American Greetings Corporation
Retiree Welfare Benefits Plan

Summary Plan Description for
Corbin Union Retirees
Medical and Prescription Drug

January 1, 2025

WHERE TO GET INFORMATION

For Assistance with Medical Benefits:	Refer to the **Medical and Prescription Drug Claim Filing and Appeal Procedure** section of this SPD
Associates needing additional assistance with Medical or Prescription Drug coverage, please contact:	**The Center for Benefits Management** **PO Box 40300** **Cleveland, OH 44140** **Phone: 1-833-615-1190**
Associates needing additional assistance after contacting The Center for Benefits Management may contact the Plan Sponsor:	American Greetings Corporation **Attn: Benefits Dept.** **One American Blvd.** **Cleveland, Ohio 44145** **Phone: (216) 252-7300, ext. 4192 or (800) 321-3040**
For Assistance with Social Security:	**Website:** www.ssa.gov **Phone:** (800) 772-1213 **Services:** Social Security benefits including administration of disability benefits

About This SPD

This booklet is provided to Corbin Union retirees of American Greetings (the "Company") to serve as the Summary Plan Description ("SPD"), as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), of the medical coverage provided under the American Greetings Corporation Retiree Welfare Benefits Plan (the "Plan").

The Plan is administered by the Company's Benefits Advisory Committee (the "Plan Administrator") and decisions of the Plan Administrator are final and binding on all individuals dealing with or claiming benefits under the Plan.

If challenged in court, the Plan intends for the Plan Administrator's decision to be upheld unless found by a court of competent authority to be arbitrary or capricious.

Effective Date

The benefits summarized in this SPD are effective as of January 1, 2025. This booklet supersedes and replaces any previously distributed materials regarding these benefits.

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DEFINITION

You / Your

You / Your means the associate or his (or her) covered dependent(s) unless the context clearly indicates otherwise.

PARTICIPATION

Who Is Eligible to Participate

When you meet the definition to be eligible for retiree medical (or if you become disabled or die and were eligible for retiree medical), you can enroll yourself and/or your eligible dependents may enroll in a retiree medical coverage option made available through the Plan.

In general, former associates are eligible under the Plan as described here as a Corbin union retiree, provided:

- You were at least age 55 and had a minimum of 15 years of continuous service with the Company when you left; or
- You were age 65 or older and had a minimum of 15 years of continuous service with the Company when you left.

Eligible dependents are:

- Your "spouse" which means an individual the associate is married to under a legally valid existing marriage, unless a court ordered separation exists, or an eligible same-sex partner as defined below.
- Your "same-sex partner", which means one of the following, as evidenced by an "Affidavit of Same-Sex Partnership" notarized and signed by the associate and same-sex partner:
    - The same-sex partner under a legally-valid civil union; or under a legally-valid registered domestic partnership.
    - The same-sex partner of the associate under an employer-recognized domestic partnership that meets all of the following criteria:
        - The associate and same-sex partner are the same gender;
        - The associate and same-sex partner are both 18 years of age or older;
        - The associate and same-sex partner are not related by blood closer than permitted by state law applicable to marriage;
        - The associate and same-sex partner are not legally married to anyone else;
        - The associate and same-sex partner are each other's sole partner and have been for at least the past 6 months and intend to remain so indefinitely;
        - The associate and same-sex partner are mentally competent to consent to contract;
        - The associate and same-sex partner are financially inter-dependent and share responsibility for each other's welfare and financial obligations and have done so for at least the past 6 months; and
        - The associate provides proof of the above as may be required by the Plan Administrator.

- Your children, including natural, foster, step, and adopted children; a child placed with you for adoption; and any other child related to you by blood or marriage for whom you can provide proof of legal guardianship who is:
    - Under the age of 26, or
    - Dependent on you for medical care in accordance with a court order, or
    - Physically or mentally disabled and incapable of earning a living at the time coverage would otherwise end (the Plan Administrator requires proof of continuing disability), or
    - The child of your unmarried dependent child under age 19 and residing in your household in a normal parent/child relationship.

If both you and your spouse are eligible for retiree medical coverage:

- You can both enroll for your own coverage under the Plan or one of you may elect to be covered as a dependent under the other's coverage.
- Your children may be covered as dependents of either you or your spouse, but not both of you if you are both enrolled.
- The spouse with the most Company service generally enrolls any dependent children under his or her coverage.

The Plan Administrator may request any documentation it deems necessary (such as a marriage certificate or birth certificate) to prove a dependent's eligibility for coverage under the Plan. Further, the Plan Administrator reserves the right to approve or deny coverage based on the documentation submitted in response to the Plan Administrator's request for proof of eligibility for coverage.

When Coverage Begins

Except as described below, once your coverage under the Active Plan ends, you and your eligible dependents must enroll in the Plan, or you will forever forfeit your eligibility to receive coverage under the Plan. Retiree medical coverage for you and your eligible dependents begins on the first day of the month following the month in which you terminate employment. For example, say you terminate on May 15; your coverage would begin June 1. However, you may delay coverage under certain circumstances as explained below.

Delaying or Adding Coverage

If, at termination of employment, you have, or if your eligible dependent has, the ability to receive coverage as a dependent under your spouse's medical coverage (either through American Greetings or through a different employer) you have the option to delay coverage under the Plan and remain covered as a dependent of the active employee. **However, once coverage ends, you or your eligible dependent must enroll in a Plan option immediately** (within 30 days of loss of other coverage or within 60 days after the date you or your dependent becomes eligible for premium assistance under Medicaid or the State child health plan (SCHIP) or the date you or your dependent's Medicaid or state-sponsored children's health insurance program (CHIP) coverage ends) **or else you will forfeit the coverage forever.** When you enroll you will be asked to provide proof of continuous valid medical coverage for the period that you delayed enrolling in the Plan to The Center for Benefits Management.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributions towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Eligible retirees and dependents may also enroll under two additional circumstances:

- the retiree's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the retiree or dependent becomes eligible for a subsidy (state premium assistance program)

The retiree or dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Your Coverage Ends

Retiree medical coverage generally ends on the last day of the month after the earliest of the following dates:

- The end of the last period for which your premium is due but not paid.

- The date you cancel your coverage or a dependent's coverage.
- The date you enroll in Medicare Part D.
- The date you die. After your death, your surviving covered dependents can continue their Company-sponsored medical coverage. See below for more details.
- The date the Plan is terminated.

When Dependent Coverage Ends

Dependent coverage generally ends the last day of the month after the earliest of the following dates:

- The date your coverage ends for any reason other than your death.
- The date the dependent no longer qualifies as a dependent.
- The date the dependent gains coverage as an associate of the Company.
- The date the dependent enters fulltime military service of any country.
- The date dependent coverage is discontinued under the Plan.
- The date the Plan is terminated.
- The date required premiums are not paid.
- The date the dependent cancels his or her Company-sponsored medical coverage or obtains coverage under another group medical plan.

Coverage for Your Spouse After Your Death

If your spouse was covered as a dependent prior to your death, then coverage will continue for your spouse's life as long as:

- He or she does not remarry.
- He or she continues to pay the required premium.
- He or she does not cancel coverage or enroll in Medicare Part D.
- The Plan is not terminated.

Cost of Coverage

The cost of retiree medical coverage – and whether or not the Company pays part of the cost – depends on your age at retirement and your years of continuous service with the Company and when you retired. If you retired before December 1, 1997 and were at least age 65 when you retired your cost is fixed for your lifetime. If you retired before December 1, 1997 and you were not 65 when you retired, the Company cost is described below. American Greetings does not subsidize pre-65 coverage.

If you were retired *after December* 1, 1997, and you met the age and service requirements:

- You are eligible to continue your Company-sponsored medical coverage through the Plan, *and*
- The Company contributes toward the cost of your coverage, as shown below.

Early Retirement	
Early retirement age	55 to 64
Minimum years of continuous service with the Company	15
Your cost before age 65	Full Retiree rate
Your cost after age 65	The Plan premium is adjusted to match the current Medicare rate (which is usually, but not always, lower than the Plan rate).

Normal Retirement	
Normal retirement age	65 and older
Minimum years of continuous service with the Company	15
Your cost	You pay the current Medicare rate for Plan coverage.

HEALTH PLAN COVERAGE OPTIONS UNDER THE PLAN

American Greetings offers medical and prescription drug coverage for associates and eligible dependents as follows:

1. **Medical for Medicare eligible** (Gold, Silver, Bronze); **and**
2. **Prescription drug coverage** for Medicare. See charts on pages 12 titled “Prescription Drug”.

Medicare Eligible – Coverage Options

For Medicare-eligible former employees and dependents, there are three levels of supplemental coverage – Gold, Silver and Bronze.

American Greetings offers different Plan options, which generally include prescription drug coverage. Before enrolling in a Plan option, you may want to check other available coverage options including Medigap policies or options (including exchanges, i.e. Marketplace) through your state or federal government.

Benefits under a Plan option are generally coordinated with Medicare (see the "Coordination of Benefits" section of this SPD). There are four parts to the Medicare program – parts A through D, as described below. **AG pays secondary for post-65 former employees and/or dependents after Medicare, regardless of whether you actually enroll in Medicare**. Therefore, at age 65, most enroll in Medicare parts A&B. However, to maintain eligibility in an option under the Plan, you cannot enroll in Medicare part D.

Medicare is a health insurance program administered by the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services, agencies of the U.S. government. For complete information on Medicare, you can visit www.medicare.gov, refer to the Medicare and You book provided to you annually or contact Medicare at 1-800-MEDICARE (1-800-633-4227).

Medicare provides health insurance for:

- People age 65 and older.
- People of any age with end-stage renal disease (kidney failure requiring dialysis or a kidney transplant).
- Some people under age 65 who are disabled.

Medicare Part A – hospital insurance – helps pay for care and treatment provided to inpatients in hospitals, critical access hospitals, skilled nursing facilities, home health agencies, and hospices. You are automatically eligible for Medicare Part A when you reach age 65. You do not have to stop working to obtain this coverage. Medicare Part A generally does not require premium payments, unless you did not pay Medicare taxes for enough of your working career.

Medicare Part B – Medical Insurance – helps pay for medically necessary services, including doctors' office visits; outpatient services and supplies; emergency room services; physical, occupational, and speech therapy; diagnostic X-ray, laboratory, and other tests; and durable medical equipment. Part B also helps pay for many preventive services. Part B requires you to enroll and pay a monthly premium, an annual deductible, and coinsurance for certain services and treatments. Note that if you don't sign up for Part B when you are first eligible, you might be charged with a late enrollment penalty every year for as long as you live (contact Medicare for specific details as additional rules apply depending on factors such as employment status etc.).

Medicare Part C – Medicare Advantage – health plan options (like an HMO or PPO) offered by Medicare-approved insurance companies. These plans provide the benefits and services covered under Parts A and B and some also provide prescription coverage that is provided under Part D. Part C requires you to enroll. You will generally pay a monthly premium in addition to the amount you pay for Part B coverage. Depending on the plan you choose, you might also have an annual deductible and coinsurance for certain services and treatments. Note that you cannot have a Medigap policy at the same time that you have a Medicare Advantage plan.

Medicare Part D – Prescription Drug Coverage – helps pay for the cost of prescription drugs. These plans are run by Medicare-approved private insurance companies. Part D requires you to enroll and to pay a monthly premium, an annual deductible, and coinsurance for certain services and treatments.

*** NOTE: If you choose to join a Medicare Part D plan you will no longer be eligible for coverage under the AG Plan unless you receive a notice that the AG plan is no longer creditable coverage. Upon receipt of this notice you would need to enroll in Medicare immediately.**

MEDICAL
OPTIONS FOR MEDICARE-ELIGIBLE
Medicare is primary, American Greetings plan is secondary

Highlights	Gold	Silver	Bronze
Annual Deductible	$350/person; $1,050/family (applies unless noted otherwise)	$350/person; $1,050/family (applies unless noted otherwise)	$350/person; $1,050/family (applies unless noted otherwise)
Annual Out-of-Pocket Maximum	$1,500/person; $4,500/family	$1,500/person; $4,500/family	$1,500/person; $4,500/family
Lifetime Benefit Maximum*	$2,000,000/person	$2,000,000/person	$2,000,000/person
Coordination of Benefits	Benefits are paid up to same amount as if American Greetings plan were primary, less any benefits paid by Medicare		
Requires you to choose a primary care physician (PCP)	No	No	No
Benefit	**Covered At**	**Covered At**	**Covered At**
Inpatient Services • Semiprivate room/board • Services/supplies • Intensive Care	100%, no deductible up to 120 days/admission	85%	80%
Emergency Room Services	80% for approved emergencies, no deductible	$75/ occurrence copay, then 85% no copay after out-of-pocket is met; copay waived if admitted	$75/occurrence copay, then 80% no copay after out-of-pocket is met; copay waived if admitted
Outpatient Services • Facility charges • X ray, lab tests, specific diagnostic procedures • Surgery	100%	85%	80%
Physician Services			
• Office visits	80%, no deductible	85%	80%
• Office surgical procedures	100%	85%	80%
• Hospital visits	100%	85%	80%

Adult Preventive Care
Includes office visit associated with the test
• Pap smear – one/12 months
• Mammogram
  ○ Age 50+, one/12 months
• Prostate specific antigen (PSA)
  ○ Age 50+, one/12 months
	100%, no deductible	100%, no deductible	$100%, no deductible

Mental Health/Substance Abuse	Covered at same benefit levels as other covered services		
Vision Exam	100%, no deductible, one/12 months; hardware not covered	100%, no deductible, one/12 months; hardware not covered	100%, no deductible, one/12 months; hardware not covered
Home Health Care	80%	85%	80%, up to 40 visits/calendar year; preauthorization required
Hospice Care	80%, up to six months (longer if certified)	85%, up to six months (longer if certified)	80%, up to six months (longer if certified)
Convalescent Facility Care	80%	85%	80%, up to 60 days/calendar year
Utilization Management Services • Preadmission testing	100%, no deductible	85%	80%, no deductible if within seven days of admission
• Preadmission certification	Per Medicare Guidelines	Per Medicare Guidelines	Per Medicare Guidelines

All covered members must be Medicare eligible, generally post 65. Retirees must enroll in Medicare Parts A and B; American Greetings plan is secondary.
Lifetime benefit maximum is applicable effective May 1, 2025 and applies to both medical and prescription drug benefits.

PRESCRIPTION DRUG

The following chart provides the prescription drug coverage associates with the medical plans.

	Gold/Silver/Bronze	
Prescription Drug Tier	Retail (30-day supply)	Mail order (90-day supply)
Annual Rx Out-of-Pocket Maximum	$1,500 Individual $2,000 family	
Generic	You pay 20% (minimum $10)	You pay 20% (minimum $20)
Preferred Brand Name	You pay 30% (minimum $30)	You pay 30% (minimum $60)
Non-Preferred Brand Name	You pay 50% (minimum $45)	You pay 50% (minimum $90)
Lifestyle drugs / Medications with OTC (Over the Counter) Alternatives*	You pay 100%	
Mail order requirements	Mail order forms may be downloaded at www.umr.com or www.americangreetingsbenefits.com or request a paper copy from The Center for Benefits Management.	

NOTES:

For post-65 Retirees, Medicare is primary, American Greetings Plan is Secondary.

Excludes certain brand-name drugs that have lower cost alternatives. These prescriptions do not apply to deductibles or out-of-pocket maximums. Contact OptumRx for more information.

American Greetings has many prescription drug cost management programs which are regularly reviewed and updated throughout the year. If you are impacted by any of these programs, you will be notified. The American Greetings Formulary excludes certain brand-name drugs that have lower cost alternatives. These excluded prescriptions drugs do not apply to deductibles or out-of-pocket maximums. The lowest cost generic may be required to be used before a more expensive drug. When a generic is available, but the pharmacy dispenses the brand-name medication you may have to pay the difference between the brand-name medication and the generic plus the brand copayment. Certain medications may require that you work with your doctor and OptumRx through an authorization process to get the prescriptions that you need.

*Drugs in the Lifestyle categories and OTC alternatives (include allergy, gastrointestinal and cough & cold medications) are not applied to your annual out-of-pocket maximum (unless covered under the PPI appeal process of the pediatric exception rule).

COORDINATION OF BENEFITS

Coordination of benefits (COB) is a group health insurance measure that eliminates duplicate payments and establishes the order in which benefits will be paid.

When a medical expense is covered by two plans, one plan has first responsibility for the expense (the "primary" plan). After the primary plan has paid benefits, the other plan (the "secondary" plan) may make additional payments, depending on its COB provision.

If you are enrolled after becoming eligible for Medicare (generally age 65):

- Medicare is your primary medical coverage. It pays benefits first without regard to any other medical coverage you may have, including coverage under the Plan.
- The Plan is your secondary medical coverage. It pays only up to the amount it would have paid if it were the primary plan, minus any amount Medicare pays. This is known as a "non-duplication of benefits" provision. **Importantly, if you have chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.**
- In many cases, the benefit paid by Medicare is the same as the benefit paid by the Plan; therefore, the Plan does not pay a benefit.

This example shows how benefits are calculated for a medical claim.

Charge for covered medical service	$ 200
Plan pays 80%	x 80%
Plan benefit (assuming deductible met)	$ 160
Medicare pays 80% (offset)	($ 160)
Plan payment	$ 0
Amount applied to Plan out-of-pocket maximum	$ 40

As shown in this example, total benefits from Medicare and the Plan combined will not exceed the benefit you would receive if the Plan were your only coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell you, or obtain your consent to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

Reimbursement to Third Party Organization

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the you or your covered dependent.

MEDICAL AND PRESCRIPTION DRUG CLAIM FILING AND APPEAL PROCEDURE

Note that throughout this Claim Filing and Appeal Procedure section, "you" means either you or your covered dependent(s) depending on who is the person with the claims in question.

Filing a Claim

A "pre-service claim" is a claim for a Plan benefit that is subject to the prior certification as described in the Pre-service Claim Procedure section below. All other claims for Plan benefits are "post-service claims" and are subject to the rules described in Post-Service Claim Procedure section.

Post-Service Claim Procedure

- If you utilize an in-network provider, there are no claim forms to fill out.
- If you utilize an out-of-network provider, a claim form must be completed and submitted to the claims administrator at the address noted below:

United Healthcare	**OptumRx with United Healthcare**
P.O. Box 30555 Salt Lake City, UT 84130-0555 www.unitedhealthcare.com 866-844-4869	P.O. Box 30555 Salt Lake City, UT 84130-0555 www.unitedhealthcare.com 866-844-4869

Notice of Claim

A claim for benefits should be submitted to the claims administrator within ninety (90) calendar days after the occurrence or commencement of any services by the Plan, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than the time frame noted in the Filing a Claim /Post Service Claim Procedure provision, unless the claimant is legally incapacitated.

Notice given by or on behalf of you or your beneficiary, if any, to the Plan Administrator or to any authorized agent of the Plan, with information sufficient to identify you, shall be deemed notice of claim.

Foreign Claims

In the event you incur a covered expense in a foreign country, you shall be responsible for providing the following information to the claims administrator before payment of any benefits due are payable.

- The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
- The charges for services must be converted into U.S. dollars.
- A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

PRE-SERVICE CLAIM PROCEDURE

Health Care Management

Health care management is the process of evaluating whether proposed services, supplies or treatments are medically necessary and appropriate to help ensure quality, cost-effective care.

Certification of medical necessity and appropriateness by the claims administrator does not establish eligibility under the Plan nor guarantee benefits.

Filing a Pre-Certification Claim

The following services are to be certified by the claims administrator:

- All inpatient admissions (including non-emergency skilled nursing facility and rehabilitation facility admissions);
- Home health care;
- Hospice care;
- Cosmetic/reconstructive surgery;
- Dental services required due to accidental injury;
- Transplant services - as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center);
- Durable medical equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).

For non-urgent care, you or your authorized representative must call the claims administrator at least fifteen (15) calendar days prior to initiation of services. If the claims administrator is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For urgent care, you or your authorized representative must call the claims administrator within forty-eight (48) hours or the next business day after the initiation of services.

Covered persons shall contact the claims administrator by calling the phone number noted on the Medical and Prescription Drug Claim Filing and Appeal Procedure section of this document. The claims administrator's phone number is also included on the associate's medical ID card.

When you (or your authorized representative) call the claims administrator, he or she should be prepared to provide all of the following information:

- Associate's name, address, phone number and Social Security Number.
- Company's name.
- If not the associate, the patient's name, address, phone number.
- Admitting physician's name and phone number.
- Name of facility.
- Date of admission or proposed date of admission.
- Condition for which patient is being admitted.

Group health plans generally may not, under a federal law called the Newborns' and Mothers' Health Protection Act, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

However, hospital maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be pre-certified.

If you (or your authorized representative) fails to contact the claims administrator to obtain prior authorization, benefits will be reduced to fifty (50%) percent of covered expenses. If the claims administrator declines to grant the full precertification requested, benefits for days or services not certified as medically necessary shall be denied.

Note that while providers typically assist you with the process of obtaining prior authorization from the claims administrator, you are ultimately responsible for ensuring that prior pre-certification has been obtained.

Case Management
In cases where your condition is expected to be or is of a serious nature, the claims administrator may arrange for review and/or case management services from a professional qualified to perform such services. The plan administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

In addition, the claims administrator may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that:

- are not covered expenses under this Plan; or
- are covered expenses under this Plan but on a basis that differs from the alternative recommended by the claims administrator.

The recommended alternatives will be considered as covered expenses under the Plan provided the expenses can be shown to be viable, medically necessary, and are included in a written case management report or treatment plan proposed by the claims administrator.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that covered person or any other covered person.

Notice of Authorized Representative
You may provide the claims administrator with a written authorization for an authorized representative to represent and act on your behalf and consent to release of information related to you to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the American Greetings Benefits website (www.americangreetingsbenefits.com) or by contacting The Center for Benefits Management at 1-833-615-1190.

CLAIM APPEAL PROCEDURES

Action on Submitted Claims
Any time a claim for benefits receives an adverse determination (that is, the claim is denied in whole or in part), the associate or covered person shall be given written notice of such action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, you shall be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, you shall be notified of such approval and provided sufficient information to understand the import of the approval. Categories of claims, "applicable periods" and extensions are detailed below.

Urgent Care Claims
Urgent care claims are requests for verification or approval of coverage for medical care or treatment where, if the request were not handled expeditiously the delay could jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than seventy-two (72) hours. If the Plan cannot render a decision within seventy-two (72) hours because you have not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claims administrator will notify you within twenty-four (24) hours of the specific information needed to complete the claim. You will have at least forty-eight (48) hours to provide the required information. Within forty-eight (48) hours after the earlier of

(1) the Plan's receiving the required information or (2) the expiration of the period afforded to you to provide the information, the claims administrator will notify you of the Plan's benefit determination. You may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

Pre-Service Claims

A pre-service claim is any request for approval of coverage for a service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service claim is fifteen (15) days after receipt of the claim by the Plan. The claims administrator may extend the review period for an additional fifteen (15) days if necessary due to circumstances beyond the control of the Plan. The claims administrator will notify you within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If you have not followed the Plan's procedures for filing a pre-service claim, the claims administrator will notify you within five (5) days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within fifteen (15) days because you has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim; you will have at least forty-five (45) days from receipt of the notice to provide the required information; and the Plan has fifteen (15) days from the date of receiving your information to render its decision. You may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

Concurrent Care Claims

A concurrent care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care will be made sufficiently in advance of any reduction or termination in treatment to allow you to appeal the adverse Benefit determination. If a course of treatment involves urgent care, a request by you to extend the course of treatment will be decided as soon as possible, but not later than twenty-four (24) hours after receipt of the request by the claims administrator, provided that the request is made at least twenty-four (24) hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under this section. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed.

Notice will be provided a reasonable time before the coverage for treatments will stop; however, you do not have one hundred eighty (180) days to appeal the Plan's decision, before the Plan may terminate the treatment (see the rules below, concerning the time you normally have to appeal an adverse Benefit determination).

Post-Service Claims

A post-service claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is thirty (30) days after receipt of the claim by the Plan.

The claims administrator may extend the review period for an additional fifteen (15) days if necessary due to circumstances beyond the control of the Plan. The claims administrator will notify you within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within thirty (30) days because you have not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. You will have at least forty-five (45) days from receipt of the notice to provide the required information. The Plan will then have fifteen (15) days from the date of receiving your information to render its decision. You may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination will be provided to you. Notice will be written or electronic; oral notice might be provided only with respect to urgent care claims, but only if written or electronic confirmation is furnished to you within three (3) days after the oral notice is provided.

The notice will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- If applicable, a description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's review procedures, including your right to bring a civil action under Section 502(a) of ERISA;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- If the adverse determination is based on medical necessity or experimental/investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Request Review

Any covered person who has had a claim for benefits denied in whole or in part by the claims administrator, or is otherwise adversely affected by action of the claims administrator, has the right to request review by the claim administrator. Such request must be, in writing, and must be made within one hundred eighty (180) days after you are advised of the claims administrator's action. If written request for review is not made within such one hundred eighty 180-day period, you will forfeit his or her right to review. You or your duly authorized representative may review all pertinent documents and submit issues and comments, in writing. The claim administrator or its designee may prescribe a reasonable procedure under which a covered person may designate an authorized representative.

Where an appeal's submission date is within the appropriate deadline, and the appeal is later supplemented or resubmitted (either because the initial submission was incomplete, or for any other reason), the initial appeal submission date does not apply to the later supplementation or resubmission. The intent of this paragraph is to require the resubmitted appeal to be filed within the deadlines described in the preceding paragraph. In the case of an incomplete appeal, however, in no event shall the claim administrator refuse to accept for processing a resubmission or supplementation of such an appeal that is resubmitted or supplemented within the deadline described in the preceding paragraph.

Review of Claim

The named fiduciary for purposes of an appeal of a pre-service, urgent, concurrent or post-service claim, is the claims administrator.

The claim administrator or its designee will then review the claim. The person or entity that reviews the claim will be a Fiduciary under the Plan, and will not be the same person, or a person subordinate to the person, who initially decided the claim. If the adverse benefit determination was based on medical judgment, the person handling the appeal will consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional will not be the same professional who was consulted with respect to the initial action on the claim. Upon request, the claims administrator shall identify any medical expert whose advice was obtained in connection with the denied claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside the initial decision on the claim.

The decision on appeal will be made within seventy-two (72) hours for a claim involving urgent care, thirty (30) days for a pre-service claim, or sixty (60) days for a post-service claim; the time period begins to run on the date the appeal is received by the Plan or its designee. You may agree to further extend these deadlines.

A copy of the decision will be furnished to you. The decision shall set forth:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A statement that you is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the Benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- A statement of any voluntary appeals procedures and you right to receive information about the procedures as well as you right to bring a civil action under Section 502(a) of ERISA;
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- If the adverse determination is based on medical necessity or experimental/investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided without charge upon request.

The decision will be final and binding upon you and all other persons involved.

The claims administrator shall have no power to add to, subtract from or modify any of the terms of the Plan, or to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

External Appeal

You, or your authorized representative, may request a review of a denied claim by making a written request to the claims administrator, within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.

Right to External Appeal

Within five (5) business days of receipt of the request, the claims administrator will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that:

- You incurring the claim is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The final internal denial does not relate to your failure to meet Plan eligibility requirements as stated in the sections, Eligibility for Coverage and Effective Date of Coverage;
- You have exhausted the Plan's appeal process, to the extent required by law; and
- You have provided all of the information and forms required to complete an external review.

Notice of Right to External Appeal

The claim administrator (or its designee) shall provide you (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (1) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

- The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review; and
- If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for you to perfect the external review request by the later of the following:
    - The four (4) month filing period; or
    - Within the forty-eight (48) hour time period following your receipt of notification.

Independent Review Organization

An Independent Review Organization (IRO) that is accredited by URAC or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will notify you, in writing, of the request's eligibility and acceptance for external review.

Notice of External Review Determination

The assigned IRO shall provide the claim administrator (or its designee) and you (or your authorized representative) with a written notice of the final external review decision within forty-five (45) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on you, the Plan and claims administrator, except to the extent that other remedies may be available under State or Federal law.

Expedited External Review

The claim administrator (or its designee) shall provide you (or authorized representative) the right to request an expedited external review upon your receipt of either of the following:

- A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize your health or life or your ability to regain maximum function and you have filed an internal appeal request; or
- A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your health or life or your ability to regain maximum function or if the final determination involves any of the following:
    - an admission,
    - availability of care,
    - continued stay, or
    - a health care item or service for which you received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

- Perform a preliminary review to determine whether the request meets the requirements in the section, Right to External Appeal; and
- Send notice of the Plan's decision, as described in the section, Notice of Right to External Appeal.
- Upon determination that a request is eligible for external review, the Plan will do all of the following:
- Assign an IRO as described in the section, Independent Review Organization; and
- Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the claim administrator (or its designee) and you (or your authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

GENERAL PROVISIONS

Applicable Law
All provisions of the Plan shall be construed and administered in a manner consistent with the requirements of the State of Ohio to the extent it is not superseded or preempted by ERISA, as amended, or any other applicable federal law. The courts of competent jurisdiction in Cleveland, Ohio have jurisdiction for all claims, actions, or proceedings involving or related to the Plan.

Benefits Not Transferable
Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

Examination of Records
As a condition of receiving benefits under this Plan, participants and their dependents grant the company or its agents the right to examine any medical or hospital and other records that pertain directly to any claim for benefits.

Facility of Benefit Payment
Whenever payments which should have been made under this Plan have been made under any other plan, the company has the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amount it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, the company will be fully discharged from liability.

Incapacity
If, in the opinion of the plan administrator, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due the covered person and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the plan administrator may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such covered person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

Incontestability
All statements made by the plan administrator or by the associate covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the plan administrator or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Action
1. *Time Limit on Legal Procedures pursuant to an insurance contract* - A legal action on a claim may only be brought against an insurer for insured coverages during a certain period. This period is applicable to each insurance carrier as referenced in the applicable insurance certificate.
2. *Time Limit on Legal Procedures Against American Greetings and claims administrator (non-insured)* - A claimant generally must commence his claim or lawsuit against American Greetings no later than 24 months after the earliest of (1) the date of the loss for which the claimant is seeking a Plan benefit, (2) the date the claims administrator first denies the claimant’s request for a Plan benefit or (3) the earliest date claimant knew or should have known the material facts on which his lawsuit is based. However, if the claimant commences his claim within this 24-month period, the deadline for the claimant to file a lawsuit will not expire until the later of the last day of the 24-month claims period and three months after the final notice of denial of his appealed claim is sent to them by claims administrator, unless longer as required by law.

Limits on Liability
Liability hereunder is limited to the services and benefits specified, and the plan sponsor or plan administrator shall not be liable for any obligation of the covered person incurred in excess thereof. The plan sponsor and/or plan administrator shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

Lost Distributees
Any benefit payable under the Plan will be deemed forfeited if the Plan Administrator is unable to locate the covered person to whom payment is due, provided however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits with the time prescribed by the claims procedures detailed herein.

No Assignment of Benefits
You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a healthcare provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

Physical Examinations Required by the Plan
The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

Plan is Not a Contract
The Plan shall not be deemed to constitute a contract between American Greetings and any associate or to be a consideration for, or an inducement or condition of, the employment of any associate. Nothing in the Plan shall be deemed to give any associate the right to be retained in the service of American Greetings or to interfere with the right of American Greetings to terminate the employment of any associate at any time.

Proof of Claim
As a condition of receiving benefits under the Plan, participants are required to submit whatever proof the Plan Administrator, company, insurer, or any related party may require.

Plan Modification
The plan sponsor may modify or amend the Plan at any time and for any reason (subject to the provision of the collective bargaining agreement where applicable), and such amendments or modifications which affect covered persons will be communicated to the covered persons as and when required by applicable law. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the plan sponsor's designee.

Pronouns
All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Recoupment
The Plan has the right to recover directly from you any overpayments or mistaken benefit payments it has made to you or on your behalf. Overpayments and mistaken payments include payments that the Plan makes while you are waiting for approval or settlement of your workers' compensation benefits, Plan payments resulting from any failure to provide accurate information to the Plan, and Plan payments not otherwise provided for by its terms. Throughout this section, the term "you" refers to you and your spouse, dependent or beneficiary.

The Plan may appoint an agent to act on its behalf to recover overpayments or mistaken payments.

You are required to give any necessary authorization for the Plan's recovery of overpayments or mistaken payments. This includes your permission for the Plan to deduct the amount of the overpayments or mistaken payments from any future amounts due to you under the Plan.

The Plan has the option of recovering overpayments or mistaken payments by: (1) reducing future payments due to you under the Plan, and/or (2) bringing an action in court against you.

Right of Subrogation, Reimbursement and Offset

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the company will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA. The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal

common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by theories such as comparative/contributory negligence, the "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

3. Assisting in the Plan's Reimbursement Activities. The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan's (or any Plan fiduciary's) enforcement of the terms of the Plan, including the exercise of the Plan's right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the plan administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator or claims administrator to enforce the Plan's rights.

The Plan Administrator has delegated to the claims administrator for medical claims the right to perform ministerial functions required to assert the Plan's rights with regard to such claims and benefits; however, the Plan Administrator shall retain discretionary authority with regard to asserting the Plan's recovery rights.

Severability

If any provision of this Plan is held to be invalid or unenforceable, that holding will not affect any other provision of the Plan and the Plan will be construed and enforced as if such provision had not been included.

OTHER IMPORTANT INFORMATION

Continuation of Coverage Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that has several provisions designed to protect you and your eligible dependents against a sudden loss of healthcare coverage if there is a "qualifying event" (explained below) that would cause the loss of healthcare coverage under the Plan. The following information outlines the continuation of coverage available under COBRA.

- **General Explanation of COBRA Continuation Coverage:** COBRA requires most employers who sponsor group healthcare plans to provide a temporary extension of healthcare coverage to employees and their eligible dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called "continuation coverage." Individuals who are eligible for COBRA coverage are called "qualified beneficiaries". The events which entitle them to coverage are called "qualifying events." To be a qualified beneficiary for a specific type of healthcare coverage (e.g., medical or dental coverage), the qualified beneficiary must have had that particular coverage under the plan(s) on the day before a qualifying event occurs.

- **Who Must Provide Notice When Coverage is Lost:** When a qualifying event occurs, you and your covered eligible dependents have certain responsibilities. If the qualifying event is a divorce or loss of eligible dependent status, you or a covered eligible dependent must notify the Plan Administrator in writing within 60 days of the qualifying event.

When the Plan Administrator is notified or learns of a qualifying event, the Plan Administrator will send your spouse and/or eligible dependents a written explanation of the right to elect continuation coverage. They will then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which their existing coverage would end to notify the Plan Administrator of their election. If your spouse and/or an eligible dependent does not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost. The below chart describes who may be eligible for COBRA benefits and how long those benefits will last.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF COVERAGE
Covered Spouse of a Retiree	• Divorce	36 months
Covered Eligible Dependent Child of a Retiree	• Death of employee (but coverage only ceases if spouse remarries following death) • Divorce of retiree and spouse • Failure of child to qualify as an eligible dependent under the Plan	36 months 36 months 36 months
Covered Retiree, Covered Spouse & Dependent Child of Retiree	• Company bankruptcy	36 months

The 36 month continuation coverage begins on the date that coverage would originally end.

- **<u>If Continuation Coverage is Elected</u>:** Each covered eligible dependent who is eligible to elect continuation coverage may make a separate election to continue coverage, or one covered eligible dependent may make an election that covers some or all of the others. If continuation coverage is elected, the covered individual must pay a total premium equal to the cost to the Plan of such coverage, plus a 2% monthly administration charge (or such higher charge as may be permitted by law). The total premium includes both the Company's contribution and any contribution that an active retiree would be required to make under the Plan for the same coverage. The first payment must be made within 45 days following the date of the election and must cover the number of full months from the date coverage ended to the time of the election. Premiums for each month after the election are due by the 1st day of the month and must be paid not later than the last day of that month. Premium rates will change periodically for all qualified beneficiaries if costs to the Company change. Continuation coverage will be identical to the coverage provided to similarly situated retirees and/or eligible dependents. Healthcare coverage will continue to be provided by the insurer, or other provider that is providing benefits on the date of the qualifying event. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

- **<u>Coverage That May Be Elected</u>:** Qualified beneficiaries may elect to continue only those coverages that were in effect on the date of the qualifying event.

- **<u>When COBRA Benefits End</u>:** Generally, continuation coverage runs for 36 months as described in the chart above. However, COBRA benefits will end immediately if:

  - the person whose coverage is being continued fails to pay the premium on time;

  - the person whose coverage is being continued becomes, after the date of the election of continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation which does not apply to, or is satisfied by, the person under applicable provisions of federal law);

  - the person whose coverage is being continued becomes, after the date of the election of continuation coverage, entitled to Medicare benefits; or

  - the Company no longer maintains any plan covering any employee.

- **Conversion to an Individual Policy:** At the end of the 36-month continuation period, a qualified beneficiary may be eligible to convert their medical coverage to an individual policy to the extent permitted under the Contract. If eligible, they must apply in writing and pay the first premium for the converted policy within 31 days after the date his/her insurance coverage ceases.

HIPAA PRIVACY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that imposes requirements on employer health plans concerning the disclosure of individual health information, known as protected health information (PHI). PHI includes individually identifiable health information that relates to a covered person's past, present or future health treatment, or payment for health care services. The Plan is administered to comply with HIPAA.

Both the Plan and the claims administrators, United Healthcare (for the medical benefits) and Prescription Solutions by OptumRx (for the prescription drug benefits), take the privacy of a covered person's PHI seriously and handle all PHI as required by state and federal laws and regulations. The Plan has developed a privacy notice that explains the procedures. A copy of the Notice of Privacy Practice will be provided to Plan participants and is also available upon request.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) greatly expands and broadens HIPAA's privacy and security provisions. Under the HITECH Act, certain privacy and security obligations are extended directly to business associates, including the civil and criminal penalties. This act provides notification requirements when there is a breach of protected health information (PHI) or electronic health records (EHR). In addition, this act heightens the enforcement of the privacy and security rules, increasing transparency and accountability.

Permitted Use and Disclosure of Protected Health Information

The company may only use and disclose protected health information it receives from the Plan (or a health insurance issuer or HMO with respect to the Plan) as permitted and/or required by, and consistent with HIPAA, as amended by the HITECH Act, and its accompanying regulations. This includes, but is not limited to, the right to use and disclose participant's protected health information (including electronic protected health information) in connection with payment, treatment and health care operations.

The Plan (or a health insurance issuer or HMO with respect to the Plan) will disclose protected health information to the company only upon receipt of a certification by the company that the Plan documents have been amended to incorporate all the required provisions as described below.

The company agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agent, including a subcontractor, to whom it gives protected health information received from the Plan, agrees to the same restrictions and conditions that apply to company with respect to such information;
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that is creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that any agent, including a subcontractor, to whom it gives electronic protected health information, agrees to implement reasonable and appropriate security measures to protect such information;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the company;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which the company becomes aware;

- Report to the Plan any security incident of which the company becomes aware;
- Make available PHI in accordance with individuals' rights to access and review their protected health information;
- Make available PHI for amendment and incorporate any amendments to protected health information consistent with HIPAA and its implementing regulation concerning privacy of individually indentifaible health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002) (the “Privacy Rules”);
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rules;
- Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with the Privacy Rules;
- If feasible, return or destroy all protected health information received from the Plan that the company still maintains in any form. The company will retain no copies of protected health information when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Separation of the Company and the Plan

The company shall restrict the access to and use of protected health information by such employees and other persons described above to the plan administration functions (e.g., claims processing, auditing, quality assessments) that the company performs for the Plan, including payment and health care operations. No other persons shall have access to protected health information. The company shall ensure that the separation between the Plan and the company is supported by reasonable and appropriate security measures.

The company shall provide an effective mechanism for resolving any issues of noncompliance by such employees or persons. Access to and use by such employees and other persons described in this section shall be restricted to the plan administration functions that the company or its delegate performs for the Plan. Any incidents of noncompliance by such individuals with the provisions of this section shall subject such individuals to disciplinary action and sanctions, including the possibility of termination of employment. The company will report such noncompliance to the Plan and will cooperate with the Plan to correct the noncompliance, impose an appropriate disciplinary action or sanction, and mitigate the effect of the noncompliance.

Qualified Medical Child Support Orders

A Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that:

- Provides for child support with respect to your child under a group health plan or provides for health benefit coverage for your child.
- Is made pursuant to a state domestic relations law (including community property law) and relates to benefits under a Company-sponsored medical plan.

A Qualified Medical Child Support Order creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive, benefits for which you are eligible under a Company-sponsored medical plan.

An "alternate recipient" is each of your children recognized under the Medical Child Support Order as having a right to enroll in a Company-sponsored medical plan.

To be "qualified," a Medical Child Support Order must:

- State your name and last known mailing address (if any) and the name and mailing address of each alternate recipient covered by the order.

- Provide a reasonable description of the type of coverage to be provided or a reasonable description of the manner in which such coverage is to be determined.
- State the period to which the order applies.
- Specify the plans to which it applies.

Upon receipt of a Medical Child Support Order, the Plan Administrator will, at no cost to you:

- Notify you and each alternate recipient that the order has been received, and
- Inform you and each alternate recipient in writing within a reasonable period whether or not the order has been determined to be "qualified."

If it is determined that the Medical Child Support Order is qualified, the Company will make payments to:

- The appropriate alternate recipient,
- His or her custodial parent or legal guardian, or
- Any medical provider or facility to which benefits have been assigned.

Coverage for your child under a Medical Child Support Order will end on the earlier of the date such coverage is no longer required under the order, or the date your child ceases to otherwise be eligible for dependent coverage under the Plan.

Plan Administration

As described in more detail below, the self-insured benefits hereunder are provided pursuant to administrative services agreements between American Greetings Corporation and the following claims administrators: United Healthcare Services, Inc., UMR, and OptumRx. The fully-insured benefits are provided pursuant to an insurance contract between American Greetings Corporation and United Healthcare. If the terms of this document conflict with terms of the applicable insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.

Plan Name

The official name of the Plan is the American Greetings Corporation Retiree Welfare Benefits Plan. The medical and prescription drug benefits described in this document are provided under that plan.

Name, Address and Phone Number of Employer/Plan Sponsor

American Greetings Corporation
c/o Benefits Dept.
One American Blvd
Cleveland, Ohio 44145
216-252-7300 ext. 4192

Employer Identification Number

34-0065325

Plan Number

559

Type of Plan

Group welfare Benefit Plan: medical and prescription drug benefits.

Type of Administration and Funding

Contract administration: The processing of claims for self-funded benefits under the terms of the Plan is provided through third-party administrators contracted by the Company and shall hereinafter be referred to as the Claims Administrator.

Certain self-funded medical benefits are provided pursuant to an administrative services agreement between American Greetings Corporation and the Claims Administrators.

The self-funded prescription drug benefits are provided pursuant to an administrative services agreement between American Greetings Corporation and OptumRx. OptumRx is the Claims Administrator for these prescription drug benefits under the Plan.

The Plan is self-insured. Benefits are paid from the general funds of the Employer or from a VEBA that was established to hold plan assets. The Plan is funded through employer and retiree contributions.

Name, Address and Phone Number of Plan Administrator

Benefits Advisory Committee
American Greetings Corporation
c/o Benefits Dept.
One American Blvd.
Cleveland, Ohio 44145
216-252-7300 ext. 4192

Name, Address and Phone Number for Legal Service

The agent for legal process on the Plan is:

General Counsel and Chief Human Resources Officer
American Greetings Corporation
One American Blvd.
Cleveland, Ohio 44145
216-252-7300 ext. 4192

A copy of legal process shall be served to:

General Counsel
American Greetings Corporation
One American Blvd.
Cleveland, Ohio 44145

Plan Year

The Plan's financial records and annual reporting are on a fiscal-year basis: March 1 through the last day of February. The Plan is administered on a calendar-year basis: January 1 through December 31.

Effective Date

The Plan was originally effective February 28, 1990. Amendments to the Plan have been made multiple times and the provisions in this document are effective January 1, 2025.

Plan Amendment and Termination:

The Plan sponsor reserves the right to amend and/or terminate the Plan at any time and for any reason. Upon termination, the rights of covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to covered persons.

FEDERAL LAW REQUIREMENTS

Your Rights Under ERISA

As an associate in the American Greetings Corporation Retiree Welfare Benefits Plan (the "Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits – Contact AG Benefits Dept.

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as work sites) all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to AG Benefits Dept., copies of documents governing the operation of the Plan, including insurance contracts, the latest annual report (Form 5500 Series), and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 employee benefit plans. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company or any other group or person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain without charge copies of documents relating to the decision, 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 and do not receive it 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 for reasons beyond the Plan Administrator's control.
- If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 or 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 if it finds your claim is frivolous.

Answers to Your Questions

If you have any questions about your plan, you should contact The Center for Benefits Management or the Plan Administrator. If you have questions about this statement or your ERISA rights or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefit Security Administration, U.S. Department of Labor (listed in your telephone directory), or
- The Division of Technical Assistance and inquiries, Employee Benefit 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 Benefit Security Administration at 800-998-7542.

ACA[1]

Notwithstanding anything in this SPD to the contrary, the Plan complies with the ACA. Specifically:

- *Lifetime or Annual Limits*. The Plan does not impose a lifetime or annual limit on the dollar value of Essential Health Benefits provided. "Essential Health Benefits" are health-related items and services that fall into ten categories, as defined in the ACA and further determined by the Secretary of Health and Human Services.

- *No Rescission of Coverage*. The Plan will not cancel or discontinue medical benefits with a retroactive effect with respect to you or your covered dependents except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc.

- *No Pre-Existing Condition Exclusion*. The Plan will not impose a pre-existing condition exclusion on medical benefits.

- *No Cost Sharing on Recommended Preventive Care*. The medical benefits under the Plan will not require participant cost-sharing on recommended preventive care provided by in-network providers.

- *Coverage of Clinical Trials*. Medical benefits under the Plan shall not deny participation in an approved clinical trial for which a participant is a "qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A participant participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms "qualified individual," "life threatening disease or condition," approved clinical trial" and "routine patient costs" shall have the same meaning as found in Section 2709 of the Public Health Services Act.

- *Cost Sharing Limits*. Medical benefits under the Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the ACA. For purposes of this provision, cost-sharing includes deductibles, coinsurance, copays or similar charges, and any other required expenditure that is a qualified medical expense with respect to Essential Health Benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Health Plan. Notwithstanding the foregoing, the company reserves the right to maintain bifurcated out-of-pocket maximums as permitted by law.

- *Patient Protections*. To the extent applicable, medical benefits under the Plan shall comply with the patient protections regarding choice of health care professionals and Medical Emergency care services under Public Health Services Act Section 2719A.

Surprise Medical Billing[2]

Issued as part of the Consolidated Appropriations Act of 2021, the No Surprises Act prevents surprise medical bills in connection with claims for services to treat an emergency medical condition that are performed by out-of-network providers, and limits the amount you may be required to pay. For more information on the No Surprises Act, please visit: www.uhc.com and searching "No Surprises Act".

[1] Effective May 1, 2025, the Plan is a retiree-only plan and no longer subject to the ACA. This section applies to periods prior to May 1, 2025.

[2] Effective May 1, 2025, the Plan is a retiree-only plan and no longer subject to the No Surprises Act. This section applies to periods prior to May 1, 2025.

Mental Health Parity[3]

Notwithstanding anything in this SPD to the contrary, the Plan will provide parity between mental health or substance use disorder benefits (including treatment for alcoholism as described below) and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder. Specifically:

- *Lifetime or Annual Dollar Limits*. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

- *Financial Requirement or Treatment Limitations*. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the plan administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

- *Criteria for medical necessity determinations*. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the plan administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the plan administrator in its sole discretion in light of applicable regulations and other guidance.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurers 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 cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Cybersecurity

It is critical that you take steps to ensure the security of your health and benefit information to reduce the risk of fraud and loss. This includes, among other things, using a strong and unique password when establishing online accounts with the Plan, the claims administrator(s), or your providers (such as avoiding dictionary words and letters and numbers in sequence, using both letters and numbers and special characters, changing your password regularly, not using repeated or reused passwords from other sites, etc.), enabling two-factor authentication to verify that you are the one accessing your account, monitoring your account—including your online account—and Plan communications (including mailings to your home from the Company, the claims administrators, or providers), keeping your contact information and communication preferences up to date to ensure that you receive all Plan notices, being careful when using free Wi-Fi networks that impose security risks, and being aware of phishing attacks that attempt to trick you into sharing your passwords, account numbers and sensitive information. Many security features that are available require you to opt into the feature.

[3] Effective May 1, 2025, the Plan is a retiree-only plan and no longer subject to the Mental Health Parity and Addiction Equity Act. This section applies to periods prior to May 1, 2025.

To understand the security features that are available to you, and to make sure that you have elected all of the security features you wish, please contact the Company and the claims administrators.

The Company's Rights

Nothing in the American Greetings Corporation Retiree Welfare Benefits Plan or this summary plan description guarantees your right to benefits under the Plan.

The Company reserves the right to amend the American Greetings Corporation Retiree Welfare Benefits Plan as consistent with and necessary for meeting the strategic goals and objectives of the Company.

The Company further reserves the right to terminate the Plan at any time and for any reason without the consent of any employee or retiree.

If the Plan is terminated, you will be notified in advance as to the procedures and deadlines for submitting claims for reimbursement from the Plan.