Group Insurance Benefits

Joachim-Plattin Ambulance District

Group Vision Insurance

Class 01

KANSAS CITY LIFE
INSURANCE COMPANY

Notice of Protection Provided By Missouri Life and Health Insurance Guaranty Association

This notice provides a *brief summary* of the Missouri Life and Health Insurance Guaranty Association (""the Association"") and the protection it provides for policyholders. This safety net was created under Missouri law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are as follows:

- Life Insurance
    - $300,000 in death benefits
    - $100,000 in cash surrender and withdrawal values
- Health Insurance
    - $500,000 in hospital, medical, and surgical insurance benefits
    - $300,000 in disability insurance benefits
    - $300,000 in long-term care insurance benefits
    - $100,000 in other types of health insurance benefits
- Annuities
    - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance
- $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Missouri law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mo-iga.org, or contact:

Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, Missouri 65109
Ph: 573-634-8455
Fax: 573-634-8488

Missouri Department of Insurance, Financial Institutions and Professional Registration
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph: 573-522-6115

Insurance Companies and agents are not allowed by Missouri law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Missouri law, then Missouri law will control.

KANSAS CITY LIFE
INSURANCE COMPANY

Certificate of Vision Insurance

Kansas City Life Insurance Company certifies that in accordance with and subject to the terms of the Group Master Policy, the Insured Individual is insured for the coverage described in this certificate. The Group Master Policy provides the coverage described in this certificate for certain Insured Individuals covered under the Policy.

This certificate describes the Vision Insurance coverage provided by the Group Master Policy. This certificate supersedes and replaces any which may have been issued to You previously.

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, Kansas City, Missouri 64111.

A. Craig Mason Jr.

Secretary

Walter E Bixby

President, CEO, and Vice Chairman

Guide to Certificate Provisions

Schedule of Benefits

Policyholder:
Joachim-Plattin Ambulance District

Group Number:
27986

Classes of Eligible Individuals

All full-time employees in active employment in the United States with the Employer working a minimum of 30 hours per week.

You must be an Employee of the Employer in an eligible class.

Temporary and seasonal workers are excluded from coverage. Persons who are not legal residents or citizens of the United States are not eligible for coverage.

Probationary Waiting Period: As noted in Your Employer's Group Vision Insurance Policy

Plan Benefits

	FREQUENCY OF USE
Eye Examination	Once every 12 months beginning with the first date of service
Materials **Lenses**	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) Once every 12 months beginning with the first date of service
Materials **Frame**	Once every 12 months beginning with the first date of service

	COPAYMENT
Eye Examination	$10.00 shall be payable by the Covered Person at the time of examination
Materials	$10.00 shall be payable by the Covered Person at the time when materials are purchased

Any Copayments required under this plan shall be the responsibility of the Covered Person receiving Plan Benefits. Copayments are to be paid at the time services are rendered or materials ordered. Amounts which exceed plan Allowances, annual maximum benefits, or any other stated plan limitations are not considered Copayments but are also the responsibility of the Covered Person.

A Covered Person may use the Provider of their choice for the following covered vision services. Plan Benefits will be paid up to the Allowance shown below. The balance of the charge is the Covered Person's responsibility.

Plan Benefits
(Continued)

In-Network Provider Services: To utilize Plan Benefits, Covered Persons may select an In-Network Provider, schedule an appointment, and inform the doctor's office that they are Covered Persons of VSP. The In-Network Provider will contact VSP to obtain a Benefit Authorization. If a Covered Person receives Plan Benefits from an In-Network Provider without Benefit Authorization, any services or materials received from the doctor will be treated as benefits from an Out-of-Network Provider.

Out-of-Network Provider Services: When Covered Persons elect to utilize the services of an Out-of-Network Provider, benefit payments for services from such Out-of-Network Provider will be determined according to the Plan's Out-of-Network Provider benefit fee schedule if Out-of-Network Provider reimbursement is available. COVERED PERSONS MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Out-of-Network Provider may bill Covered Persons for that Provider's standard rates, regardless of the amount of our Plan Benefits. If Covered Person is eligible for and obtains Plan Benefits from an Out-of-Network Provider, Covered Person remains liable for the provider's full fee. Covered Person will be reimbursed by Us in accordance with the Out-of-Network Provider Reimbursement Schedule shown below, less any applicable Copayments.

COVERED SERVICES AND MATERIALS	**IN-NETWORK BENEFITS (Using an In-Network Provider)**	**OUT-OF-NETWORK BENEFITS (Using an Out-of-Network Provider) Reimbursement Schedule**
Eye Examination Comprehensive examination of visual functions and prescription of corrective eyewear.	Covered in full less any applicable Copayment	Up to $45.00 Allowance
Lenses	**(Glass or plastic Single Vision, Lined Bifocal, Lined Trifocal or Lenticular)** Covered in full less any applicable Copayment Polycarbonate lenses are covered in full for dependent children up to age 26.	**Single Vision** Up to $30.00 Allowance **Lined Bifocal** Up to $50.00 Allowance **Lined Trifocal** Up to $65.00 Allowance **Lenticular** Up to $100.00 Allowance
Frames	Covered up to $150.00 Allowance less any applicable Copayment The In-Network Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.	Covered up to $70.00 Allowance
Elective Contact Lenses Contact Lenses are provided in place of spectacle lens and frame benefits available herein.	Covered up to $150.00 Allowance less any applicable Copayment The Elective Contact Lens Allowance applies to materials only.	Covered up to $105.00 Allowance The Elective Contact Lens Allowance applies to materials only.

Plan Benefits
(Continued)

COVERED SERVICES AND MATERIALS	IN-NETWORK BENEFITS (Using an In-Network Provider)	OUT-OF-NETWORK BENEFITS (Using an Out-of-Network Provider) Reimbursement Schedule
Necessary Contact Lenses Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor. Contact Lenses are provided in place of spectacle lens and frame benefits available herein.	Covered in full less any applicable Copayment	Covered up to $210.00 Allowance
Low Vision Professional services for severe visual problems not correctable with regular lenses, including: Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.	**Supplemental Testing** Covered in full* Includes evaluation, diagnosis and prescription of vision aids where indicated. **Supplemental Aids** 75% of In-Network Provider's fee, up to $1,000.00* *Maximum benefit for all Low Vision services and materials is $1,000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.	**Supplemental Testing** Up to $125.00* Includes evaluation, diagnosis and prescription of vision aids where indicated. **Supplemental Aids** 75% of Provider's fee, up to $1,000.00* *Maximum benefit for all Low Vision services and materials is $1,000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Definition of Certain Terms

Actively-at-Work
You will be considered to be actively-at-work with Your Employer on a day, which is one of Your Employer's scheduled workdays if You are performing, in the usual way, all of the regular duties of Your job on a full time basis on that day. You will be deemed to be actively-at-work on a day, which is not one of Your Employer's scheduled workdays, only if You were actively-at-work on the preceding scheduled workday.

Active Full-time Employee
An employee who works the minimum number of regularly scheduled hours for the Employer indicated on the Schedule of Benefits. An Employee is not someone who is temporary or seasonal; who is a consultant to the Employer; who is a subcontractor or independent contractor; or who is a member of the board of directors of the Employer. Owners, partners and sole proprietors are considered to be Employees only if they work the minimum number of regularly scheduled hours for the Employer.

Allowance
The flat dollar amount payable under this Policy for eye examinations, the fitting of eyeglasses, or Materials received and/or purchased by the Covered Person.

Annual Enrollment Period
The period of time, established by the Employer, during which You have an opportunity to select Your benefits and Your Dependent's benefits for the coming year.

Benefit Authorization
A process used to confirm eligibility of a Covered Person and identify those Plan Benefits to which Covered Person is entitled.

Copayments
Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.

Covered Person
All individuals and dependents whose insurance is in force under the policy.

Eligibility Date
The date a full-time employee in an eligible class satisfies the probationary waiting period shown in Section 1. Policy Data.

Enrollment, Enrollment Form
The written request for enrollment in the plan of insurance by an eligible person on a form acceptable to Us.

In-Network Provider
An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide Plan Benefits to Covered Persons.

Insured Individual
An individual whose insurance is in force under the terms of the Policy.

Insured Dependent
A Spouse or Child(ren) whose insurance is in force under the terms of the Policy.

Kansas City Life
Kansas City Life Insurance Company, a Missouri corporation, with its Home Office located at 3520 Broadway, Kansas City, Missouri 64111 and the telephone number is (816) 753-7000.

Life Event
Life Event means one of the following: 1) Your marriage or divorce; 2) the death of Your spouse; 3) the birth or adoption of Your child; 4) the death of Your child; 5) a change in the employment status of Your spouse; or 6) a change in Your employment status.

Materials
Frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

Out-of-Network Provider
Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons.

Plan Benefits
The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy.

Policy
The contract of insurance made by Kansas City Life and the Policyholder.

Policyholder
The firm or other organization in whose name the Policy is issued. The term Policyholder will include only those Subsidiaries, Divisions, and Affiliates listed in the Policy.

We, Us, and Our
Kansas City Life Insurance Company also referred to as Kansas City Life.

You/Your
The individual who is insured under this plan. The words "You" and "Your" with respect to any benefits, rights and privileges outlined in this certificate, refer to the employee.

Eligibility and Effective Dates

Who can be insured?
All members of the eligible classes shown on the Schedule of Benefits can be insured.

When am I eligible to be insured?
You are eligible to be insured on the latest of:

1) the policy effective date;
2) the date You become a member of an eligible class shown on the Schedule of Benefits; or
3) the date You complete the probationary waiting period (if any).

The probationary waiting period may differ for current and new Insured Individuals. The probationary waiting periods are shown in the Vision Insurance Policy.

When does my insurance begin?
To become insured, You must complete, sign, and submit an enrollment form to the Policyholder within 31 days of Your eligibility date.

(Contributory-If the first of the policy month effective date applies)
Your insurance begins on the later of the following dates, but only if You are a member of an eligible class on the date insurance is to begin:

1) the first day of the policy month which coincides with or next follows the date You are first eligible, if You submit the enrollment form on or before the date You are first eligible;
2) the first day of the policy month, which coincides with or next follows the date You submit the enrollment form, if You submit the enrollment form within 31 days after the date You are first eligible;
3) the first day of the policy month which follows the Annual Enrollment Period; or
4) the date You submit the enrollment form, if You submit the enrollment form within 31 days of a Life Event.

You cannot apply for insurance or for a change in Your insurance option at any other time.

If You are not a member of an eligible class on the date insurance is to begin, such insurance will begin on the first day of the policy month following Your entry into an eligible class.

When am I eligible for insurance for my dependents?
You are eligible for insurance for Your dependents on the later of:

1) the date You are eligible to be insured; or

2) the date You acquire an eligible dependent.

The date acquired for eligible dependents is as follows:

1) a spouse is deemed acquired on the date of marriage;

2) a natural child is deemed acquired on the date of birth;

3) an adopted child is deemed acquired on the date of placement for the purpose of adoption and continues to be eligible unless the placement is disrupted prior to legal adoption and the child is removed from placement;

4) a stepchild is deemed acquired on the date of marriage to the natural parent; and

5) a grandchild or other child is deemed acquired on the first date he or she meets the definition of "child" as shown below.

Who are eligible dependents?
Eligible dependents are:

1) Your spouse; and/or

2) each unmarried child who is:

   a) under 26 years of age (until the end of the month in which the child turns age 26);

   b) age 26 or over if the child:

      i) is incapable of earning a living due to mental or physical handicap on the day before reaching the age limit;

      ii) depends on You for more than half of his or her support on that day; and

      iii) remains incapacitated and dependent as described. You must submit proof of incapacity and dependency to Kansas City Life within 31 days after the child reaches the age limit. Kansas City Life can require proof of continued incapacity and dependency but not more than once each year after the two-year period following the child reaching that age limit.

Child includes only:

1) Your natural child or adopted child; and/or

2) Your stepchild, grandchild, or other child who lives with You in a regular parent-child relationship and for whom You (or Your spouse who lives with You) have legal custody ordered by a court of competent jurisdiction.

No one can be insured as a dependent of more than one Insured Individual.

No one on active duty in the Armed Forces of any country can be insured as a dependent.

No one can be insured as a dependent if eligible for insurance as an Insured Individual, except if You and Your spouse can be insured as an Insured Individual, one (and only one) of You may insure the other for vision care expenses.

When does insurance for dependents begin?
To insure Your dependents, You must complete, sign, and submit an enrollment form to the Policyholder within 31 days after Your dependent becomes eligible. Your request must include all Your dependents then eligible.

(Contributory-If the first of the policy month effective date applies)
The dependent's insurance begins for each dependent then eligible on the later of:

1) the date Your insurance begins;

2) the first day of the policy month which coincides with or next follows:

   a) the date You are first eligible for insurance for Your dependents, if You submit the enrollment form on or before the date You are first eligible for insurance for Your dependents;

   b) the date You submit the enrollment form, if You submit the enrollment form within 31 days after the date You are first eligible for insurance for Your dependents;

   c) the first day of the policy month which follows the Annual Enrollment Period; or

   d) the date You submit the enrollment form, if You submit the enrollment form within 31 days of a Life Event.

You cannot apply for insurance or for a change in Your dependent's insurance option at any other time.

You must inform Kansas City Life and the Policyholder in writing when Your last dependent is no longer eligible. The Policyholder has forms available for this purpose. Kansas City Life will not give refunds or credits for Your payment toward the cost of insurance for Your dependents for any period before the later of:

1) the date Your last dependent's insurance ends; or

2) 90 days before the date Kansas City Life is informed.

Dependents acquired after Your coverage is effective.
Newborns are covered from the date of birth to the next premium due date that is at least 31 days after the child's birth. To continue coverage after this date You must request the coverage in writing and agree to make any required contributions.

All other dependents will be covered from the date of eligibility, if written request and payment of any required premium is submitted within 31 days.

Termination Provisions

When does insurance terminate?
Insurance under the Policy for You or Your dependents will end at 11:59 p.m. on the earliest of:

1) the date the Policy terminates;

2) the date the Policy is amended or changed to end the insurance for the class of eligible individuals to which You belong;

3) the date You cease to be a member of a class for whom insurance is provided;

4) the date that ends the period for which You last made any required payment toward the cost of insurance for You or Your dependents;

5) the date You cease to be actively-at-work as a full-time employee of the employer, if the Policy requires You to be actively-at-work except as provided under a covered leave of absence or temporary layoff;

6) the date Your dependents cease to be eligible;

7) the date, which You or Your dependent enters the Armed Forces, other than for reserve duty of 30 days or less.

If I terminate my coverage when will I be eligible to re-enroll in coverage?
Once You enroll in this coverage, You can't terminate Your vision coverage until the next Annual Enrollment Period. If You terminate Your vision coverage, You can't enroll again until the next Annual Enrollment Period. If Your insurance ends because You fail to make the required premium contribution, You and Your Dependents, if any, will not be eligible until the next Annual Enrollment Period.

Can my coverage continue while I am not actively-at-work?
The Policyholder may (but is not required to) consider You a member of an eligible class (and continue Your insurance) even though You are:

1) put on approved leave of absence;

2) temporarily laid-off and the Policyholder expects to call You back to work.

The Policyholder must treat all Insured Individuals the same for purposes of continuing insurance.

If Your insurance is so continued, it will end on the earliest of:

1) the date the Policyholder notifies Kansas City Life that You are no longer a member of an eligible class; or

2) the date that ends the period for which the Policyholder last paid the premium for You; or

3) the date that ends the maximum continuation period for which the insurance can be continued.

The maximum continuation period is as follows:

- for FMLA or State FML – leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments or by applicable state law
- for temporary lay-off – one month

Benefits Payable

What benefits are payable?
Subject to all the terms of the Policy, we will pay for covered vision expenses incurred by You and Your Covered Dependents as shown in the Schedule of Benefits. Benefits will be payable after the Covered Person has paid any applicable Copayment. Benefits for certain covered vision expenses may be provided in the form of an Allowance.

We will provide the In-Network Benefits shown in the Schedule of Benefits for covered vision expenses incurred by Covered Persons if the examination is provided by or materials are purchased from an In-Network Provider.

We will provide the Out-of-Network Benefits shown in the Schedule of Benefits for covered vision expenses incurred by Covered Persons if the examination is provided by or materials are purchased from an Out-of-Network Provider. You must pay the entire amount at the time of service, after which the Allowance will be reimbursed to You. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.

Services from an Out-of-Network Provider are in lieu of services from an In-Network Provider.

Are You required to get a Benefit Authorization?
A Benefit Authorization must be obtained before a Covered Person can use Plan Benefits from an In-Network Provider. When a Covered Person seeks Plan Benefits from an In-Network Provider, the Covered Person must schedule an appointment and identify himself/herself as a Covered Person under this policy so the In-Network Provider can obtain a Benefit Authorization from VSP. VSP shall provide a Benefit Authorization to the In-Network Provider to authorize the administration of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date and must be used by the Covered Person to obtain Plan Benefits prior to the date the Benefit Authorization expires.

VSP shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Policyholder and the Covered Person's past service utilization, if any. Any Benefit Authorization so issued by VSP shall constitute a certification to the In-Network Provider that payment will be made to In-Network Provider, irrespective of a later loss of eligibility of the Covered Person, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

Covered Vision Expenses

Subject to the Limitations and Exclusions, covered vision expenses include charges made by a Provider for the following vision care services while You or Your Dependents, if any, are insured for these benefits. The benefits payable under the Policy vary depending upon which Provider rendered the services.

Covered vision expenses include expenses for eye examinations and Materials shown in the Schedule of Benefits.

Eye Examination
Comprehensive examination of visual functions and prescription of corrective eyewear.

Eye examinations from an In-Network Provider are subject to the Copayment shown in the Schedule of Benefits. The Covered Person must contact an In-Network Provider before an eye examination. The In-Network Provider will verify that person's eligibility for Covered Expenses with Us before the examination takes place. The Provider will submit the Covered Person's claim directly to Us.

Benefits under the Policy for eye examinations from an Out-of-Network Provider are payable up to the Allowance shown in the Plan Description or the actual charge for the eye examination, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance.

Materials
1) Lenses – Glass or plastic single vision, lined bifocal, lined trifocal or lenticular. Polycarbonate lenses are covered in full for dependent children up to age 26.

2) Frames – If vision correction is recommended by a Provider, Covered Vision Expenses will include the fitting of eyeglasses and follow-up adjustments.

3) Contact Lenses – Elective Contact Lenses and Necessary Contact Lenses. Necessary Contact Lenses are prescribed by the Provider when a specific criterion is met to correct extreme visual acuity problems that cannot be corrected with regular lenses. Contact Lenses are provided in place of spectacle lens and frame benefits.

The above materials are subject to the Copayment for In-Network Benefits shown in the Schedule of Benefits.

Frames and lenses from an Out-of-Network Provider are payable up to the Allowance shown in the Schedule of Benefits for Out-of-Network Materials or the actual charge for the frames and lenses, whichever is less. A Covered Person is responsible for any amount in excess of the Allowance shown in the Schedule of Benefits.

Low Vision Program
Low Vision services are prescribed by the Provider when specific criterion is met for professional services for severe visual problems not correctable with regular lenses. Supplemental testing includes evaluation, diagnosis and prescription of visual aids where indicated. Benefits are payable up to the Allowance, subject to the maximum shown in the Schedule of Benefits for the Covered Vision Expense.

Limitations and Exclusions

What are the limitations and exclusions?
Benefits will not be paid for and the term "Covered Vision Expenses" will not include charges for:

1) Services and/or materials not specifically included in the Schedule of Benefits as covered Plan Benefits.
2) Plano lenses (lenses with refractive correction of less than ± .50 diopter).
3) Two pair of glasses instead of bifocals.
4) Replacement of lenses, frames and/or contact lenses furnished under this Policy which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
5) Orthoptics or vision training and any associated supplemental testing.
6) Medical or surgical treatment of the eyes.
7) Contact lens insurance policies or service agreements.
8) Refitting of contact lenses after the initial (90-day) fitting period.
9) Contact lens modification, polishing or cleaning.
10) Services or materials furnished to a Covered Person before the Effective Date of the Policy or after the date a Covered Person's Insurance ends.
11) Services or materials obtained while outside the United States, except for emergency vision care.
12) Eye examinations or corrective eyewear required by an Employer as a condition of employment.

Coordination of Benefits ("COB")

This coordination of benefits (COB) provision applies to **this plan** when a Covered Person has health care coverage under more than one **plan**. **Plan** and **this plan** are defined here. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of **this plan** are determined before or after those of another **plan**. The benefits of **this plan**:

a) Shall not be reduced when, under the order of benefit determination rules, **this plan** determines its benefits before another **plan**; but
b) May be reduced when, under the order of benefits determination rules, another **plan** determines its benefits first.

DEFINITIONS

Plan is any of these which provides benefits or services for vision care:

a) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.

b) Coverage under a governmental **plan**, or coverage required or provided by law. This does not include a state **plan** under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act).

Each contract or other arrangement for coverage under (a) or (b) is a separate **plan**. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate **plan**.

This plan is the part of the group contract that provides benefits for vision care expenses.

Primary plan/secondary plan. The order of benefit determination rules state whether **this plan** is a **primary plan** or **secondary plan** as to another **plan** covering the person. When **this plan** is a **primary plan**, its benefits are determined before those of the other **plan** and without considering the other **plan's** benefits. When **this plan** is a **secondary plan**, its benefits are determined after those of the other **plan** and may be reduced because of the other **plan's** benefits. When there are more than two **plans** covering the person, **this plan** may be a **primary plan** as to one or more other **plans** and may be a **secondary plan** as to a different **plan(s)**.

Allowable expense means a necessary, reasonable and customary item of expense for vision care, when the item of expense is covered at least in part by one or more **plans** covering the person for whom the claim is made. When benefits are reduced under a **primary plan** because a covered person does not comply with the **plan** provisions, the amount of that reduction will not be considered an **allowable expense**. An example of these provisions is preferred provider arrangements.

Claim determination period means a calendar or plan year. However, it does not include any part of a year during which a person has no coverage under **this plan** or any part of a year before the date this COB provision or similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

GENERAL

When there is a basis for a claim under **this plan** and another **plan**. **This plan** is a **secondary plan** which has its benefits determined after those of the other **plan**, unless:

a) The other **plan** has rules coordinating its benefits with those of **this plan**; and

b) Both those rules and **this plan's** rules require that **this plan's** benefits be determined before those of the other **plan**.

RULES

This plan determines its order of benefits using the first of the following rules which applies:

a) Nondependent/dependent. The benefits of the **plan** which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the **plan** which covers the person as a dependent;

b) Dependent child/parents not separated or divorced. Except as stated in paragraph (c), when **this plan** and another **plan** cover the same child as a dependent of different persons, called parents:

   i. The benefits of the **plan** of the parent whose birthday falls earlier in a year are determined before those of the **plan** of the parent whose birthday falls later in that year; but

   ii. If both parents have the same birthday, the benefits of the **plan** which covered one (1) parent longer are determined before those of the **plans** which covered the other parent for a shorter period of time. However,

if the other **plan** does not have the rule described previously in Rules, (i) or (ii) and if, as a result, the **plans** do not agree on the order of benefits, the rule in the other **plan** will determine the order of benefits.

c) Dependent child/separated or divorced. If two or more **plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   i. First, the **plan** of the parent with custody of the child;

   ii. Then, the **plan** of the spouse of the parent with the custody of the child; and

   iii. Finally, the **plan** of the parent not having custody of the child. However, if the specific terms of a court decree state that one (1) of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the **plan** of that parent or spouse of the other parent has actual knowledge of those terms, the benefits of that **plan** are determined first. The **plan** of the other parent shall be the **secondary plan**. This paragraph does not apply with respect to any **claim determination period** or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d) Joint custody. If the specific terms of a court degree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the **plans** covering the child shall follow the order of benefit determination rules outlined in paragraph (b), above.

e) Active/inactive Enrollee. The benefits of a **plan** which covers a person as an Enrollee who is neither laid off nor retired are determined before those of a **plan** which covers that person as a laid off or retired Enrollee. The same would hold true if a person is a dependent of a person covered as a retiree and an Enrollee. If the other **plan** does not have this rule and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored.

f) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another **plan**, the following shall be the order of benefit determination:

   i. First, the benefits of a **plan** covering the person as an employee, member, or subscriber (or as that person's dependent); and

   ii. Second, the benefits under the continuation coverage. If the other **plan** does not have the rule described here and if, as a result, the **plans** do not agree on the order of benefits, this rule is ignored.

g) Longer/shorter length of coverage. If none of the previous rules determines the order of benefits, the benefits of the **plan** which covered an employee, member, or subscriber longer are determined before those of the **plan** which covered that person for the shorter term.

EFFECT ON THE BENEFITS OF THIS PLAN

WHEN THIS SECTION APPLIES

This section applies when, in accordance with the Order of Benefit Determination Rules, **this plan** is a **secondary plan** as to one or more other **plans**. In that event the benefits of **this plan** may be reduced under this section. Other plan(s) are referred to as the "other plans" in "Reduction in this plan's benefits", immediately following.

REDUCTION IN THIS PLAN'S BENEFITS

The benefits of **this plan** will be reduced when the sum of:

(a) The benefits that would be payable for the **allowable expense** under **this plan** in the absence of this COB provision; and

(b) The benefits that would be payable for the **allowable expenses** under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those **allowable expenses** in a **claim determination period**. In that case, the benefits of **this plan** will be reduced so that they and the benefits payable under the other plans do not total more than those **allowable expenses**. When the benefits of **this plan** are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of **this plan**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. Kansas City Life Insurance Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Kansas City Life Insurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under **this plan** must give Kansas City Life Insurance Company any facts it needs to pay the claim.

FACILITY OF PAYMENT

A payment made under another **plan** may include an amount which should have been paid under **This Plan**. If it does, Kansas City Life Insurance Company may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under **this plan**. Kansas City Life Insurance Company will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by Kansas City Life Insurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of:

a) The person it has paid or for whom it has paid;

b) Insurance companies; or

c) Other organizations.

Subrogation will not be allowed in any **plan** as distinguished from the rights to recovery.

Claim Provisions

How do I file a claim?
All claims for benefits should be submitted on Our forms. All claims for Out-of-Network benefits should be submitted on Our forms. You or the Provider should obtain claim forms from the Policyholder or Us. If We fail to provide You with claim forms within 15 days of Your request, You:

1) May submit Your claim in a letter stating the vision expense for which the claim is made.

2) Will be deemed to have complied with the requirements of the Proof of Loss provision upon submitting to Us written proof covering the occurrence and the character and the extent of loss for which a claim is made, within 180 days from the date of loss. Failure to give notice of claim within such time shall not invalidate nor reduce any claim if it was not reasonably possible to give notice of claim within such time and that notice was given as soon as reasonably possible.

When are benefits payable?
Subject to proof of loss, any benefits payable under the Policy will be paid within 30 days of Our written receipt of such proof of loss, or Our initial notice of decision of claim, if later.

All In-Network benefits will be paid directly to the Provider. Out-of-Network benefits will be paid to You unless You provide written authorization for payment to the Provider. Any accrued benefits unpaid at the time of Your death will either be paid to Your beneficiary or to Your estate.

When must a claim be filed to receive benefits?
Written notice of a claim must be given to Us within 180 days after the incurred date of the Covered Vision Expense or as soon thereafter as reasonably possible. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required. If an In-Network Provider is used, notice of claim will be given to Us directly by the Provider on behalf of the Covered Person.

No action at law or in equity may be brought to recover under the Policy before 60 days after proof of loss has been filed nor will such action be brought at all unless brought within three years from the end of the time allowed for furnishing proof of loss.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:

1) give the specific reason(s) for the denial;

2) make specific reference to the policy provisions on which the denial is based;

3) provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and

4) provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

1) request a review upon written application within 180 days of the claim denial;

2) review pertinent documents; and

3) submit issues and documents in writing.

We will make a decision no more than 60 days after the receipt of the request, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. The written decision will include specific references to the policy provisions on which the decision is based.

The Following Important Notice is Provided by Your Employer for Your Information Only.

Conforming Instrument
For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your booklet are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

1. Plan Name

Group Plan for employees of Joachim-Plattin Ambulance District

2. Plan Number

3. Employer/Plan Sponsor

Joachim-Plattin Ambulance District
1235 N Truman Blvd
Crystal City, MO 63019

4. Employer Identification Number

431057397

5. Type of Plan

Welfare Benefit Plan providing Group Vision benefits.

6. Plan Administrator

Joachim-Plattin Ambulance District
1235 N Truman Blvd
Crystal City, MO 63019

7. Agent for Service of Legal Process

For the Plan:

Joachim-Plattin Ambulance District
1235 N Truman Blvd
Crystal City, MO 63019

For the Policy:

Kansas City Life Insurance Company
PO Box 219425
Kansas City, MO 64121-9425

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8. Sources of Contributions -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

9. Type of Administration -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

10. The Plan and its records are kept on a Policy Year basis.

11. Labor Organizations

None

12. Names and Addresses of Trustees

Joachim-Plattin Ambulance District
1235 N Truman Blvd
Crystal City, MO 63019

13. Plan Amendment Procedure

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

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

1) Receive Information About Your Plan and Benefits:

   a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, 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 and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

   c) 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.

2) Continue Group Health Plan Coverage:

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuous coverage rights.

3) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “"fiduciaries”" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4) Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful

the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5) Assistance with Your Questions:

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claim Procedures for Vision Insurance Plans

How to File a Claim

To file a claim for benefits for yourself or your insured dependents, you must complete a claim form. You can get a claim form from the Policyholder or from Kansas City Life.

Send the completed claim form and bills to Kansas City Life. You may assign your vision care benefits. Unless you assign your benefits to a health care provider, payment will be made to you.

Claim Procedures

a) For Post-Service claims, a decision will be made on your claim within 30 days after receipt. The time for decision may be extended for an additional 15 day period provided that, prior to any extension period, Kansas City Life notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, you will have 45 days from receipt of the notice to provide the specified information.

b) For Pre-Service claims, a decision will be made on your claim within 15 days after receipt. The time for decision may be extended for an additional 15 day period provided that, prior to any extension period, Kansas City Life notifies you in writing that an extension is necessary due to matters beyond the control of the plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, you will have 45 days from receipt of the notice to provide the specified information.

c) For Urgent Care claims, a decision will be made on your claim within 72 hours after receipt, unless you fail to submit information necessary to decide your claim. If this is the case, Kansas City Life will notify you no later than 24 hours after receipt of the claim of the specific information needed. You will then have 48 hours to provide the specified information.

If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination will:

a) state the specific reason(s) for determination;

c) reference specific plan provision(s) on which the determination is based:

d) describe additional material or information necessary to complete the claim and why such information is necessary;

e) describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and

f) disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or provide that such information will be provided free of charge upon request.

Appealing Denial of Claims

You are entitled to full and fair review of the denial of a claim which has been wholly or partially denied. The procedure for review is as follows:

a) We must receive your written request within 180 business days of the notice of denial.

b) You may review pertinent documents and submit issues and comments in writing.

c) For Post-Service claims, a decision will be made on your request for review within 60 days after receipt unless special circumstances require an extension of time for processing.

d) For Pre-Service claims, a decision will be made on your request within 30 days after receipt unless special circumstances require an extension of time for processing.

e) For Urgent Care claims, a decision will be made within 72 hours after receipt.

f) The review will be conducted by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate.

g) The written decision will include specific references to the plan provisions on which the decision is based and will include any other information required by applicable law.

h) The above appeal procedure will pre-empt any state requirements on internal appeals except to the extent that both federal and state requirements can be met.

COBRA CONTINUATION OF COVERAGE

(applies only to groups of 20 or more, as defined below)

What is COBRA Continuation?
It is a federal continuation of coverage requirement. Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to any employer (except the federal government and religious organizations) who:

- maintains a group health plan; and
- normally employs 20 or more employees on a typical business day during the preceding calendar year.

For this purpose, “employee” means all owners, partners, and common-law employees (full-time and part-time).

Federal law requires that certain group plans allow qualified persons who would otherwise lose coverage under the plan as a result of a qualifying event, to elect to continue group health coverage after it would otherwise end.

See your Employer for details on this continuation provision. All compliance obligations under COBRA are the responsibility of the Employer and Employee.

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review It Carefully.

As used in this notice, “WE” and “OUR” refer to the functions of Kansas City Life Insurance Company and its insurance subsidiaries, Old American Insurance Company and Sunset Life Insurance Company of America, which are covered by federal laws and regulations governing use and disclosure of personally identifiable health information (“protected health information” or “PHI”). The functions which are covered by these rules include: administration of Kansas City Life's group dental and group vision policies. “YOU” means a named insured of a group health insurance policy or an enrollee in the health or dental benefit plan.

Our Duties.
We are required by the Health Insurance Portability and Accountability Act of 1996 to maintain the privacy of your PHI and to provide you with this Notice of our privacy practices and legal duties. We must abide by the terms of this Notice. We reserve the right to change the terms of this notice and to make the new terms effective as to all of the PHI that we maintain about you. In that case we will provide you with a new Notice by mailing it to the address you have last provided us, or with your consent by sending it to you electronically.

Your Rights.
You have a right to access, inspect and copy the PHI we maintain about you. We may impose a reasonable fee where permitted by law.

You have the right to request that we amend your PHI. We may deny your request if we did not create the PHI you want us to amend, or for other reasons. If we do not agree to amend your PHI as you request, you may submit a short statement of dispute and we will include it with your records.

You have the right to an accounting of disclosures we have made of your PHI to others after April 14, 2003, except for disclosures related to your treatment, payment or other health care operations. We may impose a reasonable fee if you make such a request more than once in any 12-month period.

You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to additional restrictions.

You have the right to request that we communicate with you in confidence about your PHI by providing us with an alternate means or location. You must inform us that this is required to avoid endangering you.

If we provide you this Notice by electronic means, you have the right to request a paper copy.

You may exercise any of the rights stated in this section of the Notice by making your request in writing and sending it to us, postage prepaid, at the address shown at the end of this Notice.

Where We Get Your PHI.
We get most health history and treatment information from you or somebody you have authorized to provide it to us. For instance, we get medical information about you in order to pay a health insurance benefit or to pay providers of medical treatment.

Permitted Disclosures of Your PHI.
We are allowed to use and disclose your PHI without your authorization as necessary to conduct or service our business or when disclosure is legally required. For instance, we may use and disclose your PHI as needed to pay claims, set premiums, reinsure policies and underwrite for health care coverage. If you are an enrollee of an employee dental or medical benefit plan, we may disclose limited PHI to your plan’s sponsor to permit the sponsor to perform plan administration functions. We may also disclose your PHI when we are required to do so by law (for instance, by subpoena, administrative order or discovery request), or as requested by the U.S. Department of Health and Human Services. If you want us to disclose your PHI to any other person or entity, you must give a written authorization. You may revoke your authorization at any time in writing.

We will not otherwise disclose your PHI to an affiliate or any third party who helps administer our business unless they agree in writing to maintain its confidentiality, use it only as intended and if feasible destroy it when no longer needed.

We do not sell your PHI or disclose it to anyone for purposes unrelated to our services.

We will comply with applicable health information privacy law of any state which is more stringent than and not pre-empted by federal law.

Complaints.
If you want further information or have any questions about our privacy practices, please contact us using the information provided in this section. You also may submit a written complaint to the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way if you file a complaint.

Contact: Privacy Official, Legal Department, Kansas City Life Insurance Company, PO Box 219139, Kansas City, MO 64121-9139. Or, telephone us at 800-874-5254 ext. 6046.

Questions or Additional Information
Should you have any questions or want additional information about your coverage, this notice, or our privacy practices; please contact KCL Group Administration, PO Box 219425, Kansas City, MO 64121-9425, phone 1-800-874-5254 ext. 6046.