AG Benefits

American Greetings Corporation

Dental Benefit Plan

Summary Plan Description

Updated January 1, 2021

Where to Get Information

For assistance with dental plan benefits:

MetLife Dental Plan
Website: www.metlife.com/mybenefits
Phone: (800) 474-7371
Services: Member Services, Providers and Claims

Associates needing additional assistance regarding eligibility, enrollment, and COBRA, please contact:
AGBenefits Service Center
Phone: (877) 213-6240
www.americangreetingsbenefits.com

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

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HIGHLIGHTS OF THE DENTAL BENEFIT PLAN

American Greetings Corporation offers two dental plan options to eligible ***full-time*** and ***part-time associates.*** Participation in the dental plan is optional. ***Associates*** who desire coverage must elect coverage and pay their required contribution.

- MetLife Standard Plus Plan
- MetLife Standard Plan

COMPARISON OF PLAN HIGHLIGHTS

Highlights	**Standard Plus Plan**		**Standard Plan**	
	In-Network Provider	***Out-of-Network Provider***	***In-Network Provider***	***Out-of-Network Provider***
Annual Deductible	$20 individual $60 family	$50 individual $150 family	$20 individual $60 family	$50 individual $150 family
Annual Benefit Maximum	$1,250 per person	$1,250 per person	$1,000 per person	$1,000 per person
Requires selection of a Primary Care Dentist	no		no	

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

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the ***eligibility*** requirements for a person to participate in the dental ***Plan.***

ELIGIBILITY

The following ***associates*** are eligible to enroll for ***company-***sponsored dental coverage described here:

1. All regular ***full-time associates*** that meet any of the following requirements:
    - On the regular payroll working at least thirty-six (36) hours per work week
    - Benefit eligible part-time officers
    - Full-time associates working reduced schedules under the transition to retirement program
    - Full-time associates returning to work under the phase back into work program following a leave for the birth/placement of a child working a schedule of at least thirty-two (32) hours per week.
2. All regular ***part-time associates*** on the regular payroll working at least twenty (20) but less than thirty-six (36) hours per work week.
3. All Territory Lead/Revision Lead/Full-time Merchandiser ***associates***.
4. All eligible ***associates*** of the following unions:
    - Cleveland
    - Greeneville

The following ***associates*** are not eligible to enroll for ***company***-sponsored dental coverage:

1. ***All other full-time*** and ***part-time associates*** in merchandiser classifications not listed in the Eligibility section number 3.
2. Temporary, seasonal or on-call ***associates***.
3. Group Class 99.
4. ***Associates*** represented by a collective bargaining agent and/or union other than those named above.
5. ***Associates*** working at least twenty (20) hours per work week and are a third country national or working on a foreign assignment for American Greetings Corporation, Papyrus Recycled Greetings and outside the U.S. are eligible to be covered under CIGNA International.

ENROLLMENT

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

EFFECTIVE DATE

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

REINSTATEMENT

Non-Union Associates

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

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

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

3. The ***associate*** must complete the enrollment process within thirty (30) days of rehire or return to work.

4. Coverage shall be effective on the date of rehire or return to work. Prior benefits and limitations, such as deductible and ***maximum benefit***, shall be applied if in the same plan year.

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

Union Associates

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

DEPENDENT(S) ELIGIBILITY

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

1. The term "***spouse***" means the spouse of the ***associate*** under a legally valid existing marriage, unless court ordered separation exists.

2. The term "child" means the ***associate's*** child (natural, foster, step, and adopted; ***placed for adoption***; and any other children related to the associate by blood or marriage for whom the associate can provide proof of legal guardianship, provided the child is less than twenty-six (26) years of age and residing in the associate's household in a normal parent-child relationship. Coverage ends on the last day of the month in which the child turns twenty-six (26).

3. An eligible child shall also include any other child of an ***associate*** who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***associate's*** household. Such child shall be referred to as an ***alternate recipient. Alternate recipients*** are eligible for coverage only if the ***associate*** is also covered under this ***Plan.*** The ***plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. You may receive from the ***plan administrator*** by contacting the AGBenefits Service Center, without charge, a copy of the ***Plan's*** QMCSO procedures.

4. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***associate*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or due to other loss of ***dependent's*** eligibility and who lives with the ***associate***, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided to the AGBenefits Service Center within thirty (30) days of the child's loss of eligibility and thereafter as requested by the ***plan administrator*** or ***claims administrator***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

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

DEPENDENT ENROLLMENT

An ***associate*** must enroll eligible ***dependents*** for coverage within thirty (30) days after the ***associate's*** eligibility date of coverage; and within thirty (30) days after any other event permitting the addition of ***dependents***, as described below. In all cases, the ***associate*** shall have the responsibility of completing their enrollment through the AGBenefits Service Center.

DEPENDENT(S) EFFECTIVE DATE

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

1. The date the ***associate's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***associate*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired. An adopted child will be considered acquired when the child is ***placed for adoption***.

3. Newborn children will be considered a ***dependent*** under this ***Plan*** for thirty (30) days immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***associate*** must complete an application for enrollment through the AGBenefits Service Center within thirty (30) days of birth.

ANNUAL OPEN ENROLLMENT

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

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

SPECIAL ENROLLMENT PERIOD FOR QUALIFYING LIFE EVENTS AND CHANGE IN STATUS

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

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

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

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

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

5. Employment Status Change:
    a. Commencement or termination of employment (***associate***, ***spouse*** or ***dependen***t)
    b. Commencement of, or return from, leave of absence under Family and Medical Leave Act
    c. Change from part-time to full-time status, or vice versa
    d. Strike or lockout

6. Judgment, Decree or Order Requiring Coverage:
    a. Qualified Medical Child Support Order

7. Change in Residence (***associate***, ***spouse*** or ***dependent***):
    a. May qualify if there is a loss of eligibility for a region-specific plan

8. Significant changes in dental coverage, including:
    a. A significant change in cost of coverage under employer's group medical plan

b. Significant coverage curtailment, with or without a loss of coverage
c. Addition or significant improvement of benefit package options

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

10. A COBRA qualifying event.

METLIFE DENTAL PLAN

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *How the Plan Works, Dental Claim Filing Procedure,* and *Dental Expense Benefit*.

METLIFE PPO PLAN

	Standard Plus Plan		**Standard Plan**	
	In-Network Provider (% of ***negotiated rate*)***	**Out-of-Network Provider** (% of ***customary and reasonable amount***)***	**In-Network Provider** (% of ***negotiated rate*)***	**Out-of-Network Provider** (% of ***Scheduled Amount**)***
Calendar Year Deductible: Applies to Basic and Major Dental Services				
Individual	$20	$50	$20	$50
Family (Aggregate)	$60	$150	$60	$150
Maximum Benefit Per Covered Person Per Calendar Year:				
Preventive, Basic and Major Dental Services (other than orthodontics)	$1250	$1250	$1,000	$1,000
Maximum Benefit Per Covered Person Per Lifetime:				
Orthodontic Services While Covered By This Plan (Children to age 20)	$1,000	$1,000	n/a	n/a
Percentage of Payable For:				
Type A - Preventive & Diagnostic Dental Services	100%	75%	100%	75%
Type B - Basic Dental Services	80% after deductible	65% after deductible	70% after deductible	55% after deductible
Type C - Major Dental Services	50% after deductible	20% after deductible	50% after deductible	20% after deductible
Type D - Orthodontic Services	50%, no deductible	50%, no deductible	n/a	n/a

(1) Out-of-Network coinsurance percentages, calendar year deductibles, and maximum benefits per ***covered person*** for ***associates*** who reside in the states of Louisiana, Mississippi, Montana, or Texas will be the same as the In-Network coinsurance percentages, calendar year deductibles, and maximum benefits per ***covered person*** stated above. Out-of-Network benefits for these ***associates*** are still based on the reasonable and customary charge or scheduled amount.

Benefits for residents in states with extraterritorial laws where in and out of network benefits differ are subject to state law, refer to the policy certificate for your state for full details regarding coverage.

(2) The following Dental Plan Summaries are incorporated by reference and included in your Summary Plan Description. If you do not have a copy of the Dental Plan Summaries for the state in which you reside, please contact your plan administrator.

Dental Plan Summaries
American Greetings Dental Plan Summary – Dual Option Alaska
American Greetings Dental Plan Summary – Dual Option-ET States LA-MS-TX
American Greetings Dental Plan Summary - Dual Option Montana

*Negotiated Rate refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

***R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

The covered person is responsible for all provider charges in excess of those paid by the Plan. Refer to *Dental Expense Benefit* for complete details.

HOW THE PLAN WORKS

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

IN-NETWORK PROVIDERS

An ***in-network provider*** is a ***dentist, physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons***. This is known as the ***negotiated rate***. The ***in-network provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate***.

Covered persons can find ***in-network providers*** by contacting MetLife as noted below:

Phone: 800-474-7371
Website: www.metlife.com/mybenefits

OUT-OF-NETWORK PROVIDERS

An ***out-of-network provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***out-of-network provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person***.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan,*** the ***Plan*** will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the ***customary and reasonable amount*** for ***out-of-network providers*** or the ***negotiated rate*** for ***in-network providers*** for covered dental expenses, as shown on the *Schedule of Benefits*.

DEDUCTIBLE

Individual Deductible

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

Family Deductible

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

COINSURANCE

For services, supplies and treatments of an ***in-network provider,*** the ***Plan*** pays a specified percentage of the ***negotiated rate*** for ***covered expenses***. For services, supplies and treatments of an ***out-of-network provider***, the ***Plan*** pays a specified percentage of the ***customary and reasonable amount***. Those percentages are listed on the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the ***Plan's*** payment and the ***negotiated rate*** for ***in-network providers***, and the difference between the ***Plan's*** payment and the amount billed for ***out-of-network providers***.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits*. If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan***.

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also specified on the *Schedule of Benefits*.

ALTERNATIVE TREATMENT

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred,*** except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;

2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;

3. For endodontic treatment, on the date the pulp chamber is opened.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this ***plan***, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the ***plan*** will only pay benefits for the root canal therapy.

PREDETERMINATION OF BENEFITS

"Predetermination of benefits" allows the patient to learn an estimate of the amount the ***Plan*** will pay for extensive work the ***dentist*** recommends before the work is performed. The ***dentist*** submits a dental treatment before treatment starts for:

1. Any Basic or Major Dental Service expected to result in charges for covered dental expenses of three hundred dollars ($300) or more; and

2. For all orthodontic treatment.

The ***claims administrator*** will inform the ***covered person*** the level of benefits from the ***Plan*** for the covered dental services, supplies and treatments recommended. This predetermination is not an agreement for payment of the dental expenses.

Actual claim payment will be based on the coverage in effect on the date each service is performed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Type A - Diagnostic and Preventive Dental Services

1. Oral exams and problem-focused exams, but no more than two exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Full mouth or panoramic x-rays once every 60 months.
5. Bitewing x-rays 1 set in a Year.
6. Intraoral-periapical and extraoral x-rays.
7. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
8. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
9. Diagnostic casts.
10. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
11. Emergency palliative treatment to relieve tooth pain.
12. Topical fluoride treatment for a Child under age 14 once in a Year.

Type B - Basic Dental Services

1. Initial placement of amalgam fillings.
2. Replacement of an existing amalgam filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
3. Initial placement of resin-based composite fillings.
4. Replacement of an existing resin-based composite filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
5. Protective (sedative) fillings.
6. Periodontal scaling and root planing, but no more than once per quadrant in any 36 month period.
7. Full mouth debridements, but not more than once in any 36 month period.
8. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
9. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed.

Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
10. Pulp capping (excluding final restoration).
11. Therapeutic pulpotomy (excluding final restoration).
12. Local chemotherapeutic agents.
13. Injections of therapeutic drugs.
14. Tissue conditioning.
15. Space maintainers for a Child under age 14.
16. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
17. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
18. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
19. Occlusal adjustments.

Type C - Major Dental Services

1. Pulp therapy.
2. Apexification/recalcification.
3. Pulpal regeneration, but not more than once per lifetime.
4. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
5. Initial installation of full or partial Dentures (other than implant supported prosthetics).
6. Addition of teeth to a partial removable Denture.
7. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 84 months prior to replacement.
8. Replacement of a non-serviceable removable Denture if such Denture was installed more than 84 months prior to replacement.
9. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
11. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.

11. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
12. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
13. Initial installation of Cast Restorations (except implant supported Cast Restorations)
14. Replacement of Cast Restorations (except an implant supported Cast Restoration), but only if at least 84 months have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.

15. Prefabricated crown, but no more than one replacement for the same tooth within 84 months.
16. Core buildup, but no more than once per tooth in a period of 84 months.
17. Posts and cores, but no more than once per tooth in a period of 84 months.
18. Labial veneers, but no more than once per tooth in a period of 84 months.
19. Oral surgery, except as mentioned elsewhere in this certificate.
20. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12-month period.
21. Other consultations, but not more than twice in a 12-month period.
22. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24-month period for the same tooth.
23. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.

24. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period.
25. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
26. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in an 84-month period.
27. Repair of implants, but no more than once in a 12-month period.
28. Implant supported Cast Restorations, but no more than once for the same tooth position in an 84-month period.
29. Implant supported fixed Dentures, but no more than once for the same tooth position in an 84-month period.
30. Implant supported removable Dentures, but no more than once for the same tooth position in an 84-month period.
31. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12-month period.
32. Modification of removable prosthodontic.
33. Multiple injections of therapeutic drugs.
34. Cleaning and inspection of a removable appliance twice in a Year.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements for or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one (1) of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridge cannot be made serviceable and was installed at least eighty-four (84) months prior to its replacement.

Covered expenses for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Type D - Orthodontic Services (for ***dependent*** children under age twenty (20) only) (Standard Plus Plan only)

Orthodontic Covered Services

Orthodontia, for a ***dependent*** child under age twenty (20), if the orthodontic appliance is initially installed while dental coverage is in effect for such ***dependent*** child.

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the maximum benefit amount for orthodontia. The allowable charge will be considered as noted on the Schedule of Benefits (subject to 50% coinsurance).

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental coverage is in effect for the ***covered person*** receiving the orthodontic treatment; and
- Proof is given to the claims administrator that the orthodontic treatment is continuing.

If the initial placement was made prior to this dental coverage being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this dental coverage being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this dental coverage was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

DENTAL EXCLUSIONS

The ***plan*** will not pay benefits for charges incurred for:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. fixed and removable appliances for correction of harmful habits;
24. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
25. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;

26. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
27. duplicate prosthetic devices or appliances;
28. replacement of a lost or stolen appliance, Cast Restoration or Denture;
29. replacement of an orthodontic device;
30. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
31. intra and extraoral photographic images.
32. For the Standard Plan: orthodontic services or appliances; repair of an orthodontic device;

WHEN COVERAGE ENDS

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

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

TERMINATION OF ASSOCIATE COVERAGE

1. The date the ***plan sponsor*** terminates the ***Plan***.

2. The last day of the month in which the ***associate*** ceases to meet the eligibility requirements of the ***Plan***.

3. The last day of the month in which employment terminates, unless otherwise defined by the continuation of coverage provisions or Collective Bargaining Agreement***.***

4. If the ***associate*** ceases to make any required contributions, coverage ends at the end of the period for which any required contributions are paid.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***associate's*** coverage terminates.

2 The last day of the month in which the dependent ceases to meet the eligibility requirements of the ***Plan***.

3. The date the ***associate*** ceases to make any required contributions on the ***dependent's*** behalf.

4. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

5. The date the ***dependent*** becomes eligible as an ***associate***.

CONTINUATION OF COVERAGE PROVISIONS

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

- If the ***associate*** is on approved leave and is receiving payments through payroll (i.e. Short-Term Disability, Vacation) the ***associate's*** contributions for coverage will continue as scheduled through the normal payroll cycle.

- If the ***associate*** is on approved leave and is not receiving payments through payroll, the balance of owed associate contributions for continued coverage will be billed to the associate each month following the ***plan administrator's*** uniform procedures. ***Associates*** are required to make timely payments to prevent a break in coverage.

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

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

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

If the ***company*** grants an ***associate*** an approved leave of absence in accordance with FMLA, the ***associate*** can continue health care coverage for the associate during the leave, provided the ***associate*** makes any required contributions according to the ***plan administrator's*** uniform procedures.

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

Reinstatement

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

LEAVE OF ABSENCE- Personal and Medical Non-FMLA

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

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

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

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

Reinstatement

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

LEAVE OF ABSENCE – Military

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

Military Mobilization

- For the first six (6) months the ***associate*** pays the active ***associate*** contribution rate.
- For up to the next eighteen (18) months the ***associate*** pays 102% of the cost of coverage.

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

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***associate*** fails to return to employment within the time allowed.

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

Reinstatement

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

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

LAYOFF

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

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

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

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

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

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

ELIGIBILITY FOR CONTINUED COVERAGE FOR DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE

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

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

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

SEVERANCE

Coverage may be continued for a limited time if an ***associate*** is granted a severance agreement upon separation of employment. The group dental coverage in which the ***associate*** is enrolled will remain in effect through the end of the month in which the ***associate's*** severance of employment occurs. COBRA health coverage runs concurrently with the ***associate's*** severance benefit period. The remaining period of benefit continuation under COBRA generally to a maximum of eighteen (18) months, will be at the full premium rate, plus a 2% administration fee.

COBRA

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

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

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

COBRA Qualifying Events

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

1. Death of the ***associate***.

2. The ***associate's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan***. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce, legal separation from the ***associate***.

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

5. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***associate*** informs the ***company*** that the associate will not be returning to work.

COBRA Notification Requirements

1. When eligibility for continuation of coverage results from a ***spouse*** being divorced or legally separated from a covered ***associate***, or a child's loss of ***dependent*** status, the ***associate*** or ***dependent*** is responsible for notifying the AGBenefits Service Center within sixty (60) days of the latest of:
   a) The date of the event; or
   b) The date on which coverage under this ***Plan*** is or would be lost as a result of that event.
   A copy of the Qualifying Event Notification form is available from the AGBenefits Service Center. In addition, the ***associate*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

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

2. When eligibility for continuation of coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the American Greetings Benefits Department must

notify the AGBenefits Service Center not later than thirty (30) days after the date on which the ***associate*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the AGBenefits Service Center will furnish the Election Notice to the ***associate*** or ***dependent***.

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

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

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

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

Cost of COBRA Coverage

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

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

When COBRA Coverage Begins

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

Family Members Acquired During COBRA

A ***spouse*** or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born

to or ***placed for adoption*** with a covered ***associate*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

Extension of COBRA Coverage

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

1. Death of the ***associate***.
2. Divorce or legal separation from the ***associate***.
3. The child's loss of ***dependent*** status.

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

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

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

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

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

1. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60_{th}) day of continuation coverage; and
2. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the AGBenefits Service Center within the initial eighteen (18) month period of continuation coverage.

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

End of COBRA

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

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

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

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

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

5. The date the ***covered person*** first becomes covered under any other employer's group health plan after the original date of the ***covered person's*** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

Special Rules Regarding COBRA Notices

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

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

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

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

DENTAL CLAIM FILING PROCEDURE

FILING A CLAIM

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

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

MetLife Standard Plus Plan & Standard Plan
MetLife Dental Claims P. O. Box 981282 El Paso, TX 79998-1282

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

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

4. Properly completed claims should be submitted within the time frame noted below.

   MetLife Dental Claims – 90 days after the date on which the services were rendered.

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

   Associates enrolled in CIGNA International coverage should refer to the CIGNA International booklet for claim payment information.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***claims administrator*** with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the American Greetings Benefits website (www.agbenefits.com) or by contacting the AGBenefits Service Center at 877-213-6240.

NOTICE OF CLAIM

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

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

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

TIME FRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the ***claims administrator*****,** and no additional information is required, the ***claims administrator*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***claims administrator*****,** and if additional information is needed for determination of the claim, the ***claims administrator*** will provide the ***covered person*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) 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 Benefit Denial within the time frames described immediately above.

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

1. The specific reasons for the denial.
2. Reference to the ***Plan*** provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the ***Plan's*** claim review procedure and applicable time limits.
5. A statement that if the ***covered person's*** appeals (Refer to *Appealing a Denied Claim* 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.
6. 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.
7. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** 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

The "***named fiduciary***" for purposes of an appeal of a denied claim is the ***claims administrator***.

A ***covered person*****,** or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred 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, ***relevant information*** to the claim for benefits
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 ***named fiduciary*** will not afford deference to the original denial.
5. The ***named fiduciary*** 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 ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
7. If requested, the ***named fiduciary*** 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*** or their designee shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within thirty (30) calendar days of receipt of a written request for the appeal.

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 ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A description of the ***Plan's*** claim review procedure and applicable time limits.
5. A statement that if the ***covered person's*** appeals (Refer to *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.
6. 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.

7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

SECOND LEVEL APPEAL

The ***claims administrator***, upon request by the ***covered person*** (or authorized representative) following a claim denial on appeal, will conduct a second level appeal. This appeal is comprised of ***professional providers*** that were not consulted in connection with the original claim 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 ***Plan***. 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 thirty (30) business days. Notification of the outcome of the review will be communicated verbally and in writing.

The ***Plan*** 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.***

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

FOREIGN CLAIMS

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

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into U.S. dollars.

3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

COORDINATION OF BENEFITS

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

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

DEFINITIONS APPLICABLE TO THIS PROVISION

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

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

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

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

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis;

2. A licensed Health Maintenance Organization (HMO);

3. Any coverage under a government program and any coverage required or provided by any statute;

4. Group automobile insurance;

5. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

6. Any plan or policies funded in whole or in part by an employer**,** or deductions made by an employer from a person's compensation or retirement benefits;

7. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

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

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

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

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

ORDER OF BENEFIT DETERMINATION

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

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

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

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

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule may not initially apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.

   b. In the absence of such a court decree, the primary plan is the Plan of the parent whose birthday falls earlier in the Year.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.
However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

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

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

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

LIMITATIONS ON PAYMENTS

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

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

SUBROGATION/REIMBURSEMENT

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

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

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

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

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

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA. The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule. Further, the ***Plan's*** right to subrogation or reimbursement will not be affected or reduced by theories such as comparative/contributory negligence, the "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the ***Plan's*** right to subrogation or reimbursement.

   The ***Plan*** will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from the ***company***.

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

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

HIPAA PRIVACY

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

Both American Greetings and the ***claims administrator***, MetLife, take the privacy of a ***covered person's*** PHI seriously and handle all PHI as required by state and federal laws and regulations. The ***claims administrator***, MetLife, has developed privacy notices that explain the procedures. A copy of the Notice of Privacy Practices will be provided to plan participants and is also available upon request.

DEFINITIONS

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

Accident

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

Alternate Recipient

Any child of an ***associate*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***.

Associate

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

Claims Administrator

MetLife is the ***claims administrator*** for the MetLife Plan benefits.

For associates enrolled in CIGNA International, CIGNA International is the ***claims administrator*** for the Dental benefits not covered under the MetLife Plan benefits.

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

Coinsurance

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

Company

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

Copay

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

Cosmetic Services

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

Covered Expenses

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

Covered Person

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

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from

a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dental Emergency

A dental emergency is any dental condition which:

- Occurs unexpectedly,
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Dentally Necessary

Dental services or treatments performed in accordance with generally accepted dental standards as determined by the ***claims administrator*** and:

1. necessary to treat decay, disease or injury of the teeth; or

2. essential for the care of the teeth and supporting tissues of the teeth.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), who is practicing within the scope of his license.

Dependent

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

Effective Date

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

Emergency

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

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Enrollment Date

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

Full-time

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

Incurred or Incurred Date

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

Injury

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

In-Network Provider

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

Layoff

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

Leave of Absence

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

Maximum Benefit

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

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan***.

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under this ***Plan***, or
    b. A specified period of time, such as a calendar year.

3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of treatments during a specified period of time.

Dentally Necessary (or Dental Necessity)

A dental service or treatment is performed in accordance with generally accepted dental standards and is:
- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***dentally necessary***. The determination of the ***claims administrator, named fiduciary for post-service claims, named fiduciary for pre-service claims, plan administrator*** or its designee shall be final and binding.

Medicare

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

Named Fiduciary for Pre-service or Post-service Claim Appeals

The ***name fiduciary for pre-service or post-service claims*** appeals is the applicable ***claims administrator.***

Negotiated Rate

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

Out-of-Network Provider

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

Part-time

Refer to *Eligibility, Associate Eligibility* for a definition of the term ***part-time.***

Physician

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

Placed For Adoption

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

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the American Greetings Corp. Insured Welfare Benefits Plan.

Plan Administrator

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

Plan Sponsor

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

Plan Year End

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

Preferred Provider Organization (PPO) also referred to as Preferred Dental Program (PDP)

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

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** are:

Dental Hygienist
Dentist
Physician
Physician's Assistant

Relevant Information

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

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

Required By Law

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

Specialist Dentist

Any ***dentist*** who by virtue of advanced training is board eligible or certified by a specialty board as being qualified to practice in a special field of dentistry.

SUMMARY PLAN DESCRIPTION

The fully insured benefits hereunder are provided pursuant to an insurance contract between American Greetings Corporation and the following insurer: MetLife. If the terms of this document conflict with terms of the applicable insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.

Name of Plan:

The official name of the fully insured plans under the under the American Greetings Benefit Program is the American Greetings Corporation Insured Welfare Benefits Plan. The dental benefits described in this document are provided under that plan.

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

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

Employer Identification Number:

34-0065325

Plan Number:

502

Group Number:

MetLife PPO dental benefits: 84998

Type of Plan:

Welfare Benefit Plan: dental benefits

Type of Administration:

The dental benefits described in this document are provided pursuant to insurance contracts issued to American Greetings Corporation.

> MetLife PPO dental benefits are provided pursuant to an insurance contract issued to American Greetings Corporation by MetLife (group contract number 84998-G). MetLife is the Claims Administrator for these Plan benefits.

Name, Address and Phone Number of Plan Administrator

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

Name, Address and Phone Number of Legal Service:

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

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

Legal process may be served with a copy to:

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

Union Plans:

This ***Plan*** is established in accordance with collective bargaining agreements for the Cleveland and Greeneville Unions. ***Associates*** that are subject to the Collective Bargaining Unit have a right to obtain a copy of the collective bargaining agreement by contacting their union.

Eligibility Requirements:

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

Eligibility, Enrollment and Effective Date of Coverage

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

Schedule of Benefits
When Coverage Ends
Plan Exclusions

Plan Termination:

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

Source of Plan Contributions:

Contributions for ***Plan*** premiums are obtained from the covered ***associates***. The insurance company establishes the required premiums. Contributions by the covered ***associates*** are deducted from their pay on a pre-tax basis as authorized by the ***associate*** on the enrollment form or other applicable forms.

Funding Method:

MetLife PPO dental benefits are provided under a fully insured policy with MetLife (group contract 84998-G).

Effective Date of the Plan:

The ***effective date*** of this Summary Plan Description is January 1, 2021.

Ending Date of Plan Year:

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

Procedures for Filing Claims:

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

Name, Address and Phone Number of Claims Administrator:

MetLife PPO Dental Benefits
MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 800-438-6388
Claims processing and other administrative services for MetLife PPO Dental Benefits are provided under MetLife group contract number 84998.

Qualified Medical Child Support Orders

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

STATEMENT OF ERISA RIGHTS

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

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

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

3. Receive a summary of the ***Plan's*** annual financial report. The ***plan administrator*** is required by law to furnish each participant with a copy of this summary annual report, if applicable.

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

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

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

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

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the ***plan administrator*** to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***plan administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court. In addition, if you disagree with the ***Plan's*** decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the ***plan administrator,*** by contacting the AGBenefits Service Center, for questions about the ***Plan***. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of

Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

MetLife is the ***claims administrator*** for the Dental PPO Plan benefits.

The ***plan administrator*** has delegated to ***claims administrator*** its entire 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. The ***plan administrator*** retains all of its other authority. MetLife's documents govern for any appeals of denials of benefits and will be used in a court of law.

APPLICABLE LAW

All provisions of the Plan shall be construed and administered in a manner consistent with the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ASSIGNMENT

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

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

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

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

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

BENEFITS NOT TRANSFERABLE

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

CLERICAL ERROR

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

CONFORMITY WITH STATUTE(S)

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

INCAPACITY

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

INCONTESTABILITY

All statements made by the ***plan sponsor*** or by the ***associate*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***plan 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 Pursuant to an Insurance Contract
A legal action on a claim may only be brought against the insurance carrier during a certain period for insured programs. This period is applicable to each ***Claims Administrator*** as referenced in the applicable insurance certificate.

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

LIMITS ON LIABILITY

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

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure*.

MISREPRESENTATION

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

PLAN IS NOT A CONTRACT

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

PLAN MODIFICATION AND AMENDMENT

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

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***plan sponsor***, or a written copy thereof shall be deposited with such master copy of the ***Plan***. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***plan sponsor***.

PRONOUNS

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

RECOVERY FOR OVERPAYMENT

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

STATUS CHANGE

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

TIME EFFECTIVE

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

WORKERS' COMPENSATION NOT AFFECTED

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