Group Insurance Benefits

THE EMPLOYER ADVANTAGE

Group Vision Insurance

Class 01

KANSAS CITY LIFE
INSURANCE COMPANY

Notice Concerning Coverage Limitations and Exclusions Under the Life and Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Missouri Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Missouri Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Missouri. You should not rely on coverage by the Missouri Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

YOU MAY CONTACT EITHER THE ASSOCIATION OR THE MISSOURI DEPARTMENT OF INSURANCE AT THE FOLLOWING ADDRESSES SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE.

The Missouri Life and Health Insurance Guaranty Association
994 Diamond Ridge, Suite 102
Jefferson City, MO 65109

Missouri Department of Insurance
PO Box 690
Jefferson City, MO 65102-0690

The state law that provides for this safety-net coverage is called the Missouri Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's right or obligations under the act or the rights or obligations of the guaranty association.

(Continued on Reverse Side)

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

- the person is eligible for protection under the laws of another state;
- the person purchased the insurance from a company that was not authorized to do business in this state;
- the policy is issued by an organization which is not a member insurer of the association; or
- the person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees).

The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($300,000) for any one insured for any combination of insurance benefits.

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.

Secretary

President, CEO and Chairman

Guide to Certificate Provisions

Schedule of Benefits

Policyholder:
The Employer Advantage

Group Number:
GV-21369

Classes of Eligible Individuals:
All full-time W-2 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 Description

FREQUENCY OF USE

Eye Examination	Once every 12 months
Materials	
Lenses	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every 12 months
Frame	Once every 24 months

IN-NETWORK BENEFITS

	Copayment*
Eye Examination	$10.00
Materials	
Eyeglasses (lenses and frames**)	$25.00
Contact Lenses***	
Formulary	$25.00
Medically Necessary Contact Lens	$25.00

The Covered Person or the attending Provider must send a completed request to Us for medically necessary contact lenses before the lenses are dispensed. Any amount due, over the Allowance for such lenses, is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be Your responsibility.

*Copayment does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.

**Frames other than Davis Vision's Designer or Premier Collections will be paid up to a maximum of $130.00. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Premium Collection there is an additional Copayment; see "Optional In-Network Items" below.

***Contact lenses other than Formulary contact lenses will be paid up to a maximum of $130.00. The balance, if any, is the Covered Person's responsibility.

Plan Description (Cont.)

Designer Plan — Eyewear from Davis Vision's Designer Collection. In-Network Providers will have a complete exclusive Tower Collection (of Davis Vision frames). In addition, You and Your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Premier Collection. All Optional In-Network Items are subject to the applicable Copayment.

Optional In-Network Items	Copayment
Premier Frame	$25.00
Progressive Addition Multifocal Lenses	
Standard Types	$50.00
Premium Types	$90.00
Photochromic Glass Lenses	$20.00
Scratch Resistant Coating	$0
Anti-Reflective Coating	
Standard Types	$35.00
Premium Types	$48.00
Ultra Types	$60.00
Blended Invisible Bifocal Lenses	$20.00
Ultra Violet Coating	$12.00
Polycarbonate Lenses	$30.00*
High Index Lenses	$55.00
Plastic Photosensitive Lenses	$65.00
Polarized Lenses	$75.00
Intermediate Vision Lenses	$30.00
Scratch Protection Plan	
Single Vision Lenses	$20.00
Multifocal Lenses	$40.00

*no Copayment for children up to age 19 or monocular patients.

OUT-OF-NETWORK BENEFITS

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

	Allowance*
Eye Examination	$40.00
Materials	
Frames	$45.00
Lenses	
Single Vision	$40.00
Bifocal	$60.00
Trifocal	$80.00
Lenticular	$80.00
Contact Lenses	$120.00

*Unless the examination and materials are medically necessary, any charges in excess of the Allowance are Your responsibility.

Medically Necessary Contact Lens	$210.00

The Covered Person or the attending Provider must send a completed request to Us for medically necessary contact lenses before the lenses are dispensed. Any amount due, over the Allowance for such lenses, is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be Your responsibility.

LOW VISION PROGRAM

Comprehensive Evaluation	Once every 60 months (includes four follow-up visits)
Maximum per Evaluation	$300.00
Maximum per Follow-up Visit	$100.00
Low Vision Aids	
Maximum per Aid	$600.00
Lifetime Maximum for all Aids	$1,200.00

Note this program is available both In and Out of network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Us prior to the initial evaluation. Once approved, a Covered Person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids, is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services or supplies will be Your responsibility.

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.

Copayment
The amount the Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in the Plan Description.

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

Covered Vision Expense
An expense for eye examinations, the fitting of eyeglasses or Materials, incurred by the Covered Person, for which benefits are payable 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
Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network.

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.

Optional In-Network Items
Materials provided under the Policy that can be selected at the Covered Person's option, subject to a Copayment, if any, shown in the Plan Description.

Out-of-Network Provider
Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services.

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.

Provider
A practitioner who is a legally qualified professional providing eye examinations and refractive and/or post-refractive services within the scope of their license. This term includes an ophthalmologist, an optometrist or an optician recognized as such in accordance with the laws of the state in which the services are provided. The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

Scheduled Fee
The amount negotiated between an In-Network Provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and Materials received or purchased by the Covered Person.

Usual and Customary Charge
That portion of a charge, as determined by Us, made by a Provider for eye examinations, the fitting of eyeglasses or Materials which does not exceed the lesser of:

1) the customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
2) the usual charge the provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

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.

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;
    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.

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;

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;

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

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 Plan Description.

What is the difference between an In-Network Provider and an Out-of-Network Provider?
In-Network Providers have entered into a contract with Davis Vision to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of Davis Vision's Provider Network. Out-of-Network Providers of optometric services have *not* entered into a contract with Davis Vision to provide vision care services.

You and Your Dependents may use either an In-Network or an Out-of-Network Provider for Covered Vision Expenses. If an In-Network Provider is used, You will only be billed for the difference between the applicable Copayment, if any, and the Scheduled Fee for the Covered Vision Expense. Use of an Out-of-Network Provider may result in additional charges. Out-of-Network Providers may bill You for the difference between the Allowance and the Provider's *actual charge* for the eye examination and materials.

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.

Eye Examination
Covered Expenses for an eye examination include the following procedures:

1) Case history - chief complaint, eye and vision history, medical history

2) Entrance distance acuities

3) External ocular evaluation including slit lamp examination
4) Internal ocular examination
5) Tonometry
6) Distance refraction - objective and subjective
7) Binocular coordination and ocular motility evaluation
8) Evaluation of pupillary function
9) Biomicroscopy
10) Gross visual fields
11) Assessment and plan
12) Advise a Covered Person on matters pertaining to vision care
13) Form completion - school, motor vehicle, etc.

Eye examinations from an In-Network Provider are subject to the Copayment shown in the Plan Description. 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.

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

Materials
Designer Collection frames and the following lenses as provided through Davis Vision:

1) Glass or plastic lenses, in single vision, bifocal or trifocal prescriptions. The following types of lenses are also included:
    a) Prescription sunglasses with grey glass #3 lenses
    b) Oversized lenses
    c) Fashion and gradient tinting of plastic lenses
    d) Cataract lenses
    e) Contact lenses

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

2) Optional In-Network Items. These materials are subject to the Copayment for Optional In-Network Items shown in the Plan Description:
    a) Progressive Addition Multifocal Lenses (e.g. invisible bifocals)
    b) Photochromic Lenses - Single vision or multifocal
    c) Scratch Resistant Coating
    d) Standard Anti-Reflective Coating
    e) Premium Anti-Reflective Coating
    f) Ultra Anti-Reflective Coating
    g) Blended Invisible Bifocal Lenses
    h) Ultraviolet Coating

i) Polycarbonate Lenses (covered in full for children up to age 19 and monocular individuals)

j) High index lenses

k) Plastic Photosensitive Lenses

l) Polarized lenses

m) Intermediate Vision Lenses

n) Premier Frames - Frames from the Premier Collection are available with the Designer Collection package at the option of the Covered Person.

Frames and lenses from an Out-of-Network Provider or from an In-Network Provider's own collection are payable up to the Allowance shown in the Plan Description 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 Plan Description.

Medically necessary contact lenses prescribed for a Covered Person are subject to prior approval. The Covered Person or the attending Provider must send a completed request to Us before the lenses are dispensed. If the required approval is not obtained no benefit will be paid for such lenses and the entire charge will be Your responsibility.

The incurred date of charge for a vision care examination, refractive and/or post refractive services or materials, as evidenced by a proper receipt, is:

1) the date a service or procedure is performed; or
2) the date a purchase is made.

Low Vision Program
Benefits are payable up to the allowance, subject to the maximum shown in the Plan Description for the Covered Vision Expense. Covered Vision Expenses include:

- Comprehensive low vision evaluation in addition to a comprehensive eye examination when the comprehensive eye examination indicates a need for such an evaluation
- Follow-up visits
- Low Vision Aids

This benefit is subject to prior approval. The Covered Person or the attending Provider must send a completed request to Us prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for the above expenses and the entire charge will be Your responsibility.

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:

1) For services or supplies not recommended by a Provider.

2) For periodic vision examinations, except as provided for in the Plan Description.

3) For eye examinations required by an Employer as a condition of employment.

4) For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.

5) For lenses which do not provide vision correction.

6) For two pair of glasses in lieu of bifocals.

7) For charges for the replacement of lost or stolen lenses or frames within 24 months of service.

8) For sickness or injury covered by a workers' compensation act or other similar legislation.

9) Incurred as a direct or indirect result or war (declared or undeclared).

10) Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

11) For services or supplies furnished to a Covered Person before the effective date of the Policy or after the date a Covered Person's Insurance ends.

12) For services or supplies which are not generally accepted in the United States as being necessary and appropriate for the treatment of a patient's sickness or injury.

13) For any medical treatment rendered outside the United States.

14) For services rendered by practitioners who do not meet the definition of Provider.

15) For expenses covered by:
a) Any other group insurance.

b) A health maintenance organization or hospital or medical services prepayment plan available through an Employer, union or association.

16) For any expenses covered by any union welfare plan or governmental program or a plan required by law.

17) For medically necessary contact lenses prescribed for a Covered Person for which prior approval was not obtained from Us.

18) For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Us.

Coordination of Benefits ("COB")

It is common for family members to be covered by more than one Vision care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers. Kansas City Life will request information regarding eligible dependents' coverage under other plans once per year.

The purpose of this coverage is to provide protection not profit. In no event will reimbursement by all coverages combined exceed 100% of allowable expenses during a benefit determination period.

Benefit Determination Period – A calendar year beginning on January 1st and ending on December 31st.

Allowable Expenses - Any medically necessary, reasonable and customary item of expense that is covered in part or in full by either one or both plans. If a plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an expense incurred and a benefit paid. Benefit reductions for failure to follow the primary plans rules are not an allowable expense.

Primary Plan – The plan that pays benefits first based on the established Order of Benefit Determination rules.

Secondary Plan – The plan that coordinates benefits with the primary plan and usually pays a reduced benefit.

Credit Reserve – The difference between what the plan would have paid had there been no other coverage and the amount actually paid after coordinating benefits.

Order of Benefit Determination

If you or a family member are covered under another group plan as well as this one, the following Order of Benefit Determination will be used to determine which plan is primary and which plan is secondary.

1) The plan that does not have a COB provision will always be primary.

2) The plan that covers the claimant, as an employee will pay their benefits before the plan that covers the claimant as a dependent.

3) In the case of a dependent child, the plan that covers the parent whose birthday (month/day) occurs earlier in the year will pay their benefits before the plan that covers the parent whose birthday occurs later in the year. If both parents have the same birthday then the plan that has covered the child the longest will pay their benefits first. If the other plan does not have this "birthday rule" then the rule of the other plan (the "gender rule") will apply.

4) In the case of divorced or legally separated parents, the plan covering the claimant as a dependent of the natural parent with custody will pay their benefits before the plan covering the claimant as a dependent of the parent without custody.

5) If the parent with custody has remarried then the plan covering the claimant as a dependent of the parent with custody pays their benefits first, the plan covering the claimant as a dependent of the step-parent with custody pays second and the plan covering the claimant as a dependent of the parent without custody pays last.

6) If there is a court order that establishes financial responsibility for medical, dental or other health care expenses of the child, the plan that covers the parent with such financial responsibility will pay their benefits before any other plan that covers the child as a dependent.

7) If the above rules do not establish Order of Benefit Determination then the plan that has covered the claimant the longest will be primary.

How COB works

As the primary carrier, we will pay the benefits due under this plan as if there were no other coverage.

As the secondary carrier, we will require an Explanation of Benefits from the primary carrier. We will calculate our normal benefit, subtract the primary carrier's payment from the allowable expense and pay the difference up to our normal benefit. The difference between the amount paid and the amount we would have paid had there been no other coverage is put into a credit reserve account. This reserve is used to pay for expenses incurred during a benefit determination period that might not otherwise have been payable. In no event will we pay more that we would have paid in the absence of other coverage.

In the event the primary carrier has a different allowance for the same service, we will consider the higher of the two as an allowable expense.

In the event the primary carrier covers a service that is not covered under this plan, benefits may be payable up to the amount held in credit reserve for the year. If there is no credit reserve, no benefits will be payable.

In order to make this provision work properly you are required to furnish other coverage information to Kansas City Life and all charges must be submitted to both carriers.

As permitted by law, Kansas City Life may:

1) Obtain from any person, provider, insurance company or organization information required to make this provision work; and

2) Release to any person, provider, insurance company or organization information required to make this provision work.

Under this provision, Kansas City Life reserves the right to:

1) Recover any overpayment which Kansas City Life may have made to you or any provider, insurance company, person or organization on your behalf, and

2) Reimburse any other organization up to the limits of our liability under this plan for payments that should have been made by Kansas City Life but were made by the other organization in error. Any amount paid under this provision will be considered a benefit paid and will be applied to the claimant's annual and/or lifetime maximum.

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 medical expense for which the claim is made.

2) Will be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for submitting proof of loss, written proof covering the occurrence for which a claim is made, and the character and the extent of loss for which a claim is made.

When are benefits payable?

Subject to satisfactory written proof of loss, any benefits payable under the Policy will be paid within 35 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. If any benefits are payable to Your estate, or to a person who is a minor, or otherwise not competent to give a valid release, We may pay the indemnity to an amount not exceeding $1,000 to any of Your relatives by blood or marriage who We deem to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

When must a claim be filed to receive benefits?
Written notice of a claim must be given to Us within 20 days after the incurred date of the Covered Vision Expense or as soon thereafter as reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. 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 inequity 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 The Employer Advantage

2. Plan Number

3. Employer/Plan Sponsor

The Employer Advantage
1027 S. Main Street, Suite 401
Joplin, MO 64801

4. Employer Identification Number

43-1542967

5. Type of Plan

Welfare Benefit Plan providing Group Vision benefits.

6. Plan Administrator

The Employer Advantage
1027 S. Main Street, Suite 401
Joplin, MO 64801

7. Agent for Service of Legal Process

For the Plan:
The Employer Advantage
1027 S. Main Street, Suite 401
Joplin, MO 64801

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

The Employer Advantage
1027 S. Main Street, Suite 401
Joplin, MO 64801

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;

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

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

d) 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

e) 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:

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

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

h) 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.

i) 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.

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

k) 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.

l) 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.

m) 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.