AG Benefits

American Greetings Corporation

Short Term Disability Policy

Effective Date of Policy: December 1, 2025
Revised: December 1, 2025

Where to Get Information

Short Term Disability (STD):	
For assistance with STD Program, to file a claim or check on claim status:	To File a Claim – Phone: (833) 357-5153 or through the MyBenefits website at: abilityadvantage.thehartford.com/mybenefits To Check on Claim Status – abilityadvantage.thehartford.com /mybenefits

Associates **needing additional assistance with STD, please contact:**
The Hartford
Phone: (833) 357-5153
www.AGBenefits.com

Associates **needing additional assistance after contacting may contact the program administrator:**
American Greetings Corporation
Attn: Benefits Dept.
One American Blvd
Cleveland, Ohio 44145

Phone: 216-252-7300, ext. 4192 option 4
WHQ.LOA@amgreetings.com

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ELIGIBILITY, HIGHLIGHTS & EFFECTIVE DATE

This section identifies the ***program's*** requirements for a person to participate in coverage for:

Short Term Disability

ELIGIBILITY

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

The following chart summarizes coverage available to different classes of eligible ***associates.***

Associate **Class**	**Short Term Disability**
Non-Union Full-Time and Part-Time Exempt **(Full-Time = 36+ hours)** **(Part-Time = 20 but less than 36 hours)**	***Company*** Paid
Non-Union Full-Time and Part-Time Non-Exempt **(Full-Time = 36+ hours)** **(Part-Time = 20 but less than 36 hours)**	***Company*** Paid
Full-Time and Part-Time Cleveland Union **(Refer to applicable Collective Bargaining Agreement)**	***Company*** Paid
Full-Time Greeneville Non-Exempt Union **(Refer to applicable Collective Bargaining Agreement)**	***Company*** Paid

The following ***associates*** are not eligible for ***company*** sponsored Short Term Disability benefits:

1. ***Associates*** in Merchandiser classifications
2. Temporary, seasonal or on-call ***associates***
3. Group class 99
4. Revision Lead & Full-Time Merchandisers

SHORT-TERM DISABILITY (STD)

Short term disability coverage provides an income stream and therefore a measure of financial security for the ***associate*** and family if the ***associate*** is found to be unable to work because of a non-work related illness or injury. All claims must be reviewed and approved by the Company's disability ***claims administrator*** to receive payment under this policy.

- **Exempt STD Coverage Benefits (no cost to *associate*):**

  Short term disability replaces 100% or 75% of the ***associate's*** base pay for up to a maximum of 26 weeks total, depending on the length of the ***associate's*** disability.

  100% of base pay for the first 13 weeks of approved disability leave.

  If the disability extends beyond 13 weeks, the STD benefit continues at 75% of base pay for the remaining 13 weeks of approved disability leave.

- **Non-Exempt and Cleveland Union STD Coverage Benefits (no cost to *associate*):**

  Short term disability replaces 66 2/3% of the ***associate's*** base pay for up to a maximum of 26 weeks total. However, the actual length of the ***associate's*** STD benefit depends on the length of the ***associate's*** disability.

- **Greeneville Union STD Coverage Benefits (no cost to *associate*):**

  Short term disability replaces 66 2/3% of the ***associate's*** base pay for up to a maximum of 26 weeks total. However, the actual length of the ***associate's*** STD benefit depends on the length of the ***associate's*** disability.

EFFECTIVE DATE

Coverage will become effective as noted below provided that the ***associate*** is ***actively at work*** on the date that coverage (or a change in coverage) would otherwise become effective. Refer to *Eligibility/Actively at Work* for additional details.

Short Term Disability Coverage

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

The ***associate*** may not be covered for these benefits under more than one policy owned and paid for by the policy holder.

*REINSTATEMENT**

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

1. Reinstatement of coverage is available to ***associates*** who were previously covered under the ***program***.

2. Rehire or return to active service must occur within one (1) year of the last day worked.

3. Coverage shall be effective on the date of rehire or return to work. Prior benefits and limitations, such as the eligibility elimination period, shall be applied with no break in coverage.

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

***Union Associates (Refer to applicable Collective Bargaining Agreement)**

ACTIVELY AT WORK

Coverage will become effective when the ***associate*** becomes eligible, provided the ***associate*** is ***actively at work*** on that date (If an ***associate*** is not ***actively at work*** on the date the insurance (or a change in coverage) would otherwise take effect, the benefit will take effect on the day the ***associate*** resumes ***active work).***

SCHEDULE OF BENEFITS

SHORT TERM DISABILITY PROGRAM BENEFITS *Full-Time Exempt and Part-Time Exempt* ***Associates***	
Elimination Period: Accident or Illness:	Benefits begin on the 6th calendar day of disability
Maximum Benefit:	100% of base ***earnings*** for 13 weeks 75% of base ***earnings*** for 13 weeks

SHORT TERM DISABILITY PROGRAM BENEFITS *Full-Time Non-Exempt, Part-Time Non-Exempt and Cleveland Union* ***Associates***	
Elimination Period: Accident: Illness:	Benefits begin on the 4th calendar day of disability Benefits begin on the 8th calendar day of disability
Maximum Benefit:	66 2/3% of base weekly ***earnings*** for 26 weeks

Greeneville Union: *Refer to applicable Collective Bargaining Agreement for schedule of Short Term Disability benefits.*

Notes:

- The Short term Disability elimination period does not count against the maximum payment period. The maximums are calculated from the date benefit payments become effective, not the date of disability.
- Disability benefits will follow the ***associate's*** normal pay cycle (e.g. semi-monthly, weekly).
- Disabled ***associate's*** must be otherwise scheduled to work to qualify for disability benefits. An ***associate*** on layoff qualifies for disability when they would otherwise have been recalled. An ***associate*** receiving disability benefits becomes ineligible for those benefits when they would otherwise have been laid off.
- If an ***associate*** receiving disability benefits does not qualify for unemployment compensation solely because of that disability, they shall continue to be eligible for the disability benefit amount provided under this ***program***, but no more than the lesser of $275 per week or the applicable maximum benefit, as long as they continue to be disabled.

WHEN BENEFITS BEGIN AND END

The short term disability benefit shall apply to covered ***associates*** only. If an ***associate*** becomes ***disabled***, the ***program*** will pay short term disability benefits at the rate of the maximum benefit according to the *Schedule of Benefits*.

1. Benefits will begin after the elimination period as shown on the *Schedule of Benefits*. The elimination period shall begin on the date a ***physician*** certifies the disability of the ***associate***.

   Short term disability benefits are not payable during the elimination period. However, associates have the option to use available earned paid time off during the elimination period.

2. Benefits end when the earliest of any reason listed below occurs:

   a. The number of weeks shown as the maximum payment period on the *Schedule of Benefits* for any one (1) continuous period of disability.
   b. The date the ***associate*** returns to active employment.
   c. The date the ***associate*** ceases to be under the care of a ***physician***.
   d. The date the ***associate*** ceases to be ***disabled***.
   e. The date the ***associate*** engages in any kind of work for wage or profit.
   f. The date the ***associate*** dies.
   g. The date as of which the ***associate*** fails to undergo a medical examination or provide proof of disability as requested by the ***claims administrator.***

3. In the event of termination of employment during a period of disability, STD Benefits shall be continued as specified in item 2 above.

4. ***Earnings*** are computed as noted on the *Schedule of Benefits*.

PERIODS OF DISABILITY

Disability due to the same cause or causes is considered one (1) period of disability unless the ***associate*** returns to active service for at least thirty (30) days.

If the ***associate*** becomes ***disabled*** due to a cause(s) unrelated to the prior disability**,** the ***associate*** is eligible for separate maximum periods of disability if they return to active status for one (1) full day. The ***associate*** must complete a separate elimination period for each separate period of disability.

EXCLUSIONS

No benefit will be provided for the following periods of disability:

1. A period of disability for which the ***associate*** is not under the regular and continuous care and treatment of a ***physician,*** unless the ***claims administrator*** determines that such regular and continuous care and treatment are not medically indicated given the nature of the disability
2. A period of disability that arises out of, relates to, is caused by or results from an ***illness*** or ***injury*** to which a contributing cause was the ***associate's*** commission or attempted commission of a felony, or the ***associate's*** engagement in an illegal occupation;
3. A period of disability for which the ***associate*** is incarcerated in any federal, state or municipal penal institution, jail, medical facility, hospital or any other place because of a criminal conviction under a federal, state or municipal law or ordinance;
4. A period of disability caused or contributed to by elective treatment or procedures that are not medically necessary, such as:
   - Cosmetic surgery or treatment primarily to change appearance;
   - Reversal of sterilization;
   - Liposuction;
   - Vision correction surgery
5. A period of disability during which the ***associate*** engages in any kind of work for wage or profit without the approval of the ***claims administrator.***
6. A period of disability that arises out of, relates to, is caused by a workplace injury or illness covered under Workers' Compensation.

OFFSET OF DISABILITY INCOME FROM OTHER SOURCES

The disability benefit will be reduced by any of the following which are available to the ***associate*** or to the ***associate's*** spouse and child(ren) if applicable, for the same period for which the disability benefit is payable hereunder:

1. Primary and dependent disability benefits under the Federal Social Security Act, or any similar plan or act; provided, however that any cost-of-living increases in such benefits, effective after the initial reduction in the short term disability benefit, will not serve to further reduce the benefit.
2. Benefits under any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any compulsory benefit act or law of any government.
3. Benefits under a state-mandated disability plan or a ***company*** plan established in lieu thereof. Short term disability for state disability maximum will be offset until award is provided. If offset is greater than benefit awarded you will be reimbursed.
4. Disability or retirement benefits under any other ***company*** sponsored or ***company*** funded plan.

If an ***associate*** is or might be entitled to any of the above itemized benefits, the full short term disability benefit will be paid upon receipt by the ***claims administrator*** of:

1. Evidence that the ***associate*** has applied for such benefits and
2. An executed agreement to reimburse the ***program***, up to the amount of payments made, immediately upon receipt of such benefits.

If an ***associate*** fails to apply for any of the above itemized benefits, to which the ***associate*** might be entitled, the benefit will be reduced by the estimated amount of the benefit which the **associate** would have received had application been made. The ***claims administrator*** will make determination of the amount of such benefit.

WORKERS' COMPENSATION

As noted under Exclusions above, STD benefits are not payable for periods of disability that are related to a workplace injury or illness covered under Workers' Compensation. However, if a Workers' Compensation claim is denied, the ***associate*** may apply for STD benefits. In such a case:

- The ***associate*** must submit an STD claim to the Company's disability ***claims administrator***.
- Supporting medical documentation will be required.
- Approval is **not automatic** and will depend on whether the disability meets the STD plan's medical and administrative requirements. Evidence of Workers' Compensation denial must be provided to the disability ***claims administrator***.

Each STD claim will be reviewed independently, and benefits will be determined according to the terms of the STD policy.

TAXES ON BENEFITS

Disability benefits are subject to social security (FICA), federal income taxes, and state taxes (where mandated by state law) which are automatically withheld from the ***associate's*** benefit payments. Income taxes are withheld in accordance with the ***associate's*** W-4 elections.

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event that an ***associate*** is injured through the acts or omissions of another person or organization, benefits will be provided only on condition that the ***associate*** agree in writing to the following:

1. To reimburse the short term disability ***program***, for the full amount of payments made under the terms of the ***program***, immediately upon receipt of the proceeds of any settlement of, or judgment in, an action at law, arbitration, claim , or other proceeding to determine the ***associate's*** rights of recovery arising out of his or her ***injury***, net of the ***associate's*** reasonable expenses in collecting such amount including reasonable attorney's fees, and net of any amounts which are allocated by terms of any judgment for the payment of unreimbursed medical expenses. The ***associate*** will execute and deliver instruments and papers and do whatever else is reasonably necessary to secure the rights of the short term disability ***program*** to reimbursement out of such proceeds, and do nothing to prejudice such rights.

2. To provide the short term disability ***program*** with a lien on the proceeds described in the preceding paragraph, to the extent of the full amount of payments made under the terms of the short term disability ***program***.

3. To provide the short term disability ***program*** with a credit against payments to be made in the future under the ***program*** equal to the proceeds described above, less any amount paid to the short term disability ***program*** by way of reimbursement.

WHEN COVERAGE ENDS

Coverage will terminate on the earliest of the following dates:

TERMINATION OF ASSOCIATE COVERAGE

1. The date the ***program*** sponsor terminates the ***program***.

2. The date on which the ***associate*** ceases to meet the eligibility requirements of the ***program***.

3. The date on which employment terminates.

4. The date on which coverage is exhausted.

Termination of coverage may not discontinue the Disability Benefit payments for disability events prior to coverage termination. Refer to the sections entitled, *Short Term Disability Program Benefit*.

CLAIM FILING PROCEDURE

FILING A DISABILITY CLAIM

Timely reporting of the ***associate's*** disability is critical to the continuation of the ***associate's*** pay. If the ***associate*** expects to be out of work for more than three (3) days (either consecutively or intermittently):

1. The ***associate*** must notify their supervisor and/or local Human Resource Department as soon as possible. Private health issues do not need to be discussed when providing this information.

2. The ***associate*** must report the absence to the ***claims administrator*** (The Hartford) at 833-357-5153 to initiate the disability claim. The claim for short term disability benefits must be reported within fifteen (15) days from the first day of disability related absence. Failing to file within this timeframe may result in STD benefits not being approved. The ***associate*** should not call the ***claims administrator*** more than thirty (30) days before their disability begins.

3. The ***associate*** will need to provide basic information about the nature of the leave. The ***associate*** should be prepared to provide the following information:

    a. Personal information – name, address, telephone number and social security number.
    b. Job information – job title, job description, workplace location and address, work schedule, supervisor's name and telephone number, date of hire and last day worked.
    c. Illness/Injury information – nature of the illness, how, when and where the injury occurred and when disability commenced.
    d. ***Physician*** information – name, address, telephone number and fax number for each treating ***physician***.

4. Recertification of disability or medical conditions may be requested as needed and only in connection with an absence by the ***associate***, unless:

    a. Circumstances described by the previous certification have changed significantly (e.g., the duration or frequency of absences, the severity of the condition, complications); or
    b. The ***company*** or ***claims administrator*** receives information that casts doubt upon the ***associate's*** stated reason for the absence.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***claims administrator*** with a written authorization for an (authorized representative) to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the (authorized representative) with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the ***claims administrator***.

TIME FRAME FOR BENEFIT DETERMINATION

After a claim has been reported to the ***claims administrator*****,** and no additional information is required, the ***claims administrator*** will generally complete its determination of the claim within forty-five (45) calendar days of receipt of the completed claim form unless an extension is necessary due to circumstances beyond the ***claims administrator's*** control.

After a completed claim form has been submitted to the ***claims administrator*****,** and if additional information is needed for determination of the claim, the ***claims administrator*** will provide the ***associate*** (or authorized representative) with a notice detailing the information needed, this notice will be provided within forty-five (45) calendar days of receipt of the completed claim form and will state the date as of which the ***claims administrator*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***claims administrator*** will complete its determination of the claim within thirty (30) calendar

days of receipt by the ***claims administrator*** of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the ***claims administrator*** shall provide the ***covered person*** (or authorized representative) with a written notice of a benefit denial within forty-five (45) calendar days of receipt of a completed claim form, or if the ***claims administrator*** had requested additional information from the ***covered person*** (or authorized representative), within thirty (30) calendar days of receipt of such information. The notice will contain the following:

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the short term disability ***program*** provisions on which the denial is based.
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary.
4. A description of the short term disability ***program's*** review procedure and applicable time limits.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If denial was based on medical necessity, experimental treatment or similar exclusion or limit, the ***claims administrator*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the short term disability ***program*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED CLAIM

A ***covered person*****,** or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims administrator*** within one hundred and eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.
2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
   Relevant information is defined as any document, record or other information:
   a. Relied on in making the benefit determination, or
   b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, or
   c. That demonstrates compliance with the duties to make benefit decisions in accordance with short term disability ***program*** documents and to make consistent decisions, or
   d. That constitutes a statement of policy or guidance for the short term disability ***program*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.
3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
4. The review by the ***claims administrator*** will not afford deference to the original denial.
5. The ***claims administrator*** will not be:
   a. The individual who originally denied the claim, nor

b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment,
   a. The ***claims administrator*** will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
   b. The professional provider utilized by the ***claims administrator*** will be neither:
      1. An individual who was considered in connection with the original denial of the claim, nor
      2. A subordinate of any other professional provider who was considered in connection with the original denial.
7. If requested, the ***claims administrator*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***claims administrator*** shall provide the ***associate*** (or authorized representative) with a written notice of the appeal decision within forty-five (45) calendar days of receipt of a written request for the appeal. If special circumstances require an extension, the ***claims administrator*** will provide, before the end of such forty-five (45) day period, a written notice explaining the extension and the date by which the ***claims administrator*** expects to render a decision.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific short term disability ***program*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
5. If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the short term disability ***program*** provisions to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
6. In the case of a denied long term disability claim, a statement that if the ***covered person 's*** appeals (See *Second Level Appeal* below) are denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

SECOND LEVEL APPEAL

The ***claims administrator***, upon request by the ***covered person*** (or authorized representative) following a determination on appeal, will conduct a second level appeal. This appeal is comprised of professional providers that were not consulted in connection with the original post-service denial. The ***covered person's*** decision as to whether to submit a previously denied appeal to the appeal process will have no effect on the ***covered person's*** rights to any other benefits under the ***program***. There are no fees or costs imposed as a condition to use of the appeal process. The ***covered person's*** request for a second level appeal must be submitted within sixty (60) calendar days following the receipt of Notice of Appeal Decision.

Upon receipt of the request to conduct a second level appeal, a determination will be made within forty-five (45) business days. Notification of the outcome of the review will be communicated verbally and in writing.

The ***program*** agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the second level appeal process.

Upon written request, more information about the second level appeal process is available, free of charge, from the ***claims administrator.***

DEFINITIONS

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

Actively at Work or Active at Work

The ***associate*** is performing all of the usual and customary duties of the ***associate's*** job. This must be done at:

- The ***company's*** place of business;
- An alternate place approved by the ***company;*** or
- A place to which the ***company's*** business requires the ***associate*** to travel.

An ***associate*** will be deemed to be ***actively at work*** during weekends or ***company*** approved vacations, holidays or business closures if the ***associate*** was ***actively at work*** on the last scheduled workday preceding such time off.

Associate

Refer to *Eligibility* for a complete definition of the term ***associate***.

Claims Administrator

The Hartford is the ***claims administrator*** for the short term disability ***program*** coverage.

Company

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

Covered Person

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

Disabled

Any physical or mental condition arising from an illness, pregnancy or injury which renders an ***associate*** incapable of performing the material duties of his or her regular job or any reasonably related job. An ***associate*** will also be considered to have sustained a disability if:

- the ***associate*** is ordered not to work by written order from a state or local health officer because they are infected with, or suspected of being infected with, a communicable disease; or
- the ***associate*** has been referred or recommended by competent medical authority to participate as a resident in either an alcohol abuse treatment program or drug abuse treatment program, or to participate in an outpatient program for the treatment of drug or alcohol abuse which requires attendance for a minimum of five (5) days per week for a minimum of six (6) hours per day. However, such disability will be considered to continue only for ninety (90) days while the ***associate*** is receiving services in an alcohol abuse treatment program or a drug abuse treatment program.

An ***associate*** will not be considered ***disabled*** if:

- the ***associate*** is performing work of any kind for remuneration or profit unless with the approval of the ***claims administrator***, or

- the ***associate*** declines alternative employment by the ***company*** which is within the ***associate's*** capabilities and, as determined solely by the ***company*** has status and compensation comparable to the ***associate's*** previous job.

Earnings

The gross pay rate used to calculate your disability benefit.

- Exempt ***associates***: Annual base salary (based on the last day of active work before the leave begins) which does not include annual incentive pay, bonuses, overtime pay and any other extra pay sources that may exist within the payroll system.
- Non-Exempt and Cleveland Union ***associates***: Hourly rate of pay (based on the last day of active work before the leave begins) multiplied by the number of hours in the ***associate's*** normal work week (not to exceed 40 hours) and then annualized by 52 weeks. Pay does not include bonuses, overtime pay and any other extra pay sources that may exist within the payroll system.
- Greeneville Union: Refer to applicable Collective Bargaining Agreement.
- For all ***associates***: Contributions the ***associate*** is making through a salary reduction agreement with the company to any of the following will continue during the benefit period:
    - an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
    - the associate's fringe benefits under an IRC Section 125 plan.

Effective Date

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

Facility

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

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of an ***associate***.

Incurred or Incurred Date

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

Injury

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

Layoff ("Company Convenience")

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

Leave of Absence

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

Named Fiduciary for Claim Appeals

The ***named fiduciary for claim*** appeals is the applicable ***claims administrator.***

Occupational Injury or Illness

An ***injury*** or ***illness*** that was caused by or aggravated by any employment for pay or profit or any ***injury*** or ***illness*** which the ***associate*** alleges was caused by any employment for pay or profit.

Physician

A physician, surgeon, dentist, podiatrist, osteopathic or chiropractic practitioner, or psychologist who is duly licensed and acting within the scope of his or her practice. “Psychologist” means a licensed psychologist in the state of practice, with a doctorate degree in psychology and who either:

- has at least two (2) years clinical experience in a recognized health setting, or
- has met the standards of the National Register of the Health Service Providers in Psychology.

For the purpose of disability related to normal pregnancy or childbirth, a midwife, nurse-midwife and a nurse practitioner duly licensed and acting within the scope of his or her practice are physicians.
In all cases, the physician may not be the ***associate***, a relative by blood or marriage, or a domestic partner.

Program

“***Program***” refers to the benefits and provisions for payment of same as described herein.

Proof

Written evidence satisfactory to the ***Claims Administrator*** that a person has satisfied the conditions and requirements for any benefit described in this booklet. When a claim is made for any benefit described in this document, ***proof*** must establish:

- the nature and extent of the loss or condition;
- the ***Claims Administrator’s*** obligation to pay the claim; and
- the claimant’s right to receive payment.

Proof must be provided at the claimant's expense.

Relevant Information

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

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PROGRAM

The program administrator is American Greetings Corporation. The program administrator shall have full charge of the operation and management of the ***program*** and discretion to interpret this Policy. In general, the program administrator is the sole judge of the application and interpretation of the ***program***, consistent with the appropriate collective bargaining agreement provisions, and has the discretionary authority to construe the provisions of the ***program***, 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 program administrator has the authority, in the program administrator's sole discretion, to interpret the ***program*** and resolve ambiguities therein, to develop rules and regulations to carry out the provisions of the ***program***, and to make factual determinations. However, the program administrator shall have the right to hire all persons providing services to the ***program.***

The Hartford is the ***claims administrator*** for the Short Term Disability Program Benefits.

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

APPLICABLE LAW

The Short Term Disability Program is not subject to ERISA. It is subject to Ohio law.

ASSIGNMENT

No ***associate*** may otherwise assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the ***program***, and any attempt to do so will be void.

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

No clerical error on the part of the program sponsor or ***claims administrator*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***associate*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of 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 ***program*** which is in conflict with statutes which are applicable to this ***program*** is hereby amended to conform to the minimum requirements of said statute(s).

INCAPACITY

If, in the opinion of the employer, a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due them and in the absence of written evidence to the ***program*** of the qualification of a guardian or personal representative for their estate, the program sponsor may on behalf of the ***program***, at their 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 ***program's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the program sponsor or by the ***associate*** covered under this ***program*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***program*** or be used in defense to a claim unless they are contained in writing and signed by the program sponsor 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

Time Limit on Legal Procedures Against American Greetings
In particular, under the ***program*** as amended, a claimant generally must commence their claim or lawsuit against American Greetings no later than 24 months after the earliest of (1) the date of the loss for which the claimant is seeking a ***program*** benefit, (2) the date the Claims Administrator first denies the claimant's request for a ***program*** benefit or (3) the earliest date claimant knew or should have known the material facts on which their lawsuit is based. However, if the claimant commences their claim within this 24-month period, the deadline for the claimant to file a lawsuit will not expire until the later of the last day of the 24-month claims period and three months after the final notice of denial of their appealed claim is sent to them by the Claims Administrator unless longer as required by law.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the program 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 or withholds information with intent to deceive the ***claims administrator***, program administrator or the ***company ,*** or otherwise misleads the ***program***, the ***program*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***program***, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** shall render the coverage under this ***program*** null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PROGRAM

The ***claims administrator*** or program administrator, at its own expense, shall have the right to require an examination of a person covered under this ***program*** when and as often as it may reasonably require during the pendency of a claim.

PROGRAM IS NOT A CONTRACT

The ***program*** 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 ***program*** shall be deemed to give any ***associate*** the right to be retained in the service of American Greetings or to interfere with the right of American Greetings to terminate the employment of any ***associate*** at any time.

PROGRAM MODIFICATION

The program administrator may modify the ***program*** (subject to the provision of the collective bargaining agreement where applicable), and such modifications which affect ***covered persons*** will be communicated to the ***covered persons*** as and when required by applicable law. Any such modifications shall be in writing, setting forth the modified provisions of the ***program***, the ***effective date*** of the modifications, and shall be signed by the program sponsor's designee.

Such modification shall be duly incorporated in writing into the master copy of the ***program*** on file with the program sponsor***,*** or a written copy thereof shall be deposited with such master copy of the ***program***.

RECOVERY FOR OVERPAYMENT

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

WORKERS' COMPENSATION NOT AFFECTED

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