AG Benefits

American Greetings Corporation Welfare Benefits Plan & Insured Welfare Benefits Plan Summary Plan Description

Relating to

Self-Insured Medical & Prescription Drug Benefits and

Insured Medical Benefits through Kaiser of Hawaii and CIGNA International Medical & Dental

Updated January 1, 2025

Where to Get Information

For Assistance with Consumer Plans, Traditional Plan Medical Benefits, and Prescription Drug Benefits:

Consumer Plan	**United Healthcare Services, Inc.**
Enhanced Consumer Plan	**Participant Website:** www.myuhc.com
Traditional Plan	**Locate Network Providers:** www.myuhc.com
	Phone: (866) 844-4869
	Services: Member Services, Providers, Prescription Coverage, and Claims

For Assistance with Coverage through Kaiser Permanente (Hawaii) & CIGNA International:

(NOTE: Associates should reference the insurance booklets issued by these insurers for details on the available medical benefit options, including specific benefit plan designs, covered services and treatments, and exclusions.)

Kaiser Permanente (Hawaii associates)	**Kaiser Permanente** **Website/Locate Network Providers: www.kp.org** **Phone: 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands)** **Services:** Member Services, Providers and Claims
CIGNA International	**CIGNA International** **Website:** www.cignaenvoy.com **Phone: Located on back of ID card** **Services:** Member Services, Providers and Claims

Associates needing additional assistance regarding eligibility, enrollment, and COBRA, please contact:

AGBenefits Service Center
Phone: (877) 213.6240
www.americangreetingsbenefits.com

Associates needing additional assistance after contacting the AGBenefits Service Center may contact the plan administrator:
American Greetings Corporation
Attn: AG Benefits Dept
One American Blvd
Cleveland, Ohio 44145
Phone: 216-252-7300, ext. 4192 or (800) 321-3040
HRServices@amgreetings.com

This summary plan description describes the medical and prescription drug benefits offered under two different welfare benefit plans sponsored by American Greetings Corporation:

- American Greetings Corporation Welfare Benefits Plan (Plan Number 556) and
- **American Greetings Insured Welfare Benefits Plan** (Plan Number 502).

The medical and prescription drug benefits described in this document are provided under those plans.

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MEDICAL AND PRESCRIPTION DRUG COVERAGE HIGHLIGHTS

American Greetings Corporation offers three medical plan options to eligible ***full-time*** and ***part-time associates.*** Participation in the medical plan is optional. ***Associates*** who desire coverage must elect coverage and pay their required contribution. **This summary chart below is not for associates living in Hawaii or associates living outside of the United States.** ***Associates*** living in Hawaii should reference the Kaiser Member Handbook and Features of Your Group Plan and ex-patriot ***associates*** should reference the CIGNA International Global Health Advantage booklet for a description of their medical coverage options.

COMPARISON OF MEDICAL COVERAGE OPTIONS

Highlights	Enhanced Consumer Plan		Consumer Plan		Traditional Plan	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***	***In-Network***	***Out-of-Network***
Lifetime Maximum	unlimited		unlimited		unlimited	
Annual Deductible	$1,800 single $3,600 family	$3,600 single $7,200 family	$3,500 single $7,000 family	$7,000 single $14,000 family	$700 individual $2,100 family	$1,400 individual $4,200 family
	(for coverage greater than single, the full family deductible must be met before benefits are paid)		*(family coverage allows an individual to meet a single deductible and then coinsurance will begin paying up to the single out-of-pocket maximum)*			
Annual Medical Out-of-Pocket Maximum	$3,600 single $7,200 family	$7,200 single $14,400 family	$4,500 single $9,000 family	$9,000 single $18,000 family	$2,700 individual $8,100 family	$5,400 individual $16,200 family
	(includes deductible)		(includes deductible) (family coverage allows an individual to meet the single out-of-pocket maximum)		*(includes deductible)*	
Annual Rx Out-of-Pocket Maximum	Included in medical out-of-pocket maximum				$1,500 individual $2,000 family	
American Greetings HSA Contribution	$500 single/$1,000 family		$300 single/$600 family		Not Applicable	
	May be used to offset deductible					
Coinsurance	80%	60%	80%	60%	80%	60%
Coinsurance non-UHC Premium Providers & Hospital Based Labs & Hospital based Imaging	60%	60%	60%	60%	60%	60%
Office Visits	80%	60%	80%	60%	PCP: $30 ***copay*** Specialist: $50 **copay** *No deductible; applies to out-of-pocket*	60%
Preventive Care	100% *No deductible*	0%	100% *No deductible*	0%	100% *No deductible*	0%

Annual Deductible and Annual Out-of-Pocket Maximum amounts apply to the 12 month period that begins on January 1.

COMPARISON OF PRESCRIPTION DRUG PLAN OPTIONS

	Consumer and Enhanced Consumer Plans	Traditional Plan
Limitation: 30 day retail/90 day mail order program Mail order is required for maintenance drugs.	**Covered Person's Coinsurance**	**Covered Person's Coinsurance** (retail/mail order)
Tier 1	20%	20% (minimum $10/$20)
Tier 2	25%	30% (minimum $30/$60)
Tier 3/4	50%	60% (minimum $45/$90)
Medications with Over the Counter (OTC) Alternatives (e.g. allergy & gastrointestinal)	100%	100%
Lifestyle Drugs (e.g. Viagra, Levitra and Retin A)	100%	100%
Annual Rx Deductible Amount	Included in medical plan deductible	Not subject to deductible
Annual Rx Out-of-Pocket Maximum	Included in medical out-of-pocket maximum	$1,500 individual $2,000 family

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the ***eligibility*** requirements for a person to participate in the medical and prescription drug coverage.

ELIGIBILITY

The following ***associates*** are eligible to enroll for ***company***-sponsored medical and prescription drug coverage described here.

1. All regular ***full-time associates*** that meet any of the following requirements:

   - On the regular payroll working at least thirty-six (36) hours per work week
   - Benefit eligible part-time officers
   - Full-time associates working reduced schedules under the transition to retirement program
   - Full-time associates returning to work under the phase back into work program following a leave for the birth/placement of a child working a schedule of at least thirty-two (32) hours per week.

2. All regular ***part-time associates*** on the regular payroll working at least twenty (20) but less than thirty-six (36) hours per work week.

3. All Field Coordinator/Revision Lead/Full-time Merchandiser associates.

4. All eligible ***associates*** of the following unions:

   - Cleveland
   - Greeneville

5. If you are a regular full-time associate working thirty-six (36) hours per work week, regular part-time associate working at least twenty (20) hours or a Field Coordinator/Revision Lead/Full-Time Merchandiser associate and are a third country national, or working on a foreign assignment for American Greetings Corporation outside the U.S. you are eligible to be covered under CIGNA International.

6. Associates who do not meet the eligibility requirements described at items 1 – 5 above, may be eligible for medical and prescription drug coverage if they meet eligibility requirements established in accordance with rules under the Affordable Care Act. For these associates, eligibility is determined by using a "look-back measurement" method. Associates who are eligible for coverage under the look-back measurement method will be notified.

   New associates (not otherwise eligible for coverage), who are not regularly scheduled to work 20 hours or more per week, and whose amount of work hours per week cannot be reasonably determined at the time of hire, are considered "***variable-hour"*** associates. For variable-hour associates, the look-back measurement method uses the following periods:

   Initial Measurement Period - the 12-month consecutive period beginning on the first day of the month following the variable-hour associate's date of hire.
   Initial Administrative Period - the one-month period immediately following the Initial Measurement Period.
   Initial Stability Period - the 12-month consecutive period immediately following the Initial Administrative Period.

   If a new variable-hour associate works an average of 30 hours or more per week during the Initial Measurement Period, the associate will be eligible for coverage during the Initial Stability Period. The newly eligible associate must elect coverage during the Initial Administrative Period. If coverage is elected, coverage becomes effective the first day of the Initial Stability Period.

A new variable-hour associate who does not work an average of 30 hours or more per week during the Initial Measurement Period, will not be eligible for coverage during the Initial Stability Period.

Once a new variable-hour associate has been employed for the 12-month period of November 1 – October 31, the associate is considered an ***"on-going" associate***. For on-going associates, the look-back measurement method uses the following periods:

Standard Measurement Period - the 12-month consecutive period beginning November 1 and ending October 31.
Standard Administrative Period - the 2-month period of November 1 – December 31, immediately following the Standard Measurement Period.
Standard Stability Period - the 12-month period of January 1 – December 31.

Coverage eligibility for on-going associates is determined annually. If an on-going associate works an average of 30 hours or more per week during the Standard Measurement Period, the associate will be eligible for coverage during the Standard Stability Period. The associate must elect coverage during the Standard Administrative Period. If coverage is elected, coverage becomes effective January 1, the first day of the Standard Stability Period.

An on-going associate who does not work an average of 30 hours or more per week during the Standard Measurement Period will not be eligible for coverage during the Standard Stability Period.

Special rules apply if an associate experiences a change in job status (for example, to a full-time or part-time position), a leave of absence or a break in service. Associates will be notified and provided with more information if these special rules apply.

The following ***associates*** are not eligible to enroll for ***company***-sponsored medical and prescription drug coverage:

1. ***All other full-time*** and ***part-time associates*** in merchandiser classifications not listed in the Eligibility section number 3.
2. Temporary, seasonal or on-call ***associates***.
3. Group Class 099

This SPD does not cover collective bargaining ***associates*** other than those named above.

ENROLLMENT

An ***associate*** must enroll for coverage hereunder within thirty (30) days of hire date (or eligibility date, if later) or any qualified life event, or during any annual enrollment period. The ***associate*** shall have the responsibility of completing their enrollment through the AGBenefits Service Center.

EFFECTIVE DATE

Eligible ***associates***, as described in *Eligibility*, are covered under the ***Plan*** on the first day of the month coincident with or following completion of one full month of employment in an eligible classification, provided the ***associate*** has enrolled for coverage as described in *Enrollment.* Note that if employment begins on the first calendar day of the month, coverage will be effective the first of the month following employment. However, if an associate transfers from an ineligible class to an eligible class, coverage is effective the date of transfer, provided the associate has already met the length of service requirements (1st of the month following one full month since recent hire date). If associate has not met, then eligibility is effective once the associate has met length of service requirements.

REINSTATEMENT

NON-UNION ASSOCIATES

Associates who lose coverage due to an approved ***leave of absence***, ***layoff***, or termination of employment with the ***company*** are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to ***associates*** who were previously covered under the ***Plan***.
2. Rehire or return to active service must occur within one (1) year of the last day worked.
3. Coverage shall be effective on the date of rehire or return to work. Prior benefits and limitations, such as the eligibility waiting period, shall be applied with no break in coverage.

An ***associate*** who returns to work more than one (1) year following an approved ***leave of absence***, ***layoff***, or termination of employment will be considered a new ***associate*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage.

UNION ASSOCIATES

Associates represented by a Collective Bargaining Unit who lost coverage due to an approved ***leave of absence, layoff*** or termination of employment with the ***company*** are eligible for reinstatement of coverage according to the Collective Bargaining Agreement. If not specified by the Collective Bargaining Agreement, the Reinstatement provisions for Non-Union ***Associates*** will apply.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements.

The term "***spouse***" means the spouse of the ***associate*** under a legally valid existing marriage, unless court ordered separation exists. As used herein, the term "***spouse***" also includes an eligible ***domestic partner***.

1. The term "domestic partner" means one of the following, as evidenced by an "Affidavit of Domestic Partnership or Civil Union" notarized and signed by the ***associate*** and ***domestic partner***:
    a. The ***same-sex or opposite-sex partner*** of the ***associate*** under a legally valid civil union.
    b. The ***same-sex partner*** of the ***associate*** under a legally valid registered domestic partnership.
    c. The ***same-sex partner*** of the ***associate*** under an employer-recognized domestic partnership that meets all of the following criteria:
        - The associate and the partner are both eighteen (18) years of age or older;
        - The associate and the partner are not related by blood closer than permitted by state law applicable to marriage;
        - The associate and the partner are not legally married to, or in a domestic partnership or civil union with anyone else;
        - The associate and the partner are each other's sole partner and have been for at least the past six (6) months and intend to remain so indefinitely;
        - The ***associate*** and the ***partner*** are mentally competent to consent to contract;
        - The associate and the 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 six (6) months;
        - The associate provides proof of the above as may be required by the plan administrator.

The full fair market value of the domestic partner's coverage must be added as imputed income to the associate's W-2 unless the domestic partner meets certain dependency requirements for federal income tax purposes and the associate has certified that status by completing an Affidavit of Tax-Qualified Dependent which is available upon request.

The ***associate*** must notify the ***plan administrator*** by contacting the AGBenefits Service Center in writing within 30 days of any status change in the ***domestic partner*** relationship based on the eligibility requirements previously identified. The ***associate*** and ***domestic partner*** will be responsible for all claims paid by the ***plan administrator*** resulting from late notification of the status change.

The ***plan administrator*** retains the right to revoke or revise its ***domestic partner*** policy at any time for any reason including compliance with government regulations or to serve the discretionary interests of the ***plan administrator***. The ***plan administrator*** has full discretion and authority to make all decisions on the interpretation and administration of this policy. The decision of the ***plan administrator*** is final and binding.

1. The term “child” means the ***associate’s*** unmarried or married child (natural, foster, step, adopted or children of a domestic partner; ***placed for adoption***; and any other children related to the ***associate*** by blood or marriage for whom the ***associate*** can provide proof of legal guardianship) provided that the child is less that twenty-six (26) years of age.

2. The term “child” includes the ***associate’s*** unmarried grandchild under the age of nineteen (19). An eligible grandchild must be the natural child of the ***associate’s*** unmarried ***dependent*** child. The ***associate’s*** unmarried ***dependent*** child must reside in the ***associate’s*** household and is one of the following:

    - under the age of nineteen (19);
    - between the ages of nineteen (19) and twenty-three (23) and a ***full-time student*** at an accredited secondary/trade school;
    - a disabled ***dependent*** child of the ***associate***.

3. An eligible child shall also include any other child of an ***associate*** who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***associate’s*** household. You may receive from the ***plan administrator*** by contacting the AGBenefits Service Center, without charge, a copy of the ***Plan’s*** QMCSO procedures.

4. A child who is unmarried and incapable of self-sustaining employment, and dependent upon the ***associate*** for support due to a permanent and total mental and/or physical disability at the time coverage would otherwise end (e.g., upon reaching age 26).

Eligibility may not be continued beyond the earliest of the following:

a. Cessation of the mental and/or physical disability;
b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination. Proof of incapacitation must be provided to the AGBenefits Service Center within thirty (30) days of the child’s loss of eligibility and thereafter as requested by the ***plan administrator*** or ***claims administrator***, but generally not more than once every two (2) years.

Every eligible ***associate*** may enroll eligible ***dependents***. However, if both the husband and wife are ***associates***, they may choose to have one covered as the ***associate***, and the ***spouse*** covered as the ***dependent*** of the ***associate***, or they may choose to have both covered as ***associates***. Eligible children may be enrolled as ***dependents*** of one ***spouse***, but not both.

Also note that if your grandchild is not a tax dependent according to specific IRS requirements, then the value of the benefits provided to your child will be taxable to you. You will need to inform the AGBenefits Service Center in writing within 30 days of the enrollment that your grandchild does not meet the IRS definition of a qualifying child or qualifying relative to receive tax free health benefits.

PROOF OF LEGAL DEPENDENT STATUS

The ***plan administrator*** requires proof that all ***dependents*** covered by the ***Plan*** are legal ***dependents***. This verification process ensures only those who qualify for coverage are covered under the benefits program. Proof of ***dependent*** status must be submitted by the deadline established by the ***plan administrator***.

Types of acceptable proof include:

1. For spouses:

    a. a copy of the marriage certificate or valid marriage documentation from a church; and
    b. a copy of the current federal or state income tax return (page 1 only) showing “married filing jointly” or “married filing separately”. The ***spouse’s*** name must appear on the tax form on the line after the “married filing separately” status (or vice versa). Mark out all financial information and all but the last four digits of all social security numbers.

2. For domestic partners:

a. a copy of the current Affidavit of Domestic Partnership or Civil Union Form notarized and signed and dated by the ***associate*** and ***domestic partner***; and
b. a copy of proof of permanent residence: document establishing a common residence for at least the past six months, such as a residential lease identifying both partners as tenants, or a "common – joint ownership" of a residence such as a house, condominium, or mobile home;
c. copy of proof of financial inter-dependence, such as a joint banking account, joint investment account, or joint ownership or lease of a motor vehicle.

3. For children:

a. Natural Child: copy of the birth certificate or baptismal certificate or verification of live birth from a hospital on hospital stationary or laboratory report showing biological mother and/or father. All documentation must indicate the child's birth date and the name of the covered parent (at minimum).
b. Foster Child: copy of the court order or other legal document placing the child with the ***associate*** who is a licensed foster parent.
c. Step Child or child of domestic partner:

- copy of the birth certificate or baptismal certificate or verification of live birth from a hospital on hospital stationary. All documentation must indicate the child's name, birth date and the names of both parent; and
- Proof that the natural parent and the subscriber are married or in a registered domestic partnership (see ***spouse/domestic partnership*** documentation requirement above).

d. Adopted Child: copy of court documentation verifying completed adoption or letter of placement from an adoption agency, an attorney or State Department of Social Services, verifying the adoption is in progress.
e. Children of ***associate's*** unmarried ***dependent*** child (***associate's*** grandchild under age 19):

- copy of the grandchild's birth certificate or baptismal certificate or verification of live birth from a hospital on hospital stationary. All documentation must indicate the child's birth date and the name of the ***associate's dependent*** child (at minimum); and
- Proof that the parent of the child is the ***associate's*** unmarried ***dependent*** child who is:
- under age 19; or
- if age 19 to 23, enrolled ***full-time*** in a recognized course of study or training in an institution such as a high school, vocational school, university, college or technical school; or
- disabled (see item 4.a. below).

f. Other: For all other children for whom the ***associate*** has legal custody – a copy of the court order or other legal document granting custody of the child to the ***associate***. Documentation must verify the ***associate*** has guardianship responsibility.

4. Children with Disabilities:

a. copy of a current letter from the ***dependent*** child's ***physician*** certifying that the child is incapable of self-support because of a continuously disabling illness or injury and must be principally supported by the ***associate***; and
b. the appropriate child type (natural, foster, step, adopted or other) above for acceptable proof of relationship.

5. Children with Qualified Medical Child Support Order (QMCSO):

a. Copy of the QMCSO used to enforce the order to provide child support health benefits; and

b. the appropriate child type (natural, foster, step, adopted or other) above for acceptable proof of relationship.

The ***plan administrator*** may, at its discretion, audit the status of all ***associates*** covering ***dependents*** to ensure that proper proof of ***dependent*** status has been provided. ***Associates*** will be required to submit proof by the deadline established by the ***plan administrator*** in order to keep ***dependent*** coverage. If the ***associate*** does not submit proof within the required timeframe, the ***dependent's*** coverage will be terminated and COBRA will be offered (if applicable).

If an ***associate*** is audited and has knowingly enrolled a ***dependent(s)*** who is not eligible for coverage, the ***associate*** may be subject to disciplinary action.

DEPENDENT ENROLLMENT

An ***associate*** must enroll eligible ***dependents*** for coverage within thirty (30) days after the ***associate's*** eligibility date of coverage; and within thirty (30) days after any other event permitting the addition of ***dependents***, as described below. Note that a sixty (60) day enrollment window is provided when a ***dependent*** child loses coverage under a state children's health insurance plan or Medicaid or becomes eligible for premium assistance under these programs. In all cases, the ***associate*** shall have the responsibility of completing their enrollment through the AGBenefits Service Center.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s)***, as described in *Eligibility*, will become covered under the ***Plan*** on the later of the dates listed below, provided the ***associate*** has enrolled them in the ***Plan*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements:

1. The date the ***associate's*** coverage becomes effective.
2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***associate*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired. An adopted child will be considered acquired when the child is ***placed for adoption***.
3. Newborn children will be considered a ***dependent*** under this ***Plan*** for thirty (30) days immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***associate*** must complete an application for enrollment through the AGBenefits Service Center within thirty (30) days of birth.

ANNUAL OPEN ENROLLMENT

Annual open enrollment is the period designated by American Greetings during which the ***associate*** may enroll in the ***Plan*** if the ***associate*** did not do so when first eligible or change current coverage elections for the associate and/or their eligible ***dependents***. An ***associate*** must make application during the annual open enrollment period to change benefit elections. An annual enrollment will be permitted once in each calendar year. Specific dates will be announced by American Greetings.

Election changes requested during the annual open enrollment are made effective January 1 of the following year. Elections cannot be changed during the year unless an event occurs allowing for an election change, as described in the next section below.

SPECIAL ENROLLMENT PERIOD FOR QUALIFYING LIFE EVENTS AND CHANGE IN STATUS

Associates and/or ***dependents*** may make mid-year enrollment changes within thirty (30) days of a qualifying life event or status change under the following circumstances:

1. Marital Status Change:
   a. Marriage
   b. Death of ***spouse*** or partner
   c. Divorce or annulment
   d. Legal separation

2. Number of ***Dependents*** Change:

   a. Birth
   b. Adoption or placement for adoption
   c. Death of a ***dependent*** child
   d. Newly eligible ***dependents***

3. Loss/Gain of Other Coverage

   a. If the ***associate*** and/or ***dependent(s)*** loses/gains other coverage (i.e. spouse's health plan coverage terminates, cessation of employer contributions towards other coverage, termination of other employment or reduction in number of hours of other employment, ***associate*** and/or ***dependent(s)*** no longer resides or works in service area, or Medicare or Medicaid eligibility ends)

4. ***Dependent*** Status Change:

   a. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements

5. Employment Status:

   a. Commencement or termination of employment (***associate***, ***spouse*** or ***dependent***)
   b. Commencement of, or return from, ***leave of absence*** under Family and Medical Leave Act
   c. Change from ***part-time*** to ***full-time*** status, or vice versa
   d. Strike or lockout
   e. An associate may revoke the employer-sponsored health coverage to enroll in another plan that provides minimum essential coverage if hours of service are reduced to an average of less than 30 hours per week, but are still eligible for health coverage.

6. Judgment, Decree or Order Requiring Coverage

   a. Qualified Medical Child Support Order

7. Change in Residence (***associate***, ***spouse*** or ***dependent***):

   a. May qualify if there is a loss of eligibility for a region-specific plan

8. Significant changes in health coverage, including:

   a. A significant change in cost of coverage under employer's group medical plan
   b. Significant coverage curtailment, with or without a loss of coverage
   c. Addition or significant improvement of benefit package options

9. Change in coverage of associate or spouse attributable to spouse's employment.

10. An associate may cease coverage under the employer-sponsored health plan when the associate has purchased coverage on a public exchange.

11. In addition***,*** the Children's Health Insurance Program Reauthorization Act of 2009 allows ***associates*** to make mid-year enrollment changes within sixty (60) days of certain events.

    An ***associate*** who is currently covered or not covered under the ***Plan*** may request a special enrollment period for the associate, if applicable, and their ***dependent***. Special enrollment periods will be granted if:

    a. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance plan or Medicaid; or
    b. the individual becomes eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

    The ***associate*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

PAYING FOR BENEFITS

The ***associate's*** cost is determined by his status as a tobacco user or non-tobacco user and the medical coverage category elected; see the next section below for additional information regarding tobacco use and medical premiums. These are the coverage categories:

1. No medical coverage.
2. ***Associate*** Only medical coverage.
3. ***Associate*** & ***Spouse*** medical coverage.
4. ***Associate*** & Child(ren) medical coverage.
5. ***Associate*** & Family medical coverage – ***associate***, ***spouse*** and child(ren).

The prices of these coverage categories are located on the ***associate's*** secure enrollment site. ***Associates*** decide the coverage category in which they want to enroll.

VOLUNTARY WELLNESS PROGRAMS

Associates and family members eligible for the Company's health benefits programs may have rights under applicable federal or state laws relating to employee benefit plans. American Greetings voluntary wellness programs are designed to comply with all applicable legislation, including Health Insurance Portability and Accountability Act (HIPAA), Americans with Disability Act (ADA), Patient Protection and Affordable Care Act (ACA) and U.S. Equal Employment Opportunity Commission (EEOC). Only aggregate medical information is provided to American Greetings from any third-party vendor to help design wellness programs that promote health and/or prevent disease. American Greetings does not receive any individual data from wellness vendors or programs.

NON-TOBACCO USER AND WELLNESS DISCOUNTS

The company provides wellness programs that encourage good health and healthy lifestyles. These programs may include discounts/incentives to associates and covered dependents for participating.

NON-TOBACCO USER DISCOUNT

The ***company*** offers a discount on medical coverage contributions to ***associates*** and their covered ***spouse*** who do not use any tobacco products or who takes certain steps related to ceasing tobacco use, as described below. To qualify for non-tobacco user status, the ***associate*** selects the appropriate tobacco user status when enrolling and completes certain necessary steps.. For example:

- non-tobacco user (the ***associate*** and spouse are tobacco free)
- tobacco user (the ***associate*** is not tobacco free or the ***associate*** is tobacco free but the covered ***spouse*** is not)

If the ***associate*** selected "tobacco user" status during annual open enrollment and later meets the non-tobacco user status requirements noted below, the ***associate*** can change status and receive the non-tobacco user discount.

If the ***associate*** selected "non-tobacco user" during annual open enrollment and the ***associate*** (or a covered ***spouse***) starts using tobacco during the plan year, the ***associate*** must report the change to tobacco user status. The ***associate's*** monthly medical plan premiums will change to the tobacco user rate.

To initiate a change in tobacco status or appeal a determination regarding your tobacco status, *Associates* must call the AGBenefits Service Center at 877-213-6240 to report the change in status.

To qualify for non-tobacco user status:

1. The ***associate*** and covered spouse must certify that they are tobacco free for 90 days. To be considered a non-tobacco user, an individual must have not used tobacco in the past 90 days; or

2. The ***associate*** and/or covered ***spouse*** have successfully completed a smoking cessation program within the current plan year (proof of program completion will be required). A list of free tobacco cessation programs may be found on the benefits website, AGBenefits.com; or

3. The ***associate's*** and/or covered ***spouse's physician*** has determined that it is medically inadvisable or unreasonably difficult for ***associate*** and/or covered ***spouse*** to stop using tobacco products and has provided the ***associate*** with a note stating this within the current plan year (a copy of the ***physician's*** note will be required).

OTHER WELLNESS DISCOUNTS/CREDITS

The ***company*** may offer additional wellness incentives/discounts for participating in activities and programs such as a health survey, biometric screening, physical exam, physical activity cancer screenings, or other educational programs.

If it is unreasonably difficult to achieve the standards for the incentives/discounts, you can appeal to receive the wellness incentives/discounts. To appeal the physical exam and/or biometric screening wellness reward call American Greetings' wellness partner, Rally, serviced by the AGBenefits Advisor at 1-800-397-9249.

MEDICAL BENEFITS

THE MEDICAL BENEFITS SECTION IS NOT FOR ASSOCIATES LIVING IN HAWAII OR ASSOCIATES LIVING OUTSIDE OF THE UNITED STATES.

ASSOCIATES LIVING IN HAWAII SHOULD REFERENCE THE KAISER PERMANENTE HAWAII GUIDE TO YOUR HEALTH PLAN INCLUDING THE BENEFIT AND PAYMENT CHART

ASSOCIATES COVERED UNDER CIGNA INTENRATIONAL SHOULD REFERENCE THE CIGNA INTERNATIONAL GLOBAL HEALTH ADVANTAGE BOOKLET FOR A DESCRIPTION OF THEIR MEDICAL BENEFITS, INCLUDING THE APPLICABLE SCHEDULES OF BENEFITS.

SCHEDULE OF BENEFITS

ENHANCED CONSUMER PLAN

The following *Schedule of Benefits* is designed as a quick reference (for all U.S. associates not living in Hawaii). For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical Claim Filing Procedure, Medical Expense Benefit, Prescription Drug Program, Plan Exclusions and How the Plan Works*.

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical and Prescription Drug	unlimited	
Bariatric Surgery	One surgery per lifetime	
Fertility/Infertility Services	$35,000 medical/$15,000 prescription drug per lifetime	
Hospice Services	360 days per lifetime	
Education and Training (including diabetic nutritional counseling, obesity counseling)	unlimited	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Home Healthcare Services	100 visits	
Skilled Nursing Facility Services	180 days	
Outpatient Therapy (Habilitative, Physical, Chiropractic, Occupational, Speech & Pulmonary combined limit)	60 visits	
Outpatient Cardiac Rehabilitation (There may be additional visits for professional cardiac services. Contact your Claims Administrator for more information.)	36 visits	
Benefit Per Covered Procedure For:		
Transplant Travel and Lodging Allowance	$10,000	
Out-of-Network Transplant Procedures	Excluded	
Combined Medical & Prescription Drug Deductible Per Calendar Year:	***In-Network Provider***	***Out-of-Network Provider***
Individual (Single)	$1,800	$3,600
Family (Collective)	$3,600	$7,200
All family members contribute towards the family deductible. An individual cannot have claims covered under the ***Plan coinsurance*** until the total family deductible has been satisfied. Amounts applied toward satisfaction of the ***out-of-network provider*** deductible may also be applied toward satisfaction of the ***in-network provider*** deductible and vice versa.		
Employer Contribution to Health Savings Account (HSA) Per Calendar Year:		
Single	$500	
Family	$1,000	
HSA funds may be used for any eligible health care expense, including the ***Plan*** deductible and ***coinsurance*** amounts.		
Combined Medical & Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network Provider***	***Out-of-Network Provider***
Individual (Per Person)	$3,600	$7,200
Family (Collective)	$7,200	$14,400
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges which are not applied toward satisfaction of the out-of-pocket expense limit.		
Amounts applied toward satisfaction of the ***out-of-network provider*** out-of-pocket expense limit may also be applied toward satisfaction of the ***in-network provider*** out-of-pocket expense limit and vice versa.		

SCHEDULE OF BENEFITS
Enhanced Consumer Plan (continued)

Coinsurance: The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or single deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

BENEFIT DESCRIPTION	***In-Network Provider*** (% of ***negotiated rate***)	***Out-of-Network Provider*** (% of ***customary and reasonable or allowed amount)***
Inpatient Hospital & Outpatient Hospital (other than emergency room charges)	80%	60%
Emergency Use of Emergency Room (Facility & Physician Services) ***Facility*** & ***physician*** charges ***incurred*** for non-emergency use of the emergency room are not a ***covered expense***	80%	80%
Urgent Care Center Services	80%	80%
Physician's Services (Office Visits, Office Services, Inpatient Visit, Surgery (office, ***inpatient*** or ***outpatient***), Pathology, Radiology, Anesthesiology (***inpatient*** or ***outpatient***))	80%	60%
Outpatient Diagnostic X-rays & Lab (other than ***hospital*** charges)	80%	60%
Hospital Based Labs, hospital based imaging and not using UHC Premium Providers	60%	60%
Preventive Care (Well Baby/Child Care, Well woman/man exams, Women's Preventive Care, eligible well screenings & immunizations, Routine physical exam and lab work, subject to recommended age and frequency)	100%*	0%
Mental & Nervous Disorders and Chemical Dependency Care Any applicable deductible, ***coinsurance*** or ***copayment*** corresponds to the type of service received and is payable on the same basis as any other ***illness*** (e.g., emergency room visits for mental ***illness*** will be paid according to the emergency room services listing above)	Same as any other ***illness***	
Maternity/Obstetrical Charges (Initial visit to confirm ***pregnancy*** and office visits in addition to the global maternity services fee)	80%	60%
Skilled Nursing Facility, Home Health Care, Hospice Care	80%	60%
Durable Medical Equipment, Prosthetic Devices	80%	Excluded
Education and Training (including diabetic nutritional counseling, obesity counseling)	100%*	100%*
Dialysis	80%	Excluded
Spinal Fusion	80%	Excluded
Pain Management	80%	Excluded
Sleep Studies	80%	Excluded
Outpatient Therapy Services (Habilitative, Physical, Speech, Occupational & Pulmonary), Outpatient Cardiac Rehabilitation, Chiropractic Care	80%	60%
Ambulance Services (Emergency & Non-Emergency)	80%	80%
Obesity/Bariatric Surgery	80%	Excluded
Transplant Procedures	80%	Excluded
All Other Covered Expenses	80%	60%

* Deductible Waived

Refer to *Medical Expense Benefit* for complete details.

SCHEDULE OF BENEFITS

CONSUMER PLAN

The following *Schedule of Benefits* is designed as a quick reference (for all U.S. associates not living in Hawaii). For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical Claim Filing Procedure, Medical Expense Benefit, Prescription Drug Program, Plan Exclusions* and *How the Plan Works.*

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical and Prescription Drug	unlimited	
Bariatric Surgery	One surgery per lifetime	
Fertility/Infertility Services	$35,000 medical/$15,000 prescription drug per lifetime	
Hospice Services	360 days per lifetime	
Education and Training (including diabetic nutritional counseling, obesity counseling)	unlimited	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Home Healthcare Services	100 visits	
Skilled Nursing Facility Services	180 days	
Outpatient Therapy (Habilitative, Physical, Chiropractic, Occupational, Speech & Pulmonary combined limit)	60 visits	
Outpatient Cardiac Rehabilitation (There may be additional visits for professional cardiac services. Contact your Claims Administrator for more information.)	36 visits	
Benefit Per Covered Procedure For:		
Transplant Travel and Lodging Allowance	$10,000	
Out-of-Network Transplant Procedures	Excluded	
Combined Medical & Prescription Drug Deductible Per Calendar Year:	***In-Network Provider***	***Out-of-Network Provider***
Individual (Single)	$3,500	$7,000
Family (Collective)	$7,000	$14,000
Family coverage allows an individual to meet a single deductible and then coinsurance will begin paying up to the single out-of-pocket maximum. Amounts applied toward satisfaction of the ***out-of- network provider*** deductible may also be applied toward satisfaction of the ***in-network provider*** deductible and vice versa.		
Employer Contribution to Health Savings Account (HSA) Per Calendar Year:		
Single	$300	
Family	$600	
HSA funds may be used for any eligible health care expense, including the ***Plan*** deductible and ***coinsurance*** amounts.		
Combined Medical & Prescription Drug Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network Provider***	***Out-of-Network Provider***
Individual (Per Person)	$4,500	$9,000
Family (Collective)	$9,000	$18,000
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges which are not applied toward satisfaction of the out-of-pocket expense limit. Amounts applied toward satisfaction of the ***out-of-network provider*** out-of-pocket expense limit may also be applied toward satisfaction of the ***in-network provider*** out-of-pocket expense limit and vice versa.		

SCHEDULE OF BENEFITS
Consumer Plan (continued)

Coinsurance: The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or single deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

BENEFIT DESCRIPTION	***In-Network Provider*** (% of ***negotiated rate***)	***Out-of-Network Provider*** (% of ***customary and reasonable amount or allowed amount)***
Inpatient Hospital & Outpatient Hospital (other than emergency room charges)	80%	60%
Emergency Use of Emergency Room (Facility & Physician Services) ***Facility*** & ***physician*** charges ***incurred*** for non-emergency use of the emergency room are not a ***covered expense***	80%	80%
Urgent Care Center Services	80%	80%
Physician's Services (Office Visits, Office Services, Inpatient Visit, Surgery (office, ***inpatient*** or ***outpatient***), Pathology, Radiology, Anesthesiology (***inpatient*** or ***outpatient***))	80%	60%
Outpatient Diagnostic X-rays & Lab (other than ***hospital*** charges)	80%	60%
Hospital Based Labs, hospital based imaging and not using UHC Premium Providers	60%	60%
Preventive Care (Well Baby/Child Care, Well woman/man exams, Women's Preventive Care, eligible well screenings & immunizations, Routine physical exam and lab work, subject to recommended age and frequency)	100%*	0%
Mental & Nervous Disorders and Chemical Dependency Care	Same as any other ***illness***	
Any applicable deductible, ***coinsurance*** or ***copayment*** corresponds to the type of service received and is payable on the same basis as any other ***illness*** (e.g., emergency room visits for mental ***illness*** will be paid according to the emergency room services listing above)		
Maternity/Obstetrical Charges (Initial visit to confirm ***pregnancy*** & office visits in addition to the global maternity services fee)	80%	60%
Skilled Nursing Facility, Home Health Care, Hospice Care	80%	60%
Durable Medical Equipment, Prosthetic Devices	80%	Excluded
Education and Training (including diabetic nutritional counseling, obesity counseling)	100%*	100%*
Dialysis	80%	Excluded
Spinal Fusion	80%	Excluded
Pain Management	80%	Excluded
Sleep Studies	80%	Excluded
Outpatient Therapy Services (Habilitative, Physical, Speech, Occupational & Pulmonary), Outpatient Cardiac Rehabilitation, Chiropractic Care	80%	60%
Ambulance Services (Emergency & Non-Emergency)	80%	80%
Obesity/Bariatric Surgery	80%	Excluded
Transplant Procedures	80%	Excluded
All Other Covered Expenses	80%	60%

* Deductible Waived

Refer to *Medical Expense Benefit* for complete details.

SCHEDULE OF BENEFITS

TRADITIONAL PLAN

The following *Schedule of Benefits* is designed as a quick reference (for all U.S. associates not living in Hawaii). For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical Claim Filing Procedure, Medical Expense Benefit, Prescription Drug Program, Plan Exclusions* and *How the Plan Works*.

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical and Prescription Drug	unlimited	
Bariatric Surgery	One surgery per lifetime	
Fertility/Infertility Services	$35,000 medical/$15,000 prescription drug per lifetime	
Hospice Services	360 days per lifetime	
Education and Training (including diabetic nutritional counseling, obesity counseling)	unlimited	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Home Healthcare Services	100 visits	
Skilled Nursing Facility Services	180 days	
Outpatient Therapy (Habilitative, Physical, Chiropractic, Occupational, Speech & Pulmonary combined limit)	60 visits	
Outpatient Cardiac Rehabilitation (There may be additional visits for professional cardiac services. Contact your Claims Administrator for more information.)	36 visits	
Benefit Per Covered Procedure For:		
Transplant Travel and Lodging Allowance	$10,000	
Out-of-Network Transplant Procedures	Excluded	
Medical Deductible Per Calendar Year:	***In-Network Provider***	***Out-of-Network Provider***
Individual (Per Person)	$700	$1,400
Family (Aggregate)	$2,100	$4,200
Amounts applied toward satisfaction of the ***out-of- network provider*** deductible may also be applied toward satisfaction of the ***in-network provider*** deductible. However, amounts applied toward satisfaction of the ***in-network provider*** deductible will not be applied toward satisfaction of the ***out-of-network provider*** deductible.		
Copays Per Admission Or Occurrence: (Refer to Medical Expense Benefit, Copay) (co-pay applies toward out-of-pocket maximum)		
In-Network Provider Office Visit Copay	$30	
Emergency Room Services Copay	$200	
Urgent Care Provider Services Copay	$50	
Medical Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network Provider***	***Out-of-Network Provider***
Individual (Per Person)	$2,700	$5,400
Family (Aggregate)	$8,100	$16,200
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges which are not applied toward satisfaction of the out-of-pocket expense limit. Amounts applied toward satisfaction of the ***out-of-network provider*** out-of-pocket expense limit may also be applied toward satisfaction of the ***in-network provider*** out-of-pocket expense limit. However, amounts applied toward satisfaction of the ***in-network provider*** out-of-pocket expense limit will not be applied toward satisfaction of the ***out-of-network provider*** out-of-pocket expense limit.		

SCHEDULE OF BENEFITS
Traditional Plan (continued)

Coinsurance: The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or single deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

BENEFIT DESCRIPTION	***In-Network Provider*** (% of ***negotiated rate***)	***Out-of-Network Provider*** (% of ***customary and reasonable amount or allowed amount)***
Inpatient Hospital & Outpatient Hospital (other than emergency room charges)	80%	60%
Emergency Use of Emergency Room (One ***copay*** applies to ***facility*** & ***physician*** services, ***copay*** waived if admitted) (co-pay applies toward out-of-pocket maximum) ***Facility*** & ***physician*** charges ***incurred*** for non-emergency use of the emergency room are not a ***covered expense***	$200 ***copay***, then 80%*	
Urgent Care Center Services (co-pay applies toward out-of-pocket maximum)	$50 ***copay***, then 100%*	
Physician Office Visits/Services *(*Generally, one ***copay*** applies to most services performed in and billed by ***physician*** office on the same day) (co-pay applies toward out-of-pocket maximum) Note that the provider may bill separately for certain additional services performed by ***physician*** office during the visit, and those amounts may not be covered by the ***copay***.	PCP $30 ***copay*** Specialist $50 ***copay***, then 100%**	60%
Other Physician Services Inpatient Visit, Surgery (office, ***inpatient*** or ***outpatient***), Pathology, Radiology, Anesthesiology (***inpatient*** or ***outpatient***)	80%	60%
Outpatient Diagnostic X-rays & Lab (other than ***hospital*** charges)	80%	60%
Hospital Based Labs, hospital based imaging and not using UHC Premium Providers	60%	60%
Preventive Care (Well Baby/Child Care, Well woman/man exams, Women's Preventive Care, eligible well screenings & immunizations, Routine physical exam and lab work, subject to recommended age and frequency)	100%*	0%
Mental & Nervous Disorders and Chemical Dependency Care	Same as any other ***illness***	
Any applicable deductible, ***coinsurance*** or ***copayment*** corresponds to the type of service received and is payable on the same basis as any other ***illness*** (e.g., emergency room visits for mental ***illness*** will be paid according to the emergency room services listing above)		
Maternity/Obstetrical Charges Global Maternity Services Fee (Initial visit to confirm ***pregnancy*** & office visits in addition to the global maternity services fee are covered as ***physician*** office visits/services)	80%	60%
Skilled Nursing Facility, Home Health Care, Hospice Care	80%	60%
Durable Medical Equipment, Prosthetic Devices	80%	Excluded
Education and Training (including diabetic nutritional counseling, obesity counseling)	100%*	100%*
Dialysis	80%	Excluded
Spinal Fusion	80%	Excluded
Pain Management	80%	Excluded
Sleep Studies	80%	Excluded
Outpatient Therapy Services (Habilitative, Physical, Speech, Occupational & Pulmonary), Outpatient Cardiac Rehabilitation, Chiropractic Care (co-pay applies toward out-of-pocket maximum)	$30 ***copay***, then 100%*	60%
Ambulance Services (Emergency & Non-Emergency)	80%	80%
Obesity/Bariatric Surgery	80%	Excluded

Transplant Procedures	80%	Excluded
All Other Covered Expenses	80%	60%

* Deductible Waived

** Deductible Waived for services performed and billed by ***physician*** office on the same day, other than certain additional services which may be billed separately by the ***physician*** office.

Refer to *Medical Expense Benefit* for complete details.

HOW THE PLAN WORKS

Certain information in this section may not apply to associates covered under Kaiser or CIGNA International. These associates should reference the Kaiser Member Handbook and Feature of Your Group Plan or the CIGNA International Global Health Advantage booklet for a description of how their medical plan options work.

Covered persons have the choice of using either an in-network provider or an out-of-network provider.

IN-NETWORK PROVIDERS

An ***in-network provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***preferred provider organization*** to accept a reduced rate for services rendered to ***covered persons***. This is known as the ***negotiated rate***. The ***in-network provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate***. In-network providers include claims for out-of-country services.

Covered persons can find ***in-network providers*** by contacting the ***claims administrator*** noted on the Where to Get Information page. Phone numbers and websites for the ***claims administrators*** can also be found on the medical and prescription drug ID cards.

OUT-OF-NETWORK PROVIDERS

An ***out-of-network provider*** does not have an agreement in effect with the ***preferred provider organization***. This ***Plan*** will only allow as a ***covered expense*** the ***Medicare*** *reimbursement rate of 110%* or an amount based on various factors, including, but not limited to, market rates for that service, negotiated amounts for that service, and the Medicare reimbursement for that service. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person***.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by an ***out-of-network provider*** where ***covered expenses*** shall be payable at the ***in-network provider*** level of benefits:

1. ***Emergency*** treatment rendered at an ***out-of-network facility***. If the ***covered person*** receives treatment on an ***emergency*** basis, ***covered expenses*** shall be payable at the ***in-network provider*** level.
2. ***Out-of-network*** anesthesiologist when the ***facility*** rendering such services is an ***in-network provider***.
3. ***Out-of-network*** assistant surgeons if the operating surgeon is an ***in-network provider.***
4. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by an ***out-of-network provider*** when the ***facility*** rendering such services is an ***in-network provider***.
5. Diagnostic laboratory and surgical pathology tests referred to a ***non-provider*** by an ***in-network provider***.
6. ***Medically necessary*** services, supplies and treatments not available through any ***in-network provider***.

MEDICAL EXPENSE BENEFIT

Certain information in this section may not apply to associates covered under Kaiser or CIGNA International. These associates should reference the Kaiser Permanente Hawaii Guide to Your Health Plan or the CIGNA International Global Health Advantage booklet for a description of their covered expenses.

This section describes the ***covered expenses*** of the ***Plan***. All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay***, ***coinsurance*** and ***maximum benefit*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***covered person*** for services, supplies or treatment that is greater than the ***customary and reasonable amount or allowed amount*** for ***out-of-network providers*** or ***negotiated rate*** for ***in-network providers*** will not be considered a ***covered expense*** by this ***Plan***. Specified preventive care expenses will be considered to be ***covered expenses***.

COPAY –TRADITIONAL PLAN OPTION ONLY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment rendered by an ***in-network provider***. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***covered person*** selects an ***in-network provider*** and pays the ***in-network provider*** the ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate***. The ***copay*** must be paid each time a treatment or service is rendered. The ***copay*** will not be applied toward the following:

1. The calendar year deductible.

DEDUCTIBLES

TRADITIONAL PLAN

Individual Deductible

The individual deductible is the dollar amount of medical ***covered expenses*** which each ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

If, in any calendar year, covered members of a family incur medical ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

ENHANCED CONSUMER PLAN OPTION

Single Deductible

The single deductible applies to ***associates*** that are enrolled with single coverage. The single deductible is the dollar amount of non-preventive medical and prescription drug ***covered expenses*** which a ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The single deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

When the ***associate*** is enrolled with family coverage (single plus one or more ***dependents***) the family deductible will apply. If, in any calendar year, covered members of a family incur non-preventive medical and prescription drug ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. The entire family deductible must be satisfied before the claims are covered under the ***Plan coinsurance***. Any number of family members may help to meet a portion of or the full family deductible amount.

CONSUMER PLAN OPTION

Single Deductible

The single deductible applies to ***associates*** that are enrolled with single coverage. The single deductible is the dollar amount of non-preventive medical and prescription drug ***covered expenses*** which a ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The single deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

When the ***associate*** is enrolled with family coverage (single plus one or more ***dependents***) the family deductible will apply. However, family coverage allows an individual to meet the single deductible and then coinsurance will begin paying up to the single out-of-pocket maximum. If, in any calendar year, covered members of a family incur non-preventive medical and prescription drug ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the applicable deductible (single or family) shown on the *Schedule of Benefits*, then the deductible will be considered satisfied for that calendar year. The applicable deductible (single or family) must be satisfied before the claims are covered under the ***Plan coinsurance***. Any number of family members may help to meet a portion of or the full family deductible amount.

COINSURANCE

The **Plan** pays a specified percentage of **covered expenses** at the **customary and reasonable amount or allowed amount** for **out-of-network providers**, or the percentage of the **negotiated rate** for **in-network providers**. That percentage is specified on the Schedule of Benefits. For **out-of-network providers**, the **covered person** is responsible for the difference between the percentage the **Plan** paid and one hundred percent (100%) of the billed amount. The **covered person's** portion of the **coinsurance** represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has ***incurred*** an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** (after satisfaction of any applicable deductibles), the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the remainder of the calendar year.

After a covered family has ***incurred*** a combined amount equal to the family out-of-pocket expense limit shown on the *Schedule of Benefits*, the ***Plan*** will pay one hundred percent (100%) of ***covered expenses*** for all covered family members for the remainder of the calendar year.

OUT-OF-POCKET EXPENSE LIMIT EXCLUSIONS

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable.
2. Expense ***incurred*** as a result of failure to obtain precertification.

   Special note regarding the Out-of-Pocket Expense Limit:

   - Traditional Plan Option – deductibles and prescription drug ***coinsurance*** are excluded from the medical out-of-pocket expense limit. Prescription drugs are subject to a separate out-of-pocket expense limit.
   - Enhanced Consumer Plan and Consumer Plan Options – deductibles and prescription drug ***coinsurance*** are included in the out-of-pocket expense limit.

MAXIMUM BENEFIT

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan***. No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan***.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to precertification. Failure to obtain precertification will result in a reduction of benefits (refer to *Medical Claim Filing Procedure*).

Covered expenses shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital's semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount or allowed amount for out-of-network providers and the percentage of the negotiated rate for in-network providers. A full private room rate is covered if the private room is necessary for isolation purposes or when a semiprivate room is not available.

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

4. If the ***covered person*** is admitted to an ***out-of-network hospital*** after ***emergency*** treatment, ambulance service is covered to transport the ***covered person*** from the ***out-of-network hospital*** to a

preferred ***hospital*** after the patient's condition has been stabilized, provided such transport is certified by the attending ***physician*** as ***medically necessary***.

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits.* The emergency room ***copay*** shall be waived if the patient is admitted directly into the ***hospital***.

URGENT CARE CENTER

Covered expenses shall include charges for treatment in an urgent care center, payable as specified on the *Schedule of Benefits.*

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.
2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty (50) percent of the surgical allowance for the second highest paying procedure and fifty (50) percent of the surgical allowance for each additional procedure.

When two (2) or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

1. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance.
2. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
3. Consultations requested by the attending ***physician*** during a ***hospital confinement***. Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.
4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
5. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.
6. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory tests, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging, and x-rays.

LAB, X-RAY AND DIAGNOSTICS - OUTPATIENT

Services for sickness and injury-related diagnostic purposes, received on an Outpatient basis at a hospital or alternative facility or in a physician's office include:

1. Lab and radiology/X-ray
2. Mammography

Benefits under this section include:

1. The facility charge and the charge for supplies and equipment.
2. Physician services for radiologists, anesthesiologists and pathologists.

3. Genetic testing ordered by a Physician which results in available medical treatment options following genetic counseling

4. Presumptive drug tests and definitive drug tests.

Any combination of network benefits and non-network benefits is limited to 18 presumptive drug tests per plan year. Any combination of network benefits and non-network benefits is limited to 18 definitive drug tests per plan year.

TRANSPLANT

Transplant procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits for the ***hospital confinement*** as specified in *Medical Claim Filing Procedure.*

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under this ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, provided the recipient is also covered under this ***Plan***. ***Covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan***.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan***.

5. Transportation, lodging and meals for the covered recipient and one (1) other person (two (2) other persons if the recipient is an eligible ***dependent*** child) to accompany the recipient to and from a ***facility*** and for lodging and meals at or near the ***facility*** where the recipient is confined, up to the ***maximum benefit*** specified on the *Schedule of Benefits*.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***associate***, a covered female ***spouse*** of a covered ***associate*** and ***dependent*** female children. The ***Plan*** shall cover services, supplies and treatments for therapeutic or elective abortions.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures. Reversal of sterilization is not a ***covered expense***.

FERTILITY/INFERTILITY SERVICES (FERTILITY SOLUTIONS PROGRAM)

Fertility Solutions is a program administered by the Claims Administrator and is made available to you. The program provides:

- Specialized clinical consulting services to educate on infertility treatment options.
- Access to a specialized network of facilities and physicians for infertility services.

The Plan pays benefits for the infertility services, up to the lifetime limits, when provided by providers participating in the Fertility Solutions program. The Fertility Solutions program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics. To find out more information about covered infertility services contact the Fertility Solutions Program at 1-866-774-4626.

Members who do not live within a 60-mile radius of a Fertility Solutions provider will need to contact a Fertility Solutions case manager to determine a provider prior to starting treatment. For infertility services and supplies to be considered covered through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered spouse/domestic partner (dependent children are not eligible for this program) may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call 1-866-774-4626. The Plan will only pay benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the provider performing the services (even if you self-refer to a provider in that network).

CONTRACEPTIVES

Covered expenses shall include charges for medical procedures or supplies related to contraception, including contraceptive devices (IUD and diaphragm), contraceptive injections and the surgical implantation and removal of contraceptive devices (Norplant and similar devices).

Charges for other contraceptives, including oral contraceptives (birth control pills) and contraceptive devices obtainable by prescription (Nuvaring, transdermal patches) shall be covered under the *Prescription Drug Program* only.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care. ***Covered expenses*** for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and ***coinsurance*** from the mother.

Such care shall include, but is not limited to:

1. ***Physician*** services
2. ***Hospital*** services
3. Circumcision

PREVENTIVE CARE/WELLNESS BENEFITS

Preventive care and wellness benefits include age appropriate exams and screenings according to guidelines and frequency recommendations established by the following agencies:

1. United States Preventive Services Task Force (USPSTF recommendations Grade A or B);
2. Center for Disease Control and Prevention (CDC) recommendations for immunizations;
3. Health Resources and Services Administration (HRSA) recommendations for children and women preventive care and screening.

These benefits are provided without any cost-sharing by the ***covered person*** when the services are provided by an ***in-network provider***. Note that the ***claims administrator*** must process the charges based on how they are billed. If a claim is not billed using preventive codes, the charges are applied as diagnostic and may be subject to a ***copay*** or ***deductible*** and ***coinsurance***.

Examples of ***covered expenses*** include:

1. ***Well child care*** provided to covered ***dependent*** children including routine pediatric examinations for a reason other than to diagnose an ***injury*** or ***illness***; immunizations (including those approved for work purposes); laboratory and other tests given in connection with pediatric examinations.
2. Routine physical examinations for a reason other than to diagnose an ***injury*** or ***illness***; immunizations; laboratory and radiology services given in connection with ***routine examinations***.
3. Routine 2D or 3D mammograms: One (1) baseline mammogram for women age thirty-five (35) through thirty-nine (39); One (1) mammogram every calendar year for women age forty (40) and over.
4. Annual gynecological examination and papanicolaou test (Pap Smear).
5. Annual prostate examination and prostate specific antigen (PSA) test for persons age 50 and above (earlier if recommended by ***physician*** due to risk factors such as family history).
6. Routine colonoscopy/sigmoidoscopy for persons age 45and above (earlier if recommended by ***physician*** due to risk factors such as family history).

THERAPY SERVICES

Outpatient therapy services are subject to the ***maximum benefit*** specified on the *Schedule of Benefits*. Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury***, for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, speech therapy or pulmonary respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.

SKILLED NURSING FACILITY

Skilled nursing facility confinement is subject to precertification. Failure to obtain precertification shall result in a reduction of benefits as specified in *Medical Claim Filing Procedure*.

Skilled nursing facility services, supplies and treatments shall be a ***covered expense*** provided the ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

If the ***covered person*** is discharged from the s***killed nursing facility*** and again becomes an ***inpatient*** in such ***facility*** within fourteen (14) days of the original discharge, it is considered one (1) period of ***confinement***.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***skilled nursing facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and
2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***skilled nursing facility*** for ***inpatient*** medical care.

Skilled nursing facility benefits are subject to the **maximum benefit** specified on the Schedule of Benefits.

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include the following services and supplies provided by a ***home health care agency***:

1. Part-time or intermittent nursing care by a ***nurse***;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;
4. Medical social service consultations;
5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

Covered expenses shall be subject to the **maximum benefit** specified on the Schedule of Benefits.

A visit by a member of a home health care team and four (4) hours of ***home health aide service*** will each be considered one (1) home health care visit.

No home health care benefits will be provided for dietitian services, homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of ***durable medical equipment*** or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill, and
2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.
2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.
3. ***Physician*** services and/or nursing care by a ***nurse***.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.
6. Counseling services provided through the ***hospice***.
7. Respite care by an aide who is employed by the ***hospice*** for up to four (4) hours per day. (Respite care provides care of the ***covered person*** to allow temporary relief to family members or friends from the duties of caring for the ***covered person***).

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan***.

Covered expenses shall be subject to the **maximum benefit** specified on the Schedule of Benefits.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of ***medically necessary durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense***.

A charge for the purchase or rental of ***durable medical equipment*** is considered ***incurred*** on the date the equipment is received/delivered. ***Durable medical equipment*** which is received/delivered after the termination date of a ***covered person's*** coverage under this ***Plan*** is not covered. Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A charge for the purchase of a prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis which is received/delivered after the termination date of a ***covered person's*** coverage under this ***Plan*** is not covered. Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement.

HEARINGS AIDS

Covered expenses shall include charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid or for a cochlear implant of up to $2,500 per ear, with a new replacement hearing aid allowed every three years (excluding over-the-counter alternatives). ***Covered person*** must see a provider in the UnitedHealthcare Hearing network.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Treatment must be started within three (3) months of the injury and completed within twelve (12) months of the ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall include charges for oral surgery such as closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofascial pain syndrome shall be a ***covered expense*** if it is determined to be ***medically necessary***. However, orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist*** shall not be covered. Benefits for treatment of temporomandibular joint (TMJ) or myofascial pain syndrome require pre-authorization by the ***claims administrator***.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; certain diabetic supplies; enteral nutrition (only when ***medically necessary*** and for the sole source of nutrition and inborn error of metabolism); crutches; electronic pacemakers; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of ***illness*** or

injury of the eye; support stockings, such as Jobst stockings, limited to two (2) pairs per calendar year; a wig or hairpiece when required due to chemotherapy, surgery or burns, limited to one (1) while covered by this ***Plan****;* surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

The following diabetic medicines and supplies are covered under the *Medical Program*:

- Glucose Monitors
- Injectables (other than Insulin)

The following diabetic medicines and supplies are covered under the *Prescription Drug Program*:

- Alcohol Wipes
- Injectables (other than Insulin)
- Insulin
- Lancet Devices
- Lancets
- Strips
- Syringes

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the ***covered person*** to their normal function immediately prior to the ***accident***.
2. It is required to correct a congenital anomaly, for example, a birth defect.
3. It is required to restore normal function as a result of a medical condition.
4. It is part of a breast augmentation completed for the treatment of gender dysphoria.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This ***Plan*** intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered person*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

a. reconstruction of a surgically removed breast; and
b. surgery and reconstruction of the other breast to produce a symmetrical appearance.

An external breast prosthesis shall be covered once every three (3) calendar years, unless recommended more frequently by a ***physician***. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a ***covered expense***.

Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MENTAL AND NERVOUS DISORDERS AND CHEMICAL DEPENDENCY

This ***Plan*** complies with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Any applicable deductible, ***coinsurance*** or ***copayment*** applied to mental and nervous disorders and chemical dependency corresponds to the type of service received and is payable on the same basis as any other illness. For example, emergency room visits for mental ***illness*** will be paid in the same manner as emergency room visits for accidental ***injury***.

INPATIENT OR PARTIAL CONFINEMENT

Subject to the precertification provisions of the ***Plan***, the ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***mental and nervous disorders*** and for ***chemical dependency***.

Covered expenses shall include:

1. Inpatient hospital confinement;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***;

OUTPATIENT

The ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits,* for ***outpatient*** treatment, services and supplies related to the treatment of ***mental and nervous disorders*** and ***chemical dependency***.

PODIATRY SERVICES

Covered expenses shall include medically necessary surgical podiatry services for the treatment of metabolic or peripheral vascular illnesses, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (with physician documentation that the treatment is resulting in physical improvement), subject to the ***maximum benefit*** shown on the *Schedule of Benefits*.

EDUCATION AND TRAINING

Covered expenses shall include ***medically necessary*** diabetic education and training, including related nutritional counseling and obesity counseling.

OUTPATIENT CARDIAC REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified ***medically necessary outpatient*** cardiac rehabilitation programs. Coverage for ***medically necessary*** services shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

HABILITATIVE SERVICES

Benefits are provided for habilitative services provided on an outpatient basis for covered persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the covered person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the covered person reaches his/her maximum level of improvement or does not

demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the covered person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the covered person to achieve demonstrable progress, the plan administrator may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of ***morbid obesity*** for ***covered persons*** with health problems which are aggravated by or related to the ***morbid obesity,*** including, but not limited to gastric by-pass, gastric stapling or gastric balloon. Coverage for ***medically necessary*** services shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

AUTISM

Covered expenses shall include Applied Behavioral Analysis (ABA), in addition to testing, diagnosis, and treatment.

GENDER DYSPHORIA

Covered expenses shall include charges for services, supplies, or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment as dictated within the UnitedHealthcare Medical Policy. Some examples of covered services are tracheal shave/reduction, voice modification surgery, voice modification therapy, breast augmentation and hair removal (as part of the reconstructive surgery or not part of the reconstructive surgery). All gender transition services must be received by an in-network provider for the services to be a covered benefit. See the *Medical Exclusions section* for specific exclusions.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.
2. Charges for treatment or surgery for sexual dysfunction or inadequacies.
3. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.
4. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.

5. Charges for services, supplies or treatment for behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the ***illness*** shall be a ***covered expense***.

6. Charges for biofeedback therapy.

7. Charges for services, supplies or treatments which are primarily educational in nature, except as specified in the *Medical Expense Benefit/Patient Education* section*;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

8. Charges for career or legal counseling.

9. Except as specifically stated in *Medical Expense Benefit/Dental Services* section, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

10. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of surgery.

11. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

12. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular ***illness***, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

13. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

14. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements except as provided in *Prescription Drugs*. Refer to the *Medical Expense Benefit /Special Equipment and Supplies* section for coverage of ***medically necessary*** enteral nutrition.

15. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts (except when there is a diagnosis of diabetes).

16. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in the *Medical Expense Benefit/Cosmetic Surgery* section.

17. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications.

18. Charges for services, supplies or treatment primarily for non-surgical weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

19. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches except as provided in *Prescription Drugs*.

20. Charges related to acupuncture treatment.

21. Charges for temporomandibular joint dysfunction (TMJ), except for ***medically necessary*** treatment that has been pre-authorized by the ***claims administrator***.

22. Charges for methods of treatment to alter vertical dimension.

23. Charges for ***custodial care***, domiciliary care or rest cures.

24. Charges for travel or accommodations, whether or not recommended by a ***physician***, except as specifically provided herein.

25. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth except as specified herein.

26. Charges for expenses related to hypnosis.

27. Charges for the expenses of the donor of an organ or tissue for transplant to a recipient who is not a ***covered person*** under this ***Plan***.

28. Charges for ***outpatient*** prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug deductible ***coinsurance*** applicable thereto. ***Outpatient*** prescription drugs are paid under the *Prescription Drug Program* and under no other provision of this ***Plan***.

29. Charges for professional services billed by a ***physician*** or ***nurse*** who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

30. Charges for environmental change including ***hospital*** or ***physician*** charges connected with prescribing an environmental change.

31. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example).

32. Charges for any services, supplies or treatment not specifically provided herein.

33. Charges for chelation therapy, except as treatment of heavy metal poisoning.

34. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

35. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

36. Charges for holistic medicines or providers or naturopathy.

37. Charges for or related to the following types of treatment:

    a. primal therapy;
    b. rolfing;
    c. psychodrama;

38. Charges for structural changes to a house or vehicle.

39. Charges for exercise programs for treatment of any condition, except as specified herein.

40. Charges for private duty nursing.

41. Charges for chiropractic treatment without physician documentation of physical improvement.

42. Certain Prescription Drug Products, including New Prescription Drug Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

43. Charges for the following procedures as part of gender dysphoria treatment: facial surgical procedures, abdominoplasty, lipofilling, liposuction, excision of excess skin, implants, Mons reduction, reversal procedures, penile or uterine transplant, fertility preservation, or wigs.

PRESCRIPTION DRUG BENEFITS

This section is not for associates living outside of the United States. Associates covered under CIGNA International should reference the CIGNA International Global Health Advantage booklet for a description of how their medical plan options work. Associates living in Hawaii and covered under the Kaiser of Hawaii plan should reference the Kaiser Permanente Hawaii guide to your health plan including the benefit and payment chart.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

ENHANCED CONSUMER, CONSUMER AND TRADITIONAL PLAN

Prescription Drug Tier	**Consumer and Enhanced Consumer Plans**	**Traditional Plan**	
	Covered Person's Coinsurance	**Covered Person's Coinsurance**	
	Up to 30 day retail/ 90 day mail order/maintenance*	**Retail** Up to 30 day supply	**Maintenance/Mail Order*** Up to 90 day supply
Preventive Drugs	Not subject to deductible; Subject to coinsurance (if required by ACA, plan pays 100%)	Not subject to deductible; Subject to coinsurance (if required by ACA, plan pays 100%)	Not subject to deductible; Subject to coinsurance (if required by ACA, plan pays 100%)
Tier 1	20%*	20% (minimum $10)	20% (minimum $20)
Tier 2	25%*	30% (minimum $30)	30% (minimum $60)
Tier 3	50%*	60% (minimum $45)	60% (minimum $90)
Medications with Over the Counter (OTC) Alternatives (e.g. allergy & gastrointestinal)	100%(1)	100%(1)	
Lifestyle Drugs (e.g. Viagra, Levitra & Retin A)	100%(1)	100%(1)	
Compounds	Compound medications $50 and greater are subject to a prior authorization. Bulk chemicals are not covered as part of compound medications.		
Specialty Drug Management(2)	Program that supports the safe, clinically appropriate, and cost-effective use of specialty medications.		
Annual Rx Deductible Amount	A combined medical & prescription drug deductible applies(3) Waived for drugs on preventive drug list(3)	Not subject to deductible	
Annual Rx Out-of-Pocket Maximum	A combined medical & prescription drug deductible applies (3)	$1,500 individual $2,000 family	
*** Maintenance drugs (medicines taken regularly for chronic conditions or long term therapy). Your pharmacy benefit covers only a limited number of 30-day refills of a maintenance medication. After the allowed refills, you must choose to fill your prescription from UHC mail order or at a Walgreens retail pharmacy, or pay the full cost for your maintenance medication. Mail order forms may be downloaded at www.myuhc.com or AGBenefits.com. A paper copy is available from the AGBenefits Advisor.**			

(1) The cost of medications with over the counter alternatives and lifestyle drugs do not apply towards the Consumer Plan or Enhanced Consumer Plan combined medical & prescription drug deductible or out-of-pocket expense limits or to the Traditional Plan Rx out-of-pocket expense limit.

(2) Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as oncology, hormonal therapies, Hepatitis C, multiple sclerosis, psoriasis and rheumatoid arthritis.

(3) Refer to the *Medical Benefits, Schedule of Benefits, Enhanced Consumer Plan* and *Consumer Plan* options to identify the applicable deductible and out-of-pocket amounts.

PRESCRIPTION DRUG BENEFITS

When an ***associate*** enrolls in a ***company***-sponsored medical plan, the ***associate*** is automatically covered under the ***company's*** prescription drug program. The prescription drug program offers a full range of convenient prescription services:

- Retail service at pharmacies participating in the UHC network
- Maintenance/Mail order service - required for maintenance drugs after two fills (first fill and a refill) at a retail pharmacy, unless you opt-out of the maintenance/mail program.
- Online services

PRESCRIPTION DRUG PROVISIONS

Refer to the Prescription Drug Schedule of Benefits to identify applicable deductible, ***coinsurance*** and out-of-pocket maximum provisions applicable to prescription drug coverage.

Coverage levels of drugs are available depending on their classification:

1. ***Generic drugs.*** These are usually the most economical choice;

   a. Prescription step therapy requires the lowest cost generic to be used before a more expensive drug. When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic, plus the brand co-payment.

2. Brand name drugs on the ***claims administrator's*** Prescription Drug List (PDL). These are a cost effective alternative when a ***generic drug*** is not available.

3. Brand-name drugs not on the ***claims administrator's*** Prescription Drug List (PDL) (with appeal).

4. Drugs with over-the-counter (OTC) alternatives. Drugs in the "OTC alternative" category include allergy, gastrointestinal and cough and cold medications. If a ***covered person*** is taking a proton-pump inhibitor (PPI) for certain gastrointestinal conditions, the ***Plan*** may cover more of the cost of the prescription if the ***covered person's*** meets the conditions of the PPI appeal process. In addition, ***covered persons*** under the age of eleven (11) can receive their allergy and PPI medications at the generic, PDL, or brand ***coinsurance*** level (depending on the medication). See the *Over-the-Counter Alternatives* provision for the PPI appeal process and pediatric exception process.

5. Drugs in the "lifestyle" medications category. Lifestyle medications are FDA approved prescription medications that improve patients satisfaction with the quality of their lives but generally has minimal impact on improving medical outcomes or reducing the chances of more serious medical interventions. Lifestyle medications include all drugs in the following therapeutic (treatment) categories:

   - Antifungal medications (such as Lamosil and Sporanox)
   - Antiwrinkle agents (such as Renova)
   - Hair growth treatments (such as Rogaine and Propecia)
   - Hair reductions agents (such as Vaniqa)
   - Depigmenting agents (such as Alustra)
   - Erectile dysfunction medications (such as Viagra and Levitra)

Note: Some drug classes require prior authorization or have quantity limits. To obtain a list of these prescriptions, visit www.myuhc.com.

Note that the ***claims administrator's*** Prescription Drug List (PDL) is updated periodically and a drug's class (tier) may change at any time during the year. In the event that a drug's coverage tier changes (for example, a generic becomes available) those impacted and their prescribing ***physicians*** will be notified by UHC. ***Covered persons*** should verify tier placement with the ***claims administrator,*** UHC, before submitting a new prescription or requesting a refill.

Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

To obtain an estimate of the cost of a prescription before filling, visit www.myuhc.com or call the number listed on the back of your ID card.

RETAIL PHARMACY SERVICE

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

In most cases, you will pay the full cost from a non-Network Pharmacy, as non-Network Pharmacies are not covered.

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan by submitting a claim within 31 days of the date in which you obtained your Prescription Drug Product. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Coinsurance, and any deductible that applies.

Submit your claim to:

UHC
PO Box 29077
Hot Spring, AR 71903

MAIL SERVICE SAVER PLUS AND WALGREENS RETAIL PHARMACY (WALGREENS90)

The mail order service program provides the delivery up to a 90 day supply of maintenance or long term medications. The Walgreens90 program is an alternative to mail order service where a maintenance or long term prescription drug may be filled at a Walgreens retail pharmacy at the mail order ***coinsurance***. Mail order or a local Walgreens pharmacy must be used to obtain maintenance or long-term medications after two fills. Otherwise, the ***associate*** pays the full cost. Maintenance or long term medications are those that are taken regularly for chronic conditions or for long term therapy. Examples are drugs sometimes prescribed for heart disease, high blood pressure and asthma.

The ***coinsurance*** amount applied to each covered mail order or local Walgreens pharmacy prescription charge is shown on the *Schedule of Benefits*. The prescription drug ***coinsurance*** amount is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

When obtaining new maintenance medications through the mail service pharmacy, ask the ***physician*** to write two prescriptions:

1. One prescription to have filled at a Network Pharmacy for up to a 30-day supply (plus one refill) for immediate use, and
2. A second prescription to be ordered through the mail order service for long-term use. Prescriptions for maintenance drugs are generally written for a 90-day supply and up to three refills. New prescriptions are filled by UHC within 10 business days once they receive the request. Allow three weeks from the time UHC receives the initial order for the prescription to be delivered to the ***covered person's*** home. Thereafter, refills generally take approximately ten days to reach the ***covered person's*** home.

Mail order service forms may be obtained from www.myuhc.com or by calling the number listed on the back of your ID card.

NEW PRESCRIPTIONS

To have a new prescription filled, complete a New Prescription Mail-In Form and send it to UHC, along with the original prescription(s) and the appropriate ***coinsurance*** for each prescription. Be sure to send original prescriptions, not photocopies.

PRESCRIPTION DRUG LIST (PDL)

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call UnitedHealthcare at the number on your ID card for the most current information.

Each tier is assigned a Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Generally, here's how the tier system works:

> **Tier 1 ($) Lower-cost**: Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included. Use Tier 1 drugs for the lowest out-of-pocket costs.
> **Tier 2 ($$) Mid-range cost**: Medications that provide good overall value. A mix of brand-name and generic drugs. Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
> **Tier 3 ($$$) Highest-cost**: Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. Ask your doctor if a Tier 1 or Tier 2 option could work for you.

Covered persons can work with the pharmacist to determine the best options that are available. For example, the pharmacist will dispense a ***generic drug*** at the ***covered person's*** request. However, if there is no generic or if the ***covered person's*** prescription is not on the PDL, your prescription will be filled as written.

The UHC Prescription Drug List (PDL) for American Greetings is updated periodically and a drug's class (tier) may change at any time during the year. A common reason for this is when the patent protection for a brand drug expires and generic alternatives become available. In the event that a drug's coverage tier changes, negatively impacting a member by paying a higher cost of the drug being excluded, affected patients and their prescribing ***physicians*** will be notified by UHC. ***Covered persons*** can verify tier placement and cost with the ***claims administrator,*** UHC, before submitting a new prescription or requesting a refill. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent.

To find out the cost of your prescription before ordering, contact UHC at *www.myuhc.com* or call the number listed on the back of your ID card.

SUPPLY LIMITS

For Prescription Drug Products with quantity limits, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing by logging onto www.myuhc.com or by calling the telephone number on your ID card.

OVER-THE-COUNTER (OTC) ALTERNATIVES

Over-the-Counter Alternatives is a category of prescription drugs that are available through the ***Plan***, however ***covered persons*** will pay 100% of Optum Rx discounted cost for them.

Prescription drugs with over-the-counter alternatives are:

1. Antihistamines for allergy symptom relief (such as Allegra and Clarinex). However, medication for ***covered persons*** under age eleven (11) will be covered at the generic, PDL, or brand ***coinsurance*** level (depending on the medication) for this category. See the *Pediatric Exception* provision below for more information.

2. Cough and cold medications (including narcotic and non-narcotic antitussive decongestants/expectorants and miscellaneous respiratory medications). Examples include: Mytussin, Oridol and Tussin

3. Gastrointestinal medications (including H-2 antagonists and proton-pump inhibitors). Examples include: Zantac and Prevacid. However, medication for ***covered persons*** under age eleven (11) will be covered at the generic, PDL, or brand ***coinsurance*** level (depending on the medication) for this category. See the *Proton-Pump Inhibitors (PPI) Appeal Process* provision below for more information.

PROTON PUMP INHIBITORS (PPI) APPEAL PROCESS

The process and criteria for allowing coverage of prescription proton-pump inhibitors (PPI) at a reimbursement level below the 100% ***coinsurance*** level follows.

Covered persons must submit to UHC written documentation on physician letterhead covering all of the following:

1. The ***covered person*** has attempted step therapy treatment using an Over-the-Counter version of a PPI for a reasonable period and it has been ineffective. A description of treatments attempted and duration of treatment must be included.

2. The ***covered person*** is being treated for one of the following diagnosed conditions:

    a. Maintenance of Healed Duodenal Ulcer
    b. Risk Reduction of NSAID Associated Gastric Ulcer (NSAID – i.e. Motrin, Naproxen, Relafen)
    c. Maintenance of Healing of erosive esophagitis
    d. Pathological Hypersecretory conditions i.e. Zollinger-Ellison, Barretts Esophagus, systemic mastocytosis, Multiple Endocrine Adenomas
    e. GastroEsophageal Reflux Disease – Chronic (GERD)

3. The ***covered person*** has been counseled on diet restrictions associated with their condition and has made dietary changes as appropriate (per the ***physician's*** assessment). If this is not applicable to a particular patient, ***physician*** must note the reason.

4. ***Physician's*** estimate of length of PPI treatment needed.

5. Signature of ***physician***.

Covered persons meeting the above criteria and documentation will be eligible to receive PPIs at a reimbursement level below the 100% ***coinsurance*** level. If the appeal is approved, the ***coinsurance*** level will be determined by the formulary or generic status per ***Plan*** provisions. This ***coinsurance*** level will remain in effect for the entire appeal period. Documentation will be good for the period of time stated by the ***physician*** up to a one-year period. If the ***covered person*** is on medication for longer than one year, updated documentation will be required on a yearly basis. If the formulary or generic status of the medication has changed at the time of the appeal renewal, the ***coinsurance*** level will change accordingly.

Retail Pharmacy (for First Time Users of Prescription Proton-Pump Inhibitors)

1. Prior to filling a prescription at a retail pharmacy, the ***covered person's physician*** can mail and/or fax the above documentation to UHC for review. If UHC determines that member meets criteria, system will be coded to allow lower ***coinsurance*** level. Once the system is coded, the ***covered person*** can present the prescription to the retail pharmacy to be filled at the lower ***coinsurance*** level. The ***associate***

will receive a letter from UHC stating that the appeal has been approved. One refill will be allowed as per normal ***Plan*** provisions. (If the appeal is denied the **covered person** will receive a letter from UHC indicating that it has been denied.)

2. If ***covered person*** presents prescription to retail pharmacy without documentation previously being submitted and approved, the prescription will be processed at the 100% ***coinsurance*** level. The ***covered person*** has sixty (60) days after the prescription is filled to file an appeal with the supporting documentation. No refunds will be permitted retroactively for medications purchased prior to the ***effective date*** of this policy or for medications purchased prior to documentation being approved by UHC.

Mail Order Pharmacy Procedure

1. If documentation was submitted previously in retail pharmacy process, system will be coded for up to a one-year period. When mail order prescription is received, dispense will occur at the lower ***coinsurance*** level without any further documentation needed.

2. If documentation was not submitted under retail pharmacy process, the ***covered person*** should call the number on the back of their ID card for additional information. If UHC determines that member meets the criteria, the prescription will be dispensed at the lower ***coinsurance*** level. The ***coinsurance*** amount will be charged to credit card on file. If no credit card on file, member will be advised of ***coinsurance*** amount and the drug will be dispensed after ***coinsurance*** is received.

Pediatric Exceptions

American Greetings will cover prescription medications for the treatment of an allergy or gastrointestinal medical condition as authorized by your ***physician*** for any ***covered person*** **under age eleven (11)** at the generic, PDL, or brand ***coinsurance*** level (depending on the medication).

If the ***associate*** has a ***dependent*** child under the age of eleven (11) who requires a prescription allergy or gastrointestinal medication, contact UHC to request that an exception be made.

LIFESTYLE MEDICATIONS

Lifestyle medications is a category of prescription drugs that are available through the ***Plan***, however ***covered persons*** will pay 100% of UHC's discounted cost for them. Lifestyle medications are FDA approved prescription medications that improves a patients' satisfaction with the quality of their lives but generally has minimal impact on improving medical outcomes or reducing the chances of more serious medical interventions. Examples of lifestyle prescription drugs include medications for sexual dysfunction (such as Viagra and Levitra) and for cosmetic purposes (such as: Propecia).

Prescription drugs in the "lifestyle" category include:

1. Antifungal medications (such as Lamosil and Sporanox)
2. Antiwrinkle agents (such as Renova)
3. Hair growth treatments (such as Rogaine and Propecia)
4. Hair reductions agents (such as Vaniqa)
5. Depigmenting agents (such as Alustra)
6. Erectile dysfunction medications (such as Viagra and Levitra)

SPECIALTY PHARMACY PROGRAM

Optum Rx Specialty is a dedicated source for specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed for cost effective drug management. Prior authorization for these drugs is required. The ***associate*** must fill these prescriptions through the specialty pharmacy delivery program and will not be filled through retail drugstores or mail order. Examples may include but are not limited to asthma, hepatitis C, and seizure disorders, multiple sclerosis, HIV, etc.

Specialty pharmaceuticals:

1. are used in the management of specific chronic or genetic conditions;

2. are often injectable or infused medicines, but may also include oral medicines;
3. require additional education of the member and close monitoring of their clinical response in collaboration with their doctor;
4. may require member-specific dosing, medical devices to administer the medicine, and/or special handling and delivery;
5. require extensive member education for safe and cost-effective use.

Certain Specialty Prescription Drug Products may be dispensed by the UHC specialty pharmacy in 15-day supplies up to 90 days and at a pro-rated Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You can find a list of eligible Specialty Prescription Drug Products at www.myuhc.com or by calling the telephone number on your ID card.

HOW TO USE SPECIALTY PHARMACY SERVICES

1. ***Associates*** whose medications are covered under this program are identified when the ***associate*** or ***physician*** requests the medication.
2. Once identified, order through a dedicated toll-free number which is available 24/7.
3. Upon contacting the dedicated toll-free number, coverage eligibility is validated. UHC coordinates approval with ***physician*** and discusses treatment guidelines and/or options for lower cost and equally effective alternatives. If the prescription does not fall within the treatment guidelines or alternatives exist, the Specialty Pharmacy is denied.
4. Personal attention from Optum Rx Specialty that provides condition-specific education, medication administration instruction, and expert advice to help newly diagnosed patients manage their therapy.
5. Easy access to pharmacists and other health experts 24 hours a day, seven days a week.
6. Confidential and convenient delivery to the location of the ***associate's*** choice, whether it's to the ***associate's*** home or doctor's office.

Associates whose medications are covered under this program are contacted and invited to participate. If you have questions about your eligibility for Optum Rx Specialty, contact UHC at 1-800-776-1355.

UTILIZATION MANAGEMENT

Cost Management Programs

American Greetings and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on the back of your ID card.

Mandatory Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the directed Mail Order Network Pharmacy, you will pay an increased cost share. If you choose to not use aa Mail Order Network Pharmacy but do not inform UnitedHealthcare, you will be subject to the Non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prior Authorization

This is a program designed to help ensure the appropriate use of selected prescription drug classes. The pharmacist will contact your prescribing doctor when a prescription requires a prior authorization for medical necessity.

Rebates and Other Discounts

UnitedHealthcare and American Greetings may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Step Therapy

Certain Prescription Drug Products for which benefits are described in this section are subject to Step Therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting www.myuhc.com or by calling the number on the back of your ID card.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the ***Plan***.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, insulin needles and syringes and diabetic test strips.
4. Oral contraceptives, contraceptive ring and transdermal contraceptives;
5. Yohimbine and injectable and inter-urethral erectile dysfunction drugs;
6. Prescription drugs for smoking cessation purposes;
7. Growth hormones.
8. Specific medical supplies, including disposable needles and syringes; disposable blood/urine glucose/acetone testing agents, including but not limited to Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips, and Tes-Tape.
9. Prescribed prenatal vitamins and single entity vitamins.
10. Acne products (such as Retin-A) *as long as the user is under the age of thirty-five, does not need prior authorization.*

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.
2. Refills up to one year from the date of order by a ***physician***.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

4. ***Experimental*** drugs and medicines (that are not approved by the FDA), even though a charge is made to the ***covered person***, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness). This exclusion does not apply to off-label use of drugs otherwise approved by the FDA. An off-label drug is a drug that is approved for sale for one purpose and a ***physician*** prescribes it for any other purpose that in their professional judgment is both safe and effective.
5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.
6. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.
7. Any charge for the administration of a covered prescription drug.
8. Any drug or medicine that is consumed or administered at the place where it is dispensed.
9. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
10. Antiwrinkle agents (such as Renova)
11. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital*** confined. This includes being confined in any institution that has a ***facility*** for dispensing drugs.
12. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
13. A charge for legend vitamins, except pre-natal legend vitamins.
14. A charge for most cosmetic products not including acne medications.
15. A charge for diet medications/weight loss drugs.
16. A charge for prostaglandin impotence agents (including Viagra).
17. A charge for allergy serums.
18. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and American Greetings determines do not meet the definition of a Covered Health Service.
19. Unit dose packaging or repackagers of Prescription Drug Products.
20. A Prescription Drug Product that contains marijuana, including medical marijuana.
21. Dental products, including but not limited to prescription fluoride topicals.
22. Diagnostic kits and products, except as otherwise required by applicable law.
23. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

EMPLOYEE ASSISTANCE PLAN

All ***associates*** and eligible dependents at American Greetings shall have the option of participating in the Employee Assistance Plan provided by Health Advocate, a third-party vendor.

To participate, ***associates*** can call Health Advocate toll free at 1-877-240-6863 or visit www.HealthAdvocate.com/members. ***Associates*** will be able to receive 5 short-term counseling sessions and referrals to extended care if needed. There shall be no charge for ***associates*** to participate in referrals or seeing a clinician within Health Advocate's network. In addition, ***associates*** shall not be charged for initial consultation with financial and legal experts, or mediators.

This ***Plan*** provides confidential twenty-four (24) hour support for ***associates*** struggling with personal issues or problems. For example:

1. Depression, anxiety, and stress
2. Substance abuse
3. Relationship problems
4. Workplace conflicts
5. Parenting and family issues
6. Living with chronic conditions
7. Children and elder care
8. Financial services
9. Legal services

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. “War” means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker’s Compensation law, Employer’s liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed ***customary and reasonable amount or allowed amount*** or exceed the ***negotiated rate*** as applicable.
7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during commission or attempted commission of a felony by the ***covered person***.
8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred***.
9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person’s coverage.
10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
11. Charges for services, supplies or treatment that are considered ***experimental/investigational/unproven***. This exclusion does not apply to off-label use of drugs otherwise approved by the FDA.
12. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person***.
13. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.
14. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation/Reimbursement*.
15. Claims not submitted within the ***Plan’s*** filing limit deadlines as specified in *Medical Claim Filing Procedure*.

16. Charges for telephone or e-mail consultations, completion of claim forms, charges associated with missed appointments.

17. If the primary plan has a restricted list of healthcare providers and the ***covered person*** chooses not to use a provider from the primary plan's restricted list, this ***Plan*** will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.

18. This ***Plan*** will not pay for any charge which has been refused by another plan covering the ***covered person*** as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

WHEN COVERAGE ENDS

Cancellation or discontinuance of coverage is permitted only prospectively unless there is failure to pay required premiums or contributions, in which case coverage may be discontinued retroactively.

Except as provided in the ***Plan's*** *Continuation of Coverage* provisions, coverage will terminate on the earliest of the following dates:

TERMINATION OF ASSOCIATE COVERAGE

1. The date the ***plan sponsor*** terminates the ***Plan***.
2. The last day of the month in which the ***associate*** ceases to meet the eligibility requirements of the ***Plan***.
3. The last day of the month in which employment terminates, unless otherwise defined by the continuation of coverage provisions or according to a severance agreement***.*** Note: ***Associates*** at least age 55 with 15 years of services or at age 65 or greater with 10 years of service may be eligible for retiree medical benefits under the Plan.
4. If the ***associate*** ceases to make any required contributions, coverage ends at the end of the period for which any required contributions are paid.
5. Date of ***associate's*** death.

TERMINATION OF DEPENDENT(S) COVERAGE

Dependent coverage generally ends on the first to occur of the following dates, unless due to the ***associate's*** death, in which case coverage terminates on the last day of the month after three months. If the ***associate*** was at least age 55 and had 15 years of service or at least age 65 and 10 years of service, then the surviving ***spouse*** may be eligible for retiree medical benefits coverage under the Plan.

1. The date the ***associate's*** coverage terminates.
2. The last day of the month in which the ***dependent*** ceases to meet the eligibility requirements of the ***Plan*** if the ***dependent*** is not a ***dependent*** described in items 3 or 4 below.
3. The last day of the month which follows the date a ***dependent*** child reaches the limiting age of twenty-six (26).
4. The date the ***dependent*** enters the full-time military service of any country or government-sponsored organization.
5. The date the ***dependent*** becomes eligible as an ***associate***.
6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

CONTINUATION OF COVERAGE PROVISIONS

This section identifies the ***Plan's*** allowances for an ***associate*** to continue coverage for a limited time while on an approved Family and Medical Leave, or another approved leave or ***layoff***. Coverages that may be continued and coverages for which the ***associate*** must make a contribution for continued coverage and allowable continuation period are identified below. When required, ***associate*** contributions are handled as follows:

- If the ***associate*** is on approved leave and is receiving payments through payroll (i.e. Short-Term Disability, Vacation) the ***associate's*** contributions for coverage will continue as scheduled through the normal payroll cycle.
- If the ***associate*** is on approved leave and is not receiving payments through payroll, the balance of owed associate contributions for continued coverage will be billed to the associate each month following the ***plan administrator's*** uniform procedures. ***Associates*** are required to make timely payments to prevent a beak in or termination of coverage.

The following provisions apply to non-union and union ***associates*** unless the collective bargaining agreement specifies differently.

Union associates should refer to their collective bargaining agreement for more details.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Associates who are eligible for ***company***-sponsored benefits may be covered under the Family and Medical Leave Act of 1993 (FMLA).

If the ***company*** grants an ***associate*** an approved ***leave of absence*** in accordance with FMLA, the ***associate*** may continue coverage for the associate during the leave, provided the ***associate*** makes any required contributions according to the ***plan administrator's*** uniform procedures. The ***associate*** also can suspend his employer-sponsored benefits during the leave.

In no event will coverage continue for more than the approved length of the ***associate's*** leave. If the ***associate*** does not return at the end of the approved leave, employment may be terminated and the ***associate*** and any eligible ***dependents*** will be offered COBRA continuation coverage.

REINSTATEMENT

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***associate*** returns to active work immediately upon completion of that leave, ***Plan*** coverage may be reinstated on the date the ***associate*** returns to active work. Coverage will be reinstated on the date the ***associate*** returns to active work provided that the ***associate*** re-enrolls for coverage within thirty (30) days of his return to active work.

LEAVE OF ABSENCE – PERSONAL AND MEDICAL NON-FMLA

The following provisions apply to non-union and union **associates** unless the collective bargaining agreement specifies differently.

Union associates should refer to their collective bargaining agreement for more details.

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***associates*** and/or ***dependents***, when the ***associate*** is on an authorized ***leave of absence*** from the ***company***.

In no event will coverage continue for more than the approved length of the ***associate's*** leave. After 12 months of leave, employment will be terminated and the ***associate*** and any eligible ***dependents*** will be offered COBRA continuation coverage.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved personal or medical non-FMLA leave, and the ***associate*** returns to active work immediately upon completion of that leave, ***Plan*** coverage may be reinstated on the date the ***associate*** returns to active work. If the ***associate*** returns from an approved leave in the

subsequent plan year, coverage will be reinstated on the date the ***associate*** returns to active work provided that the ***associate*** re-enrolls for coverage within thirty (30) days of his return to active work.

LEAVE of ABSENCE – MILITARY

The ***company*** will grant a ***leave of absence*** to an ***associate*** when he enters a period of service in the armed forces of the United States. The ***company*** shall grant to each ***associate*** who applies for return to work such rights as he shall be entitled to under the existing statutes.

Military Mobilization

- For the first six (6) months the ***associate*** pays the active ***associate*** contribution rate.
- For the next eighteen (18) months the ***associate*** pays 102% of the cost of coverage, running concurrent with COBRA.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the ***associate*** fails to return to employment within the time allowed.

Upon return from active duty, the ***associate*** and the ***associate's dependent*** will be reinstated without a waiting period, regardless of their election of continuation coverage.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved military leave, and the ***associate*** returns to active work immediately upon completion of that leave, ***Plan*** coverage may be reinstated on the date the ***associate*** returns to active work. If the ***associate*** returns from an approved military leave in the subsequent plan year, coverage will be reinstated on the date the ***associate*** returns to active work provided that the ***associate*** re-enrolls for coverage within thirty (30) days of his return to active work.

LAYOFF

The following provisions apply to non-union and union ***associates*** unless the collective bargaining agreement specifies differently.

Union associates should refer to their collective bargaining agreement for more details.

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***associates*** and/or ***dependents***, when the ***associate*** is subject to a temporary ***layoff ("company convenience")***.

Associates may call the AGBenefits Service Center to drop coverage within thirty (30) days following the date of ***layoff***.

Coverage will continue through the end of the month in which the ***associate's layoff*** occurs.

Coverage will end on the first of the month following the month of the ***associate's layoff***. ***Associates*** will be offered COBRA continuation coverage. Contributions for the first month of COBRA continuation coverage following a **layoff** will be subsidized at the active associate cost. In no event will the cost of coverage continue to be subsidized beyond the first month of COBRA continuation coverage.

Reinstatement

If coverage under the ***Plan*** was terminated during a ***layoff*** and the ***associate*** returns to active work within twelve (12) months following the ***layoff***, ***Plan*** coverage will be reinstated as of the date the ***associate*** returns to active work based on the ***associate's*** coverage at the time of the ***layoff***. If the ***associate's*** return to work falls in the subsequent plan year and the ***associate*** completed open enrollment for the subsequent plan year, coverage will be reinstated as of the date the associate returns to active work based on the coverage elections made during open enrollment. ***Associates*** may make a change to reinstated ***Plan*** coverage within thirty (30) days of returning to active work.

If COBRA continuation coverage was elected following a ***layoff***, associates are required to make timely COBRA payments to prevent a break in coverage prior to returning to active work. In the event an ***associate*** made payment(s) in advance for COBRA continuation coverage and returns to active work with an excess contribution balance, the ***associate*** will be refunded based on the date the ***associate*** returns to active work, following the reinstatement of ***Plan*** coverage.

ELIGIBILITY FOR CONTINUED COVERAGE FOR DEPENDENT STUDENT ON MEDICAL LEAVE OF ABSENCE

Michelle's Law provides continued coverage under group medical plans for ***dependent*** children who are covered under the ***Plan*** as ***full-time students*** but lose this status because they take a ***physician*** certified ***medically necessary leave of absence*** from school.

If the ***associate's dependent*** grandchild loses coverage because his parent (the ***associate's*** child) loses ***full-time student status***, as defined in the ***Plan***, because the ***associate's*** child is on a ***medically necessary leave of absence***, the grandchild may continue to be covered under the ***Plan*** for up to one year from the beginning of the ***leave of absence***; provided the grandchild otherwise continues to meet the ***dependent*** eligibility requirements.

If a child is eligible for Michelle's Law's continued coverage and loses coverage under the ***Plan*** at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

CONTINUE COVERAGE WITH COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that contains provisions that apply to American Greeting's medical plans. The act gives ***associates*** and their ***dependents*** who lose their health benefits upon the occurrence of certain events (known as "qualifying events") the right to choose to continue their health benefits for limited periods of time after the qualifying event. The coverage offered through COBRA is identical to the coverage provided under the ***Plan***, before the qualifying event occurred.

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with COBRA, as amended.

The AGBenefits Service Center administers COBRA on behalf of the *plan administrator.*

COBRA QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the ***associate***.
2. The ***associate's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan***. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce, legal separation from the ***associate***.
4. The ***associate's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.
5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***associate*** informs the ***company*** that the associate will not be returning to work.

COBRA NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a ***spouse*** being divorced or legally separated from a covered ***associate***, or a child's loss of ***dependent*** status, the ***associate*** or ***dependent*** is responsible for notifying AGBenefits Service Center within sixty (60) days of the latest of:

   a. The date of the event; or
   b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event.

   A copy of the Qualifying Event Notification form is available from the AGBenefits Service Center. In addition, the ***associate*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

   Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the AGBenefits Service Center will notify the ***associate*** or ***dependent*** of his rights and obligations to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the American Greetings AG Benefits Department must notify the AGBenefits Service Center not later than thirty (30) days after the date on which the ***associate*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the AGBenefits Service Center will furnish the Election Notice to the ***associate*** or ***dependent***.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the AGBenefits Service Center will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible ***associate*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the ***Plan*** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***associate*** or ***dependent*** chooses to have continuation coverage, the **associate** or **dependent** must advise the AGBenefits Service Center of this choice by returning to the AGBenefits Service Center a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the AGBenefits Service Center, it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or
   b. The date the person receives the Election Notice from the AGBenefits Service Center.

5. Within forty-five (45) days after the date the person notifies the AGBenefits Service Center that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month, subject to a 30-day grace period.

COST OF COBRA COVERAGE

1. The ***Plan*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the AGBenefits Service Center by or before the first day of each month during the continuation period, subject to a 30-day grace period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an ***associate*** or as a ***spouse*** the cost of coverage is the amount applicable to an ***associate*** if coverage is continued for the associate alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***associate***.

WHEN COBRA COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

FAMILY MEMBERS AQUIRED DURING COBRA

A ***spouse*** or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***associate*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF COBRA COVERAGE

In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

1. Death of the ***associate***.
2. Divorce or legal separation from the ***associate***.
3. The child's loss of ***dependent*** status.
4. The ***associate's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.

Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the AGBenefits Service Center within sixty (60) days of the latest of:

1. The date of that event; or
2. The date on which coverage under this ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred.

A copy of the Additional Extension Event Notification form is available from the AGBenefits Service Center. In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

Only a ***dependent*** covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***associate*** (or former ***associate***) during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

1. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and

2. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the AGBenefits Service Center within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

The date of the disability determination by the Social Security Administration;

The date of the 18-Month Qualifying Event; or

The date on which the person loses (or would lose) coverage under this ***Plan*** as a result of the 18-Month Qualifying Event.

Should the disabled person fail to notify the AGBenefits Service Center in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The ***Plan*** may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the date of the final determination by the Social Security Administration.

MEDICAL COVERAGE CONTINUATION POST COBRA

Former associates who are beyond their COBRA continuation coverage period are not able to make changes due to Qualifying Life Events, therefore, cannot add coverage for dependents at any time (e.g. marriage, adoption, birth of a child). They may decrease the number of dependents covered on the plan at any time, and, during Open Enrollment can change their medical plan election (e.g. Enhanced Consumer Plan to Consumer Plan).

END OF COBRA

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***associate***, divorce or legal separation from the ***associate***, or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment by the date specified by the AGBenefits Service Center. In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

4. The date coverage under this ***Plan*** ends and the ***plan sponsor*** offers no other group health benefit plan to any ***associate***. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

5. Unless covered under an employer subsidized portion of a severance agreement where the Company is paying part of the COBRA premium, the date the ***covered person*** first becomes entitled, after the date of the ***covered person's*** original election of continuation coverage, to ***Medicare*** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the ***covered person*** first becomes covered under any other employer's group health plan after the original date of the ***covered person's*** election of continuation coverage, but only if: a) such group health plan does not have any exclusion or limitation that affects coverage of the ***covered person's pre-existing condition*** *or 2) until the Company is done paying part of the COBRA premium under a*

severance agreement. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. For the ***spouse*** or ***dependent*** child of a covered ***associate*** who becomes entitled to ***Medicare*** prior to termination of employment (for reasons other than gross misconduct) or reduction in work hours, thirty-six (36) months from the date the covered ***associate*** becomes entitled to ***Medicare***.

SPECIAL RULES REGARDING COBRA NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the AGBenefits Service Center is able to determine from such notice the ***associate*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan***, any notice required to be provided by any individual who is either the ***associate*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***associate*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***associate*** and the ***spouse*** will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the ***spouse*** resides at the same location as the ***associate***; and
    b. A single notice addressed to the ***associate*** or the ***spouse*** will be sufficient as to each ***dependent*** child of the ***associate*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

MEDICAL AND PRESCRIPTION DRUG CLAIM FILING AND APPEAL PROCEDURE

FILING A CLAIM

Certain information in this section may not apply to associates covered under Kaiser or CIGNA International. These associates should reference the Kaiser Member Handbook and Feature of Your Group Plan or the CIGNA International Global Health Advantage booklet for a description of the claims and appeals procedures.

The prescription drug appeals section does apply to associates living in Hawaii.

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

POST-SERVICE CLAIM PROCEDURE

1. If the ***covered person*** utilizes an ***in-network provider***, there are no claim forms to fill out.

2. If the ***covered person*** utilizes an ***out-of-network provider***, a claim form must be completed and submitted to the ***claims administrator*** at the address noted below:

United Healthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555

The date of receipt will be the date the claim is received by the ***claims administrator.***

3. All claims submitted for benefits must contain all of the following:

   a. Name of patient
   b. Patient's date of birth.
   c. Name of ***associate.***
   d. Address of ***associate.***
   e. Name of ***company*** and group number***.***
   f. Name, address and tax identification number of provider.
   g. ***Associate*** Social Security Number.
   h. Date of service.
   i. Diagnosis (applies to medical claims ONLY))
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident, injury*** or ***illness*** being treated.

4. Properly completed claims not submitted within twelve (12) months from the date the services were rendered will not be a ***covered expense*** and will be denied.

The ***covered person*** may ask the health care provider to submit the claim directly to the ***claims administrator***, or the ***covered person*** may submit the bill with a claim form. The date of receipt will be the date the claim is received by the ***claims administrator***. It is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

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 a ***covered person*** or his beneficiary, if any, to the ***plan administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***covered person***, shall be deemed notice of claim.

FOREIGN CLAIMS

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

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

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***claims administrator*** with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** 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 AGBenefit Advisor.

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***:

1. All scheduled *inpatient* admissions *(including non-emergency skilled nursing facility and rehabilitation facility admissions)* and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery*;*
2. Home health care, including nutritional foods;
3. Non-Emergency ambulance transportation;
4. Congenital Heart Disease surgery;
5. *Hospice* care;
6. Emergency Health Services – Outpatient. (Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.)
7. *Cosmetic/reconstructive surgery;*

8. 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);

9. Diabetes Services;

10. *Durable medical equipment, including DME for the management and treatment of diabetes, and Prosthetic Devices that costs more than $1,000 (either purchase price or cumulative rental of a single item*;

11. For a scheduled admission for Mental Health Services Neurobiological Disorders –Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), you must notify obtain prior authorization five business days prior to the admission, or provide notification as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions);

12. Lab, X-Ray and Diagnostic – Outpatient – sleep studies.

13. Obesity Surgery;

14. Physician's Office Services – Sickness and Injury – Genetic Testing – BRCA;

15. Surgery – Outpatient - blepharoplasty, uvulopalatopharyngoplasty, vein procedures, sleep apnea surgeries and orthognathic surgeries;

16. Therapeutic Treatments – Outpatient - dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound;

17. Approval clinical trials – as soon as the possibility of a clinical trial arises;

18. Gender Dysphoria;

19. Cellular and Gene Therapy

For non-urgent care, the ***covered person*** or their 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,*** the ***covered person*** or their 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 Where to Get Information page of this document.**

The ***claims administrator's*** phone number is also included on the *associate's* medical ID card.

When a ***covered person*** (or authorized representative) calls the ***claims administrator***, the covered person should be prepared to provide all of the following information:

1. ***Associate's*** name, address, phone number and Social Security Number.

2. Company's name.

3. If not the ***associate***, the patient's name, address, phone number.

4. Admitting ***physician's*** name and phone number.

5. Name of ***facility.***

6. Date of admission or proposed date of admission.

7. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any **hospital** length of stay in connection with childbirth for the mother or newborn child to less than 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 precertified.

If the ***covered person*** (or 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 the ***covered person*** with the process of obtaining prior authorization from the ***claims administrator***, the ***covered person*** is ultimately responsible for ensuring that prior pre-certification has been obtained.

CASE MANAGEMENT

In cases where the ***covered person's*** 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:

1. are not ***covered expenses*** under this ***Plan***; or
2. 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***.

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, the ***covered person*** 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, the ***covered person*** shall be notified of such approval and provided sufficient information to understand the importance 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 the life or health of the ***covered person*** or the ability of the ***covered person*** to regain maximum function, or in the opinion of a ***physician*** with knowledge of the ***covered person's*** medical condition, would subject the ***covered person*** 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 the ***covered person*** has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the ***Plan***, the ***claims administrator*** will notify the ***covered person*** within twenty-four (24) hours of the specific information needed to complete the claim. The ***covered person*** 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 the ***covered person*** to provide the information, the ***claims administrator*** will notify the ***covered person*** of the ***Plan's*** benefit determination. The ***covered person*** 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 the ***covered person*** within the timeframe of the reason for the extension and the date the ***Plan*** expects to render its decision.

If the ***covered person*** has not followed the ***Plan's*** procedures for filing a pre-service claim, the ***claims administrator*** will notify the ***covered person*** 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 the ***covered person*** 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; the ***covered person*** 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 the ***covered person's*** information to render its decision. The ***covered person*** 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 the ***covered person*** to appeal the adverse benefit determination. If a course of treatment involves urgent care, a request by the ***covered person*** 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, the ***covered person*** does 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 a ***covered person*** normally has 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 the ***covered person*** 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 the ***covered person*** 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. The ***covered person*** 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 the ***covered person's*** information to render its decision. The ***covered person*** 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 the ***covered person***. 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 the ***covered person*** within three (3) days after the oral notice is provided.

The notice will include the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific ***Plan*** provisions on which the determination is based;
3. If applicable, a description of any additional information needed for the ***covered person*** to perfect the claim and an explanation of why such information is needed;
4. A description of the ***Plan's*** review procedures, including the ***covered person*** right to bring a civil action under Section 502(a) of ERISA;
5. 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;
6. If the adverse determination is based on ***medical necessity*** or ***experimental/investigational/ unproven*** treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or a statement that this will be provided without charge upon request; and
7. 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 the ***covered person*** is advised of the ***claim administrator's*** action. If written request for review is not made within such one hundred eighty 180-day period, the ***covered person*** will forfeit their right to review. The ***covered person*** or a duly authorized representative of the ***covered person*** 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. The ***covered person*** may agree to further extend these deadlines.

A copy of the decision will be furnished to the ***covered person***. The decision shall set forth:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific ***Plan*** provisions on which the determination is based;
3. A statement that the ***covered person*** 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;
4. A statement of any voluntary appeals procedures and the ***covered person's*** right to receive information about the procedures as well as the ***covered person's*** right to bring a civil action under Section 502(a) of ERISA;
5. 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;
6. If the adverse determination is based on ***medical necessity*** or ***experimental/investigational/ unproven*** treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or a statement that this will be provided without charge upon request.

The decision will be final and binding upon the ***covered person*** 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

The ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making 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:

1. The ***covered person*** 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;
2. The final internal denial does not relate to the ***covered person's*** failure to meet ***Plan*** eligibility requirements as stated in the sections, *Eligibility for Coverage* and *Effective Date of Coverage*;
3. The ***covered person*** has exhausted the ***Plan's*** appeal process, to the extent required by law; and
4. The ***covered person*** has 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 the ***covered person*** (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:

1. 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
2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the ***covered person*** to perfect the external review request by the later of the following:
    a. The four (4) month filing period; or
3. Within the forty-eight (48) hour time period following the ***covered person's*** 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 the ***covered person***, 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 the ***covered person*** (or 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 the ***covered person***, 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 the ***covered person*** (or authorized representative) the right to request an expedited external review upon the ***covered person's*** receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function and the ***covered person*** has filed an internal appeal request; or

2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the ***covered person*** or the ***covered person's*** ability to regain maximum function or if the final determination involves any of the following:

    a. an admission,
    b. availability of care,
    c. continued stay, or
    d. a health care item or service for which the ***covered person*** 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:

1. Perform a preliminary review to determine whether the request meets the requirements in the section, *Right to External Appeal*; and

2. 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:

1. Assign an IRO as described in the section, *Independent Review Organization*; and

2. 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 the ***covered person's*** 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 the ***covered person*** (or authorized representative) written confirmation of its decision within forty-eight (48) hours after the date of providing that notice.

If the ***covered person*** is not satisfied with the outcome of the appeals procedure, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974. The ***covered person*** may not initiate a legal action against the ***plan*** until the ***covered person*** has completed the both the initial and second level appeal processes.

COORDINATION OF BENEFITS

NON-DUPLICATION METHOD

Certain information in this section may not apply to associates covered under Kaiser or CIGNA International. These associates should reference the Kaiser Member Handbook and Feature of Your Group Plan or the CIGNA International Global Health Advantage booklet.

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed one hundred percent (100%) of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit***.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under this ***Plan***, part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan***.

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. "Other Plan" does not include Tricare, ***Medicare*** or Medicaid. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, ***hospital*** indemnity benefits and ***hospital*** reimbursement-type plans;
2. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer**,** or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***company's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits that would be payable under this ***Plan*** for each claim in the absence of this provision shall be calculated and reduced by the benefits payable under all other plans for the expenses covered in whole or in part by this ***Plan***.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member /Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent***.

3. Dependent Children
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***associate*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***associate***, or as that person's ***dependent*** pays second.

5. Limited Continuation of Coverage
   If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary.

6. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

7. The American Greetings Corporation Welfare Benefits Plan & Insured Welfare Benefits Plan reserves a secondary payer status to automobile insurance for medical expenses as a result of an auto accident if permitted by law.

COORDINATION WITH MEDICARE

Individuals may be eligible for ***Medicare*** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in ***Medicare*** Parts B and D are available to all individuals who make application and pay the full cost of the coverage.

1. When an ***associate*** becomes entitled to ***Medicare*** coverage (due to age or disability) and is still actively at work, the ***associate*** may continue health coverage under this ***Plan*** at the same level of benefits and associate contribution (payroll deduction) that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage (due to age or disability) and the ***associate*** is still actively at work, the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***associate*** and/or ***dependent*** is also enrolled in ***Medicare*** (due to age or disability), this ***Plan*** shall pay as the primary plan. If, however, the ***Medicare*** enrollment is due to end stage renal disease, the ***Plan's*** primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in ***Medicare*** law and regulations.

4. If the ***associate*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan***. ***Medicare*** will be the only payor.

5. For a ***retiree***, ***Medicare*** shall be the primary payor and this ***Plan*** shall be secondary. If someone is Medicare eligible and should be Medicare primary, the Plan will pay for covered services and assume Medicare payment, regardless of whether or not the retiree actually signed up for Medicare.

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***company*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***company*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***company*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***company*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

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 attorney's fees or costs associated with the claim or lawsuit without express written authorization from the ***company***.

3. Assisting in ***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.

HIPAA PRIVACY

Certain information in this section may not apply to associates covered under Kaiser or CIGNA International. These associates should reference the Kaiser Member Handbook and Feature of Your Group Plan or the CIGNA International Global Health Advantage booklet.

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 Services, Inc. (for the medical benefits and prescription drug benefits) and UHC (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.

Company **agrees to:**

- Not use or further disclose the information other than as permitted or required by the ***Plan*** documents or as r***equired 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 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 rule***;
- 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 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.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc.***,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;
2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;
3. Does not provide ***inpatient*** accommodations; and
4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Ancillary Charge

A charge, in addition to the Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product, and the Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Associate

Refer to the *Eligibility, Enrollment and Effective Date* section for a complete definition of the term ***associate.***

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) criteria.

Chemically Equivalent

When Prescription Drug Products contain the same active ingredient.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Administrator

For self-insured benefits under the ***Plan***:

United Healthcare is the ***claims administrator*** for the following medical plan options:

- Enhanced Consumer Plan and Consumer Plan
- Traditional Plan

UHC is the ***claims administrator*** for the Prescription Drug benefits.

For insured benefits under the ***Plan***:

Kaiser Permenante is the ***claims administrator*** for the following medical plan option:

- Kaiser Permenante of Hawaii (***associates*** living in the state of Hawaii)
- CIGNA International is the ***claims administrator*** for the following medical plan option:
- CIGNA International

Refer to the *Summary Plan Description* (SPD) section of this document for additional information.

Clinical Trial

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:

- certain Category B devices;
- certain promising interventions for patients with terminal illnesses; and
- other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
- National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
- Centers for Disease Control and Prevention (CDC);
- Agency for Healthcare Research and Quality (AHRQ);
- Centers for Medicare and Medicaid Services (CMS);
- a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
- a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
- comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
- ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If prior authorization is not obtained, you will be responsible for paying all charges and no benefits will be paid.

Close Relative

The ***associate's spouse***, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***associate's spouse***.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Company

The ***company*** is American Greetings Corporation.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective cesarean section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** or their authorized representative to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***. Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay.

Copay or Copayment

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount or Allowed Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

For contracting providers, the ***allowed amount*** is the lesser of the applicable negotiated rate or covered expense. For non-contracting providers, the ***allowed amount*** is the non-contracting amount, which will likely be less than billed charges.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of his license.

Dependent

For a complete definition of **dependent,** refer to Eligibility, Enrollment and Effective Date, Dependent Eligibility.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an ***illness*** or ***injury***;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency

An accidental ***injury***, or the sudden onset of an ***illness*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire. For a ***covered person*** who enrolls in the ***Plan*** as the result of a Special Enrollment Period or as the result of late enrollment or open enrollment period, if available, the ***enrollment date*** is the date the enrollment form is signed.

Experimental/Investigational/Unproven

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating ***facility*** or the protocol(s) of another ***facility*** studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating ***facility*** or by another ***facility*** studying substantially the same drug, device, medical treatment or procedure.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Freestanding facility

An outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Full-time

Refer to *Eligibility* for a definition of the term ***full-time***.

Full-time Student or Full-time Student Status

An ***associate's dependent*** grandchild who is enrolled in and regularly attending secondary school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain ***full-time student status***.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Home Health Aide Services

Services which may be provided by a person, other than a ***nurse***, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one ***nurse***. It must provide for full-time supervision of such services by a ***physician*** or ***nurse***.
3. It maintains a complete medical record on each ***covered person***.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a ***physician***.
4. It has a coordinator who is a ***nurse***.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of ***hospice*** services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the ***covered person***.
9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.
2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of ***nurses***.
4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It must be approved by ***Medicare***.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a ***facility*** designed exclusively for physical rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for ***mental and nervous disorders*** or ***chemical dependency***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Hospital based lab

An outpatient facility that performs services and submits claims as part of a Hospital.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

In-Network Provider

A ***physician***, ***hospital*** or other health care ***facility*** that has an agreement in effect with the ***in-network provider*** organization at the time services are rendered. ***In-network providers*** agree to accept the ***negotiated rate*** as payment in full.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one ***nurse*** in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Layoff

A period of time during which the ***associate***, at American Greetings' request, does not work for American Greetings, but which is of a stated or limited duration and after which time the ***associate*** is expected to return to ***full-time***, active work. ***Layoffs*** will otherwise be in accordance with American Greetings' standard personnel practices and policies.

Leave of Absence

A period of time during which the ***associate*** does not work, but which is of stated duration after which time the ***associate*** is expected to return to active work.

Mail Order Network Pharmacy

A mail order pharmacy that UnitedHealthcare identifies as a preferred pharmacy within the Network.

Maintenance Medication

Medications that are taken regularly for chronic conditions or for long term therapy. Examples are drugs sometimes prescribed for heart disease, high blood pressure, and asthma.

Maximum Allowable Cost (MAC) List

A list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:
    a. The entire time the ***covered person*** is covered under this ***Plan***, or
    b. A specified period of time, such as a calendar year.
2. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:
    a. Treatments during a specified period of time, or
    b. Days of confinement, or
    c. Visits by a ***home health care agency***.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims administrator*** or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims administrator*** or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims administrator*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Morbid Obesity

A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight in the most recent Metropolitan Life Insurance company tables for a person of the same height, age and mobility as the ***covered person.***

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Network Pharmacy

A pharmacy that has:

1. Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
2. Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
3. Been designated by UnitedHealthcare as a Network Pharmacy.

New Prescription Drug Product

A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Out-of-Network Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***preferred provider organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;
2. A ***physician's*** office, laboratory or x-ray ***facility***; or
3. An ambulatory surgical facility; and

The stay is less than twenty-three (23) consecutive hours.

Pharmacy Organization

The Pharmacy Organization is UHC.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed for Adoption

The date the ***associate*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of the same as described herein. The ***Plan*** as described in this summary plan description consists of two welfare benefit plans: the American Greetings Corporation Welfare Benefits Plan (plan number 556) and the American Greetings Insured Welfare Benefits Plan (plan number 502).

Plan Administrator

The ***plan administrator*** is the Benefits Advisory Committee.

Plan Sponsor

The ***plan sponsor*** is American Greetings Corporation.

Plan Year End

The ***plan year end*** is the twelve (12) consecutive month period beginning on March 1st and ending on the last day in February.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***.

Pregnancy

The physical state which results in childbirth or miscarriage.

Prescription Drug Charge

The rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL)

A list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to UnitedHealthcare's periodic review and modification.

Prescription Drug List (PDL) Management Committee

The committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product

A medication, or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Prescription Order or Refill

The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable 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).

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Certified Addictions Counselor
Certified Registered Nurse Anesthetist
Chiropractor
Christian Science Practitioner
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dental Hygienist
Dentist
Dietitian
Dispensing Optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Nurse Practitioner

Occupational Therapist
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist
Respiratory Therapist
Speech Therapist

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Routine Examination

A comprehensive history and physical examination which would include services as defined in *Medical Expense Benefit, Preventive Care/Wellness Benefit*.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Skilled Nursing Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or ***nurse***.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders***.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as an Extended care facility, convalescent nursing facility, or any such other similar designation.

Specialty Prescription Drug Product

Medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions such as oncology, hormonal therapies, Hepatitis C, multiple sclerosis, psoriasis and rheumatoid arthritis.

Spouse

The ***associate's spouse*** of a legal marriage.

Step Therapy

The Plan will cover lower cost medications such as Generic Drugs and Preferred Brand Name drugs as the first step before higher cost medications are considered.

Therapeutic Class

A group or category of Prescription Drug Product with similar uses and/or actions

Therapeutically Equivalent

When Prescription Drug Products have essentially the same efficacy and adverse effect profile,

Total Disability or Totally Disabled

The ***associate*** is prevented from engaging in his regular, customary occupation or from an occupation for which the associate becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician***.
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
    d. It provides at least the following basic services:

        (1) Room and board

(2) Evaluation and diagnosis
(3) Counseling
(4) Referral and orientation to specialized community resources.

UHC Premium Provider (in UHC provider contracts could be referred to as Designated Network Benefits or Designated Provider and can also be called Tier 1 providers)

Apply to covered services that are provided by a network physician or other provider or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthare's behalf, to provide covered health services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions or procedures.
- A Premium Designated Provider may or may not be located within your geographic area. Not all network hospitals or network physicians are designated providers.

You can find if your provider is a Premium Provider by contacting UnitedHealthcare at www.myuhc.com or the telephone number on your ID card.

Urgent Care

An ***emergency*** or an onset of severe pain that cannot be managed without immediate treatment.

Usual and Customary Charge

The usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Well Child Care

Preventive care rendered to ***dependent*** children.

SUMMARY PLAN DESCRIPTION

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. and UHC. The fully insured benefits hereunder are provided pursuant to insurance agreements between American Greetings Corporation and the following insurance carriers: Kaiser Permanente and CIGNA International. 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.

Name of Plan:

The official names of the two plans described in this single summary plan description are: the **American Greetings Corporation Welfare Benefits Plan** (Plan Number 556) and the **American Greetings Insured Welfare Benefits Plan** (Plan Number 502). The medical and prescription drug benefits described in this document are provided under those plans.

Name, Address and Phone Number of Employer/Plan Sponsor:

American Greetings Corporation
One American Blvd
Cleveland, OH 44145
AG Benefits Dept.
216-252-7300 ext. 4192

Employer Identification Number:

34-0065325

Plan Number:

556 (self-insured plan providing medical and prescription drug benefits)
502 (fully insured plan providing medical and prescription drug benefits for Hawaii and Ex-patriot ***associates***)

Type of Plan:

Welfare Benefit Plan: medical and prescription drug benefits

Type of Administration:

Self-Insured Benefits Administration: The processing of claims for benefits under the terms of the American Greetings Corporation Welfare Benefits Plan is provided through a company contracted by the ***company*** and shall hereinafter be referred to as the ***claims administrator***.

The medical benefits are provided pursuant to an administrative services agreement between American Greetings Corporation and the ***claims administrator***.

United Healthcare is the ***claims administrator*** for the following medical plan options:

- Enhanced Consumer Plan and Consumer Plan
- Traditional Plan

The prescription drug benefits are provided pursuant to an administrative services agreement between American Greetings Corporation and UHC. UHC is the ***claims administrator*** for these ***Plan*** benefits.

Insured Benefits Administration: The processing of claims for insured benefits under the terms of the American Greetings Insured Welfare Benefits Plan are provided through a company contracted by the ***company*** and shall hereinafter be referred to as the ***claims administrator***.

The medical benefits are provided pursuant to an insurance agreement between American Greetings Corporation and the ***claims administrator***.

Kaiser Permenante is the ***claims administrator*** for the following medical plan option:

- Kaiser Permenante of Hawaii (***associates*** living in the state of Hawaii)

CIGNA International is the ***claims administrator*** for the following medical plan and pharmacy plan option:

- CIGNA International

Note that the prescription drug benefits under the American Greetings Insured Welfare Benefits Plan are provided pursuant to an administrative services agreement between American Greetings Corporation and UHC. UHC is the ***claims administrator*** for these prescription drug benefits.

Name, Address and Phone Number of Plan Administrator

Benefits Advisory Committee
American Greetings Corporation
Attn: AG Benefits Dept.
One American Blvd
Cleveland, OH 44145
216-252-7300 ext. 4192

Name, Address and Phone Number of Legal Service:

The agent for service of legal process for the ***Plan*** is:

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

Legal process may be served with a copy to:

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

Name, Address and Phone Number of the Trustee

KeyBank
127 Public Square
Cleveland, OH 44114

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following section:

- *Eligibility, Enrollment and Effective Date of Coverage*

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, termination of coverage or ***Plan*** exclusions, refer to the following sections:

- *Schedule of Benefits*
- *When Coverage Ends*
- *Plan Exclusions*

PLAN TERMINATION:

The ***plan sponsor*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons***.

Source of Plan Contributions:

Contributions for ***Plan*** costs are obtained from the ***company*** and from covered ***associates***. For self-insured benefits, the ***company*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***company*** and the amount to be contributed by the covered ***associates***. For fully-insured benefits, the applicable insurance company establishes the required premiums. Contributions by the covered ***associates*** are deducted from their pay on a pre-tax basis as authorized by the ***associates*** on the enrollment form or other applicable forms.

Funding Method:

Premium costs are paid by a combination of ***company*** and contributions received from **covered persons**. In addition, in the **company's** sole discretion and at the **company's** election, the **company** may pay the cost of premiums and benefits from the [Insert name of the trust] All self-insured **Plan** benefits and administration expenses are paid directly from general assets of the ***company*** or, at the **company's** election, from the [insert name of the trust]. All fully insured benefits are paid solely by the applicable insurance company. Contributions received from **covered persons** are used to cover **Plan** costs and are expended immediately.

Collective Bargaining Agreements:

This ***Plan*** is partially maintained pursuant collective bargaining agreements between the ***company*** and International Brotherhood of Teamsters, Local 52, an affiliate of the International Brotherhood of Teamsters, Chauffeurs, Warehouseman and Helpers of American and The Southern Regional Joint Board of Workers United. ***Associates*** that are subject to the Collective Bargaining Unit have a right to obtain a copy of the collective bargaining agreement by contacting their union.

Effective Date of the Plan:

This summary plan description describes the ***Plan*** as in effect as of January 1, 2025

Ending Date of Plan Year:

The plan year is March 1st – last day in February. The benefit/elections year is January – December.

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled *Claim Filing Procedure.*

Name, Address and Phone Number of Claims Administrator:

United Healthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555

Kaiser Permanente
Kaiser Foundation Health Plan, Inc.
Attn: Claims Administration
80 Mahalani St.
Wailuku, HI 96793

CIGNA International
CIGNA Worldwide Insurance Company
Connecticut General Life Insurance Company
P.O. Box 15050
Wilmington, DE 19850

Qualified Medical Child Support Orders

If required by any Qualified Medical Child Support Order ("QMCSO") defined in ERISA Section 609(a), the ***Plan*** will extend benefits to a covered ***associate's*** non-custodial child (***alternate recipient***). Covered ***associates*** and beneficiaries can obtain from the ***plan administrator***, without charge, a copy of the procedures used for determining whether an order satisfies the requirements of ERISA by contacting the AGBenefits Service Center.

Statement of ERISA Rights

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

1. Examine, without charge, all documents governing the ***Plan***, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** with the U.S. Department of Labor, if applicable, by contacting the AGBenefits Service Center.

2. Obtain, upon written request by contacting the AGBenefits Service Center, copies of documents governing the operation of the ***Plan,*** including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable, by contacting the AGBenefits Service Center. Although presently American Greetings does not charge, the ***plan administrator*** may require payment of a reasonable charge for the copies.

3. 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, if applicable.

4. Continue health care coverage for the participant, the participant's ***spouse*** or ***dependents*** if there is a loss of coverage under the ***Plan*** as the result of a qualifying event. The participant or ***dependent*** may have to pay for such coverage. Review this summary plan description and the documents governing the ***Plan*** on the rules governing COBRA continuation coverage rights.

In addition to creating rights for ***Plan*** participants, ERISA imposes obligations upon the people who are responsible for the operation of the ***Plan***. The people who operate the ***Plan***, called "fiduciaries" of the ***Plan***, have a duty to do so prudently and in the interest of all ***Plan*** participants.

No one, including American Greetings, a union, or any other person, may terminate an ***associate*** or discriminate against an ***associate*** to prevent the ***associate*** from obtaining any benefit under the ***Plan*** or exercising their rights under ERISA.

If claims for benefits under the ***Plan*** are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the ***Plan*** review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the ***plan administrator*** to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***plan administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court. In addition, if you disagree with the ***Plan's*** decision or lack thereof concerning the qualified status of a 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 participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the ***plan administrator,*** by contacting the AGBenefits Service Center, for questions about the ***Plan***. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***plan administrator*** is the Benefits Advisory Committee. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. All matters relating to the administration of the ***Plan***, including the duties imposed upon the ***plan administrator*** by law and the interpretation of the ***Plan*** provisions are the responsibility of the ***plan administrator***. In general, the ***plan administrator*** is the sole judge of the application and interpretation of the ***Plan***, consistent with the appropriate collective bargaining agreement provisions, and has the discretionary authority to construe the provisions of the ***Plan***, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits except where such decisions would be in conflict with such collective bargaining unit provisions. The ***plan administrator*** has the authority, in the ***plan administrator's*** sole discretion, to interpret the ***Plan*** and resolve ambiguities therein, to develop rules and regulations to carry out the provisions of the ***Plan***, and to make factual determinations. However, the ***plan sponsor*** and/or the ***plan administrator*** shall have the right to hire persons to provide services to the ***Plan***; for example, American Greetings has hired ADP to provide the AGBenefits Service Center for employee servicing and enrollment. The ***plan administrator*** has appointed the following ***claims administrator(s)*** to receive, review and process claims for benefits:

Regarding self-insured medical benefits under the ***Plan***,

United Healthcare is the ***claims administrator*** for the following medical plan options:

- Enhanced Consumer Plan and Consumer Plan
- Traditional Plan

UHC is the ***claims administrator*** for the Prescription Drug Plan benefits.

Regarding insured medical benefits under the ***Plan***,

Kaiser Permenante is the ***claims administrator*** for the following medical plan option:

- Kaiser Permenante of Hawaii (***associates*** living in the state of Hawaii)

CIGNA International is the ***claims administrator*** for the following medical plan option:

- CIGNA International

The ***plan administrator*** has delegated to the ***claims administrator*** the discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the ***Plan***.

APPLICABLE LAW

All provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements of the law of the State of Ohio to the extent it is not superseded 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.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***associate*** unless payment has been assigned to a ***hospital***, ***physician,*** or other provider of service furnishing the services for which benefits are provided herein.

In-network providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***in-network provider***.

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order.

Except as provided respect to a Qualified Medical Child Support Order, no benefit, right or interest of an associate, spouse, dependent or beneficiary under the Plan will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations except as otherwise required by law or, in the case of assignments, as permitted under the terms of an insurance policy.

Specifically, an associate, spouse, dependent or beneficiary cannot assign, transfer, or convey any rights under the Plan, or ERISA (except as provided with respect to a Qualified Medical Child Support Order). This prohibition on assignments of rights specifically includes any legal right an individual has or may have to bring claims for benefits, breaches of fiduciary duty, prohibited transactions, statutory violations or statutory penalties. Any attempt to assign any Plan benefits or legal rights to any third party, including, but not limited to, a healthcare provider, shall be immediately invalid, void, and unenforceable. The purported assignments an individual may be asked to sign by a healthcare provider do not invalidate, alter or supersede these prohibitions. The payment of benefits directly to a health care provider or facility or other provider of medical care, treatment or services, if any, is done as a convenience to the participant and does not constitute an assignment of benefits under the Plan or ERISA. The Plan Administrator, in its sole and absolute discretion, may decide to pay benefits due under the Plan directly to a healthcare provider. When this happens, it is done solely for convenience. Nothing in the Plan obligates the Plan to pay any benefits directly to any healthcare provider or alters the Plan's prohibition on assigning rights and benefits under the Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

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.

CLERICAL ERROR

No clerical error on the part of the ***plan sponsor*** or ***plan administrator*** or ***claims administrator*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***associate*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

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. 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***.

AFFORDABLE CARE ACT (ACA)

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

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: [insert American Greetings website where the notice is posted].

MENTAL HEALTH PARITY

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.

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.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider***. However, benefits will be paid in accordance with the provisions of this ***Plan***, and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of an ***out-of-network provider***.

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 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 ACTIONS

a. **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.

b. **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 hereunder shall 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 within the time prescribed in *Claim Filing Procedure*.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any state law which provides that the state has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan***, the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***Plan***, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this ***Plan*** null and void.

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.

PLAN MODIFICATION AND AMENDMENT

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.

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.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***plan administrator*** will have the right to recover these excess payments. If the ***plan administrator*** makes any payment that, according to the terms of the ***Plan***, should not have been made, the ***plan administrator*** may recover that incorrect payment, whether or not it was made due to the ***plan administrator's*** or the ***plan administrator's*** designee's own error, from the person or entity to whom it was made or from any other appropriate party. The ***plan administrator*** make take any steps it deems appropriate to recover such overpayments, including but not limited to offsetting future benefit payments by the amount of the overpayment.

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.

STATUS CHANGE

If an ***associate*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***associate***, COBRA to active) and no interruption in coverage has occurred, the ***Plan*** will provide continuous coverage with respect to any deductible(s), ***coinsurance*** and ***maximum benefit, upon associate request***.

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***plan administrator***.

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

INSURED BOOKLETS

The following Booklets are incorporated by reference and are included as part of this summary plan description. If you do not have a copy of a Booklet, please contact your ***plan administrator***.

Type of Benefit	Booklet	Funding
Health (HMO)	Kaiser of Hawaii	Insured
Health	CIGNA International Medical and Dental	Insured

Other insured benefits have separate Summary Plan Descriptions (SPD).