BENEFITS GUIDE FOR HALLMARK RETIREES
(Non-Medicare Eligible)

(Last updated January 2020)

HOW TO USE THIS GUIDE

This guide provides a reference to the value Hallmark's various retiree benefit programs offer you, along with details needed to understand and make the most of these programs.

Please refer back to this guide as you or your covered dependent has questions about these programs during the year. This guide is a summary. The information it contains – together with Insurance Certificates - make up the Summary Plan Description.

For questions about any of the information found in this guide or to request a paper copy of this document or the Certificate of Coverage for your medical plan, call the Hallmark HR Service Center at 816-545-6200 or 888-545-6200, or email HRservicecenter@hallmark.com. Representatives are available 7:30 a.m. to 5:00 p.m. (CT) weekdays.

Hallmark reserves the right to amend or terminate any of the benefit programs provided at any time.

ELIGIBILITY

A summary of the eligibility guidelines for retiree benefits is provided in this guide. For more information, contact the HR Service Center.

HEALTH CARE

Hallmark's health care benefits provide affordable access to quality care and resources to keep you healthy.

ELIGIBILITY

Former employees of Hallmark Cards, Inc. and Litho-Krome Co. must meet each of the following conditions and be eligible for medical, dental and vision coverage in retirement:

- Hired prior to January 1, 2010 and retired from full-time or part-time active employment in a benefits-eligible position at or after age 50 (with 15 years of service), or at age 65 (with at least 10 years of service.)
- Have completed 10 or more years of continuous Hallmark medical benefit participation immediately preceding retirement.
- Have completed at least 10 years of designated full-time employment during their period of employment, enrolled in the year of retirement and elects or waives coverage at retirement.
- Must meet the eligibility rules for retiree medical in order to be eligible for dental and vision coverage at retirement..

An employee who completes 1,000 or more hours of service in a calendar year is credited with a "year of service."

Dependent Eligibility – Eligible retirees may also insure their spouse or domestic partner at the time of retirement in the plans the retiree is eligible for and enrolls in. If the retiree later drops any benefit, their spouse/domestic partner will no longer be eligible for that particular benefit and will also be dropped.

The exception is if the retiree becomes Medicare eligible and either elects to drop or is not

HEALTH BENEFITS

Active benefits for employees retiring from Hallmark will terminate at the end of the month in which the employee retirees. Retiree benefits will begin the first of the month following retirement.

MEDICAL

Hallmark offers two comprehensive and affordable health coverage options through UnitedHealthcare (UHC). Retirees and their spouse or domestic partner will be auto enrolled in the same medical options they had immediately prior to retirement. At annual enrollment, retirees may choose either coverage level. (Note: The medical plan available to benefits eligible retirees residing in Hawaii is a different, Hawaii- specific, health plan through UHC.)

There are two different coverage levels available to retirees – the High Deductible and the Traditional plan. Key provisions of both coverage levels include:

- Coverage for hospital care, surgeons' and physicians' fees, diagnostic services, prescription drugs and other related medical services
- Employee premiums that are highly subsidized by Hallmark. Hallmark is committed to contributing to the cost of health care and offers substantial subsidies toward the cost of coverage.
- Reimbursement for a high percentage of covered expenses after annual deductible has been met (deductibles, coinsurance and out of pocket maximums vary by coverage level).
- Protection from catastrophic expenses with an annual out-of-pocket maximum. Once the out-of-pocket maximum is met, the plan covers 100% of covered expenses, including prescriptions.
- All coverage levels meet the individual mandate coverage requirement of the ACA.

For details as to what the plans covers contact UnitedHealthcare at 833-209-6469 or go to welcometouhc.com/hallmark. Once enrolled, you can find providers, check the status of claims and pay at MyUHC.com or by downloading the UHC app.

Both plans have an embedded deductible. In other words, once a covered member meets the individual deductible, your insurance will begin paying benefits for that member. Charges for all covered members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered members up to the family out-of-pocket maximum.

Covered expenses are paid at allowable levels for in-network providers. Those who

eligible for Hallmark retiree medical, the Pre-Medicare spouse can elect to continue medical coverage as spouse only until becoming Medicare eligible.

The retiree is responsible for payment of premiums for self and dependent. Retirees who fail to complete and submit the Retiree Health Care Election Form within 30 days of retiring, drop their (or their spouse's) medical, dental or vision coverage, or are cancelled for any reason, forfeit eligibility for the dropped/cancelled coverage(s) in the future and will not be allowed to enroll at a later date.

For those who retire on or after January 1, 2012, Hallmark no longer offers medical coverage for retirees and/or spouse/domestic partner who are or become Medicare eligible. Retiree coverage will end at 11:59 p.m. on the day prior to the retiree's Medicare eligibility date.

Effective January 1, 2012, an otherwise eligible retiree will not be eligible for medical or dental benefits if (i) you were considered a highly compensated employee (as defined by Internal Revenue Code 414(q)) at any time during your employment with Hallmark or Litho-Krome and (ii) are engaged directly or indirectly in a business or other endeavor with a "direct competitor" of Hallmark. The term "direct competitor" shall mean any entity including subsidiaries, affiliates, successors and/or assignees of same identified as such in Hallmark's Non-Compete Guidelines, as published and amended from time to time by the Competition Board.

As of January 1, 2021, eligibility for retiree medical subsidy is changing. Must be a minimum of 59 years of age with 20 or more vested years of service. Lower levels of subsidy are not available. Hallmark's subsidy will be a flat dollar amount of $4,000 for Hallmark retiree and $8,000 for retiree and spouse. This dollar amount may increase each year with cost of living.

choose to receive care from Tier 1 providers will pay a lower coinsurance upon reaching their deductible than those who receive care from other in-network providers. Tier 1 providers are recognized by UnitedHealthcare for providing quality, cost-effective care. Covered expenses for out-of-network providers are paid at the maximum reimbursable charge established by the insurance company. By using Tier 1 or another in-network provider, you receive a greater benefit than when seeking care from an out-of-network provider. You can find a listing of Tier 1 and in-network providers by going to MyUHC.com or downloading the UHC app. Out-of-network charges do **not** count toward your in-network annual deductible or out-of-pocket max; they only count toward your out-of-network deductible or out-of-pocket max.

To help ensure you know in advance whether a procedure, treatment or service will be covered, UnitedHealthcare may require providers of medical services to receive pre-approval.

PROTECTED BY AN ANNUAL OUT-OF-POCKET MAXIMUM

When covered out-of-pocket, in-network medical expenses for a covered retiree or spouse/domestic partner reach the scheduled limit in a calendar year, the medical benefit program will pay 100 percent of the allowable amount for all additional, in-network covered charges incurred during the remainder of the calendar year. When receiving services from providers outside of the network (non-participating), amounts charged above the maximum reimbursable amount will be the responsibility of the retiree.

DETERMINING WHAT YOU PAY FOR PRESCRIPTIONS

Optum RX administers the prescription drug program for UnitedHealthcare. Simply present your medical identification card at any in-network pharmacy. If you enroll in the High Deductible plan, you'll pay 100% of the retail cost of prescription drugs until you meet the deductible. After you meet the deductible, you'll pay 20% coinsurance until you reach the out-of-pocket maximum, and then you'll pay nothing. If you enroll in the Traditional plan, your prescription drug co-payments are determined by the quantity of medication purchased as well as the category (Tier 1, Tier 2, Tier 3, Specialty) of the medication, as determined by your insurance plan. Prescription copayments for those enrolled in the Traditional Plan are not applied to the deductible but are applied to the out-of-pocket maximum. Note: Categories for prescription drugs are subject to change by UnitedHealthcare / Optum throughout the year. Once you reach the out-of-pocket maximum, you will pay nothing for covered drugs at in-network pharmacies. Updated prescription drug information can be found on UnitedHealthcare's website MyUHC.com.

COORDINATION OF BENEFITS

Your medical benefit program contains a coordination of benefits (COB) provision. Under this provision, if a retiree or spouse/domestic partner is also covered by another group program, the total amount that can be collected under all programs will not be more than the total allowable expense. Individual deductibles must be met before coordination of benefit provisions apply. Please contact UnitedHealthcare for more details.

RIGHT OF REIMBURSEMENT

The plan has the right to recover overpaid benefits and to seek subrogation or reimbursement in certain circumstances. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing documents provide

additional information about the Plan's recovery, subrogation, and reimbursement rights. By receiving benefits, the eligible retiree or covered dependent agrees to cooperate with the claims administrator in any way to secure reimbursement to the medical benefit program and will take no action that will interfere with or prejudice the medical benefit program from receiving reimbursement. Under no circumstances shall the medical benefit program be obligated to pay a fee or cost to the covered person's attorney. The medical benefit program retains all rights of subrogation, recovery and reimbursement as set out more specifically in the governing documents of the medical benefit program.

MEDICARE

For those who retired on or after January 1, 2012, Hallmark no longer offers medical coverage for retirees and/or their spouse/domestic partner who are or become eligible for Medicare (usually at age 65). Retiree coverage will end at 11:59 p.m. on the day prior to the retiree's Medicare eligibility date, whether or not they enroll in Medicare.

Retirees must notify Hallmark if a covered member becomes Medicare eligible prior to age 65. Medical benefits for the Pre-65 retiree and spouse differ from the Medicare eligible benefits. Pre-Medicare medical will end effective the date the individual becomes eligible for Medicare.

Those eligible for Hallmark's Retiree Medical Plan post-Medicare will automatically receive information from Cigna/Mercer approximately 45 days before their 65th birthday. Failure to enroll within 30 days of the Medicare eligibility date may result in the loss of eligibility.

Retirees and their spouses are not auto-enrolled in Retiree medical coverage when they become eligible for Medicare. Eligible retirees and/or their spouse must complete and return the enrollment form to Mercer and pay premiums in a timely manner to Mercer if they wish to have coverage.

Retirees must be enrolled in dental and vision in order for their spouse to be enrolled. Both members must enroll in the same option**.**

For those eligible, Hallmark's Retiree Medical Plan is designed to supplement benefits paid under Medicare by covering certain expenses not covered by Medicare or which exceed Medicare's limits. The plan will not duplicate any benefits which are payable under Medicare. You and your spouse/domestic partner should register for Medicare Part A and Part B when becoming eligible for those programs. If you or your spouse/domestic partner fails to enroll for Medicare, the Retiree Medical Plan will cover only those amounts over and above what Medicare would have paid. The Retiree Medical Plan does not cover benefits or coordinate benefits if a retiree or spouse/domestic partner chooses to enroll in a Medicare Advantage Plan or in Medicare Part D. Expenses not covered by the Medicare Advantage Plan are not eligible expenses under the Retiree Medical Plan.

Failure to enroll by the required date will result in the loss of eligibility. Failure to enroll in a timely manner may result in a delay in claims processing. In addition, late enrollment in the Medicare prescription drug coverage offered to those eligible for the Hallmark's Retiree Medical Plan post-Medicare or other credible prescription drug coverage, may result in the enrollee having to pay a late enrollment penalty for as long

as they have Medicare prescription drug coverage.

DENTAL & VISION ELIGIBILITY

You must meet the eligibility requirements for Hallmark's Retiree Medical program in order to enroll in dental and/or vision at retirement.

If you drop dental and/or vision, or are cancelled for any reason, you are no longer eligible for Hallmark coverage. Those who retired prior to 2016 and were not enrolled in dental and vision coverage as of January 1, 2016, cannot add dental and/or vision at a later date.

DENTAL

Hallmark's dental benefit program provides reimbursement for 80–100 percent of preventive and basic restorative dental expenses such as fillings and extractions based on the option selected. The program also provides coverage at lower levels of reimbursement for other major restorative work including dentures, bridges, and crowns. The regular option program provides benefits of up to $1,500 per year. An additional "high option" benefit available at higher premiums provides higher levels of coverage and benefits up to $2,000 per year.

REGULAR AND HIGH-OPTION COVERAGE

You may choose between "regular-option" and "high-option" dental coverage. Although both cover the same services, the high-option benefit offers lower deductibles and higher reimbursements for eligible expenses. You pay a higher premium for high-option than for regular-option coverage. Premiums can change annually and eligible retirees will be notified prior to annual enrollment of any changes.

You may choose between these two options during the annual open enrollment period each year.

SAVE USING IN-NETWORK PROVIDERS

You may visit any dental provider but you receive the greatest benefit by choosing a provider who participates in the CIGNA Dental Preferred Provider Organization (PPO).

Hallmark provides the same benefit, deductible and coinsurance levels for services provided by both in- and out-of-network dentists.

To find a participating in-network provider for greater savings, use the directory available from ***mycigna.com*** or call CIGNA customer service at 800-995-3396.

COVERED EXPENSES

The Hallmark retiree dental program provides benefits for a broad range of treatments up to a maximum allowable charge for preventive care and the repair and replacement of teeth, if necessary. If there is more than one suitable covered procedure for the treatment recommended, the Claims Administrator will select the least expensive one as long as the results meet acceptable dental standards. If you elect a more costly treatment, the charges in excess of the less costly treatment will be your responsibility.

If a dental claim is denied in whole or in part, claimants are entitled to a full and fair

review. A list of covered expenses and claims procedures is available on ***mycigna.com*** or by contacting CIGNA at 800-995-3396.

COORDINATION OF BENEFITS

The Hallmark retiree dental benefit program contains a coordination of benefits (COB) provision. Under this provision, if a retiree or covered dependent is also covered by another group program, the total amount that can be collected under all programs will not be more than the program-benefit percentage. Individual deductibles must be met before coordination of benefit provisions apply. To request a copy of the Certificate of Coverage for your dental plan, contact the HR Service Center at 816-545-5800.

PREDETERMINATION OF BENEFITS

Your dentist should submit a treatment plan for a pre-determination of benefits to the claims administrator for all Type III, TMJ and implant services before the services are performed. In addition, for all services involving periodontal surgery, your dentist should also request a pre-determination of benefits. The Claims Administrator will review the treatment plan indicated on a claim form and determine the availability and amount of benefits which will be payable.

If you receive a more expensive service than the service approved in the pre-determination of benefits, the excess amount will not be payable by the dental program. If there is any change in the treatment plan after services begin, an additional pre-determination form should be submitted to the claims administrator for approval.

VISION

Hallmark pre-Medicare retirees may choose between a premium and standard vision benefit coverage option. Both offer reimbursement after co-pays for the costs of vision exams and either frames or contact lenses, up to an annual allowance. Reimbursement rates are higher for the premium benefit option, in exchange for higher premiums.

DENTAL AND VISION WHEN BECOMING MEDICARE ELIGIBLE

When becoming Medicare eligible, retirees and their spouses who are already enrolled in Hallmark's retiree dental or vision don't have to take any action as these benefit plans will continue. Retirees who exercised their one-time waive of dental and/or vision, must contact the HR Service center and request to come off waive prior to becoming Medicare eligible or will lose their right to these benefits at a future date.

If the retiree drops dental and/or vision, or are cancelled for any reason, the retiree and covered spouse are no longer eligible for Hallmark coverage.

CHOOSE BETWEEN TWO PROGRAMS

You may choose to enroll in one of two available vision benefit options – the Standard Plan and the Premium Plan offered through Cigna Vision. Premium costs differ between the two plans. Cigna Vision determines the premiums and is solely responsible for providing benefits. To view a list of in-network Cigna Vision providers, visit Cigna's website at mycigna.com.

COVERED EXPENSES

Both benefit options offer benefits for vision exams, contact lenses, frames and basic and bifocal lenses, but the copays, allowances, progressive lenses and frequency of

service are different. Additional details and a schedule of benefits for both plan offerings are available by contacting the HR Service Center at 866-545-6200.

ADDITIONAL INFORMATION

- Coverage is purchased under a group master policy and individual certificates are not issued. The program is administered by Cigna Vision, PO Box 385018, Birmingham, AL 35238-5018 at 800-995-3396.
- Insurance certificates of coverage including program details can be found on the Hallmark Retiree Website.
- For questions, or to request a paper copy of any documentation, contact the Hallmark HR Service Center at 816-545-6200 or 888-545-6200 or by email at ***HRservicecenter@hallmark.com.***

PAYMENT OF PREMIUMS FOR PRE-MEDICARE RETIREES

Premiums for retiree medical, dental and vision insurance for pre-Medicare retirees and their spouses are to be paid through the Hallmark Retiree Benefit Plan, administered by Mercer, a third-party direct bill administrator. Retirees may pay premiums through electronic funds transfer (EFT) or check, or by setting up bill pay from a personal bank account. For questions regarding your bill, contact the Mercer Retiree Service Center at 877-228-9061.

WHAT RETIREES CAN EXPECT WHEN YOU OR YOUR SPOUSE BECOME MEDICARE ELIGIBLE

Below is a summary of Hallmark retiree health care plans and how these programs will change when you or your spouse become Medicare eligible.

If you are eligible for….	**Benefits for the Pre-Medicare retiree/member:**	**Benefits for the Medicare-eligible retiree /member:**
Medical	Options available through UnitedHealthcare	For those retirees who are eligible: Cigna's Medicare Surround Plan for Medical and Rx or Cigna's Medicare Surround Plan for Medical only
Dental	Cigna's Regular or High Option Retiree Dental Plan	
Vision	Cigna's Standard or Premium Option Retiree Vision	
Enrollment Support	Mercer	
Billing Support	Mercer	

LIFE INSURANCE

Hallmark's life insurance program provides financial protection to you and your loved ones.

Those who retired on or before December 31, 2010 may be eligible for life insurance.

LIFE INSURANCE

Hallmark's life insurance program provides coverage for death resulting from any cause. Coverage continues for the remainder of the eligible retiree's life. Life insurance benefits will be paid to a retiree's named beneficiary on file at the time of death. To update your beneficiary information or to notify Hallmark in the event of the retiree's death, please contact the Hallmark HR Service Center at 816-545-6200 or 888-545-6200 or by email at *HRservicecenter@hallmark.com.*

ADDITIONAL INFORMATION

- The life insurance carrier is The Metropolitan Life Insurance Company, One Madison Avenue, New York, NY 10010-3690, 800-638-5433.
- This plan is fully insured and underwritten by an insurance carrier. Any surplus or dividend which accrues under these policies is held and credited to offset future claims and/or premium payments.
- For questions, contact the Hallmark HR Service Center at 816-545-6200 or 888-545-6200 or by email at ***HRservicecenter@hallmark.com.***

BENEFITS ENROLLMENT

The following information applies to medical, dental, and vision coverage.

RETIREE BENEFITS EFFECTIVE DATE

For those who are retirement eligible, benefits terminate at 11:59 p.m. on the last day of the month in which you retire. Retiree benefits begin the first day of the month following the month in which you retire. At the time of retirement, eligible retirees will be enrolled in the same medical option they had at retirement.

Retirees must complete the Pre-Medicare Medical Enrollment form and return to Benefits MD 510 confirming they want this coverage or are electing to waive within 30 days of retirement.

Retirees wishing to enroll in Retiree dental and/or vision must complete and mail the enrollment form to Mercer within 30 days of retirement for benefits effective the 1st of the month following receipt of the enrollment form.

ANNUAL ENROLLMENT

Changes to benefits enrollment are generally limited to the annual enrollment period that typically occurs in late October or early November for coverage effective January 1 of the following year.

MEDICAL, DENTAL & VISION ONE-TIME DEFERRAL

A retiree may make a one-time deferral of the medical, dental and/or vision plan coverage for himself or herself and the spouse/domestic partner. (This is a useful option when a retiree's spouse has access to other group employer coverage prior to becoming eligible for Medicare, for example.) The retiree will then have the right to subsequently re-elect coverage under the plan if the retiree:

- Met the eligibility requirements of the Retiree Medical Plan at retirement and made a one-time deferral.
- Maintains other **group** (not individual) medical coverage with no gap in that coverage during the time the retiree is not covered under the Retiree Medical Plan.
- Requests re-enrollment and submits all required documentation (including the Certificate of Creditable Coverage from the other group plan) on or prior to the first of the month in which the retiree turns age 65.
- The spouse/domestic partner of a retiree may re-enroll in the medical plan if the retiree dies before re-enrolling if:
- The retiree met the eligibility requirements of the Retiree Medical Plan at retirement and made a one-time deferral.
- The spouse/domestic partner was covered under the Hallmark Medical Program for active employees at the retiree's retirement or death; or under this Plan at the time of deferral, as applicable.
- The spouse/domestic partner maintains other group (not individual) medical

plan coverage during the time not covered under this plan.

- The retiree and spouse/domestic partner remained married and or in a qualifying domestic partnership at the time of the retiree's death.
- The spouse/domestic partner requests re-enrollment and submits all required documentation prior to the date the deceased retiree would have turned 65.

This one-time deferral and re-enrollment right remains subject to the company's right to amend, modify or terminate any portion of the plan or the plan as a whole.

MEDICARE ELIGIBILITY (USUALLY AGE 65)

Eligible retirees must actively enroll in the Hallmark Retiree benefit plans for which they are eligible (medical, dental and/or vision) upon reaching Medicare eligibility and may allow their spouse/domestic partner to continue to participate in the Hallmark Retiree Medical Plan if the spouse/domestic partner is pre-Medicare. When making this decision, keep in mind that once the coverage is dropped, you cannot re-enroll in the Hallmark Retiree Medical Plan. If the retiree drops medical upon becoming eligible for Medicare, the spouse/domestic partner will be required to drop the Hallmark Retiree Medical Plan upon reaching Medicare eligibility. If the retiree drops dental and/or vision, or is dropped for any reason, the spouse/domestic partner will also be dropped from dental and/or vision.

COST

New insurance premium rates are available during Annual Enrollment.

- Medical – Hallmark will share the cost of Retiree Medical Plan benefits for retirees who retire at age 55 or older. Retirees who retire between the ages of 50-54 must pay the full premium for Retiree Medical Plan benefits. (Hallmarkers who were age 45 or older on January 1, 2003, are eligible to receive Hallmark subsidized Retiree Medical Plan benefits starting at age 50.) The Hallmark cost sharing is based on the retiree's years of service at the time of retirement. The exact cost for the retiree's share will be available during annual Open Enrollment.
- Dental – Retirees are responsible for 100 percent of the monthly premium.
- Vision – Retirees are responsible for 100 percent of the monthly premium.
- Life insurance – Hallmark provides this insurance at no cost to eligible retirees.

TERMINATION OF COVERAGE

To drop Medical coverage, you must contact the HR Service Center 30 business days prior to the end of the month in order for the termination to occur the following month. To drop Dental or Vision, contact Mercer. Request may be made earlier; however, terminations will occur on the first of the month.

A retiree's coverage will terminate at the earliest of the following:

- On the 1st of the month following the date of the retiree's request to terminate coverage for self or spouse/domestic partner.
- When the retiree or spouse/domestic partner no longer meets the plan eligibility requirements.
- Upon termination of premium payment for either the retiree's or spouse/domestic partner's coverage.

REHIRED RETIREES

If a retiree returns to active employment at Hallmark Cards, Inc., the retiree must be rehired into a benefit-eligible position and enroll in benefits to maintain eligibility for retiree coverages. At the time that the rehired retiree terminates employment, they will retire with the benefits in place at the time of re-retirement.

For example, if an employee retired in 2009 and received $10,000 in retiree life insurance and then is rehired in March 2016, the retiree will forfeit the life insurance coverage because the company no longer offers this benefit to new retirees. In addition, if you retire prior to January 1, 2021 and are rehired on or after January 1, 2021, any subsidy Hallmark contributes towards your cost of coverage will be those that are in place at the time or your re-retirement.

Note: Hallmark will continue to evaluate medical and other benefits on a regular basis and will make changes in light of changing circumstances such as increased costs and changes in national health care policy. Hallmark reserves the right to amend or

	modify the medical and other benefit plans, including the right to discontinue the plan.

ADDITIONAL DISCLOSURES

It is important to Hallmark that individuals enrolled in the company's benefits programs know their rights. The following legally required notices inform you of new rights or changes to existing rights that may affect you as a participant.

IMPORTANT NOTICE FROM HALLMARK CARDS INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Hallmark Cards Inc. has determined that the prescription drug coverage offered by the Hallmark Health & Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare drug plan, your current Hallmark Cards Inc. coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Hallmark Cards Inc. coverage, be aware that you and your dependent will not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?
You should also know that if you drop or lose your current coverage with Hallmark Cards Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…
Contact Hallmark HR Service Center at 816-545-6200 or 1-888-545-6200. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hallmark Cards Inc. changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

NOTICE OF PROTECTED HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice applies to the group health plans maintained by Hallmark Cards, Incorporated (the "Plan Sponsor"): the Health and Welfare Benefit Plan, the Retiree Medical Plan and the Retiree Dental Plan. We are providing you with this Notice in accordance with federal health privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act ("HIPAA").

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's legal duties and uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;

- your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Resources; and
- the person or officer to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

THE PLAN'S DUTIES

This notice is effective beginning February 17, 2010 and the Plan is required to comply with the terms of this notice as of that date. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to the effective date of the change. If a privacy practice is changed, a revised version of this notice will be provided to all past and present covered persons for whom the Plan still maintains PHI. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

MINIMUM NECESSARY STANDARD

The "Minimum Necessary Standard" means that when using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, this minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual; disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

DE-IDENTIFIED INFORMATION

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

SUMMARY HEALTH INFORMATION

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefit under the Plan without identifying information specific to any one individual.

USE AND DISCLOSURE OF PHI

The following is a description of the ways in which the Plan is permitted to use and disclose your PHI. Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that the Plan may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

<u>Uses and disclosures to carry out treatment, payment and health care operations</u>

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations of the Plan and for purposes related to those operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your health care providers. For example, the Plan may disclose to a treating specialist the name of your primary care physician so that the specialist may ask for your medical records from the referring primary care physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or

qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

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

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

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Subject to certain exceptions described elsewhere in this notice or set forth in regulations of the Department of Health and Human Services, the Plan may not disclose PHI for reasons unrelated to treatment, payment or health care operations without your authorization. If you authorize a disclosure of PHI, it will be disclosed solely for the purpose authorized and you may revoke the authorization at any time by notifying the HIPAA Privacy Officer of the revocation in writing.

Your written authorization will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI by the Plan is allowed without your authorization or request under the following circumstances:

1. When required by law.
2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds), including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Information may be disclosed about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement officer must represent that (i) the information is not intended to be used against the individual, (ii) the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and (iii) disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
7. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
8. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
9. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
10. When required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

11. If you are an organ donor, the Plan may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
12. If you are a member of the armed forces, the Plan may release your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.
13. If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
14. The Plan may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
15. If you are an inmate of a correctional institution or are in the custody of a law enforcement officer the Plan may disclose your PHI to the correctional institution or law enforcement officer if necessary (i) for the institution to provide you with health care; (ii) to protect your health and safety or the health and safety of others; or (iii) for the safety and security of the correctional institution.
16. The Plan may disclose your PHI to researchers when (i) the individual identifiers have been removed; or (ii) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

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

Government Audits: The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

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

OTHER DISCLOSURES

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

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

Spouses and Other Family Members: With only limited exceptions, the Plan will send all mail to the retiree. This includes mail relating to the retiree's spouse covered under the Plan, and includes mail with information on the use of Plan benefit by the retiree's spouse and information on the denial of any Plan benefit to the retiree's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has agreed to the request, mail will be sent as provided by the request for Restrictions or Confidential Communications.

Authorizations: Other uses or disclosures of your PHI not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. Consistent with the HITECH Act, you may request that your PHI not be disclosed to the Plan if such PHI is for payment or health care operations and the PHI pertains solely to items for which the health care provider involved has been paid out of pocket in full.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI
You have a right to inspect and obtain a copy of your PHI contained in a "designated record set" for as long as the Plan maintains the PHI. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to your PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI
You have the right to request the Plan to amend your PHI for as long as the PHI is maintained in the designated record set. However, the Plan is not required to agree with your request.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. Your or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

The Right to Receive an Accounting of PHI Disclosures
At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years

prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to April 14, 2003; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan may charge a reasonable fee for each subsequent accounting.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing using the Contact Information at the end of this Notice. The Plan will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach
You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured PHI.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To obtain such a copy, please contact the Plan using the Contact Information at the end of this Notice.

All requests or communications under this section, "Rights of Individuals", should be made in writing to the following person: HIPAA Privacy Officer, Hallmark Cards, Incorporated, 2501 McGee Trafficway, Box 419580, Mail Drop #510, Kansas City, MO 64141-6580.

Your Right to File a Complaint with the Plan or the HHS Secretary
If you believe that your privacy rights have been violated, you may complain in writing to the Plan in care of the following person: HIPAA Privacy Officer, Hallmark Cards, Incorporated, 2501 McGee Trafficway, Box 419580, Mail Drop #510, Kansas City, MO 64141-6580.

You may also fi a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for a complaint.

CONTACT FOR MORE INFORMATION
If you have any questions regarding this notice or the subjects addressed in it, you may contact the following person: HIPAA Privacy Officer, Hallmark Cards, Incorporated, Mail Drop #510, Kansas City, MO 64141-6580.

PHI use and disclosure by the Plan is regulated by a federal law known as the Health Insurance Portability and Accountability Act (HIPAA). You may fi these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be

eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**

Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**

Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

PLAN ADMINISTRATION INFORMATION

Employees of Hallmark Cards, Incorporated, and subsidiary corporations listed below are covered under the provisions of the Career Rewards Benefit programs.
Retail Plans and Management, Inc.
Hallmark Marketing Company, LLC*
Crown Center Redevelopment Corp.
Litho-Krome Company (savings portion of PSOSP only)
Hallmark Business Expressions, LLC
Hallmark Retail Services, Inc.

Hallmark Retail, LLC*
Hallmark.Com, LLC
Hallmark Global Services, Inc.
Hallmark Licensing, Inc.
Hallmark Management Services, Inc.
Hallmark Business Connections, Inc.
Day Spring Cards, Inc.
Hallmark Interactive, LLC

*Employees in the retail merchandising and installation service group of Hallmark Marketing Corporation are not eligible to participate in the Profit Sharing Ownership and Savings Plan of Hallmark Cards, Incorporated ("PSOSP"). Employees of Hallmark Retail, Inc. who work at the retail store level are not eligible for the Hallmark Disability Benefit Programs.

The Plan Administrator for the Hallmark pension benefit plans is the Hallmark Benefit Plans Advisory Committee. The Plan Administrator may be reached at:
Hallmark Benefit Plans Advisory Committee.
2501 McGee, MD #339
Kansas City, MO 64108 (816) 545-6200

The Plan Administrator and named fiduciary for the Hallmark welfare benefit plans is the Hallmark Benefit Plans Welfare Committee. The Welfare Committee may be reached at the address listed above for the Advisory Committee. Some benefits under the Plan are self-funded, and other benefits are fully insured. For the insured component benefit programs, the Welfare Committee shares plan administration responsibility with the respective insurance companies. The medical component benefit program is fully insured. The life insurance, supplemental and dependent life insurance, voluntary accident insurance and business travel accident insurance are also fully insured. The insurance companies, not the Company, are responsible for paying claims with respect to the insured component benefit programs and are a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract. The dental, long-term disability, Health FSA and DCAP programs are self-funded by the Company. The Company is responsible for paying claims with respect to the self-funded component benefit programs; claims are paid from the Company's general assets or a VEBA trust. Insurance premiums for retirees and their eligible family members in some cases are paid in part by the Company out of its general assets and in part by retirees. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the insured component benefit programs, as applicable. Retiree contributions may also be required for certain self-insured component benefit programs.

Plan Name
Health and Welfare Benefit Plan of Hallmark Cards, Incorporated (the "Plan")

The Plan is a welfare benefit plan that includes the following welfare programs- medical, wellness, dental, vision, FSA, HSA, long-term disability program of Hallmark Cards, Inc., life insurance, supplemental and dependent life insurance, voluntary accident insurance and business travel accident insurance.

Plan Records
Records for the Career Rewards Plans are kept on a calendar year basis, beginning January 1 and ending December 31 of each year.

Plan Identification Numbers
The plans are identifie d by the following numbers under Internal Revenue Service rules.
The Employer Identification Number of Hallmark Cards, Incorporated is #44-0272180.

Legal Service
Process in any legal action may be directed to the plan sponsor: Hallmark Cards, Incorporated, MD #339, 2501 McGee, Kansas City, MO 64108. Process may also be served upon the Hallmark Benefit Plans Advisory Committee as Plan Administrator or upon the plan trustee.

For the Medical, Dental and Disability Programs:
State Street Bank & Trust Co.
P.O. Box 351 Boston, MA 02101

For the Cash Balance Retirement Plan:
State Street Bank & Trust Co.

P.O. Box 351 Boston, MA 02101

For the PSOSP:
State Street Bank & Trust Co.
P.O. Box 351 Boston, MA 02101 and
Evercore Trust Company 114 West 47th Street New York, NY 10036

Plan Continuance
Hallmark intends to continue the Hallmark Cards Benefit programs indefinitely, but reserves the right to terminate or amend any part of any plan or component benefit program at any time. Upon termination or discontinuance of any welfare plan or component benefit program, retirees will have no further rights, other than for payment of benefit for covered losses or expenses incurred before such plan was terminated. In the event of termination, Plan assets will be applied to pay benefit until such assets will be depleted. The Advisory Committee shall oversee such application to assure disbursement of Plan assets in a nondiscriminatory manner.

Appeal Process
For appeal information, please see the insurance certificate of coverage.

Plan Document
The statements in this booklet are intended to explain as clearly as possible the essential features of the Hallmark benefit plans. These statements are, however, governed in all respects by the terms of the plan document or applicable master contract, which will prevail in case of conflict. For appeal information, please see the insurance certificate of coverage.

Continuation of Coverage
Retirees and dependent may extend group health plan ("Plan") coverage under the following circumstances (referred to as "qualifying events"):

Personal and family coverage for up to 18 months when terminating employment or otherwise becoming ineligible for Plan coverage due to changes in employment status. Family coverage for up to 36 months in the event of:

- the retiree's death
- the retiree's divorce or legal separation, or

An additional extension of coverage applies to retirees or dependent who meet all of the following requirements:

- Are entitled to the 18-month extension of coverage,
- Were disabled within 60 days of the date the employee terminated employment or became a part-time employee,
- Are certified as disabled under Title II or XVI of the Social Security Act before their 18-month extension of coverage ends, and
- Furnish a copy of the certification to the COBRA Administrator within 60 days of such determination and before their 18-month extension of coverage ends.
- These disabled individuals are eligible for up to an additional 11-months' extension, for a total of 29 months of extended coverage. Higher premiums are payable during this added extension period. Also, coverage will terminate during the 11-month period if the Social Security Administration determines the individual is no longer disabled.

Those who elect extended coverage must pay the full premium. Premiums are based on age and are adjusted each January 1. Retirees or their dependent is advised of the applicable premium(s) when they become eligible for extended coverage.

Coverage continues for the applicable period unless:

- Hallmark no longer provides group health coverage to any of its retirees,
- Premium payments are terminated,
- The retiree or dependent becomes entitled to Medicare after the qualifying event, or
- The retiree or dependent becomes covered under any other group medical plan, after the qualifying event. (Note: If coverage under the new group plan contains any exclusion or limitation with respect to any pre-existing condition of the retiree or dependent, the covered person may continue the Hallmark extension of coverage.)

Eligibility for this extended Plan coverage requires that the retiree or dependent be covered by the Plan on the date of the qualifying event. The only exception to this requirement is that a newborn or adopted child enrolled within 31 days of birth or placement for adoption may be added to this extension of coverage and will be eligible for benefit immediately.

Hallmark provides the retiree/dependent information about coverage extension in the event of termination of coverage. The retiree must advise Hallmark of ineligibility of a dependent for coverage in the event of divorce/legal separation within 60 days of the date eligibility ceased in order to be eligible for extended coverage by calling the HR Service Center at 1-888-545-6200 within 31 days of the

loss of coverage. Hallmark will then provide the ineligible dependent information about coverage extension. If the qualifying event does not meet the requirements for the extension of coverage, the retiree or dependent will receive written notice of ineligibility within 14 days.

An individual who wishes to continue Plan coverage must complete a COBRA election form and have it postmarked within 60 days after receiving notice from the COBRA Administrator of their COBRA rights. An individual must pay the initial premium within 45 days of electing coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Federal law requires group health plans to abide by certain court orders in family relation cases.

Special Rights on Childbirth
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefit for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act
If a Medical benefit program participant has had or is going to have a mastectomy, she may be entitled to certain benefit under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefit coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefit p rovided under the Medical plan.

Continuation Coverage under USERRA
Employees eligible to take a leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1993 (USERRA), are entitled to COBRA-like continuation of coverage rights. If the employee has coverage under a group health plan, the employee may elect to continue that coverage for up to 24 months, subject to all applicable rules of USERRA. If the employee's military leave is less than 31 days, they may not be required to pay more than their share of the cost of benefit than if they were an active employee. Upon the employee's return from military leave, they are entitled to resume their group health plan benefit without exclusions or waiting periods (on the same basis as prior to the military leave). This applies to both employee and dependent coverages, without regard to whether continuation of coverage was elected. Any plan exclusions or waiting periods that would not apply if the employee were not absent for military service may only be imposed for illnesses or injuries related to military service.

Employee Retirement Income Security Act
Participants in the Hallmark Career Rewards Plans are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Included are the rights to:

1. Examine all plan documents, including contracts with any insurance companies, annual reports, plan descriptions, and any other documents filed by the plan with the United States Department of Labor. These documents are on file in the corporate Human Resources Department and at each company's Human Resources office and may be examined without charge during regular working hours.
2. Obtain copies of all plan documents and other plan information upon written request to the company. A reasonable charge will be made to cover reproduction costs.
3. Receive a summary of the plan's annual file report. Hallmark will furnish each participant a copy of this report once each year.
4. Obtain a statement telling you whether you have a right to a pension at normal retirement age (age 65) and if so, what your benefit would be at normal retirement age if you stopped working under the plan right now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement is normally provided by Hallmark in the form of the Quarterly Benefit Statement from the Plan Administrator. If you do not receive a benefit statement, you must request this statement in writing. It is not required to be given more than once a year. The plan must provide the statement free of charge.

In addition to creating rights for plan participants, ERISA imposes duties upon those persons responsible for the operation of the plan. These persons, called "fiduciaries," have an obligation to operate the plan prudently and in the interest of plan participants and beneficiaries.

ERISA also provides that an employer may not discharge or discriminate against a participant to prevent the participant from obtaining a benefit under the plan or to exercise his or her rights under ERISA. In addition, if a claim for a benefit under the plan is denied in whole or in part, the participant must receive a written explanation of the reason for the denial and may request that the claim be reviewed and reconsidered.

Under ERISA, there are steps a participant can take to enforce these rights. For instance, if a participant does not receive materials requested from the plan within 30 days, the participant may file suit in a federal court. In such a case, the court may require the company to pay the participant up to $110 a day until the materials are received, unless they were not provided because of reasons beyond the control of the company. A participant may also file suit in a state or federal court if a claim for benefit is denied in whole or in part and the participant has exhausted his or her administrative remedies with the plan, or if the claim is ignored. In the event plan fiduciaries misuse the plan's money, or if a participant is discriminated against for asserting his or her rights under ERISA, assistance may be obtained from the U.S.

PLAN NAME	**PLAN NUMBER FOR IRS PURPOSES**
Profit Sharing Ownership and Savings Plan of Hallmark Cards, Incorporated ("PSOSP")	001
Cash Balance Retirement Plan of Hallmark Cards, Incorporated	002
Health and Welfare Benefit Plan	514

Department of Labor or the participant may file suit in a federal court. In such a suit, the court will decide who will pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant should lose the suit, the court may order the participant to pay these costs and fees; for example, if the court were to find the participant's claim frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

ERISA Statement of Rights

The following applies to Employee Welfare Benefit Plans subject to the Employee Retirement Income security Act (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, 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 United States Department of Labor, and available at the Public disclosure room of the Pension and Welfare Benefit Administration.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may charge a reasonable fee for the copies.

c. Receive a summary of the Plan's annual report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, or any other person, may file you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the

decision without charge, and to appeal any denials, all within certain time schedules.

d. Continue health care coverage for yourself or spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependent may have to pay for such coverage. Please see the COBRA continuation sections of the health care plan summaries and the documents governing the plans on the rules governing COBRA continuation coverage rights.

e. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Covered Services which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if your claim is frivolous.
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefit Administration.

f. If you have Creditable Coverage from another plan, you should be provided a Certificate of Creditable coverage, free of charge, from your group health plan or insurance issuer when: (1) you lose coverage under the plan; (2) when you become entitled to elect COBRA continuation coverage; (3) when your COBRA continuation coverage ceases, if you request it before losing coverage; or (4) if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to Pre-existing Condition exclusion for 12 months after your enrollment date in your coverage.