AG Benefits

AMERICAN GREETINGS

American Greetings Corporation

Vision Benefit Plan

Summary Plan Description

Updated January 1, 2015

Where to Get Information

For assistance with vision benefits contact the Claims Administrator:

EyeMed Vision Care
Website: **www.enrollwitheyemed.com/select**
Phone: (866) 299-1358
Members Only: **www.eyemedvisioncare.com**
Members Only Phone: (866) 723-0514

For vision benefit assistance after contacting EyeMed Vision Care, or for general assistance including eligibility and enrollment:

AGBenefits Solution Center
1-877-213-6240
www.americangreetingsbenefits.com

Associates needing additional assistance after contacting the AGBenefits Solution Center may contact the Plan Sponsor:

American Greetings Corporation
Attn: AG Shared Services
One American Drive Road
Cleveland, Ohio 44144-2398
216-252-7300 ext. 4192 or
1-800-321-3040 ext. 4192
shared.services@amgreetings.com

TABLE OF CONTENTS

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: *Vision Claim Filing Procedure, Vision Expense Benefit and Preferred Provider Organization*.

Refer to *Vision Expense Benefit* for complete details.

VISION BENEFITS - EyeMed Select Plan H

Vision Care Services	In-Network (EyeMed Select Network) Member Pays	Out-of-Network Plan Pays
Exam with Dilation as Necessary	$10 Copay	$35
Exam Options:		
Standard Contact Lens Fit & Follow-Up	Up to $40	Not Covered
Premium Contact Lens Fit & Follow-Up	90% of Retail	Not Covered
Frames:	$150 Allowance, 20% off any additional balance	Up to $35
Standard Plastic Lenses		
Single, Bifocal, Trifocal Vision	$10 copay	Up to $35 single/$45 bifocal/$60 trifocal
Standard Progressive Lens*	$10 copay	Up to $45
Premium Progressive Lens	$10 copay/80% of retail, less $120 allowance	Up to $45
Lens Options		
Scratch resistant, ultraviolet, tint	$15 copay	Not Covered
Standard Polycarbonate – Adults	$0	Up to $5
Standard Polycarbonate – Children	$0	Up to $5
Standard Anti-Reflective Coating	$45 copay	Not Covered
Polarized/Other Add-Ons	20% of Retail Price	Not Covered

* Standard Progressive Lenses include, but are not limited to the following trade names; Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.

Vision Care Services	In-Network Provider (EyeMed Select Network)	Out-of-Network Provider
Contact Lenses (Contact lens allowance includes materials only) Conventional	$150 allowance, 15% off balance	$105
Disposable	$150 allowance	$105
Medically Necessary	100%	$105
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	Not Covered
Additional Unlimited Eyeglasses and Contacts at Discounted Prices	40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses	Not Covered
Frequency Examination Lenses or Contact Lenses Frames	Once Every 12 Months Once Every 12 Months Once Every 24 Months	

Note: Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits, no remaining balance.

The covered person is responsible for all provider charges in excess of those paid by the ***Plan***.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the ***Plan's*** requirements for a person to participate in the ***Plan***.

ELIGIBILITY

The following ***associates*** are eligible to enroll for the ***company*** sponsored vision coverage:

1. All regular ***full-time associates*** on the regular payroll working at least thirty-six (36) hours per work 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, and full-time merchandiser ***associates***.
4. All eligible ***associates*** who are members of the following unions:
    - Bardstown
    - Cleveland
    - Greeneville

The following ***associates*** are not eligible to enroll for the ***company*** sponsored vision coverage:

1. ***Associates*** in merchandiser classifications except full-time merchandisers, territory leads, and revision leads.
2. Temporary, seasonal or on-call ***associates***.
3. ***Associates*** in group class 099 (Clinton Retail).
4. ***Associates*** represented by a collective bargaining agent and/or union other than those named above.
5. If you are a regular full-time associate working thirty-six (36) hours per work week, regular part-time associate working at least twenty (20) hours or a Territory Lead/Revision Lead/Full-Time Merchandiser associate and are a third country national, or working on a foreign assignment for American Greetings Corporation outside the U.S. eligible to be covered under CIGNA International.
6. 540 Realty Associates.

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 timely enrolling through the AGBenefits Solution 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 class*. However, if an associate transfers from an ineligible class to an eligible class, coverage is effective the date of transfer, provided the associate has already met the length of service requirements (1st of the month following one full month since recent hire date). If an associate has not met, then eligibility is effective once the associate has met the length of service requirements.

*Note that if employment begins on the first calendar day of the month, eligibility is the first of the month following employment

REINSTATEMENT

Non-Union Associates

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

1. Reinstatement of coverage is available to ***associates*** and ***dependents*** 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 opposite sex as the ***associate*** under a legally valid existing marriage, unless court ordered separation exists.

2. The term "***same-sex partner***" means one of the following, as evidenced by an "Affidavit of Same-Sex Partnership" notarized and signed by the ***associate*** and ***same-sex partner***:
   a. The ***same-sex partner*** of the ***associate*** under a legally valid civil union.
   b. The ***same-sex partner*** of the ***associate*** under a legally valid registered domestic partnership.
   c. The ***same-sex partner*** of the ***associate*** under an employer-recognized domestic partnership that meets all of the following criteria:
   - The ***associate*** and the ***same-sex partner*** are the same gender;

- The ***associate*** and the ***same-sex partner*** are both eighteen (18) years of age or older;
- The ***associate*** and the ***same-sex partner*** are not related by blood closer than permitted by state law applicable to marriage;
- The ***associate*** and the ***same-sex partner*** are not legally married to anyone else;
- The ***associate*** and the ***same-sex partner*** are each other's sole ***same-sex partner*** and have been for at least the past six (6) months and intend to remain so indefinitely;
- The ***associate*** and the ***same-sex partner*** are mentally competent to consent to contract;
- The ***associate*** and the ***same-sex partner*** are financially inter-dependent and share responsibility for each other's welfare and financial obligations and have done so for at least the past six (6) months;
- The ***associate*** provides proof of the above as may be required by the ***plan administrator***.

The ***plan administrator*** reserves the right to approve or deny coverage based on the documentation submitted in response to the ***plan administrator's*** request for proof of eligibility for coverage.

The payroll contribution for the ***same-sex partner's*** coverage will be deducted on a pre-tax basis. However, per IRS regulations, the full fair market value of the ***same-sex partner's*** coverage must be added as imputed income to the ***associate's*** W-2 unless the ***same-sex partner*** meets certain dependency requirements for federal income tax purposes and the ***associate*** has certified that status by completing an Affidavit Tax-Qualified Dependent.

The ***associate*** must notify the ***plan administrator*** by contacting the AGBenefits Solution Center in writing within 30 days of any status change in the ***same-sex partner*** relationship based on the eligibility requirements previously identified. The ***associate*** and ***same-sex partner*** will be responsible for all claims paid by the ***plan administrator*** resulting from late notification of the status change. COBRA benefits will not be offered to ***same-sex partners*** under any circumstances.

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

3. The term "child" means the ***associate's*** natural child, stepchild, legally adopted child (including a child placed with the associate prior to adoption), foster child, grandchild, 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-three (23) years of age and residing in the associate's household in a normal parent-child relationship. Children of ***same-sex partners*** are not eligible for coverage under this ***plan***.

4. 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 Solution Center, without charge, a copy of the ***Plan's*** QMCSO procedures.

5. 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 Solution Center within thirty (30) days of the child's loss of eligibility and thereafter as requested by the ***plan sponsor*** 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 for coverage hereunder for his eligible ***dependents*** during their own initial eligibility period, subsequent open enrollment period or within thirty (30) days of a qualifying event. The ***associate*** shall have the responsibility of timely notification to the AGBenefits Solution 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 enroll the newborn within thirty (30) days of birth.

OPEN ENROLLMENT

Open enrollment is the period designated by the ***plan sponsor*** during which the ***associate*** may change benefit plans or enroll in the ***Plan*** if he did not do so when first eligible or does not qualify for a qualifying

life event status change. An open enrollment will be held once in each calendar year, specific dates will be announced by the ***plan sponsor***.

During this open enrollment period, an ***associate*** and his ***dependents*** who are covered under this ***Plan*** or covered under any ***employer*** sponsored health plan may elect coverage or change coverage under this ***Plan*** for himself and his eligible ***dependents***. An ***associate*** must make an election during the open enrollment period to change benefit plans.

The ***effective date*** of coverage as the result of an open enrollment period will be the following January 1.

SPECIAL ENROLLMENT PERIOD FOR QUALIFYING LIFE EVENTS AND CHANGE IN STATUS

Associates and/or ***dependents*** may enroll within thirty (30) days of the qualifying life event or status change under the following circumstances:

1. Marital Status Change (including ***same-sex partner*** relationship):
    a. Marriage
    b. Death of spouse or partner
    c. Divorce or annulment
    d. Legal separation

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

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

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

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

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

9. A COBRA qualifying event.

HOW THE PLAN WORKS

Covered persons have the choice of using either an ***in-network provider*** or an ***out-of-network provider***. To save time and avoid long waits call ahead to schedule an appointment and verify your coverage.

IN-NETWORK PROVIDERS

An ***in-network provider*** is a ***physician***, or ***professional provider*** which has an agreement in effect with the ***Preferred Provider Organization (PPO)*** to accept a reduced rate for specified services rendered to ***covered persons***. This is known as the ***negotiated rate***.

When you choose an ***in-network provider***:

- Benefits are paid at a higher benefit level.
- There are no claim forms to fill out and no waiting for reimbursement.
- At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable copays.

Covered persons can find ***in-network providers*** by calling EyeMed at the numbers noted below:

Members should call: 866-723-0514
Non-Members should call: 866-299-1358
www.enrollwitheyemed.com/select

OUT-OF-NETWORK PROVIDERS

An ***out-of-network provider*** does not have an agreement in effect with the ***Preferred Provider Organization***.

When you choose an ***out-of-network provider***, benefits are paid at a lower level. In addition you must:

- Pay the provider in full at the time of service.
- Obtain a claim form (available at www.americangreetingsbenefits.com or www.eyemedvisioncare.com)
- Complete the form and mail it to EyeMed.
- Wait for reimbursement.

VISION EXPENSE BENEFIT

Vision benefits will be paid for the charges for covered vision expenses for ***covered persons*** as shown on the *Schedule of Benefits*. The benefits will apply when charges are ***incurred*** for vision care by a legally licensed ***physician*** or ***professional provider***.

COVERED VISION EXPENSES

1. *Examination Benefit*

    a. In-Network Benefit - A ***covered person*** is entitled to a paid-in-full comprehensive spectacle eye examination, including dilation, performed by a Participating Provider.
    b. Out-of-Network Benefit - A ***covered person*** is entitled to a comprehensive spectacle eye examination with dilation, up to a $35.00 retail value. The ***covered person*** must pay at the point-of-service and will be reimbursed up to $35.00 toward an eye examination after submitting a complete claim.
    c. ***Covered Person*** Pays - There is a $10.00 co-payment for in-network benefit only.
    d. Fitting and Follow up – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
        i. Standard Contact lens – spherical clear contact lenses in conventional wear and planned replacement. Examples include but not limited to disposable, frequent replacement, etc. Standard benefit: ***covered person*** pays up to $40 of the usual and customary charge.
        ii. Premium Contact Lens – all lens designs, materials and specialty fittings other than Standard Contact Lenses. Premium benefit: a 10% discount off of the usual and customary charge.
    e. Out of Network, Fitting and Follow up – Contact lens fit and two follow-ups are available once a comprehensive eye exam has been completed.
        i. Standard Contact lens – Not Available
        ii. Premium Contact Lens – Not Available
    f. Benefit Frequency - Once every twelve (12) months.

2. *Contact Lens Benefit*

    a. In-Network Benefit - In lieu of lenses, all ***covered persons*** are entitled to non-disposable, disposable or ***medically necessary*** contact lenses for the amounts below. The ***covered person*** is responsible for the balance over the allowance amount at the time of service.
        i. Conventional - a $150.00 allowance applied toward non-disposable contact lenses. The ***covered person*** is responsible for 85% of the balance amount over $150.00 at the time of service.
        ii. Disposable - a $150.00 allowance applied toward disposable contact lenses. The ***covered person*** is responsible for 100% of the balance over $150.00 at the time of service.
        iii. ***Medically Necessary*** - a paid in full benefit toward ***medically necessary*** contact lenses.
            a. ***Covered Person*** Pays - There is no co-payment.
            b. Benefit Frequency - Once every twelve (12) months.

a. Out-of-Network Benefit -In lieu of the lenses benefit, for contact lenses obtained from an ***out-of-network provider***, a ***covered person*** is entitled to the following:
   i. Non-disposable-a ***covered person*** is entitled to be reimbursed up to $105.00 for materials. The ***covered person*** must pay the ***out-of-network provider*** at the point-of-service and file a complete claim to receive the reimbursement.
   ii. Disposable-a ***covered person*** is entitled to be reimbursed up to $105.00 for materials. The ***covered person*** must pay the ***out-of-network provider*** at the point-of-service and file a complete claim to receive the reimbursement.
   iii. ***Medically Necessary*** - a ***covered person*** is entitled to be reimbursed up to $105.00 for materials. The ***covered person*** must pay the ***out-of-network provider*** at the point-of-service and file a complete claim to receive the reimbursement.
      a. ***Covered Person*** Pays - There is no co-payment.
      b. Benefit Frequency - Once every twelve (12) months.

For the purpose of this Plan, contact lenses are defined as ***medically necessary*** if the individual is diagnosed with one of the following specific conditions:

- Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -10 D or +10D in spherical equivalent in either eye
- Anisometropia of 3 D in spherical equivalent or more
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses correction.

All requests for ***medically necessary*** contact lenses must be submitted by network provider for review and approval by our Medical Director before a claim will be processed for the service.

3. *Frame Benefit*

a. In-Network Benefit - A ***covered person*** is entitled to a $150.00 allowance toward a frame with the purchase of prescription lenses. The ***covered person*** is responsible for 80% of the balance over the $150.00 at the time of service.
b. Out-of-Network Benefit - A ***covered person*** is entitled to a reimbursement of up to $35.00 toward any frame purchased from an ***out-of-network provider***. The ***covered person*** must pay the ***out-of-network provider*** at the point-of-service and file a complete claim to receive the reimbursement.
c. ***Covered Person*** Pays - There is no co-payment.
d. Benefit Frequency - Once every twenty-four (24) months.

4. *Lens Benefits*

a. In-Network Benefit - A ***covered person*** is entitled to single vision, bifocal, and trifocal lenses.
b. ***Covered Person*** Pay - There is $10 co-payment for in-network benefit only.
c. Lens Options - A ***covered person*** is entitled to the following lens options for the additional amounts set forth below:

1. Ultra Violet Coating	$15.00
2. Tint (Solid & Gradient)	$15.00
3. Standard Scratch Resistant	$15.00
4. Standard Polycarbonate	$0
5. Standard Progressive * (add on to bifocal)	$10.00
6. Premium Progressive	$10.00 (80% of retail, less $120 allowance)
7. Standard Anti-Reflective	$45.00
8. Polarized/Other Add-Ons	20% off retail

d. Out-of-Network Benefit - A ***covered person*** is entitled to be reimbursed for the following: up to $35.00 for single vision; up to $45.00 for bifocal; up to $60.00 for trifocal; up to $45.00 for progressives. The ***covered person*** must pay the ***out-of-network provider*** in full at the point-of-service and file a complete claim to receive the reimbursement.
e. The ***covered person*** must pay up to a $5.00 co-payment for standard polycarbonate adult and children lenses when purchased from an ***out-of-network provider***.
f. Benefit Frequency - Once every twelve (12) months.

* Standard Progressive Lenses include, but are not limited to the following trade names: Access®, Adaptar®, AF Mini®, Continuous®, Vue®, Freedom®, Sola VIP®, Sola XL® and True Vision®.

ADDITIONAL BENEFITS

Laser Vision Benefit

A ***covered person*** is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PR treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the ***covered person*** elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, the other provider may charge additional fees for the pre-operative and post-operative care which the ***covered person*** will be responsible for and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

Accessing the Laser Vision Benefit

1. To locate the nearest U.S. Laser Network provider, a ***covered person*** must call 1-877-5LASER6.
2. After the ***covered person*** has located a U.S. Laser Network provider, the ***covered person*** should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed ***covered person***. The ***covered person*** should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the ***covered person*** is a good candidate for laser vision correction, the ***covered person*** should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the ***covered person*** must call the U.S. Laser Network again at 1-877-5LASER6 with his or her scheduled treatment date.
5. At the time the treatment is scheduled, the ***covered person*** will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the ***covered person*** should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the ***covered person*** remits the deposit, U.S. Laser Network will issue to the ***covered person*** an authorization number confirming the EyeMed discount. This authorization number will be sent to the ***covered person's*** U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the ***covered person*** to pay or arrange to pay the balance of the fee.
8. After the treatment, the ***covered person*** should follow all post-operative instructions carefully. In addition, the ***covered person*** is responsible to schedule any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

Safety Eyewear Vision Benefit

A covered person may obtain vision services or materials connected with safety eyewear through Participating EyeMed Providers through the provider filing a paper claim. If the member uses their EyeMed routine vision benefits for safety eyewear, they will not be eligible for a routine pair of glasses or contacts. A provider MUST file a safety glass claim on a paper CMS1500 form.

Additional Purchases and Out-of-Pocket Discount

Covered persons will receive a 20% discount on remaining balance at Participating EyeMed Providers beyond plan coverage, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed's Providers professional services, disposable contact lenses or services provided by laser providers. ***Covered persons*** are also eligible for additional discounts on eyewear purchases. Once the initial benefit has been used, ***covered persons*** are eligible for 40% off the retail price of a complete pair eyeglass purchase and 15% off conventional contact lenses.

VISION EXCLUSIONS

No benefit will be provided under this ***Plan*** for vision services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses;

2. Medical and/or surgical treatment of the eye, eyes or supporting structures;

3. Any vision examination, or corrective eyewear required by a ***covered person*** as a condition of employment;

4. Services provided as a result of any worker's compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;

5. Plano (non-prescription) lenses;

6. Non-prescription sunglasses;

7. Two pair of glasses in lieu of bifocals;

8. Services or materials provided by any other group benefit plan providing vision care;

9. Services rendered after the date a ***covered person*** ceases to be covered under the ***plan***, except when vision materials ordered before coverage ended are delivered and the services rendered to the ***covered person*** are within 31 days from the date of such order;

10. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

WHEN COVERAGE ENDS

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. The date the ***associate*** ceases to make any required contributions.

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

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 vision.

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 (or before that date because they no longer meet the eligibility requirements, such as the age limit), continuation coverage under COBRA will be available and a COBRA notice will be provided at that time.

FAMILY AND MEDICAL LEAVE ACT (FMLA) CONTINUATION OF COVERAGE

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 him/herself during the leave, provided the ***associate*** makes any required contributions.

- If the ***associate*** is on approved FMLA leave receiving pay (i.e. STD, Vacation) the ***associate's*** contributions for vision will continue as usual through the normal payroll cycle, provided pay is enough to cover the deductions. If pay is not enough the associate will be billed.
- If the ***associate*** is on approved FMLA leave not receiving pay, the ***associate*** will be billed for his/her benefits (either a monthly or weekly basis, depending on the ***associate's*** location).

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 will be reinstated on the date the ***associate*** returns to active work as if coverage had not terminated, provided the ***associate*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

LEAVE OF ABSENCE- Personal and Medical Non-FMLA

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***.

- If the ***associate*** is on approved Personal or Medical Non-FMLA leave receiving pay (i.e. STD, Vacation) the ***associate's*** contributions for vision will continue as usual through the normal payroll cycle, provided pay is enough to cover the deductions. If pay is not enough the associate will be billed.
- If the ***associate*** is on approved Personal or Medical Non-FMLA leave not receiving pay the ***associate*** will be billed for his/her benefits (either a monthly or weekly basis, depending on the ***associate's*** location).

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.

LEAVE OF ABSENCE - Military

Military Mobilization

Coverage continues for the length of the approved leave up to the maximum of twenty-four (24) months under USERRA, provided contributions are paid.

If an ***associate*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***associate*** and the ***associate's dependent*** may continue their health coverage's, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

- 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 100% of the cost of coverage. (The active associate rate is 100% of the cost of coverage for Vision; therefore, the rates for both periods of time are the same.)

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.

If the leave continues beyond twenty-four (24) months of coverage may be elected under COBRA for up to eighteen (18) months at the COBRA rate of one hundred and two percent (102%) of the full cost.

LAYOFF

Non-Union Associates

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")***. In no event will coverage continue longer than the end of the month following the month in which the ***associate's layoff*** occurs.

If the ***associate*** experiences a termination of employment, coverage will terminate as noted under the *Termination of Associate Coverage* provision.

Union Associates

Coverage may be continued according to the collective bargaining agreement, contingent upon payment of any required contributions for ***associates*** and/or ***dependents***, when the ***associate*** is subject to a ***layoff***.

If the ***associate*** experiences a termination of employment, coverage will terminate as noted under the *Termination of Associate Coverage* provision.

SEVERANCE

Coverage may be continued for a limited time if an ***associate*** is granted a severance agreement upon separation of employment. The group vision 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. If on a severance program COBRA coverage runs concurrently with the 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

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 the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

This *Continuation of Coverage* provision does not apply to *same-sex partners*.

The AGBenefits Solution Center administers COBRA on behalf of the *Plan Sponsor.*

COBRA Qualifying Events

Qualifying events are any one of the following events that would cause a ***covered person*** to lose 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 he or she 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*** must submit a completed Qualifying Event Notification form to the AGBenefits Solution 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 Solution 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 Solution 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 Shared Services Department must notify the AGBenefits Solution 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 Solution 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 Solution 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 Solution Center of this choice by returning to the AGBenefits Solution 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 Solution 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 Solution Center.

5. Within forty-five (45) days after the date the person notifies the AGBenefits Solution 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 Solution 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 himself 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 Solution 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
3. The date on which the ***associate*** or ***dependent*** is furnished with a copy of this Summary Plan Description.

A copy of the Additional Extension Event Notification form is available from the AGBenefits Solution 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 Solution Center within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

1. The date of the disability determination by the Social Security Administration;
2. The date of the 18-Month Qualifying Event;
3. The date on which the person loses (or would lose) coverage under this ***Plan*** as a result of the 18-Month Qualifying Event; or
4. The date on which the person is furnished with a copy of this Summary Plan Description.

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

1. The date of the final determination by the Social Security Administration; or

2. The date on which the individual is furnished with a copy of this Summary Plan Description.

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 Solution 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 Solution 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.

VISION CLAIM FILING PROCEDURE

CLAIM PROCEDURE

FILING A CLAIM

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

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:

    EyeMed Vision Care, LLC
    Attn: OON Claims
    P.O. Box 8504
    Mason, OH 45040-7111

    It is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

3. If the covered person utilizes the benefit for safety frames and/or lenses, a paper claim form must be completed and submitted by the provider for proper reimbursement.

4. All claims submitted for benefits must include an itemized paid receipt that identifies the claimant, the services provided, the amount charged for each service and the date of service. The services must be paid in full in order to receive benefits.

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

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.american greetingsbenefits.com) or by contacting the AG Benefit Solution Center at 877-213-6240.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims administrator*** within sixty (60) 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 one (1) year after the later of the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***claims administrator*** 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*** appeal (Refer to *Appealing a Denied Claim* below) is 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 Combined Insurance Company of America (CICA), the insurance policy underwriter in conjunction with EyeMed, the ***claims administrator***. Appeals should be mailed to the following address:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040

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*** 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*** appeal (Refer to *Second Level Appeal* below) is 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 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 the 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.

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***, EyeMed, 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***, EyeMed, has developed a privacy notice that explains 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:

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

EyeMed Vision Care is the ***claims administrator***. 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.

Covered Expenses

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

Covered Person

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

Dependent

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

Effective Date

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

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.***

Illness

A bodily disorder, disease, or physical sickness. ***Pregnancy*** of a covered ***associate*** or their covered spouse shall be considered an ***illness***.

Incurred or Incurred Date

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

Injury

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

In-Network Provider

A ***physician*** or other health care ***facility*** who has an agreement in effect with ***EyeMed*** at the time services are rendered. ***In-network providers*** agree to accept the ***negotiated rate*** as payment in full for specified services.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a special enrollment period.

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.

Medically Necessary (or Medical Necessity)

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

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

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

Named Fiduciary for Vision Claims Appeals

Combined Insurance Company of America (CICA) in conjunction with EyeMed Vision Care

Negotiated Rate

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

Out-of-Network Provider

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

Placed For Adoption

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

Plan

"***Plan***" refers to the benefits and provisions for payment of 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

An organization who selects and contracts with certain ***physicians*** and other health care providers to provide specified services, supplies and treatment to ***covered persons*** at a ***negotiated rate***. The ***Preferred Provider Organization*** is EyeMed Vision – Select Network.

Professional Provider

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

Dispensing Optician

Optician

Optometrist

Physician

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.

Routine Examination

A comprehensive history and physical examination which would include services as defined in *Vision Expense Benefit*.

Same-sex Partner

Refer to *Eligibility, Enrollment and Effective Date, Dependent Eligibility* for a complete definition of the term ***same-sex partner.***

SUMMARY PLAN DESCRIPTION

The fully insured benefits hereunder are provided pursuant to an insurance contract between American Greetings Corporation and EyeMed Vision Care. 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 vision benefits described in this document are provided under that plan.

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

American Greetings Corporation
One American Road
Cleveland, OH 44144
216-252-7300 ext. 4192

Employer Identification Number:

34-0065325

Plan Number:

502

Group Number:

9768755

Type of Plan:

Welfare Benefit Plan: vision benefits

Type of Administration:

The vision benefits described in this document are provided pursuant to an insurance contract issued to American Greetings Corporation by EyeMed Vision Care. The EyeMed Vision Care policy is underwritten by Combined Insurance Company of America. EyeMed Vision Care is the Claims Administrator for these Plan benefits.

Name, Address and Phone Number of Plan Administrator

Benefits Advisory Committee
American Greetings Corporation
One American Road
Cleveland, OH 44144
800-321-3040 ext. 4192

Name, Address and Phone Number of Legal Service:

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

Sr. Vice President, Human Resources
American Greetings Corporation
One American Road
Cleveland, OH 44144
216-252-7300 ext. 4192

Legal process may be served with a copy to:

General Counsel
American Greetings Corporation
One American Road
Cleveland, Ohio 44144

Union Plans:

This ***Plan*** is established in accordance with a collective bargaining agreement for the Cleveland Union. ***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:

Vision benefits are provided under a fully insured policy with EyeMed Vision Care.

Effective Date of the Plan:

The ***effective date*** of this Summary Plan Description is January 1, 2015.

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 *Vision Claim Filing Procedure.*

Name, Address and Phone Number of Claims Administrator:

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040
866-723-0514

Claims processing and other services for the Vision plan are provided under the EyeMed Vision Care Group contract #9768755.

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 ***associates*** and beneficiaries can obtain from the ***plan administrator*** by contacting the AGBenefits Solution 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 Solution Center.

2. Obtain, upon written request by contacting the AGBenefits Solution 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 Solution Center. Although presently American Greetings does not charge, the ***plan administrator*** may require payment of a reasonable charge for the copies.

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

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

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

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

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

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

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

Participants should contact the ***plan administrator,*** by contacting the AGBenefits Solution 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 ADP to provide the AGBenefits Solution Center for employee servicing and enrollment and to appoint a ***claims administrator*** to receive, review and process claims for benefits.

EyeMed Vision Care is the ***claims administrator*** for these 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.

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

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***. Payments for services rendered by an ***out-of-network provider*** will be paid directly to the ***covered person***.

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

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

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***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).

FREE CHOICE OF HOSPITAL AND PHYSICIAN

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

INCAPACITY

If, in the opinion of the ***plan sponsor***, a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for 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 Against Insurance Carrier
A legal action on a claim may only be brought against the Claims Administrator 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 him 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.