SUMMARY PLAN DESCRIPTION

AMERICAN GREETINGS
FLEXIBLE SPENDING ACCOUNT (FSA) PLAN

American Greetings Corporation
One American Boulevard
Cleveland, OH 44145-8151
(216) 252-7300

Effective Date: January 1, 2024

Where to Get Information

For assistance with FSA, contact the Claims Administrator:

MyChoice Accounts
MSC 345475
PO Box 105168
Atlanta, GA 30348-5168

For benefit assistance after contacting MyChoice Accounts, or for general assistance including eligibility and enrollment:

AGBenefits Service Center
1-877-213-6240
www.agbenefits.com

Plan Sponsor:

American Greetings
Attn: AG Benefits Dept
One American Boulevard
Cleveland, Ohio 44145
Phone: 216-252-7300 ext. 4192 or
1-800-321-3040
HRServices@amgreetings.com

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INTRODUCTION

American Greetings has a Section 125 Cafeteria Plan and a Flexible Spending Account Plan to enable you to purchase certain benefits on a pre-tax basis. The Flexible Spending Account Plan consists of two reimbursement accounts that are further described below.

If there is any difference between information described in this Summary Plan Description and the Plan's formal documentation, the formal documentation will control. The formal documentation is subject to rules, regulations, and interpretations under Section 125 of the Internal Revenue Code and other provisions of the Internal Revenue Code.

BASIC PROVISIONS

Accounts	You can contribute before-tax dollars from your pay to a: • Health Care Spending Account, and/or • Dependent Care Spending Account
Contributions	You can contribute: • Up to $3,050 a year to a Health Care Spending Account that can be used tax-free for qualified medical, dental, vision, and prescription drugs; and • Up to $5,000 a year to a Dependent Care Spending Account, subject to certain tax rules explained in more detail below; and • You may not contribute less than $240 a year to either account.
Eligible Expenses	You can use the tax-free money in your Health Care Spending Account to reimburse yourself for: • Out-of-pocket expenses such as deductibles, co-pays, coinsurance, and amounts over usual, customary and reasonable (UCR) and plan limits. • Other eligible expenses that may not be covered by your medical or dental plan, such as hearing aids and exams, prescription eyeglasses, sunglasses, contact lenses and orthodontia. You can use the tax-free money in your Dependent Care Spending Account to reimburse yourself for: • Dependent care in your home or someone else's home or childcare in a dependent care facility. • Household services related to dependent care.
Accessing Your Accounts	Health Care and Dependent Care Spending Account Debit Cards: • Use your Debit Card(s) to pay for eligible dependent care or health care. • If you use your Debit Card(s), documentation will be requested and, if not provided, will result in the Debit Card(s) being suspended. • Refer to *Health Care Spending Account Debit Card* in the *HCSA* portion of this document or the *Dependent Care Spending Account Debit Card* in the Dependent Care Spending Account portion of this document for more detailed information.
	Reimbursement for Eligible Expenses: • When requesting reimbursement for dependent care expenses or for health care claims, you must file a request for reimbursement with the Claims Administrator. • All eligible expenses must be incurred between January 1 and December 31 of the plan year (and while you are actively enrolled), and you must submit all claims for reimbursement no later than March 31 of the next plan year. • Refer to the *Claims and Appeals Procedures* portion of this document for more detailed information.

FLEXIBLE SPENDING ACCOUNTS

As benefit options under the American Greetings Section 125 Cafeteria Plan, the American Greetings Flexible Spending Account Plan enables you to use pre-tax dollars to pay for many medical and dependent care expenses. There are two separate reimbursement accounts available to you:

- Health Care Spending Account (HCSA) for qualifying medical, dental and vision expenses incurred by you and your eligible dependents; and

- Dependent Care Spending Account (DCSA) for the costs of day care for your children or other eligible dependents.

Special rules apply to the types of expenses eligible for reimbursement under each account. This booklet provides guidelines for using these accounts and lists some of the eligible expenses. If you have questions about flexible spending accounts, contact the AGBenefits Service Center at (877) 213-6240, visit them online at www.myagbenefits.com, or download the MyChoice Accounts mobile app.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Associate Eligibility

The following associates are eligible to enroll:

1. All regular full-time associates on the regular payroll working at least thirty-six (36) hours per workweek.

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

3. All eligible associates of the following unions:

    - Cleveland
    - Greeneville

4. If you are a regular full-time associate working thirty-six (36) hours per workweek, are returning to work under the phase back into work program following a leave for the birth/placement of a child and working a schedule of at least thirty-two (32) hours per workweek, are a regular part-time associate working at least twenty (20) hours per workweek, are a third-country national or working on a foreign assignment for American Greetings Corporation outside the United States, are a benefit-eligible part-time officer, or are a full-time associate working a reduced schedule under the transition to retirement program, you are eligible.

The following associates are not eligible to enroll:

1. All other full-time and part-time associates in merchandiser classifications.
2. Temporary, seasonal or on-call associates.

3. Residents of Puerto Rico.

This Summary Plan Description does not cover collective bargaining associates other than those named above.

Associates Effective Date
Eligible ***associates***, as described in Associate *Eligibility*, are eligible 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 that the ***associate*** has enrolled as described in the *Initial Enrollment.* Note that if employment begins on the first calendar day of the month, your FSA will be effective on the first day of the month following employment.

However, if an associate transfers from an ineligible class to an eligible class, coverage is effective on the date of transfer, provided that the associate has already met the length-of-service requirements (first day of the month following one full month since recent hire date). If the associate has not met the length-of-service requirements, then eligibility is effective once the associate has met the length-of-service requirements.

Initial Enrollment Period
When first hired, you must enroll during the Initial Enrollment Period if you want to participate. You must enroll for coverage hereunder within thirty (30) days of hire date or any Qualifying Life Event. The associate shall have the responsibility of timely forwarding to the AGBenefits Service Center all applications for enrollment hereunder.

If you make an election during the Initial Enrollment Period, your participation in the spending account(s) that you elect will begin on the later of your eligibility date or the date that your election is received and processed.

The election that you make during the Initial Enrollment Period is effective for the remainder of the plan year and generally cannot be revoked during the plan year unless you experience a specified Qualifying Life Event that will allow a mid-year election change.

If you do not make an affirmative election to participate in either of the spending accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the plan year unless you experience an event that allows you to change that election during the plan year.

Annual Enrollment Period
An annual enrollment period will be scheduled by American Greetings prior to the beginning of each plan year. At that time, you will receive enrollment materials describing the Flexible Spending Accounts and the other options available to you under the Plan.

If you decide to participate in one or both of the Flexible Spending Accounts, you must elect the total amount of your annual compensation you wish to deposit into each account during the next plan year, subject to plan limits. The amount you elect to deposit into the appropriate Flexible Spending Account will be deducted pro rata from your pay beginning

the first payday of the plan year. After an election is made, it may not be modified until the next annual enrollment period unless there is a Qualifying Life Event or other Internal Revenue Service (IRS)-authorized event that allows an election change.

Special Enrollment Period for Qualifying Life Events and Change in Status
Rules of the Internal Revenue Code require that, generally, you may not change the amount you are depositing to your Flexible Spending Account Plan until the next annual enrollment period. However, you will be allowed to make a change if the change is a Qualifying Life Event and the Consistency Rule is satisfied. If you experience a Qualifying Life Event and desire to make a change, you must make the change during the special enrollment period no later than thirty (30) days following the event. Valid Qualifying Life Events that result in a Change in Status include the following:

For both Health Care and Dependent Care Spending Accounts:

1. Marital Status Change (which includes changes in **recognized *same-sex or opposite-sex*** *partner* relationship):
   a. Marriage (or equivalent for non-marital ***same-sex partner*** relationship)
   b. Death of ***spouse*** or partner
   c. Divorce or annulment (or equivalent termination of non-marital ***same-sex partner*** relationship)
   d. Legal separation

2. Number of ***Dependents*** Changes by:
   a. Birth
   b. Adoption or placement for adoption
   c. Death of a ***dependent*** child
   d. Newly eligible ***dependents***

3. **Dependent** Status Change: ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements.

4. Cost Changes
   a. Applies to Dependent Care Spending Accounts but not to Health Care Spending Accounts. If the caregiver is a relative, no change is permitted.

5. Loss/Gain of Other Coverage
   a. This event applies to Dependent Care Accounts but not to Health Care Spending Accounts
   b. If the ***associate*** and/or ***dependent(s)*** lose(s)/gain(s) other coverage (i.e., change from an unpaid to a paid provider or vice versa, eligibility for state-funded school resulting in decreased need for childcare expenses)

6. Judgment, Decree, or Order Requiring Coverage
   a. If a judgment, decree, or order (collectively called “order”) resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order under the Employee Retirement Income Security Act (“ERISA”)) requires an employee to cover a child under

the Health Care Spending Account, the employee may increase deposits to cover the child. Likewise, if the order requires another individual to provide coverage for the child and coverage is, in fact, provided, then the employee may reduce deposits.

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 change in health coverage
   a. Change in cost of coverage under employer's group medical plan
   b. Change in coverage of ***associate*** or ***spouse*** attributable to ***spouse's*** employment

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

9. 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 himself or herself, if applicable, and his or her ***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.

   Additionally, the Plan's Administrator may modify your election(s) downward during the plan year if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Consistency Rule

A change as to the Health Care Spending Account meets the consistency rule if the change results from one of the *Qualifying Life Events* described in the first three bullets above and the change is "on account of and consistent with" that Qualifying Life Event, and that *Qualifying Life* Event affects eligibility for coverage under the Health Care Spending Account.

A change as to the Dependent Care Spending Account meets the consistency rule if the *Qualifying Life* Event affects expenses under the Dependent Care Spending Account,

such as when the child becomes 13 years old and is no longer a qualifying individual or when a child is born or adopted and becomes a qualifying individual.

The determination of whether a requested change is "on account of and consistent with" a Qualifying Life Event will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the IRS. If you have questions, please contact the AGBenefits Service Center at (877) 213-6240, visit them online at www.myagbenefits.com, or download the MyChoice Accounts mobile app.

TAX ADVANTAGES

The cash compensation (wages) you receive from American Greetings Corporation is taxable. However, when you allocate a portion of your compensation on a pre-tax basis to be used for payment of your benefits, your taxable income is reduced by the amount you have allocated to benefits. This allocation results in a reduction of federal and, in most cases, state income taxes.

You do not have to pay taxes on the money you receive as reimbursement of eligible medical or dependent care expenses from your Flexible Spending Account Plan.

Social Security/Other Benefits May Be Affected
Since you do not pay Social Security taxes on any compensation you deposit to your Health Care Spending Account or your Dependent Care Spending Account, your future Social Security benefit could be slightly reduced. Although this reduction usually is quite small, it could occur if your compensation falls below the annual Social Security taxable wage base as revised each year. However, the loss in retirement benefits should be more than offset by the current tax savings under the Flexible Spending Account Plan. The resulting decrease in your taxable compensation could impact other benefits that may be available through American Greetings.

HEALTH CARE SPENDING ACCOUNT

You can deposit between $240 and $3,050 (or such other limit as updated for cost of living and communicated to you during the open enrollment process) of your compensation into your Health Care Spending Account each year to reimburse yourself for eligible medical expenses for yourself or your eligible dependents that have not been paid by any other benefit plan or if you are not enrolled in a Health Savings Account (HSA). The annual amount you elect will be divided evenly over the appropriate number of pay periods. Each pay period, an equal portion of the total amount will be deducted from your compensation and credited to the appropriate account(s).

Limited Health Care Spending Account Options – For Those Who Contribute to a Health Savings Account (HSA)
If you participate in a Consumer Directed Health Plan, American Greetings provides you with an employer-funded HSA. Under IRS guidelines, you may not participate in an HSA

and a traditional FSA at the same time. Therefore, American Greetings offers a modified FSA that meets IRS guidelines when an American Greetings associate, or his or her spouse, participates in a medical plan that has an HSA. This type of "Limited Health Care Spending Account" allows you and your spouse to participate in a medical plan with an HSA. This type of FSA can only be used for dental and vision claims.

Dependent Eligibility for Reimbursement
The Health Care Spending Account can be used to reimburse medical expenses incurred by the following individuals:

1. your spouse,
2. your child,
3. a legally adopted child (or a child placed with you for adoption or foster child who has not attained age 27 as of the close of the year)
4. a qualifying child, and
5. a qualifying relative.

For this purpose, a qualifying child and a qualifying relative are defined as follows:

1) A "qualifying child" is a child who meets the following requirements:

   - the child is your son, daughter, stepchild, foster child, brother, stepbrother, half-brother, sister, stepsister, half-sister, grandchild, niece or nephew;
   - the child lives with you for more than one-half of the year;
   - the child (a) has not attained age 19 as of the close of the year and is younger than you, (b) has not attained age 24 as of the close of the year in the case of a child who was a full-time student for at least five (5) months of the year, or (c) any age if the child is permanently and totally disabled;
   - the child does not provide more than one-half of his or her own support for the year; and
   - the child did not file a joint tax return other than to claim a refund.

2) A "qualifying relative" is an individual who meets the following requirements:

   - the individual is your son, daughter, stepchild, foster child, grandchild, parent, grandparent, brother, stepbrother, half-brother, sister, stepsister, half-sister, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law;
   - Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship is not in violation of local law;
   - you provide more than one-half of the individual's support for the year; and
   - the individual is not a qualifying child (as defined above) of you or any other taxpayer for the year.

For purposes of any requirement above that a child live in your household, temporary absences due to special circumstances, including absences due to illness, education, business, vacation or military service, are not treated as absences.

Eligible Medical Expenses
When you incur eligible expenses, you submit a reimbursement account claim form, together with the original itemized bill or receipt or the explanation of benefits form from your insurance carrier. Eligible medical expenses can include most expenses that qualify as medical expenses under the Internal Revenue Code.

Subject to certain exceptions, some of which are described below, you can refer to IRS Publication 502, "Medical and Dental Expenses," for guidelines on expenses that are eligible for reimbursement. It is available:

- Online at http://www.irs.gov/pub/irs-pdf/p502.pdf
- From your local library
- By calling 1-800/TAX-FORM (1-800-829-3676)

If you use the Health Care Spending Account to pay for a particular medical expense, *you cannot claim the same expense as a deduction on your income tax return.*

If you receive a reimbursement from your Health Care Spending Account and reimbursement for the same expense through your medical or dental coverage or another health care plan, you must refund the reimbursement you received from your Health Care Spending Account to the Plan.

Medical Expenses Not Eligible for Reimbursement
Not all medical expenses are eligible for reimbursement from your Health Care Spending Account. Here are some examples of expenses that are not eligible for reimbursement:

- Cosmetic expenditures (e.g., teeth whitening, dermabrasion, chemical peels or spider vein treatment)
- General wellness expenses (e.g., health club dues, special foods and supplements, vitamins, exercise programs and equipment, or weight-loss programs)
- Insurance premiums (other than qualified long-term care premiums)
- Other: shipping and handling charges, missed appointments, late payment or interest charges
- Controlled substances that are not legal under federal law, even if such substances are legalized by state law

Submitting a Claim
Claims can be filed online through the Plan Administrator's website www.myagbenefits.com or through the MyChoice Accounts mobile app, or by downloading a claim form from the website and faxing/mailing it to the address included on the claim form. Claims must include all supporting documentation (itemized receipts or Explanation of Benefits), and reimbursements are processed within three to five (3 to 5) business days. Be sure to keep copies of the claim form and all supporting documentation for your records.

All eligible expenses must be incurred between January 1 and December 31 of the plan year and while you are enrolled as a participant. You must submit all claims for reimbursement no later than March 31 of the next plan year. Claims submitted after the March 31 for the previous plan year will not be eligible for reimbursement.

Ex: Claims submitted for plan year 2019 on or before March 31, 2020 will be reimbursable.
Claims submitted for plan year 2019 after March 31, 2020 will not be reimbursable.

You may not be reimbursed for any expenses before the effective date or before your HCSA election becomes effective. If your participation in the plan ends mid-year, only expenses incurred through your eligibility end date will be eligible for reimbursement unless you elect to continue through COBRA.

In accordance with the Uniform Reimbursement Requirement for Medical Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain at all times throughout the year reimbursement up to the amount you have elected to deposit into your Health Care Spending Account as long as the expense was incurred while you were actively in the plan.

Health Care Spending Account Debit Card
After you enroll into the health-based FSA, you will receive a Health Care Spending Account Debit Card that can be used to pay for qualified health care–related expenses without the need to file a paper-based claim. Your card will be mailed to your home address prior to the start of the plan year.

The Health Care Spending Account Debit Card allows you to pay for eligible medical expenses at the time that you incur the expense. Guidelines on using the debit card:

- *You must make an election to use the card*. In order to be eligible for the Health Care Spending Account Debit Card, you must agree to abide by the terms and conditions of the debit card program, including any fees applicable to participate in the program, limitations to card usage, the plan's right to withhold and offset for ineligible claims, etc.

- *The card will be turned off when coverage terminates*. The card will be turned off when you terminate coverage under the plan. You may not use the card during any applicable COBRA continuation coverage period.

- *You must obtain and retain a receipt/third-party statement each time you swipe the card*. You must obtain a third-party statement from the merchant (e.g., receipt or invoice) that includes the following information each time you swipe the card:
  - *The nature of the expense (what type of service or treatment was provided)*
  - *The date the expense was incurred*
  - *The amount of the expense*

You should retain this receipt for one (1) year following the close of the plan year in which the expense was incurred. Even though payment is made under the card arrangement, a written third-party statement is generally to be submitted. You may receive a letter from the Claims Administrator that a third-party statement is needed. You must provide the third-party statement to the Claims Administrator within forty-five (45) days (or such longer period provided in the letter from the Claims Administrator) of the request. ***Failure to substantiate in a timely and sufficient manner could result in your card being deactivated for the plan.***

- *You must certify proper use of the card*. As specified in the Cardholder agreement, you certify during the applicable election period that the amounts in your HCSA will only be used for eligible medical expenses for which you have not been reimbursed and for which you will not seek reimbursement from any other source. Failure to abide by this certification will result in termination of card-use privileges.

- *Reimbursement under the card is limited to certain merchants*. Use of the card for eligible medical expenses is limited to merchants identified by the plan sponsor or its designee as an eligible merchant. The card will be administered in accordance with applicable IRS guidance.

- *You swipe the card at the merchant like you do any other credit or debit card*. When you incur an eligible medical expense, such as a co-payment or prescription drug expense, at an eligible merchant, you swipe the card at the merchant much like you would a typical credit card or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available under the HCSA. Every time you swipe the card, you certify to the plan that the expense for which payment under the HCSA is being made is an eligible medical expense for which you have not been reimbursed from any other source and for which you will not seek reimbursement from another source.

- Each time you use the card, a Merchant Category Code (MCC) tells the credit card company about the purchases made. Not all doctors or pharmacies use MCC codes, and, in those instances, you may be required to provide substantiation for any claims you may want to make for reimbursement of eligible medical expenses.

- *You must pay back any improperly paid claims.* If you are unable to provide adequate or timely substantiation as requested by the Claims Administrator, you must repay the Plan for the unsubstantiated expense. If you do not repay the Plan within the applicable period, the card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible medical expenses. If no claims are submitted prior to the date when you terminate coverage in the Plan, or is claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement), or the remaining unpaid amount may be treated as any other bad debt, which will result in additional gross income for you.

For each individual reimbursement, you can use either the Health Care Spending Account Debit Card or the traditional reimbursement request approach, but not both. If you elect not to use the Health Care Spending Account Debit Card, you may also submit claims under the reimbursement request approach. Claims for which the Debit Card has been used cannot be submitted as *requests for reimbursement.*

Unused Balances
If you have any money left in your account at the end of the year, and you have not submitted claims for that money by the deadline, you will forfeit the unused balance. The money cannot be cashed out by you, carried forward to the following year or converted to any other benefit.

All forfeitures from your contributions will be used to offset any losses American Greetings has incurred for benefit payments under the Health Care Spending Account Plan and/or to reduce costs of administering the Plan. After this, your forfeitures may be used in any manner authorized by relevant law.

DEPENDENT CARE SPENDING ACCOUNT

You can deposit between $240 and $5,000 of your compensation into your Dependent Care Spending Account each year. See the special rule below that determines whether benefits are tax-free to you. You can use the money in your account to reimburse yourself for dependent care costs that you incur so that you and your spouse (if any) can work. If you are married but your spouse does not work, your spouse may be considered working during any month that your spouse is a full-time student or is incapable of caring for himself or herself.

Special Rule
Generally, amounts reimbursed from your Dependent Care Spending Account are tax-free to you. However, federal law states that the amount excluded from your gross income cannot exceed, in any calendar year (under all dependent care plans in which you or your spouse may participate), the lesser of:

1. $5,000 ($2,500 if you are married and filing separate federal income tax returns);
2. Your annual income; or
3. Your spouse's annual income.

If your spouse is (1) a full-time student for at least five (5) months during the year or (2) physically and/or mentally disabled, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that your spouse is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent), or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or twelve (12) times the assumed monthly income amounts of either $250 or $500.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) separated for more than six (6) months and pay for more than one-half of your household expenses.

By making an election under the Dependent Care Spending Account, you are representing to the company that your contributions to the Plan are not expected to exceed these limits.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement (there are some exceptions for churches or other tax-exempt providers). The identification number of a care provider who is an individual and not a care center is that individual's Social Security number. You should make your care provider aware of this reporting requirement.

Dependent Eligibility for Dependent Care Reimbursement
The following individuals are "qualifying individuals" for whom eligible expenses may be submitted for reimbursement:

1. Your qualifying child who is your dependent and under age 13 when the care was provided, who lives in your household for more than one-half of the year, and who does not provide more than one-half of his or her own support for the year;
2. Your spouse who is physically or mentally incapable of caring for himself or herself and who lives in your household for more than one-half of the year; or
3. A relative or household member who is physically or mentally incapable of caring for himself or herself, who is principally dependent on you for support, and who resides in your household for more than one-half of the year.

Eligible Dependent Care Expenses
You can use your Dependent Care Spending Account to pay for dependent care expenses directly related to the "well-being and protection" of a qualifying individual if those expenses are necessary for you to work. If you are married, your spouse must also be employed (or seeking employment), enrolled as a full-time student, or disabled for your expenses to qualify. Expenses incurred while you are not working (e.g., sick day, vacation) do not qualify for reimbursement; provided, however, that care provided during certain "short" or "temporary" absences for illness or vacation may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly basis. Eligible dependent care expenses may include expenses for:

- care at dependent care centers (if a center provides care for more than six (6) individuals, the center must meet all applicable state and local requirements);

- day camps (including a camp that specializes in a particular activity (such as soccer or computer camp), but not overnight camps);

- services from individuals (other than your or your spouse's dependent or your or your spouse's child who is less than age 19) who provide care inside or outside your home;

- care for a disabled dependent provided outside your home as long as the dependent is a child under age 13 or is in your home for at least eight (8) hours a day;

- agency fees, application fees or deposits, if you are required to pay these expenses in order to obtain the related care; and

- services of a housekeeper, maid, cook or similar employee, for that portion of the time that is related to the care of a qualified individual.

The caregiver may be a relative if the caregiver is at least 19 years old and is not someone you can claim as a dependent on your federal tax return. Expenses or fees related to education for kindergarten and higher grades cannot be reimbursed. Other expenses not listed above that are authorized by the Internal Revenue Code may be reimbursed.

For guidelines on Dependent Care expenses that are eligible for reimbursement, you can refer to IRS Publication #503, "Child and Dependent Care Expenses." It is available:
- Online at http://www.irs.gov/pub/irs-pdf/p503.pdf
- From your local library
- By calling 1-800/TAX-FORM (1-800-829-3676)

In addition, you should know that if you use a dependent care provider inside your home, you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees."

Dependent Care Spending Account Debit Card
After you enroll into the dependent care FSA, you will receive a Dependent Care Spending Account Debit Card that can be used to pay for qualified expenses without the need to file a paper-based claim. Your card will be mailed to your home address.

The Dependent Care Spending Account Debit Card allows you to pay for eligible expenses at the time that you incur the expense. Guidelines on using the debit card:

- *You must make an election to use the card*. In order to be eligible for the debit card, you must agree to abide by the terms and conditions of the debit card program, including any fees applicable to participate in the program, limitations to card usage, the plan's right to withhold and offset for ineligible claims, etc.

- *The card will be turned off when coverage terminates*. The card will be turned off when you terminate coverage under the plan.

- *Credit to Your Debit Card.* Each pay period, an additional amount is made available under the Dependent Care Spending Account Debit Card. At any given time, the amount available under the card is equal to your year-to-date dependent care FSA contributions, less claims previously paid.

- *Initial Substantiation.* You must make an initial payment to the dependent care provider via cash or check and give the Claims Administrator a statement from the provider to substantiate the dates and amounts for the services to allow the payment to be substantiated. Once services have been provided, you can use the Dependent Care Spending Account Debit Card to pay the previously substantiated expense.

- *Subsequent Transactions*. Later card transactions that match a previously substantiated transaction as to the provider and period may be treated as substantiated without further review, so long as the amount is equal to or less than the previously substantiated amount. By contrast, if a transaction exceeds the previously substantiated amount or is with a different provider, then the Participant must submit a statement from the provider to substantiate the expense before amounts relating to the increased amount or new provider can be added to the card.

For each individual reimbursement, you can use either the debit card or the traditional reimbursement request approach but not both. If you elect not to use the debit card, you may also submit claims under the reimbursement request approach. Claims for which the debit card has been used cannot be submitted as *requests for reimbursement.*

Tax Credit Versus Dependent Care Spending Account

The federal government allows you to take a tax credit on your federal income tax return for qualified dependent care expenses. The difference between the Dependent Care Spending Account and the tax credit is that your contributions to the Dependent Care Spending Account provide a reduction of your taxable income, while the tax credit offers a direct reduction of the amount of tax you pay. Note that your contribution to a Dependent Care Spending Account lowers, dollar for dollar, the amount you may apply toward the tax credit.

Your individual financial circumstances will determine which method is best for you. You might wish to consult with a tax consultant or financial advisor before making a decision.

Submitting a Claim

When you incur an Eligible Day Care Expense, you file a claim with the Plan's Claims Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Claims Administrator by accessing the Reference Center. You must include with your Request for

Reimbursement Form a written statement from the service provider associated with each expense that indicates the following:

- the nature of the expense;
- the date or dates the services were provided; and
- the amount of the expense.

The Claims Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible Day Care Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an Eligible Day Care Expense, you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Day Care Expenses prior to the end of the Claim Filing Period.

Reimbursements for dependent day care expenses are allowed up to the amount contributed and available in your Dependent Care Spending Account at the time you submit your request. If your claim exceeds the amount currently available in your Dependent Care Spending Account, you receive additional reimbursements as more money is deposited into your account through payroll deductions.

Unused Balances
If you have any money left in your account at the end of the year, and you have not submitted claims for that money by the deadline, you will forfeit the unused balance. The money cannot be cashed out by you, carried forward to the following year or converted to any other benefit.

All forfeitures from your contributions will be used to reduce costs of administering the Plan or may be used in any manner authorized by relevant law.

WHEN COVERAGE ENDS

If your employment status changes, participation in each of the reimbursement accounts may be affected. The effects of certain changes are described below.

CONTINUATION OF COVERAGE PROVISIONS

Health Care Spending Account
Your participation in the Health Care Spending Account would be affected as follows, based on the type of employment change involved.

Leave of Absence-Family Medical Leave Act (FMLA)

If the company grants you an approved leave of absence in accordance with FMLA, you can continue your FSA account during the leave, up until the end of the plan year, provided that you make any required contributions.

- If you are on approved FMLA leave receiving pay (i.e., short-term disability, vacation),
  - your contributions for your FSA account will continue as usual through the normal payroll cycle, provided that pay is enough to cover the deductions. If pay is not enough, you will be billed.
- If you are on approved FMLA leave not receiving pay,
  - you will be billed for your contributions (either on a monthly or weekly basis, depending on your location); and
  - you can choose to stop your contributions (if any) to a Health Care Spending Account.

If your employment is terminated, you may be offered COBRA continuation coverage. See the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* section for more details.

When you return to work, contributions (if any) to a Health Care Spending Account will be reinstated, provided that you return within the same calendar year. If you stopped contributions to a Health Care Spending Account, you will have the option to either prorate your election for the remainder of the calendar year or elect the full amount of participation in effect before the leave and make up the missed contributions.

Leave of Absence-Personal, Military and Medical Non-FMLA

Your FSA account may be continued through the end of the plan year, contingent upon payment of any required contributions when you are on an authorized leave of absence from your company.

- If you are on approved personal, military or medical non-FMLA leave and receiving pay (i.e., short-term disability, vacation), your contributions will continue as usual through the normal payroll cycle, provided that pay is enough to cover the deductions. If pay is not enough, you will be billed.

- If you are on approved personal, military or medical non-FMLA leave not receiving pay, you will be billed for your contributions (either on a monthly or weekly basis, depending on your location).

In no event will enrollment continue beyond the end of the plan year of your leave. If maximum leave time has elapsed, employment will be terminated, and you may be offered COBRA continuation coverage if it is before the end of the plan year.

When you return to work, contributions (if any) to a Health Care Spending Account will be reinstated, provided that you return within the same calendar year. If you stopped

contributions to a Health Care Spending Account, you will have the option to either prorate your election for the remainder of the calendar year or elect the full amount of participation in effect before the leave and make up the missed contributions.

- **Death.** In the event of your death, deposits stop. However, your surviving dependents may submit for reimbursement of eligible expenses incurred prior to your death. Your dependents may be offered COBRA continuation coverage.

- **Change to ineligible employment status.** Deposits stop. However, you can continue to request reimbursement of eligible expenses incurred through the date of the employment status change. You may be offered COBRA continuation coverage if your status change is before the end of the plan year.

- **Severance, Separation of Employment and Termination.** If you are contributing to a Health Care or Dependent Care Flexible Spending Account, your pre-tax contributions will end as of your separation date. **If on a severance program, COBRA runs concurrently with your severance benefit period.** You may continue contributions plus a two percent (2%) administration fee to your account on an after-tax basis if you elect to continue participation in the Health Care Spending Account through COBRA generally to the end of the plan year.

Dependent Care Spending Account
A change in employment status would affect your participation in the Dependent Care Spending Account generally the same way as listed above for the Health Care Spending Account, with the following two exceptions:

1. COBRA: Dependent Care Spending Accounts are not considered health plans; therefore, federal COBRA regulations do not apply. Coverage or service dates may not be extended beyond your date of termination or date of death.

2. Leave of Absence: If you take any unpaid leave of absence, deposits will stop.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

In order to comply with federal regulations, this Plan includes a continuation-of-coverage option for certain individuals whose Health Care Spending Account coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

This *COBRA Continuation-of-Coverage* provision for the Health Care Spending Account is not applicable beyond the end of the plan year in which the qualifying event occurs.

Businessolver administers COBRA on behalf of the *Plan Sponsor.*

COBRA Qualifying Events
Qualifying events are any one of the following events that would cause a covered person to lose HCSA coverage, even if such loss of coverage 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 or legal separation from the associate.

4. A dependent child no longer meets the eligibility requirements of the Plan.

5. The last day of leave under the FMLA, or an earlier date on which the associate informs the plan sponsor that the associate will not be returning to work.

NOTE: Notwithstanding the preceding provisions, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the plan year equals or exceeds the amount of reimbursement you have available for the remainder of the plan year. You will be notified of your particular right to elect COBRA continuation coverage.

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 the 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 his or her 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 or her 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 HR Services 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 the associate 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 thirty (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 thirty (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 himself or herself 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 period required, coverage is reinstated 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 Acquired 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 later 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 his or her 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 that 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 their 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:

1. The date of the disability determination by the Social Security Administration;
2. The date of the 18-Month Qualifying Event; or
3. 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 she 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.

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. 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 such group health plan does not have any exclusion or limitation that affects coverage of the covered person's pre-existing condition. 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 (1) 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.

CLAIMS AND APPEALS PROCEDURES

The following information is provided regarding claims and review procedures for benefit plans that are covered by ERISA. It is based upon regulations issued by the U.S. Department of Labor. Only the Health Care Spending Account under this Plan is a benefit that is covered by ERISA.

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'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; 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 Claims 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 Claims Administrator's action. If written request for review is not made within such one hundred eighty (180) day period, the covered person will forfeit his or her 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 Claims 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 Claims 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 Claims 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 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 a written request to the Claims Administrator within four (4) months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth (5th) month following the receipt of the notice of final internal denial of benefits. Note: If the date of receipt of the notice is February 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1 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 Eligibility for Coverage and Effective Date of Coverage sections;

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 Claims 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

b. Within the forty-eight (48) hour 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 Claims 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 the Claims Administrator, except to the extent that other remedies may be available under state or federal law.

Expedited External Review
The Claims 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 time frame 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 time frame 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 each of the following:

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

2. Send notice of the Plan's decision, as described in the Notice of Right to External Appeal section.

Upon determination that a request is eligible for external review, the Plan will do each of the following:

1. Assign an IRO, as described in the Independent Review Organization section; 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, by facsimile, electronically or by 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 Notice of External Review Determination subsection. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Claims 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 ERISA. The covered person may not initiate a legal action against the plan until the covered person has completed both the initial and second-level appeal processes.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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 Administrator 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 PHI or electronic health records. 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 PHI 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 a participant's PHI (including electronic PHI) 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 PHI to the company only upon receipt of a certification by the company that the Plan documents have been amended to incorporate all of the required provisions as described below.

The company agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agent, including a subcontractor to whom it gives PHI received from the Plan, agrees to the same restrictions and conditions that apply to the 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 PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that any agent, including a subcontractor to whom it gives electronic PHI, 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 PHI;
- Make available PHI for amendment and incorporate any amendments to PHI 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 PHI received from the Plan available to the Secretary of HHS for purposes of determining compliance by the Plan with the privacy rule; and
- If feasible, return or destroy all PHI received from the Plan that the company still maintains in any form. The company will retain no copies of PHI 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 PHI 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 PHI. 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.

SUMMARY PLAN DESCRIPTION

The Plan is provided through American Greetings and administered by the Benefits Advisory Committee. Claims are administered by MyChoice Accounts (the "Claims Administrator").

Name of Plan:
The American Greetings Section 125 Cafeteria Plan and American Greetings Flexible Spending Account Plan are part of the American Greetings Corporation Consolidated Welfare Benefits Plan. The Flexible Spending Account Plan contains two component accounts: Health Care Spending Accounts and Dependent Care Spending Accounts.

Name, Address and Phone Number of Employer/Plan Sponsor:
American Greetings Corporation
One American Boulevard
Cleveland, Ohio 44145
216-252-7300 ext. 4192

Employer Identification Number:
The company's identification number (EIN) assigned by the IRS to American Greetings Corporation is #34-0065325

Plan Number:
555

Type of Plan:
The Health Care Spending Account is a type of welfare plan under ERISA that reimburses eligible medical expenses that are not reimbursed from other sources. The Dependent Care Spending Account is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Section 125 Cafeteria Plan is authorized by Section 125 of the Internal Revenue Code and allows payment for certain benefits on a pre-tax basis.

Type of Administration:
Contract administration: The processing of claims for benefits under the terms of the Plan is provided through a company contracted by the company and shall hereinafter be referred to as the Claims Administrator.

Name, Address and Phone Number of Plan Administrator:

Benefits Advisory Committee
American Greetings Corporation
One American Boulevard
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 & Chief Human Resources Officer
American Greetings Corporation
One American Boulevard
Cleveland, Ohio 44145

Union Plans:
This Plan is established in accordance with a collective bargaining agreement for the unions. Associates who are subject to the collective bargaining unit have a right to obtain a copy of the collective bargaining agreement by contacting their union.

Eligibility Requirements:
For detailed information regarding a person's eligibility to participate in the Plan**,** refer to the Eligibility, Enrollment and Effective Date section of this document.

For detailed information regarding a person being ineligible for benefits through termination of coverage, refer to the When Coverage Ends section of this document.

Source of Plan Contributions:
Employees contribute to the plan through pre-tax dollars that are elected by the employee and authorized by the Section 125 Cafeteria Plan. Employees select the amount of their contributions, up to authorized limits. A minimum contribution may be required.

Funding Method:
Benefits are paid from the company's general assets. There is no independent source of funds or any insurance contract that guarantees the payment of benefits. For administrative convenience, the Claims Administrator processes all claims for reimbursements on behalf of the company.

Effective Date:
The ***effective date*** of this Summary Plan Description is January 1, 2024.

Ending Date of Plan Year:
The plan year is March 1 to the last day in February. The benefit/elections year is from January 1 through December 31.

Procedures for Filing Claims:
For detailed information regarding filing a claim, refer to the Claims and Appeals portion of this document.

Name, Address and Phone Number of Claims Administrator:
MyChoice Accounts
MSC 345475
PO Box 105168
Atlanta, GA 30348-5168

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 benefit to a Participant's non-custodial child.

To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

GENERAL PROVISIONS

Administration of the Plan
The Plan Administrator is the Benefits Advisory Committee. The Plan Administrator shall have full discretion and authority over 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 Administrator shall have the right to delegate certain of its powers and duties to a third party. For example, American Greetings retained Businessolver to provide the AGBenefits Service Center for employee servicing and enrollment and to appoint a Claims Administrator to receive, review and process claims for benefits.

Businessolver is the Claims Administrator for these Plan benefits. The Plan Administrator has delegated to the Claims Administrator its entire discretionary authority to determine eligibility for benefits and the amounts of benefits due, to construe the terms of the contract, and to generally do all other things needed to administer the contract. The Plan Administrator retains all of its other authority.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

Applicable Law
The Health Care Spending Account is a type of welfare plan under ERISA that reimburses eligible medical expenses that are not reimbursed from other sources. The Dependent Care Spending Account is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Section 125 Cafeteria Plan is authorized by Section 125 of the Internal Revenue Code and allows payment for certain benefits on a pre-tax basis.

Assignment
Benefits payable under this Plan may not be assigned, transferred or in any way made over to another party by a participant or beneficiary for any reason. The Plan will not recognize any assignment of any rights under this Plan or ERISA, and any attempt to assign such rights shall be void. The payment of benefits directly to a health care or other provider, if any, shall be done as a convenience to you and shall not make the provider an assignee. In no event shall any provider of benefits be a "participant" or "beneficiary" under the Plan, and no provider shall have standing under ERISA or the claims procedures of this Plan. Neither the Employer nor the Plan shall be in any manner liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Clerical Error
No clerical error on the part of the company or Claims Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any associate or any dependent(s) hereunder or create or continue coverage that 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. No party shall be liable for the failure of any other party to perform.

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

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 him, and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for the covered person's estate, the Plan Administrator may on behalf of the Plan, at the Plan Administrator's 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 sponsor 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 company 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
No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three (3) years from the date the expense was incurred.

Limits on Liability
Liability hereunder is limited to the services and benefits specified.

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.

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.

Nondiscrimination
Contributions and benefits under the Plan will not discriminate in favor of "Highly Compensated Employees" or "Key Employees." The Plan Administrator may limit or deny compensation reduction agreement to the extent necessary to avoid such discrimination in compliance with federal law.

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 the employer to terminate the employment of any associate at any time.

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

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the plan sponsor, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered persons shall be timely made by the employer. The plan sponsor also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No modification, amendment, termination, or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of modification, amendment, termination or partial termination.

Recovery for Overpayment
Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Plan's or the Plan's designee's own error, from the person or entity to whom it was made or from any other appropriate party.

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.

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 per 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.