legal Process**

**Benefits Committee**

ITG Brands, LLC  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408

Legal Process may also be served on the Trustee or Plan Administrator.

**Collective Bargaining Agreement**

This plan is maintained pursuant to a collective bargaining agreement. A copy of any such agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and beneficiaries during regular business hours at 2525 E. Market Street, Greensboro, NC 27401.

**Future of the Plan**

The Company expects and intends to continue this Plan indefinitely, but reserves the right to amend or terminate it, or discontinue the payment of contributions should business conditions warrant such action. If the Plan is amended, however, your existing rights would not be adversely affected. If the Company terminates the Plan, the balance of your Accounts would become payable to the extent permitted by applicable IRS requirements.

**Your Rights Under ERISA**

As a participant in the Profit Sharing Plan for ITG Brands, LLC Hourly Paid Employees you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. 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 plan documents governing the plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- 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.
- Obtain a statement telling you the fair market value of your vested, accrued benefit, as of the date for which the benefits are reported, if you stop working under the Plan now. If you do not have a right to a benefit under the plan, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

### **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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have the 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 benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored in whole or in part, you have the 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plans' decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US 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 the plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

# 401(K) Savings Plan

**401(K) SAVINGS PLAN**

**FOR ITG BRANDS HOURLY EMPLOYEES  
HIRED ON OR AFTER SEPTEMBER 1, 2017**

**ITG HOLDINGS USA, INC. EMPLOYEE SAVINGS AND  
RETIREMENT PLAN**

# ITG HOLDINGS USA, INC. EMPLOYEE SAVINGS AND RETIREMENT PLAN

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## **BECOMING A PLAN MEMBER**

### **To be eligible**

for membership in the ITG Holdings USA, Inc. Employee Savings and Retirement Plan, you must be an hourly employee hired September 1, 2017 and later, be age 21 or older and have completed 90 days of service with the Company. You will automatically be enrolled on your 91<sup>st</sup> day of employment at a 2% pre-tax contribution rate unless you elect to opt out or make a different election.

### **Once you become a Member**

you will remain a Member until

- your termination of employment with the Company;
- your death

## **CONTRIBUTIONS TO THE PLAN**

### **You can contribute**

from 1%-90% of your eligible compensation as pretax or Roth contributions, or a combination, up to the annual IRS dollar limits.

If you make contributions to the plan on a pretax basis, federal, state and any local taxes will be calculated after your money goes into the plan. FICA is calculated on your pay before your money goes into the plan.

If you contribute on a Roth basis, federal, state, FICA and any local taxes will be calculated before your money goes into the Plan. Roth contributions allow you to make aftertax contributions and take any associated earnings completely tax-free at retirement, as long as the distribution is a qualified one. A qualified distribution, in this case, is one that is taken at least five tax years after your first Roth contribution and after you have attained age 59 ½, or become disabled or die.

Contributions will be made by payroll deduction and deposited directly into the investment options you have selected or if no selection is made, contributions will be deposited into the Plan's default fund, the JPMorgan SmartRetirement Fund based on your anticipated retirement date.

The Company will match 100% of the first 6% of pretax and/or Roth contributions you make to Plan.

You are always 100% vested in your own contributions and any company matching contributions to your Plan account, as well as any earnings on them.

..

## INVESTMENT CHOICES

### Once you are a Plan member

the Plan offers you a range of options to help meet your investment goals. You can select a mix of investment options that best suit your goals, time horizon, and risk tolerance. Complete descriptions of the Plan's investment options and their performance, as well as planning tools to help you choose an appropriate mix, are available online at [www.netbenefits.com](http://www.netbenefits.com). For those desiring the most investment flexibility and choice, the Plan offers a self-directed brokerage option, which gives you access to individual stocks and bonds as well as many other mutual funds.

### Making or Changing Your Investment Elections

You may make or change your investments by calling Fidelity at 800-835-5095 or by using Internet access at [www.netbenefits.com](http://www.netbenefits.com).

## LOANS & WITHDRAWALS

Following are the rules that apply to the loan program.

### Eligibility

All regular active hourly employees hired September 1, 2017, and later that has met eligibility requirements to participate in the Plan, with an account balance, valued at \$2,000 or more, are eligible to apply for a loan from their account. To apply for a loan, contact Fidelity at 800-835-5095 or at [www.netbenefits.com](http://www.netbenefits.com).

### Types of Loans

There are two types of loans available: General Purpose and Home Purchase.

- General Purpose Loan may be used for any purpose.
- Home Purchase Loan must be used for the purchase of the primary residence of the employee. Documentation must be submitted.

A Plan member may have no more than one loan outstanding at any time.

### Loan Amount

**Minimum:** For either type of loan, the minimum you may borrow is \$1,000.

**Maximum:** The maximum you may borrow is the lesser of 50% of your account balance or \$50,000 minus your highest outstanding loan balances in the prior 12 months. Please contact Fidelity for the maximum amount available for your particular situation.

**Interest Rate**

The interest you pay on your loan goes into your account in the Plan. All loans shall bear a reasonable rate of interest as determined by the Plan Administrator based on the prevailing interest rates charged by persons in the business of lending money for loans which would be made under similar circumstances. The interest rate shall remain fixed throughout the duration of the loan.

**Loan Repayment Terms**

- General Purpose Loan — Must be repaid over a period of no more than 5 years.
- Home Purchase Loan — Must be repaid over a period of no more than 15 years.
- Repayment — Will be made through automatic payroll deductions based on a schedule provided at time of application. The repaid principal and interest will go into your account in the Plan in accordance with your investment fund selections.
- Prepayment — You may repay your loan in full if approved by the Plan Administrator. Partial prepayments are also permitted.
- Loans not repaid within the maximum term will be treated as taxable distributions in accordance with IRS regulations.

**Defaults**

The Plan Administrator shall consider a loan in default if any scheduled repayment remains unpaid as of the last business day of the calendar quarter following the calendar quarter in which a loan is initially considered past due. In the event of a default, the entire outstanding principal and accrued interest shall be immediately due and payable. If you terminate your employment, you may continue to repay your loan. Any default in repayment to the Plan will result in the treating of the balance due for your loan as a taxable distribution to you.

**Withdrawals**

Withdrawals from the Plan are generally permitted when you attain age 59 ½, terminate your employment, retire or become permanently disabled, or have severe financial hardship as defined by the Plan. Refer to the Summary Plan Description or call Fidelity for more details.

## WHEN ACCOUNTS ARE PAYABLE

**A distribution can be made to you if you request one due to**

- disability
- retirement or termination of employment
- death

**If your Account becomes payable**

the following distribution options are available to you if your Account balance is greater than \$1,000:

- Lump sum distributions
- Partial distributions
- Installment distributions
- Leave the money in your Account until you are age 73

OR

- If your Account balance is \$1,000 or less, you will receive a lump sum distribution of your Account balance.

### **Beneficiary Designations**

When you first become eligible to participate in the Plan, you should complete online beneficiary information at [www.netbenefits.com](http://www.netbenefits.com). Select Profile, then Beneficiaries and follow the steps to designate your beneficiary.

**If you are not married**, you can name anyone as your beneficiary or name more than one person if you wish. (You must state each person's share if you have more than one beneficiary.)

**If you are married**, you cannot name anyone other than your spouse as beneficiary unless you have spousal consent. If you designate someone other than your spouse, a form will be sent for completion. The completed notarized form must be sent back to Fidelity to complete your request.

Remember that, if your personal situation should change, you should check to make sure that your beneficiary is updated online.

### **Taxes on Distributions**

When you receive a distribution from the Plan, you will be responsible for paying income taxes on the distribution. Because tax laws can be complicated, you may want to consult a financial advisor before you receive a distribution from the Plan.

## OTHER IMPORTANT FACTS

### Participant Rights

#### B. Claims

##### 1. Claims Procedures

A plan participant or beneficiary may make a claim for benefits under the Plan. Any such claim you file must be submitted to the Plan Administrator in a form and manner acceptable to the Plan Administrator. Contact the Plan Administrator for more information. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim within 90 days after receipt of your claim. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of the initial period the Plan Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, a description of additional material or information necessary for the claimant to perfect the claim and an explanation of why it is required, and information about the steps that must be taken to submit a timely request for review, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review.

##### 2. Review Procedures (For Appeal of an Adverse Benefit Determination)

You may appeal the denial of your claim made under the procedures described above within 60 days after the date following your receipt of notification of the denied claim by filing a written request for review with the Plan Administrator. This written request may include comments, documents, records, and other information relating to your claim for benefits. You shall be provided, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Generally, the Plan Administrator will provide you with written notice of the disposition of your claim on review within 60 days after receipt of your appeal. If the Plan Administrator determines that special circumstances require an extension of time to process your claim, the Plan Administrator will furnish written notice of the extension to the claimant prior to the expiration of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period the Plan Administrator had to dispose of your claim. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination. In the event the claim on review is denied, the Plan Administrator will disclose to you in writing the specific reasons for the denial, a reference to the specific provisions of the Plan on which the determination is based, and a statement of your right to bring a civil action under Section 502(a) of ERISA.

The Plan Administrator shall provide you with written notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by you – the specific reason or reasons for the adverse determinations, reference to the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

### **C. Statement of ERISA Rights**

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

#### **1. Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. 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 each year.
- Obtain a statement telling you the fair market value of your vested, accrued benefit, as of the date for which the benefits are reported, if you stop working under the Plan now. If you do not have a right to a benefit under the plan, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

#### **2. Prudent Actions by Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you, 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 retirement benefit or exercising your rights under ERISA.

### **3. Enforce Your Rights**

Subject to the time limitation described below, if your claim for a benefit under the Plan 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 until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. The Plan's agent for legal service of process in the event of a lawsuit is the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations 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 frivolous.

### **4. 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 your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

#### **D. When to Bring an Action in Court**

You may file a lawsuit regarding the denial of an appeal after following the claims and review procedures above. You must file any lawsuit within 12 months after the date the Plan Administrator issued its final decision on an appeal. If you do not file a claim or exhaust the claims review process for any reason, any lawsuit must be filed within 12 months of the date of the conduct at issue in the lawsuit (which includes, among other things, the date you became entitled to any Plan benefits at issue in the lawsuit). If you fail to file a lawsuit within these timeframes, you will lose your right to bring the lawsuit at any later time.

## OTHER PLAN INFORMATION

Under the Employee Retirement Income Security Act of 1974 (ERISA), employees are to be provided with the following information about the Profit Sharing Plan described in this booklet. If you need more information, contact your People & Culture Department or your local U.S. Department of Labor office.

### **Name of Plan**

ITG Holdings USA, Inc. Employee Savings and Retirement Plan

### **Plan Type**

Defined Contribution Plan

### **Plan Year**

January 1 through December 31

### **Plan Number**

001

### **Plan Sponsor**

ITG Brands, LLC  
628 Green Valley Road,  
Suite 500 Greensboro,  
NC 27408  
336-335-7000  
EIN: 94-2994213

### **Plan Administrator**

ITG Brands, LLC  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408  
336-335-7000

The Plan Administrator has delegated its duties to a Benefits Committee selected by the Company. Subject to the Plan, the Committee shall from time to time establish rules, forms and procedures for the administration of the Plan and the transaction of its business. Except as herein or otherwise expressly provided, the Committee shall have the exclusive right to interpret the Plan and to decide any matters arising thereunder in connection with the administration of the Plan. Such decisions, actions, and records of the Committee shall be conclusive and binding upon the Company and all persons having or claiming to have any right or interest in or under the Plan.

### **Plan Trustee Information and Plan Funding Medium**

All money that is contributed to the Plan is held in a trust fund. The Trustee is responsible for the safekeeping of the trust fund and must hold and invest Plan

assets (unless the investment of assets is subject to Participant or other direction) in a prudent manner and in the best interest of you and your beneficiaries. The trust fund established by the Plan's Trustee(s) will be the funding medium used for the accumulation of assets from which benefits will be distributed.

**The Plan's Trustee is:**

Fidelity Management Trust Company  
245 Summer Street  
Boston, MA 02210

**Agent for Service of Legal Process**

**Benefits Committee**

ITG Brands  
628 Green Valley Road, Suite 500  
Greensboro, NC 27408

Legal Process may also be served on the Trustee or Plan Administrator.

**Collective Bargaining Agreement**

This plan is maintained in part pursuant to a collective bargaining agreement. A copy of any such agreement may be obtained upon written request to the Plan Administrator and is available for examination by participants and beneficiaries during regular business hours at 2525 E. Market Street, Greensboro, NC 27401.

**Future of the Plan**

The Company expects and intends to continue this Plan indefinitely, but reserves the right to amend or terminate it, or discontinue the payment of contributions should business conditions warrant such action. If the Plan is amended, however, your existing rights would not be adversely affected. If the Company terminates the Plan, the balance of your Accounts would become payable to the extent permitted by applicable IRS requirements.

# Appendices

# APPENDICES

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# Appendix A-Employees Hired Prior to 9/1/17

## 2025 Medical Plans



UnitedHealthcare (UHC) has one of the largest provider networks in the U.S., and with new providers added every year, the network continues to grow. For more information and to find a provider, go to [myuhc.com](http://myuhc.com) (current members) or [uhc.com](http://uhc.com) (new members for 2025).

You have the following UHC medical plan options to choose from:

	Choice Plus Plan		Choice Plan		Choice Value Plan	
 <b>ANNUAL EMPLOYEE CONTRIBUTION</b>	HIRED PRE-SEPT 1, 2011	HIRED 9/1/11 TO 8/31/17	HIRED PRE-SEPT 1, 2011	HIRED 9/1/11 TO 8/31/17	HIRED PRE-SEPT 1, 2011	HIRED 9/1/11 TO 8/31/17
	<b>Employee Only</b>	\$ 0	\$2,084	\$ 0	\$1,929	\$ 0
<b>Employee + 1</b>	\$4,862	\$6,945	\$2,390	\$4,319	\$1,397	\$2,395
<b>Family</b>	\$7,176	\$9,259	\$4,018	\$5,947	\$2,062	\$3,060
<b>DUAL EMPLOYEE FAMILY (based on hire date)</b>						
<b>Both Pre-Sept 1, 2011</b>	\$3,703		\$ 546		\$1,064	
<b>One Pre-/One Post-Sept 1, 2011</b>	\$5,787		\$2,629		\$2,062	
<b>Both Post-Sept 1, 2011</b>	\$7,870		\$4,713		\$3,060	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY		IN-NETWORK	OUT-OF-NETWORK
<b>Office Visit Copay</b>						
• Primary Care	\$17	Plan pays 80% after deductible	\$17		\$25	Plan pays 60% after deductible
• Specialist	\$17		\$17		\$50	
<b>Emergency Room Copay</b>	\$120	\$120	\$120		\$120	\$120
<b>Outpatient Surgery</b>	\$125	Plan pays 80% after deductible	\$125		\$125	Plan pays 60% after deductible
<b>Deductible</b>		\$300 Individual			\$1,200 Individual	\$2,400 Individual
Not applicable to Prescription Drug Coverage	None	\$900 Family	None		\$2,400 Family	\$4,800 Family
<b>Coinsurance</b>	Plan pays 80% – 100%	Plan pays 80% after deductible	Plan pays 80% – 100%		Plan pays 80% after deductible	Plan pays 60% after deductible
<b>Out-of-Pocket Maximum</b>	\$500 Individual	\$1,000 Individual	\$500 Individual		\$6,000 Individual	\$12,000 Family
• Medical	\$1,000 Family	\$2,000 Family	\$1,000 Family			
<b>Out-of-Pocket Maximum</b>	\$6,100 Individual		\$6,100 Individual			
• Prescription Drug	\$12,200 Family		\$12,200 Family			
<b>Preventive Care</b>	Select services covered at 100%	Plan pays 80% after deductible	Select services covered at 100%		Select services covered at 100%	Plan pays 60% after deductible
<b>Prescription Drugs</b>	RETAIL:	MAIL*:	RETAIL:	MAIL*:	RETAIL:	MAIL*:
• Generic	\$9	\$18	\$9	\$18	\$9	\$18
• Brand-Preferred	\$18	\$36	\$18	\$36	You pay 30% (min \$25/max \$60)	You pay 30% (min \$50/max \$120)
• Brand-Non-Preferred	\$28	\$56	\$28	\$56	You pay 50% (min \$40/max \$80)	You pay 50% (min \$80/max \$160)

\*90-day supply

For Medical Plan details, please see the summary description for Benefits Provided Under Collective Bargaining Agreements Negotiated with Local 317-T Greensboro Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC) Agreement Effective October 1, 2023 to September 30, 2027, As Amended.

# Appendix B-Employees Hired Prior to 9/1/17



## The Medical Plan (cont.)

ITGB offers Hinge Health to employees and spouses enrolled in a company medical plan. Hinge Health offers access to virtual physical therapy that can help you manage back or joint pain without drugs and surgery, and is provided **at no cost to you**. This program gives you access to exercise therapy tailored to your needs, technology for instant in-app feedback, and personal coaching from a physical therapist.

To learn more, contact Hinge Health online at <https://hinge.health/itbrands-enroll> or call **855-902-2777**.



### ANNUAL EMPLOYEE DENTAL CONTRIBUTION

	HIRED PRE-SEPT 1, 2011	HIRED 9/1/11 TO 8/31/17
<b>Employee Only</b>	\$ 0	\$ 80
<b>Employee + 1</b>	\$148	\$228
<b>Family</b>	\$356	\$436
<b>Dual Employee Family Coverage Levels (based on hire date):</b>		
• Both Pre-Sept 1, 2011		\$223
• One Pre-/One Post-Sept 1, 2011		\$303
• Both Post-Sept 1, 2011		\$383

## The Dental Plan



For more information or to check on the status of your claim, go to [cigna.com](http://cigna.com) or call Cigna Healthcare toll-free at 800-244-6224. You'll receive discounts on services when you see a participating network provider.



### IN-NETWORK MEMBER COST

<b>Annual Deductible</b>	\$50 per person
<b>Preventive and Diagnostic Care</b>	Services covered at 100% of reasonable and customary (R&C) charges (no deductible)
<b>Basic Services</b>	Services covered at 100% of R&C, subject to pretreatment plan from your dentist
<b>Major Services</b>	Services covered at 70% of R&C charge after the deductible
<b>Orthodontia</b>	Installation of orthodontic appliances and treatment (insured pretreatment plan applies) covered at 70% of R&C charges after the deductible, \$1,500 lifetime maximum
<b>Annual Maximum</b>	\$1,500 per person; \$1,000 per person for Periodontal services

*For Dental Plan details, please see the summary description for Benefits Provided Under Collective Bargaining Agreements Negotiated with Local 317-T Greensboro Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC) Agreement Effective October 1, 2023 to September 30, 2027, As Amended.*



## The Vision Plan

Out-of-network benefits are available, but it pays to stay in-network. For more information go to [myuhcvision.com](http://myuhcvision.com) or call UHC Vision toll-free at 800-638-3120.



### IN-NETWORK MEMBER COST

<b>Eye Exam</b> (Once every 12 months)	
<ul style="list-style-type: none"> <li>For eyeglasses, with or without dilation, as necessary</li> <li>For necessary or elective contact lenses, fit and follow-up</li> </ul>	\$10 copay
<b>Spectacle Lenses</b> (Once every 12 months)	
<ul style="list-style-type: none"> <li>Single Vision, Bifocal, Trifocal or Lenticular</li> </ul>	\$10 copay
<b>Frames</b> (Once every 24 months)	
<ul style="list-style-type: none"> <li>Private practice provider</li> <li>Retail chain provider</li> </ul>	Private practice provider: \$130 frame allowance Retail chain provider: \$130 retail frame allowance
<b>Lens Options</b> (Once every 12 months)	
<ul style="list-style-type: none"> <li>UV coating, tint (solid and gradient), standard polycarbonate, standard anti-reflective coating, other add-ons and services</li> <li>Standard scratch resistance</li> </ul>	Discount varies by provider  Standard scratch resistance: \$0
<b>Contact Lenses</b> (in lieu of standard plastic lenses; includes materials only) (Once every 12 months)	
<ul style="list-style-type: none"> <li>Elective contacts in lieu of eyeglasses:</li> <li>Necessary contacts in lieu of eyeglasses:</li> </ul>	Covered in full after copay Plan pays in full after copay
<b>Laser Vision Correction</b>	
<ul style="list-style-type: none"> <li>Lasik or Lasik Plus (from Laser Vision Network of America (LVNA))</li> </ul>	15% off retail price or 5% off promotional price

*For Vision Plan details, please see the summary description for Benefits Provided Under Collective Bargaining Agreements Negotiated with Local 317-T Greensboro Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC) Agreement Effective October 1, 2023 to September 30, 2027, As Amended.*

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### ANNUAL EMPLOYEE VISION CONTRIBUTION

	HIRED PRE-SEPT 1, 2011	HIRED 9/1/11 TO 8/31/17
Employee Only	\$ 0	\$13
Employee + 1	\$28	\$41
Family	\$37	\$50
<b>Dual Employee Family Coverage Levels (based on hire date):</b>		
<ul style="list-style-type: none"> <li>Both Pre-Sept 1, 2011</li> <li>One Pre-/One Post-Sept 1, 2011</li> <li>Both Post-Sept 1, 2011</li> </ul>		\$15 \$29 \$42



# Appendix D-Employees Hired 9/1/17 and Later

## 2025 Medical Plans



UnitedHealthcare (UHC) has one of the largest provider networks in the U.S., and with new providers added every year, the network continues to grow. For more information and to find a provider, go to [myuhc.com](http://myuhc.com) (current members) or [uhc.com](http://uhc.com) (new members for 2025).

You have the following UHC medical plan options to choose from:

★ NEW FOR 2025 (Shown in orange)

	Health Savings Plan		Copay Plan		Basic Plan	
ANNUAL EMPLOYEE CONTRIBUTION						
<b>Employee Only</b>	\$1,067		\$2,960		\$2,144	
<b>Employee + Spouse</b>	\$2,134		\$5,920		\$4,288	
<b>Employee + Child(ren)</b>	\$1,921		\$5,328		\$3,859	
<b>Family</b>	\$2,988		\$8,287		\$6,003	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<b>Company HSA/ HRA Contributions</b>	The Company contributes \$500 or \$1,000 to your HSA annually; you and your spouse can also earn up to \$300 each for completing wellness activities		You and your spouse can each earn up to \$300 for completing wellness activities		You and your spouse can each earn up to \$300 for completing wellness activities	
<b>Deductibles</b>	<b>\$2,000</b> Individual	<b>\$4,000</b> Individual	<b>\$900</b> Individual	<b>\$1,800</b> Individual	<b>\$1,650</b> Individual	<b>\$3,300</b> Individual
	<b>\$4,000</b> Family*	<b>\$8,000</b> Family*	<b>\$1,800</b> Family	<b>\$3,600</b> Family	<b>\$3,300</b> Family	<b>\$6,600</b> Family
<b>Coinsurance</b> (e.g., x-rays, lab services, hospital stays)	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
<b>Integrated Medical/ Prescription Drug Maximum Out-of- Pocket Limits</b>	<b>\$4,500</b> Individual	<b>\$9,000</b> Individual	<b>\$3,300</b> Individual	<b>\$6,600</b> Individual	<b>\$4,150</b> Individual	<b>\$8,300</b> Individual
	<b>\$9,000</b> Family	<b>\$18,000</b> Family	<b>\$6,600</b> Family	<b>\$13,200</b> Family	<b>\$8,300</b> Family	<b>\$16,600</b> Family
<b>Preventive Care</b>	Select services covered at 100%	Plan pays 50% after deductible	Select services covered at 100%	Plan pays 50% after deductible	Select services covered at 100%	Plan pays 50% after deductible
<b>Doctor's Visits</b>	Plan pays 80% after deductible	Plan pays 50% after deductible	PCP: \$35 copay SPECIALIST: \$60 copay	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
<b>Virtual Visits</b>	\$49 per visit until deductible is satisfied; Plan pays 80% after deductible		\$20 copay		\$20 copay	
<b>Emergency Care</b>	Plan pays 80% after deductible		\$150 copay (waived if admitted)		\$150 copay (waived if admitted)	
<b>Urgent Care</b>	Plan pays 80% after deductible	Plan pays 50% after deductible	\$50 copay	Plan pays 50% after deductible	\$50 copay	Plan pays 50% after deductible
<b>Prescription Drugs</b> (Participating Network Pharmacies Only)	RETAIL: Plan pays 80% after deductible  MAIL: Plan pays 80% after deductible	N/A	RETAIL: \$10/\$35/\$60 copay  MAIL: 2.5 × retail copay	N/A	RETAIL: \$10/\$35/\$60 copay  MAIL: 2.5 × retail copay	N/A

\*For the Health Savings Plan, all eligible family members contribute toward the family deductible. Only when the full family deductible has been met will the plan pay each member's covered expenses based on the specified coinsurance. For this plan, go to [optumhealthfinancial.com](http://optumhealthfinancial.com) to open an HSA.

For Medical plan details, please see the summary description for Benefits Provided Under Collective Bargaining Agreements Negotiated with Local 317-T Greensboro Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC) Agreement Effective October 1, 2023 to September 30, 2027, As Amended.



## The Medical Plan (cont.)



ITGB offers Hinge Health to employees and spouses enrolled in a company medical plan. Hinge Health offers access to virtual physical therapy that can help you manage back or joint pain without drugs and surgery, and is provided **at no cost to you**. This program gives you access to exercise therapy tailored to your needs, technology for instant in-app feedback, and personal coaching from a physical therapist.

To learn more, contact Hinge Health online at <https://hinge.health/itgbrands-enroll> or call 855-902-2777.

### ANNUAL EMPLOYEE DENTAL CONTRIBUTION

**Employee Only:** \$170  
**Employee + Spouse:** \$339  
**Employee + Child(ren):** \$424  
**Family:** \$594

### ANNUAL EMPLOYEE VISION CONTRIBUTION

**Employee Only:** \$83  
**Employee + Spouse:** \$158  
**Employee + Child(ren):** \$166  
**Family:** \$216

## The Dental Plan

For more information or to check on the status of your claim, go to [cigna.com](http://cigna.com) or call Cigna Healthcare toll-free at **800-244-6224**. You'll receive discounts on services when you see a participating network provider.



### IN-NETWORK MEMBER COST

<b>Annual Deductible</b>	\$50 Individual / \$100 Family
<b>Preventive and Diagnostic Care</b>	Plan pays 100% of allowable charges, with no deductible (limited to 2 cleanings per calendar year per covered person)
<b>Basic Services</b>	Plan pays 80% of allowable charges after the deductible (e.g., extractions, fillings, root canals)
<b>Major Services</b>	Pays 50% of allowable charges after the deductible (e.g., inlays, crowns, dentures, bridgework)
<b>Orthodontia</b>	Plan pays 50% of allowable charges after deductible, \$1,500 lifetime maximum
<b>Annual Maximum</b>	\$2,000



## The Vision Plan

Out-of-network benefits are available, but it pays to stay in-network. For more information go to [eyemedvisioncare.com](http://eyemedvisioncare.com) or call EyeMed toll-free at **866-299-1358**.



### IN-NETWORK MEMBER COST

<b>Eye Exam</b> (Once every 12 months)	\$10 copay
<b>Single, Bifocal, Trifocal or Lenticular Lenses</b> (Once every 12 months)	\$10 copay
<b>Lens Options</b> (e.g., tinting, UV coating, anti-reflective, polycarbonate and transitions)	\$15-\$75 copay
<b>Frames</b> (Once every 24 months)	No copay; you pay 80% of balance after \$150 allowance
<b>Contact Lenses</b> (Once every 12 months)	
– <b>Conventional</b>	No copay; you pay 85% of balance after \$150 allowance
– <b>Disposable</b>	No copay; you pay 100% of balance after \$150 allowance
– <b>Medically Necessary</b>	No copay; plan pays in full
<b>Lasik or PRK</b> (from U.S. Laser Network)	15% off retail price or 5% off promotional price
<b>Hearing Care</b> (from Amplifon Hearing Network)	40% off hearing exams and a low price guarantee on discounted hearing aids

*For Dental and Vision Plan details, please see the summary description for Benefits Provided Under Collective Bargaining Agreements Negotiated with Local 317-T Greensboro Bakery, Confectionery, Tobacco Workers and Grain Millers International Union (AFL-CIO-CLC) Agreement Effective October 1, 2023 to September 30, 2027, As Amended.*

# Appendix F-Prescription Drug Benefits

## ITG Brands

### Appendix F-Prescription Drug Benefits

#### Employees Hired 9.1.7 and Later

#### Employees Hired Prior to 9.1.7 and Later

Plan:	Copay Plan	Basic Plan	Health Savings Plan			Choice Plan	Choice Plus Plan	Choice Value Plan
<b>Retail Copays/Coinsurance</b>								
Generic	\$10	\$10	20%			\$9	\$9	\$9
Preferred Brand	\$35	\$35	20%			\$18	\$18	30% (min \$25 / max \$60)
Non-Preferred Brand	\$60	\$60	20%			\$28	\$28	50% (min \$40 / max \$80)
<b>Mail / Voluntary Maintenance Choice Copays/Coinsurance</b>								
Generic	\$25.00	\$25.00	20%			\$18	\$18	\$18
Preferred Brand	\$87.50	\$87.50	20%			\$36	\$36	30% (min \$50 / max \$120)
Non-Preferred	\$150.00	\$150.00	20%			\$56	\$56	50% (min \$80 / max \$160)
<b>Accumulations</b>								
Deductible	N/A	N/A	\$2,000 IND/ \$4,000 FAM			N/A	N/A	N/A
Maximum Out of Pocket	\$3,300 IND/ \$6,600 FAM	\$4,150 IND/ \$8,300 FAM	\$4,500 IND/ \$9,000 FAM			\$6,100 IND/ \$12,200 FAM	\$6,100 IND/ \$12,200 FAM	\$6,000 IND/ \$12,000 FAM

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**Benefits provided under  
Collective Bargaining Agreements  
Negotiated with  
Local 317-T Greensboro  
Bakery, Confectionery, Tobacco Workers and  
Grain Millers International Union (AFL-CIO-CLC)  
Agreement effective October 1, 2023 to September 30, 2027**

Rev.\_02/2025