SURENCY LIFE & HEALTH INSURANCE COMPANY

AGREEMENT TO PROVIDE VISION BENEFITS

SECTION I – DECLARATIONS

This Agreement to Provide Vision Benefits ("Agreement") is made and entered into the 20th day of September, 2017 by and between USD #394 – ROSE HILL, hereinafter referred to as "Employer", and SURENCY LIFE & HEALTH INSURANCE COMPANY, hereinafter referred to as "Surency." The initial term of this Agreement shall be from October 1, 2017 to 11:59 PM central time on September 30, 2018, inclusive, and shall renew automatically for subsequent one-year terms, subject to the provisions of Section VIII. This Agreement is the controlling document for all benefits, terms and conditions and supersedes all other written or verbal communication regarding the insurance arrangement established by this Agreement.

1.1 AGREEMENT NUMBER: 22596-000-00001-00039

1.2 REQUIRED ENROLLMENT:

No less than twenty-five percent (25%) of all Eligible Employees must be Subscribers at all times, with a minimum group size of no fewer than ten (10) Subscribers who are Eligible Employees. If the enrollment falls below the required percentage of Eligible Employees, or if the minimum group size is not maintained, Surency may terminate this Agreement upon thirty (30) days' notice to the Employer.

1.3 EMPLOYER PREMIUM CONTRIBUTION:

Employer does not have a monthly contribution to the total premium paid for coverage.

1.4 WAITING PERIOD FOR NEW EMPLOYEES:

Each employee who first meets the qualifications of Section 5.1 at a time after the first day of the initial term of this Contract (without regard to whether such employee may have previously been an Eligible Employee pursuant to section 5.1) shall not be eligible for benefits hereunder until first of the month following employment and when the qualification of Section 5.1 would have otherwise been met. Each employee who meets the qualifications under Section 5.1 as of the first day of the initial term of this contract shall be eligible for benefits immediately upon the Effective Date of this Contract.

1.5 MONTHLY PREMIUM RATES:

Employee:	$9.25
Employee + Spouse:	$19.44
Employee + Child(ren):	$16.65
Family:	$31.18

NOTE: Rates guaranteed through September 30, 2020.

1.6 SELECTED NETWORK:

The provider network for this Agreement will be administered by EyeMed Vision Care, LLC ("EyeMed") through its third party administrator, First American Administrators.

1.7 SELECTED BENEFITS, COPAYMENTS AND ALLOWANCES:

For a Covered Service received by an Enrollee, Surency will provide the Benefits subject to the amount listed for each benefit which is indicated in the "Summary of Vision Plan Benefits" section, or the amount which is otherwise payable in accordance with the other provisions of this Agreement.

Summary of Vision Plan Benefits
Group # 22596-000-00001-00039
ACCESS A

SERVICES	IN NETWORK MEMBER COST	OUT OF NETWORK ALLOWANCES	FREQUENCY
Vision Examination with Dilation as Necessary Retinal Imaging	$10 Up to $39	$35 N/A	Once every 12 months
Contact Lens Fit and Follow-Up: *(Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed.)*			
Standard-spherical clear contact lenses in conventional wear and planned replacement. (Examples include but not limited to disposable, frequent replacement, etc.)	$0	$40	Once every 12 months
Premium-all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)	Access Network 10% off retail, then apply $55 allowance	$40	Once every 12 months
Frames: Any available frame at provider location.	$130 Allowance	$65	Once every 12 months
Standard Plastic Lenses: Single Vision Bifocal Trifocal	 $25 Copay $25 Copay $25 Copay	 $25 $40 $55	Once every 12 months
Lens Options: Standard Polycarbonate	 Adults: $40 Dependents under 19: $0	 $25 $25	 Once every 12 months
UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Premium Progressive Lenticular Other Add-Ons and Services	$15 $15 $15 $45 $65 $65 + 80% off Retail price less $120 $25 Copay 20% off Retail Price	Not covered Not covered Not covered Not covered $40 $40 $55 Not covered	Once every 12 months Once every 12 months
Contact Lenses: (Contact lens allowance includes materials only) (Allowance not available if eyeglass lenses are elected) Conventional Disposable Medically Necessary	 $130 allowance *15% off balance over* $130 allowance $0	 $100 $100 $200	Once every 12 months

Service frequencies are determined by date-of-service, not calendar year.

SEE SECTION IV ON EXCLUSIONS AND LIMITATIONS FOR ADDITIONAL INFORMATION

Payment of Claims
Before paying claims, Surency (or its representative or delegate) may require reasonable evidence of the benefit provided.

Child Ages
Eligible Dependents and full-time students who are children, are covered if they are under the age of twenty-six (26).

Additional Value Added Savings:
(Note: Not all providers offer or accept these discounts. Please check with them prior to services rendered or purchased.)

- Members may receive additional discounts not covered by the plan's in-network providers. Please check with your provider regarding any additional discounts. Discount does not apply to EyeMed provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Retail prices may vary by location. Services or materials provided by any other group benefit plan providing vision care may not be covered.
- Members also receive a forty percent 40% discount off of complete pairs of eyeglass purchases and a fifteen 15% discount off conventional contact lenses once the funded benefit has been used. Discounts are only available with network Providers.
- Members also receive fifteen 15% off retail price or five percent 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.
- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Additional Plan Benefits:

a. **Retinal Imaging** – a digital, high-resolution picture (image) of the inside of the eye. It helps the doctor track the health of the retina and more effectively manage potential eye and health conditions such as:
   - Glaucoma
   - Diabetic retinopathy
   - Age-related macular degeneration
   - Diabetes
   - High blood pressure
   - High cholesterol

SECTION II – GLOSSARY OF VISION TERMS

Anti-Reflective Coating – A common lens coating that allows more light to pass through the lens, cutting down on glare and distracting reflections. This coating is good for night driving and is also cosmetically appealing because it allows others to see your eyes rather than the light reflection off the lenses.

Benefits – Specific dollar amounts reimbursed or specific discounts for each covered product or service.

Bifocal Lenses – Lenses prescribed for those who need correction for both far away and up close.

Claim – A request for payment of benefits.

Conventional Contact Lenses – Contact lenses designed for long-term use (up to one year); can be either daily or extended wear.

Copay – A specified dollar amount a member must pay out-of-pocket for a specified service at the time of service.

Dependent – A member's spouse and/or child who meets the dependent criteria outlined by your employer/plan sponsor.

Disposable Contact Lenses – Contact lenses designed to be thrown away daily, weekly, bi-weekly, monthly or quarterly.

Eligible – qualified to receive benefits during a specified date range.

High Index – A lighter, thinner lens material offered to those with very high prescriptions.

Lens Add-On/Option – Any option that does not come with the basic lens. This includes, but is not limited to, polycarbonate, scratch-resistant coating, tint and UV coating. May also be referred to as an "option" or "upgrade". Add-ons listed on a plan are considered standard. Most add-ons also have premium options available.

Lenticular Lens – An infrequently-used technology needed in situations that require a high plus power that cannot be achieved with a traditional lens. This technology involves bonding one lens to the center of another to reach the correct power.

Medically Necessary Contact Lenses – Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following specific conditions:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- **Vision improvement other than Keratoconus** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

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

Network (In-Network) – The doctors, clinics, health centers, medical group practices, facilities and other professional provides that a managed care organization has selected and contracted with to provide health care for its members. In the case of EyeMed, our network includes opticians, credentialed optometrists, and ophthalmologists who can provide services and/or prove glasses and contacts covered under the plan.

Out-of-Network (OON) Provider – A professional provider who is not in the network of approved/credentialed providers.

Patient Allowance – A fixed amount of dollars that may be applied toward the payment for a professional service and/or material as specified by the benefit.

Photochromic Lenses – Lenses that change color based on different levels of light. When the lenses are exposed to sunlight they darken; when exposed to lower light (indoors), they lighten.

Plastic (Basic Lens Material) – the most widely used lens material because it is lighter in weight than glass.

Polarized Lenses – A common lens add-on that cuts down on glare from the sun. Ideal for driving or outdoor activities, especially water and snow sports.

Polycarbonate – A commonly used lighter, thinner lens material that helps create a more impact-resistant lens.

Progressive Lenses – Multifocal lenses with no lines. Available in both standard and premium brands.

Provider – An optician, optometrist or ophthalmologist who is able to provide services or materials to someone with EyeMed benefits.

Scratch-Resistant Coating – A common lens coating that helps reduce scratches on the lenses.

Single Vision Lenses – Lenses prescribed for those who only need correction for one field of vision: either far away or up close.

Tint – A common lens add-on that reduces the light that enters the eyes; can be doctor recommended or for fashion purposes.

Trifocal Lenses – Lenses prescribed for those who need correction for three fields of vision: far away, up close and intermediate.

UV Coating – A common eyeglass lens coating that protects eyes from harmful ultraviolet light.

SECTION III – DEFINITIONS

For the purpose of this Agreement, the following definitions shall apply:

Agreement – This Agreement between Surency and Employer, including group application, the attached appendices, endorsements and riders, if any. This Agreement constitutes the entire agreement between the parties.

Allowance – The amount or percentage available for a single application toward the cost of vision services and materials covered under this Agreement. Surency will pay up to the allowance shown in the "Summary of Vision Plan Benefits" section and Enrollees will be responsible for any remaining amount. Any allowance balance remaining may not be applied to any other service.

Calendar Year – The twelve (12) month period commencing on the first day of January and terminating at 11:50 P.M. on the last day of December.

Certificate of Insurance – The written summary of certain features of this Agreement.

Child – An Eligible Employee's own or lawfully adopted unmarried child or children residing with the Eligible Employee in a regular parent-child relationship. The term "Child" also includes any unmarried person placed with the Eligible Employee for adoption, and any unmarried child of the Eligible Employee who is recognized as an alternate recipient under a qualified medical child support order. A child is eligible for coverage under this Agreement if the child meets the age requirements.

In addition, a Child includes a disabled Child covered under this Agreement at the time the Child would otherwise cease to be eligible for coverage because of age and who is, at such time: i) unmarried, ii) incapable of earning his or her own living because of mental or physical disability, and iii) principally dependent upon the Eligible Employee for support at the time the Child would otherwise cease to be eligible for coverage by this Agreement because of age. A disabled Child shall continue to be an Eligible Dependent for the duration of the disability, provided: i) his or her status as an Eligible Dependent does not terminate for any other reason, and ii) proof of disability is furnished to Surency within thirty-one (31) days after the Child attains the age which would otherwise be disqualifying. Such proof of disability must thereafter be furnished from time to time as required by Surency. Surency reserves the right to determine whether an individual is disabled for purposes of this Agreement, which right will include, but will not be limited to, the right to obtain an independent medical evaluation of any such individual.

Continuation Coverage – The coverage provided under this Agreement pursuant to Section 4980B of the Internal Revenue Code of 1986, as amended ("Code"). All of the requirements, definitions and specifications of said Section 4980B of the Code which are necessary in order for this Agreement to satisfy Section 4980B of the Code, are being hereby adopted and incorporated by reference.

Contract Year – The period commencing on the Effective Date and terminating at 11:59 P.M. on the day preceding the anniversary thereof and each annual period thereafter during which the Contract remains in effect.

Covered Services – Those vision services, procedures, and products which Surency is required to provide to an Enrollee pursuant to the terms of this Agreement. A Covered Service only includes the extent to which a service, procedure, or product is to be provided under this Agreement (e.g., if only a portion of the cost of a service or product is covered hereunder, the remaining portion is not a Covered Service). Enrollees will be responsible for any vision care products and services that are not covered services under this Agreement.

Effective Date – The first day of the initial term of this Agreement.

Eligible Dependent – i) the spouse, as determined under applicable state law at the time and location that the marriage was entered into, ii) a Child of an Eligible Employee who satisfies the requirements of Section 5.4 and iii) any such spouse or Child who timely elects Continuation Coverage and for whom the appropriate premium is timely received by Surency.

Eligible Employee – Any person who meets the conditions of eligibility outlined in the "Eligibility of Employees and Their Dependents" section, and any person who no longer meets such conditions but who timely elects Continuation Coverage and for whom the appropriate premium is timely received by Surency.

Emergency – A serious condition that manifests itself by acute symptoms of sufficient severity, including severe pain, to lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate professional attention will likely result in any of the following: (a) serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; (b) serious impairment to the person's bodily functions; or (c) serious dysfunction of one or more of the person's body organs or parts.

Employer – The person(s) and/or entity(ies) named above which has hereby contracted with Surency to provide the Plan described in this Agreement, and such members of the Employer's controlled or affiliated group which are specifically listed in this Agreement.

Enrollee – A person, whether an Eligible Employee or Eligible Dependent, who is i) eligible to be covered by this Agreement, ii) validly enrolled in the Plan, and iii) for whom the appropriate premium is timely received by Surency. An Enrollee shall be deemed to have enrolled when such Enrollee's name, enrollment information and the required premium are furnished to Surency by Employer. However, in the case of an Enrollee in Continuation Coverage, such person shall be deemed to have enrolled when Surency is timely furnished by the Enrollee with the applicable enrollment form and premium.

EyeMed Vision Provider – A vision care provider who has entered into an agreement with EyeMed to provide vision benefits through Surency to Enrollees.

Group Application – the formal, written request for coverage by the Employer to Surency. The Group Application includes all data and related information which is required to be provided to Surency from time to time.

Spouse – Your spouse as determined under the laws of Kansas.

Subscriber – An Eligible Employee or member of the group covered by the Plan who (a) has completed and signed the documents necessary for coverage under the Plan, (b) has been accepted by Surency as a subscriber, and (c) for whom the appropriate premium has been paid.

Vision Examination – A comprehensive ophthalmological service as defined in the Current Procedural Terminology (CPT) and the Documentation Guidelines listed under "Eyes-examination items." Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination: biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

SECTION IV - EXCLUSIONS AND LIMITATIONS

4.1 Unless the "Summary of Vision Plan Benefits" and/or Section 1.7 Specifically Provides For Coverage, the Following Benefits And Services are NOT Covered:

a. Any service which is not a Covered Service.

b. Any services, supplies, materials, treatment or any other vision procedures, as applicable, provided, ordered or commenced prior to the effective date of the Enrollee's coverage under the Agreement.

c. Any services, supplies, materials, treatment or any other vision procedures to treat injuries or conditions related to your job, the extent that you are covered or are required to be covered by the Workers' Compensation laws or other similar employer's liability laws; or benefits or services which are available from any Federal or State government agency, or similar entity. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in the absence of that settlement.

d. Any services, supplies, materials, treatment or any other vision procedures, as applicable, except as provided in the Declarations and the "Summary of Vision Plan Benefits".

e. Aniseikonic lenses.

f. Any additional service required outside basic vision analyses for contact lenses, except fitting fees.

g. Benefits combined with any discount, promotional offering or other group benefit plans.

h. Benefits and services that are not necessary and customary as determined by the standards of general accepted vision care practice.

i. Broken, lost or stolen lenses, contact lenses, frames, or other materials.

j. Charges for consultation.

k. Vision examination for vision materials that may be required as a condition of employment, including but not limited to industrial or safety glasses.

l. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under your plan.

m. Coverage for any patient who has been, but no longer is an Enrollee.

n. Discounts do not apply for benefits provided by other group benefit plans.

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

p. Plano lenses and nonprescription sunglasses.

q. Procedures not specifically covered under this Agreement.

r. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.

s. Services rendered after the date an Enrollee ceases to be covered under the Agreement, except when vision materials ordered before coverage ended are delivered and the services are rendered to the Enrollee within thirty-one (31) days from the date of such order.

t. Vision care injuries or disease caused by riots or any form of civil disobedience if the Enrollee was a participant therein; war or act of war; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

u. Vision benefits and service and materials needed as a result of accidental injuries arising out of a motor vehicle accident, including motorcycles, to the extent such benefits and services are payable under any medical expense payment provision (by whatever terminology used – including such benefits mandated by law) of any motor vehicle insurance policy. Such excluded expenses cannot be used for any purpose under the Agreement.

v. Vision benefits, services or materials which are not completed or not delivered.

w. Services or materials rendered by a provider other than an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license.

x. Certain frame brands where the manufacturer imposes a no discount policy.

y. Services or materials provided by major medical coverage under any other group benefit.

z. Charges for completion of forms.

aa. Charges for Covered Services or related materials or supplies for which no charge is normally made, or for which no charge would be made but for the Agreement, are not Covered Services.

bb. Two (2) pair of glasses in lieu of bifocals.

cc. Treatment rendered outside of the United States.

4.2 The Vision Benefits and Services Provided Shall Be Limited as Follows, unless the "Summary of Vision Plan Benefits" section and/or Section 1.7 specifies other limitations.

a. Vision Benefit Allowances are available for a single application toward the cost of vision services and materials covered under the Agreement with Surency. Any Allowance balance remaining may not be applied to any other services. Surency Vision will pay up to the allowance shown in the "Summary of Vision Plan Benefits" and the Enrollee is responsible for any remaining amount.

b. Enrollees will also be responsible for any vision care products and services that are not Covered Services under the Agreement regardless of whether the vision care services were provided by an EyeMed Vision Provider or a non-contracted Vision Provider.

c. Some Covered Services may have specific age and frequency limitations. These limitations are generally identified in the "Summary of Vision Plan Benefits" section and/or Section 1.7. Regardless of optical necessity, Covered Services are not available more frequently than that which is specified in the Agreement and "Summary of Vision Plan Benefits".

d. EyeMed Vision Care provides coverage for Medically Necessary contact lenses only in the following situations:

1. Keratoconus, a misshaped cornea or front eye surface, where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses and provider attests to visual improvement; or

2. High Ametropia (a high prescription, exceeding –10 D or +10 D in spherical equivalent, average overall outof-focus-condition, in either eye; or

3. Anisometropia, a difference of prescription between the two eyes of 3 D in spherical equivalent or more; or

4. Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SECTION V – ELIGIBILITY

5.1 ELIGIBLE EMPLOYEE:

To qualify as an Eligible Employee, an individual must meet one (1) of the following requirements:

a. Be a full-time employee who is:

   1. actively employed to work for Employer a regularly scheduled minimum thirty (30) hour week;

   2. on paid sick leave from such active employment;

   3. on any other approved leave of absence from such active employment**;** or

b. Be a member in good standing of an organization, association or union which is the Employer, as determined under the rules of such organization, association or union.

c. Be a self-employed person who is actively engaged in a trade or business with at least one other self-employed person or employee, all as determined by Surency.

5.2 COMMENCEMENT OF COVERAGE FOR EMPLOYEE:

a. With respect to a person who is an Eligible Employee on the Effective Date, coverage hereunder shall begin upon such person becoming a Subscriber.

b. With respect to a person who is not an Eligible Employee on the Effective Date, coverage hereunder shall begin the first day of the month upon the later of i) such person becoming a Subscriber, or ii) the earlier of (A) the effective date associated with the enrollment period for a new hire or the annual open enrollment period elected by the Employer, or (B) the date the individual becomes a Subscriber in connection with a "qualifying event."

c. With respect to a person who is an Eligible Employee who experiences a "qualifying event," such Eligible Employee may make a new election within thirty-one (31) days of the qualifying event that corresponds to the gain or loss of eligibility and/or coverage under the Plan, or a plan of the Eligible Dependent's employer, that was caused by the occurrence of such qualifying event. Changes in coverage will become effective on the first day of the month coincident with or following the later of: i) the month in which the Eligible Employee becomes a Subscriber, ii) the effective date specified in the election, or iii) the submission of any required enrollment information and the payment of any required premium to Surency. For purposes of this Section V, a "qualifying event" is any of the events described below:

   1. Legal Marital Status. A change in an Eligible Employee's legal marital status such as marriage or divorce.

   2. Number of Dependents. A change in the Eligible Employee's number of Dependents, including the birth and/or adoption of a child.

   3. Gaining or Losing Coverage Eligibility Under Another Employer's Plan. A change in coverage or eligibility status in which an Eligible Employee or Eligible Dependent gains or loses eligibility for coverage under another employer's plan.

5.3 NO COVERAGE AS BOTH EMPLOYEE AND DEPENDENT:

No person may be insured both as an Eligible Employee and as an Eligible Dependent, and no person will be considered as an Eligible Dependent of more than one employee of the Employer. Eligible Dependents do not include another employee of the Employer who is insured under any employer-sponsored program providing vision expense coverage. A Child who may be otherwise eligible as a dependent under more than one vision plan sponsored by the Employer, shall be covered under the plan of the Employee as determined by Section 7.1 of this Agreement.

5.4 COMMENCEMENT OF COVERAGE FOR DEPENDENT:

a. With respect to a person who is an Eligible Dependent on the Effective Date, coverage hereunder shall begin for such Eligible Dependent upon the later of i) the first day that the coverage commences for the Subscriber, or ii) the date such person satisfies the requirements to become an Enrollee.

b. With respect to a person who is an Eligible Dependent who is not an Enrollee on the Effective Date, then coverage hereunder shall begin upon the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee, or iii) upon the effective date associated with the applicable enrollment period for the Eligible Employee.

c. With respect to a person who becomes an Eligible Dependent and therefore qualifies for coverage as a result of a qualifying event, then coverage hereunder shall begin upon the first day of the month coincident with or following the later of i) the Subscriber with respect to whom such person is a dependent becoming a Subscriber, ii) the date upon which such person satisfies the requirements to become an Enrollee.

5.5 TERMINATION OF BENEFITS:

a. If, at any time, a Subscriber fails to satisfy all of the requirements of this Agreement, coverage under this Agreement shall terminate for such Subscriber, and each Eligible Dependent of such Subscriber, in the following manner:

    1. If the Subscriber qualifies for, timely elects and timely pays for Continuation Coverage, then the Subscriber shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter coverage shall terminate.

    2. If the Subscriber fails to qualify for, timely elect or timely pay for Continuation Coverage, then coverage shall terminate at the end of the premium period in which the Subscriber first ceases to satisfy such requirements.

b. If, at any time, an Enrollee who is not the Subscriber ceases to qualify as Eligible Dependent, coverage under this Agreement shall terminate:

    1. If the Enrollee qualifies for, timely elects, and timely pays for Continuation Coverage, then the Enrollee shall continue to be covered for the applicable period during which coverage must be provided and during which premiums are timely paid, and thereafter the coverage shall terminate.

    2. If the Enrollee fails to qualify for, timely elect, or timely pay for Continuation Coverage, then coverage shall terminate at the end of premium period in which the Subscriber upon whom such person is dependent ceases to constitute a Subscriber, or at the time such dependent ceases to qualify as an Eligible Dependent, whichever occurs first.

c. At termination of coverage under this Agreement, all Benefits cease.

SECTION VI – AGREEMENTS

6.1 EMPLOYER AGREES:

Throughout the term of this Agreement, Employer agrees as follows:

a. At the time of the execution of this Agreement, to furnish Surency with accurate initial enrollment information regarding all Enrollees entitled to receive Benefits, including those on Continuation Coverage, together with the Social Security number or other identification number of all such Enrollees. Employer also agrees to furnish Surency with an accurate list of all Eligible Employees. Thereafter, Employer agrees to furnish monthly to Surency an accurate accounting of all changes to such initial list of Eligible Employees and Enrollees, in such form and manner as Surency may reasonably require.

b. To timely remit to Surency all applicable premiums as follows:

   Initial premium — on or before the tenth day of the month in which the Effective Date occurs.

   Subsequent premiums — on or before the tenth day of each month subsequent to the Effective Date.

   Continuation Coverage premiums — on or before the first day of each month commencing with the Effective Date.

   Upon discovery of any Employer clerical errors or delays regarding changes in enrollment data, premium amounts and enrollment data may be adjusted by Surency for all affected months since the Effective Date. However, Surency shall not be required to refund any amount which is based upon more than two (2) months of retroactive information, and in no event shall such refund exceed the amount of premium attributable to more than ten percent (10%) of the total number of Employer's last reported Enrollees.

c. To permit and to encourage the professional relationship between a vision care provider and Enrollee to be maintained without interference.

d. To encourage Enrollees to notify their vision care provider at the time of their first appointment that they are covered by this Agreement.

e. To permit Surency, its auditors or other authorized representatives, on reasonable advance written notice, to inspect the records of the Employer in order to verify the accuracy of all information provided by Employer to Surency.

f. To provide each Subscriber with a Benefit Booklet.

g. To provide Surency with such other information as it shall request in connection with this Agreement.

h. At the time of the execution of this Agreement, and at all times while this Agreement is in effect, Employer represents and warrants that its Employees and Enrollees constitute a "group" for purpose of state insurance laws. Employer agrees that Surency has discretion to determine if such requirements are met and will produce information requested by Surency to substantiate compliance with this requirement. Employer acknowledges no benefits will be provided under this Agreement if such persons do not constitute a "group."

6.2 SURENCY AGREES:

Throughout the term of this Agreement, Surency agrees as follows:

a. Prior to making payment for Covered Services, to require the Vision Care Provider or Subscriber, as the case may be, to timely submit a claim which satisfies the claims procedures of Surency.

b. To make no payment for any Covered Service rendered to a person who is not an Enrollee at the time such service is rendered.

c. To make payment to a Subscriber for each Covered Service received from a Non-contracted Vision Provider based upon the applicable terms of this Agreement provided that Surency has received a properly completed claim form and an acceptable itemized receipt from the provider.

SECTION VII - GENERAL PROVISIONS

7.1 NON-DUPLICATION OF BENEFITS:

A. GENERAL.

This section entitled Non-Duplication of Benefits addresses coordination of benefits (COB) and applies when a person has vision care coverage under more than one plan. The term “plan” is defined below.

B. DEFINITIONS.

1. A “plan” is any of the following that provides benefits or services for vision services or materials.

   a. The term “plan” includes group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of two hundred dollars ($200) per day; medical care components of group long-term care contracts, such as skilled nursing care; school accident-type coverage; and Medicare or other governmental benefits, as permitted by law.

   b. The term “plan” does not include individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of two hundred dollars ($200) or less per day; medical benefits under group or individual automobile contracts; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies, and coverage under other governmental plans, unless permitted by law. Each contract for coverage under (a) or (b) is a separate plan. Each plan will be treated as primary coverage.

2. “Allowable expense” means a vision care service or expense, including deductibles and co-payments, or co-insurance that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example a HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

   a. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.

   b. The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second opinions, pre-certification requirements, and preferred provider arrangements.

3. “Claim Determination Period” means a Service Year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

4. “Closed panel plan” is a plan that provides vision benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

5. “Custodial parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

C. COORDINATION OF BENEFITS.

Coverage under this plan is always considered primary.

D. EFFECT ON THE BENEFITS OF THIS PLAN.

1. Surency is always considered the primary vision care provider.

2. If Surency receives a claim from a provider/member for secondary benefit consideration, the claims department will process the claim as if Surency was the primary provider.

E. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Surency may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Surency need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Surency any facts it needs to apply those rules and determine benefits payable.

F. FACILITY OF PAYMENT.

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Surency may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Surency will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

G. RIGHT OF RECOVERY.

If the amount of the payments made by Surency is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

7.2 VISION CONDUCT:

Surency may refuse to pay for any Covered Services or materials which are provided in a matter that is inconsistent with the generally accepted applicable standards of vision care.

7.3 SURENCY LIABILITY:

Surency shall have no liability for any wrongful conduct of any third party, including but not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of any such person including but not limited to the Employer, Enrollees, vision care providers, hospitals, or the agents or employees of any of such foregoing persons, whether receiving or providing services. Further, Surency shall also have no liability for any services or facilities which, for any reason, are unavailable to any Enrollee. The Employer agrees to indemnify and hold harmless Surency from and against any cost, loss, or damage (including, but not limited to, attorney fees and litigation costs) that Surency may incur due to the negligence, wrongful act(s), or omission(s) of the Employer (or any of the Employer’s employees, contractors, or agents) in connection with this Agreement or any plan or arrangement established pursuant to, or in connection with, this Agreement.

7.4 ENDORSEMENTS:

Nothing contained in any endorsement shall affect any of the conditions, provisions or limitations of the Agreement except to the extent expressly provided in the endorsement. Otherwise, all conditions, provisions and limitations of this Agreement shall apply to any endorsement.

7.5 PUBLICATION OF THIS AGREEMENT:

No material shall be published or distributed by Employer or otherwise, interpreting, relating to or concerning this Agreement unless such material has been approved by Surency in advance of such publication or distribution.

7.6 CONFIDENTIALITY:

Surency agrees that it has “protected health information” (“Information”) as defined in 45 C.F.R. Part 160-164 (the HIPAA Privacy Rule). Surency agrees that it will:

1. not use or further disclose the Information other than as permitted or required by this Agreement or as required by law;

2. use appropriate safeguards to prevent use or disclosure of Information other than as provided for by this Agreement;

3. report to the Enrollee any use or disclosure of the Information not provided for by this Agreement of which Surency becomes aware;

4. ensure that any agents, including a subcontractor to whom Surency provides Information received from or created by the business associate on behalf of the Enrollee, agree to the same restrictions and conditions that apply to the business partner with respect to such Information;

5. make available Information in accordance with 45 C.F.R. 164.520;

6. make available Information for amendment and incorporate any amendments to Information in accordance with 45 C.F.R. 164.526;

7. make available the Information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

8. make its internal practices, books, and records related to the use and disclosure of Information received from, or created or received by, the business associate on behalf of the Enrollee available to the United States Secretary of Health and Human Services for the purpose of determining the compliance with 45 C.F.R. Part 160-164; and,

9. at the termination of this Agreement, if feasible, return or destroy all Information received from or created or received by, the business associate on behalf of the Enrollee, that the business partner still maintains in any form and retain no copies of such Information; or, if such return or destruction is not feasible, extend the protections of the this Agreement to the Information and limit further uses and disclosures to those purposes that make the return or destruction of the Information infeasible.

7.7 MISREPRESENTATIONS:

No statements made by the Employer, or any other person, shall be deemed a warranty or shall be used in defense of a claim or in any other dispute under this Agreement, unless it is contained in a written instrument, a copy of which has been agreed to in writing by Employer and Surency.

7.8 POLICY CHANGES:

No agent or representative has authority to change this Agreement or waive any of its provisions. No change in this Agreement shall be valid unless approved by an executive officer of Surency and evidenced by endorsement hereon.

7.9 LEGAL ACTIONS:

No action at law or in equity may be brought to recover on this Agreement prior to the expiration of sixty (60) days after the final written notice determining the status of a claim for breach has been delivered in accordance with the requirements of this Agreement. Further, and in all events, any action of any kind by any person who is subject to this Agreement must be commenced within five (5) years from the date on which the right, claim, demand, or cause of action shall first accrue.

7.10 GOVERNING STATUTES:

Any provision of this Agreement which is in conflict with any applicable law is hereby amended to the minimum requirements of such law.

7.11 GOVERNING LAW:

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA), the laws of the State of Kansas (irrespective of choice of law principles) shall govern the validity of this Agreement, the construction of its terms and the interpretation of the rights and duties of the parties. Any action brought to enforce, construe, or interpret this Agreement (including but not limited to any mediation or arbitration but only if arbitration is voluntarily agreed to by the parties at the time a dispute arises) shall be commenced and maintained in a location mutually agreeable by the parties to the dispute. Except to the extent preempted by ERISA, the parties irrevocably consent to the exclusive jurisdiction and venue in the court mutually agreed to by the parties and agree not to seek transfer or removal of any action commenced in connection with this Agreement.

7.12 SEVERABILITY:

If any part of this Agreement is determined to be invalid, unenforceable, or contrary to law or professional ethics, that part shall be reformed, if possible to conform to applicable law and ethics. If reformation is not possible, that part shall be deleted, and the other parts of the Agreement shall remain fully effective.

7.13 ASSIGNMENT:

Employer may not assign its interest in this Agreement without the prior written consent of Surency.

7.14 NOTICE:

Any notice required or desired to be given under this Agreement shall be deemed to have been given if delivered personally to hereinafter named designee of Employer or Surency, or sent by first-class United States Postal mail as provided herein. Any such notice shall be effective upon receipt of said notice unless an alternate date is specified. Employer shall have the right to designate a different address or agent for the receipt of notice by providing written notice of such designation in the manner set forth herein. Notices to the Employer shall be in writing and, shall be sent to the person named in the Application at the address stated therein, unless the Employer has provided written notice to Surency that notices should be sent to a different person or address. Notices to Surency shall be in writing and sent to:

Compliance Officer
Surency Life & Health Insurance Company
P.O. Box 789773
Wichita, KS 67278-9773

7.15 BENEFITS BOOKLET:

Surency shall prepare a Benefits Booklet. The Benefits Booklet shall summarize certain features of the Plan's coverage, including the eligibility rules, benefits, and methods of securing claims payments.

7.16 EMERGENCY TREATMENT:

Each individual vision care provider has its own emergency treatment protocol and Enrollees should contact their vision care provider and familiarize themselves with the procedure for emergencies that occur outside the vision care provider's normal business hours. Hospital or medical service emergency room expenses are not covered benefits under this Agreement.

7.17 CLAIMS SUBMITTAL:

Written notice of claim must be given to Surency within six (6) months of the date that the Covered Service was provided. But, failure to submit a claim within six (6) months of the date that the Covered Service provided will not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time, provided

that such claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the date the Covered Service was provided.

7.18 INQUIRIES/APPEALS:

Enrollees are encouraged to contact Surency when they have a question concerning a particular claim. Such inquiry should be directed to the Surency Customer Service Department. Telephone inquiries may be directed to the following numbers: in Wichita, 316.462.3316 or from outside of the Wichita area, 1.866.818.8805.

Enrollees who have inquiries or an appeal regarding the Agreement are encouraged to write to the Surency Customer Service Department, P.O. Box 789773, Wichita, KS 67278-9773. Written inquiries are best submitted with a copy of the Explanation of Benefits form for the claim in question and should include all of the following:

1. Employer group number and member identification number.
2. Subscriber's name and birth date. If the Enrollee is not the Subscriber, the Enrollee's name and birth date must also be included.
3. Vision care provider's name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

When appropriate, an evaluation will be made by an EyeMed provider and, in some cases the Enrollee may be examined. If necessary, additional information or documents may be requested for a full and fair review.

Normally, Enrollees will receive a written acknowledgement of their inquiry or appeal within twenty (20) days of Surency receipt. However, if the matter is referred to a review committee, or other unusual circumstances arise, the Enrollee will be advised.

7.19 REEVALUATION AND REVIEW/APPEALS:

If Surency (or its representative or delegate) denies a claimant's claim, in whole or in part, the claimant will be furnished with a written notice of adverse benefit determination setting forth:

1. The specific reason or reasons for the denial;

2. Reference to the specific provision of the Agreement on which the denial is based;

3. A description of any additional material or information necessary for the claimant to complete the claim and an explanation of why such material or information is necessary; and

4. Appropriate information as to the steps to be taken if the claimant wishes to appeal the determination, including the claimant's right to submit written comments and have them considered, the claimant's right to review (on request and at no charge) relevant documents and other information, and the claimant's right to file suit under ERISA with respect to any adverse determination after appeal of the claim. If a claim is denied in whole or in part, a claimant may appeal to Surency (or its representative or delegate) for a review of the denied claim. An appeal must be made in writing within one hundred eighty (180) days of the initial notice of adverse benefit determination, or else the claimant will lose the right to appeal the denial. If the claimant does not appeal on time, the claimant will also lose the right to file suit in court, as the claimant will have failed to exhaust the claimant's internal administrative appeal rights, which is generally a prerequisite to bringing suit. A claimant's written appeal should state the reasons that the claimant believes the claim should not have been denied.

   It should include any additional facts and/or documents that support the claim. The claimant may also ask additional questions and make written comments, and the claimant may review (on request and at no charge) documents and other information relevant to the claimant's appeal. Surency (or its representative or delegate) will review all written comments the claimant submits with the appeal.

Surency (or its representative or delegate) will review and decide an appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify the claimant of its decision in writing. The individual who decides an appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. Surency (or its representative or delegate) may secure independent medical or other advice and require such other evidence as it deems necessary to decide an appeal, except that any medical expert consulted in connection with an appeal will be different from any expert consulted in connection with the initial claim. (The identity of a medical expert consulted in connection with an appeal will be provided.) If the decision on appeal affirms the initial denial of a claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

a. The specific reason(s) for the denial;

b. The specific provision(s) of the Agreement on which the decision is based;

c. A statement of the claimant's right to review (on request and at no charge) relevant documents and other information;

If Surency (or its representative or delegate) relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

A statement of the claimant's right to bring suit under ERISA§ 502(a).

Legal action with respect to any claim may not be started until a claimant has exhausted the internal administrative appeal rights provided in connection with the Agreement.

7.20 NOTICE OF CLAIM:

Written notice of claim should be given to Surency within twenty (20) days after the occurrence or commencement of any claim/loss covered by the Agreement, or as soon thereafter as in reasonably possible. Notice given by or on behalf of the Enrollee or the beneficiary to the Enrollee to Surency at 1619 N. Waterfront Parkway, Wichita, KS 67206, or to any authorized agent of Surency, with information sufficient to identify the Enrollee, shall be deemed notice to Surency.

7.21 CLAIM FORMS:

Surency, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time frame fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

7.22 TIME OF PAYMENT OF CLAIMS:

All benefits payable under this policy other than benefits for loss of time shall be payable not more than thirty (30) days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof.

7.23 ERRONEOUS PAYMENTS:

Surency has the right to correct benefit payments that are made in error. A provider of Benefits and/or the Enrollee have the responsibility to return any overpayments to Surency. Surency has the responsibility to make additional payments if any underpayments have been made.

7.24 FRAUD OR MISREPRESENTATION:

In addition, if any person obtains coverage and/or benefits or other payments in connection with this Agreement by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by Surency (or its representative or delegate) such individual will be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or other damages suffered by, Surency by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by Surency (or its representative or delegate). Surency also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's coverage under the Agreement.

7.25 MISCELLANEOUS:

a. **Waiver of Breach**. The waiver of any breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach.

b. **Captions**. The paragraph headings are for convenience only, and shall be disregarded in interpreting this Agreement.

c. **Authorized to Enter into Agreement**. Both Employer and Surency represent and warrant they are authorized to enter into this Agreement.

d. **No Presumptions Based on Drafter**. No provisions of this Agreement shall be interpreted for or against any party hereto on the basis that such party was the draftsman of such provision, and no presumption or burden of proof shall arise disfavoring any party by virtue of the authorship of any of the provisions of this Agreement.

SECTION VIII - TERM AND TERMINATION

8.1 This Agreement shall remain in full force and effect for the term specified in Section I, but the Agreement may be terminated by Surency, if:

a. The Employer fails for longer than thirty (30) days from the due date to make a required payment; or

b. The Employer permits "voluntary enrollment" of Enrollees, or otherwise fails to satisfy the requirements of Section 1.2, except as specified in the Declarations section or as specified in a policy endorsement; or

c. The Employer voluntarily wishes to cancel this Agreement prior to renewal date and provides Surency with thirty (30) days written notice of intent to terminate; or

1. The Employer refuses to allow Surency (by its auditors or other authorized representatives) to inspect Employer's records in order to verify the accuracy of the Eligible Employee and/or enrollment information, or Employer otherwise defaults, by an act of either omission or commission, in the performance by it of any duties or obligations hereunder; or

2. The Employer breaches any representation or warranty, or does not otherwise fulfill its responsibilities, under this Agreement; or

3. The premium rate for this Agreement is determined by using the actuarial assumption that the Agreement will remain in full force and effect for a minimum period equal to the initial term hereof. If, during the initial term, the Agreement is terminated for any one or more of the preceding reasons, the Employer shall nevertheless owe Surency, in addition to whatever premium or premiums have already been paid and in addition to any accrued but unpaid premiums, a minimum termination premium that shall be calculated as follows:

$$\frac{\text{Total of premiums paid plus premiums accrued but unpaid, if any, by Employer for the months \underline{prior to termination}.}}{\text{Number of months for which such premiums were paid or accrued and owed.}} \times \text{Number of months remaining in the initial term after termination.} = \text{Amount of minimum termination premium.}$$

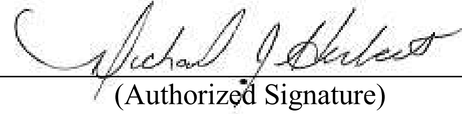
8.2 This Agreement may be terminated by Surency by delivering to Employer a notice of intention to terminate if such notice is delivered in writing to Employer at least thirty (30) days prior to such termination, except that if Employer defaults in the making of premium payments, termination of the Agreement shall become effective on the date of the expiration of the period for which the last monthly premium rate was paid.

8.3 If Employer defaults in making any payments due hereunder to Surency, the subsequent acceptance by Surency of such payments shall reinstate this Agreement, but such reinstatement shall provide coverage under the Plan only with respect to Covered Services which are first provided more than ten (10) days after the date of such reinstatement.

8.4 At least thirty (30) days prior to the expiration of the initial term of this Agreement, Surency will send Employer or Employer's designated agent written notification of renewal, setting forth adjustments to Agreement terms including premium rates. If Employer does not wish to renew the Agreement, it must provide Surency with written notification of the same. If Employer makes payment to SURENCY under the adjusted premium rates, or otherwise takes action which indicates continued performance under the Agreement after the expiration date of the term of this Agreement, the Agreement will be automatically renewed for a subsequent one year term upon the same terms and conditions as are herein set forth, modified by those adjustments set forth in the written notification of renewal. If, after the expiration of the initial term of the Agreement, Employer makes payment to Surency which is not consistent with the adjusted premium rates set forth in the written notification of renewal, then Surency may at it sole option either consider this Agreement to have been renewed under the adjustment terms set forth in the written notification and bill Employer for the remainder of the premium rate due, or consider this Agreement to have not been renewed and return the premium to Employer.

SIGNATURE PAGE

In witness whereof, the parties have caused this Agreement to be signed by their authorized representatives.

EMPLOYER NAME **USD #394 – ROSE HILL**	**SURENCY LIFE & HEALTH INSURANCE COMPANY**
By:	By:
(Authorized Signature)	 (Authorized Signature)
(Authorized Printed Name & Title)	President & CEO (Authorized Printed Name & Title)
Date:	Date: September 20, 2017