Summary of Dental Benefits (MetLife/PDP Plus Network)

	Standard Plus Plan		Standard Plan	
	In-Network based on Network Fee Schedule	Out-of-Network based on Reasonable and Customary Rate (R&C)	In-Network based on Network Fee Schedule	Out-of-Network Maximum Allowable Charge (MAC)
Plan Administrator	MetLife Group #123838		MetLife Group #123838	
Annual Deductible	$20 single / $60 family	$50 single / $150 family	$20 single / $60 family	$50 single / $150 family
Annual Benefit Maximum (for Type A, B and C services)	$1,250 per individual		$1,000 per individual	
Office Visit Copay	No		No	
Preventive and Diagnostic Services (Type A)[1] Oral exam, cleanings, fluoride, X-rays	Plan pays 100% (no deductible)	Plan pays 75% R&C (no deductible)	Plan pays 100% (no deductible)	Plan pays 75% MAC (no deductible)
Basic Services (Type B)[1] Fillings, space maintainers, sealants	Plan pays 80% (after deductible)	Plan pays 65% R&C (after deductible)	Plan pays 70% (after deductible)	Plan pays 55% MAC (after deductible)
Major Services (Type C)[1] Crowns, dentures, bridges, inlays, onlays, root canals	Plan pays 50% (after deductible)	Plan pays 20% R&C (after deductible)	Plan pays 50% (after deductible)	Plan pays 20% MAC (after deductible)
Orthodontic Services	Plan pays 50% (no deductible) (under age 20; $1,000 lifetime benefit max)		Not covered	
Contact information	1-800-474-7371		www.metlife.com/mybenefits	

1 • Please reference the SPD (on **AGBenefits.com**) or Certificate of Coverage (by calling MetLife at 1-800-474-7371) for a full description of covered services, benefit limitations and exclusions. For both plans, if you reside in the state of Louisiana, Mississippi, Montana or Texas, out-of-network/in-network coinsurance percentages and deductibles are the same.

- The R&C rate is based on the lowest of these: 1) the actual dentist's charge, 2) the dentist's usual charge for a similar service, or 3) what most dentists in your area charge for a similar service.
- The MAC is based on the lesser of the amount charged by the out-of-network dentist or out-of-network scheduled amount for the state where the service is provided.
- For Alaska and Montana, benefit levels for out-of-network in the Standard Plan are based the R&C rate.

This is a summary of benefits. For complete details, refer to the summary plan description at AGBenefits.com.

Summary of Vision Benefits (Anthem Blue View Vision/Select Network)

	In-Network MEMBER PAYS	Out-of-Network REIMBURSEMENT[1]
Exam with Dilation as necessary (once per year)	$10 copay $0 copay with Plus Providers[2]	Up to $35
Contact Lens Exam Options (once per year) - Standard contact lens fit and follow-up - Premium contact lens fit and follow-up	 Up to $40 10% off retail price	 Not covered Not covered
Lenses (once per year) - Single, Bifocal, Trifocal	$10 copay	Up to $35 Single / $45 Bifocal / $60 Trifocal
Lens Options (add to price above) - Standard progressives - Premium progressives - Scratch resistant, ultraviolet, tint - Standard Polycarbonate-Adults & Children - Standard Anti-Reflective Coating - Polarized/Other Add-Ons	 $0 copay $0 copay, 20% off retail price, less $120 allowance $15 copay $0 copay $45 copay 20% off retail price	 Up to $45 Up to $45 Not covered Up to $5 Not covered Not covered
Frames (once every two years)	$150 allowance ($200 with Plus Providers[2]), 20% off any additional balance	Up to $105
Contact Lenses (once per year in lieu of lenses)	$150 allowance, 15% off balance for conventional contact lenses	Up to $105
Laser Vision Correction	Other discount offers on LASIK surgery and much more available through Anthem's Special Offers program	Not covered
Additional Unlimited Eyeglasses at Discounted Prices	40% off retail of a complete pair eyeglass purchase	Not covered
Contact information	1-877-254-9443	anthem.com or Sydney[SM] Health app

[1] Member reimbursement out-of-network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider.

[2] Visit anthem.com or Sydney[SM] Health app to locate Plus Providers.

This is a summary of benefits. For complete details, refer to the summary plan description at AGBenefits.com.

2027 Dental/Vision Chart 8.13.2026

This information is a summary of the benefits available to eligible associates of American Greetings and its participating subsidiaries. In the event of a conflict between this and any other description of these benefit plans, the plan documents, service agreements and insurance contracts will control. As with all company-sponsored benefit plans, American Greetings reserves the right to amend (subject to provisions of collective bargaining agreements where applicable), modify, revoke or terminate these plans in whole or in part at any time. No person speaking on behalf of American Greetings or the plan can amend the plan through a verbal or written statement without a plan amendment. Neither this document nor participation in the benefit plans described herein constitutes a promise of continuing employment with American Greetings or its subsidiaries. More information is available on AGBenefits.com or by calling AGBenefits Service Center at 1-877-213-6240 for a copy of the summary plan description or plan document.