



Benefit Plans for KCP&L Employees Represented by IBEW Locals 412, 1464 and 1613



To: KCP&L Employees Represented by IBEW Locals 412, 1464 and 1613

From: KCP&L Human Resources

Date: October 2009

KCP&L provides a comprehensive benefits package as part of your total compensation. We work hard to offer meaningful benefit choices and to give you the information you need to make educated decisions, so that you make the most of your benefits.

This book of benefit Summary Plan Descriptions provides details of the benefits available to you as a member of Local 412, 1464 or 1613—all in one place. There is a lot of information in this book; here are a few tips that should make it easy to find the information you need:

- 1. Flip or click** – In addition to receiving your own personal hard copy of the book, it has been posted on the KCP&L intranet All About page as a navigable PDF. The electronic version allows you to search by key word and click on links to quickly and easily jump to the information you need.
- 2. Get to know the table of contents** – This book is organized in a way that groups similar information together. For example, eligibility information for all the Plans is in the Plan Participation section at the front of the book and claims information for all the Plans is in the General Information section at the back of the book. In between, you'll find details on specific benefit plans.
- 3. Learn the lingo** – Benefits have a language of their own. To help you better understand your benefit plans, most sections of the book include a list of important terms and their definitions.
- 4. Watch for icons** – Throughout the book, you will see icons that highlight special information. Please review this information carefully as it might point out an important provision of a plan, detail legal information related to your benefits or point you in the direction of where to find more information about a topic. These icons include:



A Closer Look



For More Information



Important Note



It's the Law

- 5. Keep everything in one place** – In the case of a plan change, you will receive a Summary of Material Modification (SMM) that describes the change. Be sure to keep your SMMs in the pocket in your book, so that you have the most up-to-date information about your benefits readily available.

Important Reminders

Update Your Beneficiary Information: Reviewing your beneficiary information and making updates on a regular basis is an important step to ensure your benefits are paid according to your wishes. In this book, you will find instructions to help you update your beneficiary information.

Report Status Changes: Generally, your benefit elections remain in effect until the next Plan Year begins. But, if you experience a status change, such as marriage or the birth of a child, you may be able to change certain elections. Keep in mind that you have 90 days from the date you experience the event to request a change. You will find further details about status changes in the book's Plan Participation section.

Questions?

If you have questions about the benefits explained in this book, please contact the HR Service Center at 816-276-5555 or hrrservicecenter@kcpl.com.

In the event of any conflict between these Summary Plan Descriptions and the actual Plan documents, the Plan documents will govern. Subject to any restrictions or limitations in the applicable collective bargaining agreement KCP&L reserves the right to amend, suspend or terminate any of its Plans or programs at any time.



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About Your Kansas City Power & Light Company Benefits Program

This book contains Summary Plan Descriptions (SPDs) that describe certain benefits offered to eligible employees of Kansas City Power & Light Company (“the Company”) who are members of IBEW Locals 412, 1464 and 1613 (“the Unions”).

Unless otherwise stated, the information provided in these SPDs applies to benefits in effect on January 1, 2009. It replaces all previous SPDs and other benefit descriptions you received about benefit plans for the Company’s bargaining unit employees.

Individual sections of this book summarize the highlights of KCP&L’s benefit plans. The information in this book does not guarantee your right to a benefit if your actual situation or the terms of the Plans do not entitle you to a benefit. In the case of a conflict or omission, the legal Plan documents will govern in all cases. Subject to any restrictions or limitations in the applicable collective bargaining agreement, the Company reserves the right to amend, suspend or terminate any of its Plans or programs at any time and in any manner.

Plan documents are available from:

HR Service Center

Kansas City Power & Light
 P.O. Box 418679
 Kansas City, MO 64141-9679
 Telephone: 816-276-5555

The Plan Participation section of this book summarizes key provisions that affect your KCP&L Benefits Program participation—including eligibility, when your coverage begins and ends, how to enroll, how you and the Company share the cost of your coverage and making changes to your benefits. For more information about your benefits, you should refer to each benefit’s individual section, as well as the General Information section in this book.

References throughout this book to KCP&L are intended to include Great Plains Energy Incorporated and its subsidiaries and affiliates as applicable.



Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Eligibility for You

If you are an employee who is represented by IBEW Local 412, 1464 or 1613, you are eligible to participate in the following Company benefit plans immediately following your hire date:

- 401(k) Savings Plan*
- Business Travel Accident Insurance*
- Survivor Benefit Plan
- Education Assistance Program*
- Employee Assistance Program*

You are eligible to participate in the Company benefit plans listed below:

- When you have been employed for at least six months by the Company in one of the bargaining units covered by collective bargaining agreements between the Company and one or more of the unions, and you are a “regular employee” as defined by such bargaining agreement
- Except as noted, if you are an employee of one of the unions and have been employed by one of the unions or by the Company for at least six months

You are eligible to participate in the following benefit plans when you meet the requirements outlined above:

- Medical Plan
- Dental Plan
- Vision Plan (Local 1613 only)*

- Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance
 - Basic Life Insurance
 - Supplemental Life Insurance*
 - Basic Accidental Death and Dismemberment (AD&D) Insurance (Locals 1464 and 412 only)
 - Supplemental AD&D Insurance (Local 1613 only)*
 - Dependent Life Insurance
 - Dependent AD&D (Local 1613 only)*
- Disability
 - Basic Long-Term Disability Plan*
 - Supplemental Long-Term Disability Plan (Local 1613 only)*
- Reimbursement Accounts
 - Medical Reimbursement Account (Local 1613 only)*
 - Dependent Care Reimbursement Account*
- Pension Plan
- Other Benefits
 - Vacation Purchase (Local 1613 only)*
 - Wellness Program*
 - Dollars to Scholars*

*Not available to employees of the unions.

Eligibility for Dependents

You may cover your eligible dependents under the following plans:

- Medical Plan
- Dental Plan
- Vision Plan (Local 1613 only)
- Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance (Local 1613 only)

Your eligible dependents include:

- **Legal spouse** – Your spouse is a person of the opposite sex to whom you are legally married (unless legally separated).
- **Domestic partner** – A domestic partner is a person of the opposite or same sex with whom you have established a “domestic partnership.” A domestic partnership is a relationship of at least 12 months in which you and your domestic partner satisfy all of the following requirements:
 - You share the same permanent residence and common necessities of life.
 - You are responsible for each other’s common welfare, including financial interdependence, as would be evidenced by any or all of the following:
 - Common ownership of real property or a common leasehold interest in such property
 - Power of attorney for health care decisions
 - Joint bank account or a joint credit account
 - Common ownership of a motor vehicle
 - Joint auto insurance coverage
 - Designation as a beneficiary for life insurance or retirement benefits or under the domestic partner’s will
 - You are not related by blood or a degree of closeness which would prohibit marriage in the laws of the state in which you reside.
 - You are not currently married to or legally separated from another person under either statutory or common law.

- You have no other domestic partners.
- You are of the age of consent in the state of legal residence and
- You were mentally competent to enter into a contract at the time the relationship began.

■ Children as follows:

- An eligible child generally includes your or your domestic partner’s unmarried natural, legally adopted (or children under age 18 who have been placed with you for adoption) or foster children, stepchildren or children under legal guardianship through the end of the calendar year in which they reach age 23 (age 25 for the Vision, Dependent Life and Dependent AD&D Insurance Plans), who do not provide more than half of their own support or who live with you for more than half of the year.
- An eligible child who is permanently and totally disabled who does not provide more than half of their own support or who lives with you for more than half the year are not subject to the limiting age of 23 or 25. A disabled child is any child who cannot engage in substantial gainful activity because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or is expected to last for at least 12 continuous months. The physical or mental impairment must begin before the child reaches age 19.

In order to continue to cover a disabled child who is incapable of self-sustaining employment past age 23 or 25 because of mental or physical disability, you must provide satisfactory proof of the incapacity. Proof of the dependent’s condition must be provided within 31 days after your child reaches age 23 or 25. You may be asked to provide continuing proof of the incapacity.

Additional eligibility requirements may apply. Please see the sections of this book applicable to specific benefit plans for more details.



A Closer Look: Dependents

Please keep the following in mind when enrolling dependents for KCP&L benefits:

- No person may be covered as a dependent of more than one eligible employee.
- Your child(ren) may be covered as an eligible dependent of you or your spouse or domestic partner, but not both.
- If your child is an eligible employee, he or she cannot be covered as a dependent child.
- If your spouse is an eligible employee, you may both be covered as employees and eligible dependents of each other.
- If both members of the domestic partnership are employed at KCP&L, both cannot be covered as dependents of each other.

Domestic Partnership

If you request domestic partner coverage you will be required to complete a "Declaration of Domestic Partnership." In addition to this Declaration, you must supply satisfactory documentation that you have been living with your domestic partner in a committed relationship for at least 12 months. If you reside in a state or municipality where registration of domestic partnership is applicable, you must register with the appropriate government agency and provide proof of such registration in lieu of the "Declaration of Domestic Partnership." The sufficiency of any proof will be solely within the discretion of the Plan.

Termination of Domestic Partnership

You will be required to notify the KCP&L HR Service Center in writing within 30 days of the termination of a domestic partnership by completing the "Declaration of Termination of Domestic Partnership." This would occur when your relationship with the domestic partner no longer satisfies the domestic partner criteria.

If the domestic partnership is terminated, active coverage for the domestic partner's children will be terminated unless there is a court order requiring you to provide benefit coverage. Coverage will terminate on the last day of the month when the eligibility terminates regardless of the date you notify the KCP&L HR Service Center.

If you reside in a state or municipality where termination of domestic partnership is applicable, you must terminate the domestic partnership with the appropriate government agency and provide proof of such termination in lieu of the "Declaration of Termination of Domestic Partnership."

Enrolling a New Domestic Partner

Following termination of a domestic partnership, and proper notification of termination of domestic partnership, there will be a waiting period of 12 months after termination of coverage of the prior domestic partner or domestic partner's dependent child(ren) before you are allowed to enroll a new domestic partner or a domestic partner's dependent child(ren).

When Coverage or Participation Begins

You are eligible upon your hire or rehire date for the 401(k) Savings Plan, Business Travel Accident Insurance, Survivor Benefit Plan, Educational Assistance Program and Employee Assistance Program.

You are eligible for additional benefits as shown on page **A-2** after you have completed six months of employment.

You must enroll for the following benefits within 30 days of your eligibility date:

- Medical
- Dental
- Vision
- Reimbursement Accounts
- Supplemental Life Insurance
- Supplemental AD&D Insurance
- Supplemental Long-Term Disability
- Vacation Purchase

If you do not enroll within this timeframe, you waive your rights to these benefits for the remainder of that Plan Year. The next available time to enroll will be during the annual open enrollment period for benefits effective January of the next year. You may also begin participating or add coverage for a dependent as of the date of certain family or employment status changes as long as you notify the HR Service Center at 816-276-5555 within 90 days of the event.

Your coverage for other benefits does not require your enrollment and is effective on your six-month anniversary of employment (your eligibility date). However, if you are not actively at work on your eligibility date, your Basic, Supplemental, and Dependent Life/AD&D and Disability Insurance benefits will become effective on the date you return to active employment. "Active employment" and "actively at work" mean that you are performing all the usual and customary duties of your job on a full-time basis at your customary work location or a work location approved by KCP&L.

Pension Plan

You automatically begin accruing benefits under the Pension Plan after six months of employment. Please refer to the Pension Plan section of this book for additional details.

401(k) Savings Plan

Your participation begins as of the first payroll period following the earlier of the date you have made an affirmative election to contribute to the Plan or the date you have been automatically enrolled in the 401(k) Savings Plan. For additional information on the 401(k) Savings Plan—including employee and KCP&L contribution limits—please refer to the 401(k) Savings Plan section of this book.

Other Benefits

You are eligible for the Wellness Benefit, Dollars to Scholars and Vacation Purchase after six months of employment.

How You and the Company Share the Costs of Your Benefits

KCP&L provides certain benefits at no cost to you.

- Basic Life Insurance
- Basic AD&D Insurance (Locals 412 and 1464 only)
- Dependent Life Insurance (Locals 412 and 1464 only)
- Business Travel Accident Insurance
- Survivor Benefit Plan
- Basic Long-Term Disability
- Pension Plan
- Other Benefits
 - Employee Assistance Program
 - Wellness Program
 - Education Assistance Program
 - Dollars to Scholars

The Company pays a portion of the cost for your medical and dental coverage. You pay any remaining monthly premium costs.

After you have been employed for 12 months, the Company matches up to the first 6% of your base pay you contribute to the 401(k) Savings Plan at a rate of 50%.

You pay the full cost of certain other benefits:

- Members of Locals 412 and 1464 pay the full cost of Supplemental Life Insurance coverage and any contributions to a Dependent Care Reimbursement Account.
- Members of Local 1613 pay the full cost of Vision, Supplemental Life and AD&D Insurance, Dependent Life and AD&D Insurance, Supplemental Long-Term Disability and any contributions to a Medical or Dependent Care Reimbursement Account.

When you pay all or a portion of the cost of these benefits through pre-tax payroll deductions, your taxable income is reduced, and you pay less in federal income and Social Security taxes. (Depending on where you live, pre-tax contributions also may reduce your state and local income taxes.)

However, if you cover your domestic partner or your domestic partner's children, the cost of benefits that you pay for these dependents may not be paid through pre-tax deductions. In addition, the amount that the Company contributes toward the cost of coverage for your domestic partner and/or your domestic partner's children is added to your taxable income.

Deductions for the following benefits are made on an after-tax basis:

- Dependent Life Insurance (Local 1613 only)
- Supplemental Life Insurance
- Supplemental AD&D Insurance (Local 1613 only)
- Dependent AD&D Insurance (Local 1613 only)
- Supplemental Long-Term Disability (effective January 1, 2010, your contributions for Supplemental Long-Term Disability will be pre-tax) (Local 1613 only)

This means the cost of these benefits is deducted after federal, state and local income and Social Security taxes have been withheld.

Local 1613 Only: You receive Flex Dollars from KCP&L to help pay your share of some of your benefits. The amount of Flex Dollars you receive each year is a percentage of your annual base pay determined by your years of service as follows:

Years of Service	Flex Dollars (Percent of Annual Base Pay)
0 through 7	1.1 percent
8 through 11	3.1 percent
12 through 19	5.6 percent
20 or more	8.1 percent

Flex Dollars apply to your portion of the cost for the following benefits:

- Medical
- Dental
- Vision
- Supplemental Long-Term Disability (effective January 1, 2010)
- Medical Reimbursement Account
- Dependent Care Reimbursement Account

- 401(k) Savings Plan
- Vacation Purchase

If your portion of the total cost for these benefits is less than your Flex Dollars, you receive the excess Flex Dollars as taxable pay. When your cost for benefits is more than your Flex Dollars, you pay the difference through pre-tax payroll deductions.



Important Note:

If you are a member of Local 1613, you may not purchase vacation amounts that cost more than your annual Flex Dollars.



Enrolling for Coverage

Newly Eligible Employees

If you are newly eligible, you must enroll within 30 days of your eligibility date. If you do not enroll by the 30-day deadline, you will waive your right to elect benefits for the remainder of that Plan Year with the exception of medical coverage. You will be treated as having elected coverage under the \$1,000 PPO Deductible Plan unless you make an election prior to the deadline provided for coverage under one of the other available options.

If you are eligible to participate in the 401(k) Savings Plan, the Company will automatically enroll you in the Plan 30 days after the later of your date of hire or the date that the 401(k) administrator sends you an automatic enrollment notice. You will be automatically enrolled at a contribution rate of 6% of your eligible pay for each payroll period, unless you elect not to participate (or elect to change your contribution amount to more or less than 6%) through the 401(k) administrator's Web site or telephone customer service center.

Annual Open Enrollment Period

Each year, KCP&L holds an open enrollment when you may change your benefit elections. Annual open enrollment is usually held near the end of each Plan Year, and your elections are effective during the next January 1 through December 31.

Unless you are notified in advance otherwise, most of your elections automatically continue into the next year if you do not make changes to them during open enrollment, except that if you elected for one calendar year a medical option that is no longer available for the succeeding calendar year, you will receive automatic coverage under the \$1,000 PPO Deductible Plan until you make a new election. For example, if you are covered under the \$300 PPO Deductible Plan in a given year and the \$300 PPO Deductible Plan is not an available option for the following year, you must make a new election to be covered under another option. If you fail to make a new election you will automatically receive coverage under the \$1,000 PPO Deductible Plan for the next calendar year. Limitations on new elections are described in "Limits on Changes of Medical Coverage Elections" on page **A-9**. However, you must enroll for the following benefits during open enrollment if you wish to participate for the following Plan Year:

- Medical Reimbursement Account (Local 1613 only)
- Dependent Care Reimbursement Account
- Vacation through Vacation Purchase (Local 1613 only)

Generally you may not make changes to your benefit elections other than at open enrollment unless you have a status change. For more information, see the section on status changes on pages **A-10 to A-11**.

Prior to the open enrollment period each year, you will receive detailed information including enrollment instructions and any changes to benefit plans that will be effective the following January 1.

Enrollment Changes

Once you have made your benefit elections at your initial eligibility or during the annual open enrollment period, you will not be eligible to make changes to the following benefits before the next open enrollment period except if you experience certain qualifying changes in your family or employment status:

- Medical, dental and vision
- Supplemental Life Insurance
- Supplemental AD&D Insurance (Local 1613 only)
- Supplemental Disability Insurance (Local 1613 only)
- Dependent Care Reimbursement Accounts
- Medical Reimbursement Accounts (Local 1613 only)

For more details, see the section on Status Changes.

You may change your participation election in the 401(k) Savings Plan at any time to contribute less or more of your eligible pay or to stop participating. You may make your participation changes through the 401(k) administrator's Web site or telephone customer service center.

Any changes to your 401(k) participation will be effective as follows:

- For changes to become effective with the pay period ending the 15th of the month, you must make your participation change by the 9th of the month.
- For changes to become effective with the pay period ending the last day of the month, you must make your participation change by the 24th of the month.

Limits on Changes of Medical Coverage Elections

If you are covered under a PPO Deductible Plan option and wish to choose an option with a lower deductible, you may improve your level of coverage by no more than one step each year. For example, if you had the \$1,000 PPO Deductible

Plan coverage in one year, the next year you could elect coverage under the \$500 PPO Deductible, but not the \$300 PPO Deductible Plan. You may change your coverage from any of the PPO Deductible Plan options to the Co-Pay Plan during any enrollment period. Another special rule applies to elections of the Co-Pay Plan coverage. If you elect the Co-Pay Plan when you are first eligible for coverage under the Plan, you may change to any of the PPO Deductible Plan options during a later enrollment period. Once you do so, however, you will be able to improve your level of coverage under the PPO Deductible Plan options by only one step each year.

If you choose coverage under one of the PPO Deductible Plan options when you are first eligible and later choose coverage under the Co-Pay Plan, another special rule applies to changes you may make later on. Under this rule, you may choose to improve the PPO Deductible Plan option you had prior to electing the Co-Pay Plan by one level for each year you have coverage under the Co-Pay Plan. For example, assume you were covered under the \$1,000 PPO Deductible Plan and later elected the Co-Pay Plan. After two years you wish to change your coverage to a PPO Deductible Plan option. At open enrollment, you could elect coverage under the \$300 PPO Deductible Plan. Had you been covered under the Co-Pay Plan for only one year, you would have been eligible to elect the \$500 PPO Deductible Plan.

In any event, you may enroll in the Medical Plan at any level of coverage during the annual open enrollment period or within 90 days after you acquire a dependent spouse or child by marriage or placement for adoption if you had previously chosen no medical coverage.

Transfers Between Bargaining Units or to a Non-bargaining Unit Position

When you transfer to a different bargaining unit, or from a bargaining unit position to a non-bargaining unit position, your coverage elections in effect on the date of the transfer will continue for the remainder of the calendar year.

Status Changes

Your benefit elections generally remain in effect until the next Plan Year begins. Because of the tax advantages provided by flexible benefits, the IRS allows you to change your benefit elections within the same Plan during the Plan Year only if you have a qualifying change in status event that affects your benefits and if the requested change is consistent with that event.

Even if you have a status change event, you may not be permitted to change from one medical benefit option to another.

If you satisfy the requirements of this section for a mid-year election change, you must contact the HR Service Center at 816-276-5555 within 90 days of the qualifying change in status event. You may be required to provide documentation of the event.

Qualifying status changes include:

- **Marital Status** – Your legal marital status changes for reasons of marriage, divorce, legal separation, annulment or death of a spouse
- **Dependents** – Your number of dependents changes for reasons such as birth, adoption or placement for adoption or death
- **Employment Status** – You or your dependent experiences a change in employment (or employment status) which affects benefits eligibility, including:
 - Termination or commencement of employment
 - A change from part-time to full-time or full-time to part-time
 - A strike or lockout
 - Beginning or returning from a leave of absence
- **Change in Dependent Status** – Your dependent becomes eligible or ineligible for coverage
- **Change in Residence** – You or your dependent changes your place of residence
- **Change in Cost** – You experience a significant overall increase or decrease in the cost of a benefit option or other coverage (for example, if you have coverage through your spouse’s employer), as determined by the KCP&L benefit Plan Administrator. This status change does not allow members of Local 1613 to make a change in their Medical Reimbursement Account.
- **Significant Reduction with Loss of Coverage** – Coverage for you or your dependent under a KCP&L benefit Plan or other coverage (for example, coverage through a spouse’s employer) is significantly reduced or eliminated. You may elect coverage under a KCP&L benefit option that provides similar coverage, or drop Plan coverage only if no other benefit option providing similar coverage is available. This status change does not allow members of Local 1613 to make a change in their Medical Reimbursement Accounts.
- **Significant Reduction without Loss of Coverage** – If the reduction does not amount to a loss of coverage under a benefit option for you or a dependent, you may revoke your election and elect coverage under another option with similar coverage. This status change does not allow members of Local 1613 to make a change in their Medical Reimbursement Accounts.

- **Loss of Coverage** – A loss of coverage includes, but is not limited to:
 - A loss of eligibility due to such causes as legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, as long as the loss of other coverage is not because you missed a premium payment or coverage was terminated for cause, such as making fraudulent claims or intentional misrepresentation
 - Exhaustion of COBRA coverage under another group health plan
 - Termination of another employer’s contribution to the other coverage
 - Elimination of a benefit option
 - A benefit option no longer being available in an area in which you live
 - Loss of all coverage under a benefit option due to an overall lifetime or annual limit
 - A substantial decrease in the medical care providers available under a benefit option or
 - A reduction in benefits for a specific type of medical condition or treatment with respect to which you or your dependent is currently in a course of treatment
- **Change in Dependent Care Needs** – You may revoke your Dependent Care Reimbursement election and make a new one if your need for dependent care from your existing provider is significantly reduced or eliminated, and your new election corresponds to that reduction or elimination. You may also change your Dependent Care Reimbursement Account participation if the cost of your dependent care increases or decreases for any reason including if you change dependent care providers.
- **Child Support Order** – You are required to provide health coverage for your child by judgment, decree or order because of divorce, legal separation, annulment or change in legal custody, or your former spouse is required to provide health coverage for the child.
- **Loss of Coverage under Governmental or Educational Institution Plan** – You may increase your contributions if you or your child loses coverage under a group health plan sponsored by a governmental or educational institution—such as the Children’s Health Insurance Program (CHIP).

- **Entitlement to Medicare or Medicaid** – If you or your dependent enrolls in Medicare or Medicaid, you may cancel that person’s health coverage. Similarly, if you or your dependent has been enrolled in Medicare or Medicaid and loses eligibility under those plans, you may elect to begin or increase that person’s health coverage.



**A Closer Look:
Special Enrollment Events**

Certain status changes create a Special Enrollment Event. Special Enrollment Events include important events like marriage, birth of a child, adoption or placement for adoption of a child or loss of coverage under another group health plan, including COBRA continuation coverage.

If you do not choose benefits for you or your dependents during the annual open enrollment period, you may enroll in medical, dental and vision benefits if you experience a Special Enrollment Event.

When one of these events occurs, you may be eligible to enroll yourself and/or your new dependent in medical, dental, and vision benefits, **if you contact the HR Service Center at 816-276-5555 within 90 days of the event.** Coverage becomes effective the day of the event.

Special enrollment also is allowed in group health plans under the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIP), which provides health insurance to certain low-income children. Effective April 1, 2009, group health plans must allow employees and dependents who are eligible for, but not enrolled in, the Plan to enroll in two additional circumstances:

- Your or your dependent’s Medicaid or CHIP coverage is terminated as a result of loss of eligibility or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (for states that have chosen to offer a premium assistance subsidy).

To take advantage of this right for a special enrollment due to CHIP, you must request coverage **by contacting the HR Service Center at 816-276-5555 within 90 days of the Medicaid or CHIP coverage termination or the date you or your dependent is determined to be eligible for assistance.**

When Coverage Ends

Generally, coverage for you and your dependents ends on the earliest of the following dates:

- The date you are no longer an eligible employee or dependent (first day of the following month for medical, dental and vision)
- The date you fail to make required contributions for your coverage
- The first day of the month after you make an election to end your coverage
- The date the Plan or coverage terminates
- The date you or your dependent enters the armed forces on active duty (see Military Leave on page **A-13** for more information)
- If you are a surviving dependent who is eligible for continued medical, dental and vision coverage, the date you become eligible for any other group medical plan because of employment, or become eligible for any other federal or state medical plan (except Medicare) but only if such a plan provides similar benefits at a comparable cost

Coverage for your dependents ends when your coverage ends—or when they no longer qualify as your dependents, whichever comes first. If you die while actively employed, your dependents are eligible to continue coverage at no cost for three months beginning with the first of the month following the date of your death.

If your dependent is covered by the KCP&L Benefits Program under the terms of a qualified medical child support order, coverage may also end when the order expires or when your enrollment under comparable health coverage ends.



A Closer Look: Surviving Dependent

A surviving dependent is any person who is the spouse or eligible dependent child (as defined on page **A-3** in the Eligible Dependent section) of a deceased eligible employee.

Life Insurance: For purposes of Life Insurance coverage, KCP&L may consider you employed during absence from work due to total disability. If KCP&L considers you totally disabled, continuation of coverage may continue for the two years that your employment may continue during your total disability.

For more details, please refer to the Life Insurance section of this book.

MetLife decides:

- What total disability means,
- What you need to do to continue to qualify for coverage and
- Who pays for coverage.

401(k) Savings Plan: Contributions to the 401(k) Savings Plan will end when you are no longer eligible to participate in the 401(k) Savings Plan. However, you will remain a participant and investment gains and losses will be credited to your account until your entire account has been paid to you or your beneficiary.

Pension Plan: Benefit accruals under the Pension Plan will end when you are no longer eligible to participate in the Pension Plan. However, you will remain a participant until the earlier of your death or when you have received all benefits you are entitled to under the Pension Plan.

Short Terminations

If your employment with the Company terminates, and you resume employment as an eligible employee with the Company within thirty (30) days of the date of termination, you will have in effect on your return to the Company the election previously in effect, unless the 30 days includes January 1, in which case the election you made for the calendar year that begins that January 1 shall take effect.

Important Information Affecting Coverage

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Certain coverage may be continued if your employment terminates or if you or your dependents experience certain other “qualifying events.” For information on your rights and benefits under COBRA, please refer to the General Information section of this book.

Family and Medical Leave Act (FMLA)

Certain coverage may be continued if you take a leave under the Family and Medical Leave Act (FMLA) of 1993. You are

responsible for all required contributions during your leave. For information on your rights and benefits under FMLA, please refer to the General Information section of this book.

Military Leave

The federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 (as amended) generally allows you and your dependents called for active military duty to continue coverage under certain of the KCP&L benefits program. For information on your rights and benefits under USERRA, please refer to the General Information section of this book.



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Medical Coverage

This section outlines the health care benefits provided to participants in the \$300, \$500 and \$1,000 PPO Deductible and Co-Pay Plans provided by the NECA/IBEW Family Medical Care Plan (referred to as “the Plan” in this booklet). These benefit plans are provided for eligible Kansas City Power & Light employees who are represented by IBEW Locals 412, 1464 and 1613.

The \$300, \$500 and \$1,000 PPO Deductible Plans are major medical plans that provide in- and out-of-network benefits, but with a higher payment level for services rendered within the PPO network. These three plans differ from each other only with respect to the annual deductible and out-of-pocket limit (see the Schedule of Benefits starting on page **B-7**). The Co-Pay Plan requires use of PPO providers in order to receive benefits (see the Schedule of Benefits beginning on page **B-9**).



Important Note: Pronouns Used in this Medical Coverage Section

Wherever the term “you” or “your” is used in this booklet, it means an eligible employee. And, to avoid awkward wording, male personal pronouns are used to refer to employees. Feminine pronouns are used when referring to spouses. Whenever a personal pronoun is used in the masculine gender, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine.

Important Medical Coverage Terms

There are certain medical terms that have specific meaning under the Plan. This section explains those terms to help you better understand your benefits. Note: A benefit is not necessarily covered because a term appears in this definition’s section.

Please note that references to “dependent” or “spouse” throughout this Medical Coverage section include a qualifying domestic partner according to the definition in the Plan Participation section of this book.

Allowable charge – The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment. You will be responsible for amounts in excess of the allowable charge even if the allowable charge is less than some determinations of what is reasonable and customary. Allowable charge limitations apply to out-of-network services only.

Association – The National Electrical Contractors Association, Inc. (NECA)

Calendar year; Year – The twelve-month period starting on January 1 of any year and ending on December 31 of that year

Chiropractic care – Any services or supplies that are provided or ordered by a chiropractor, or that are provided in connection with a course of treatment by a chiropractor

Claims administrator – The organization designated by the Trustees for handling claims. Blue Cross Blue Shield of Georgia is the claims administrator for medical claims (excluding prescription drugs). Sav-Rx is the claims administrator for prescription drug claims.

Collective bargaining agreement – The negotiated labor agreement between a Union and an employer or Association requiring the employer or Association to make contributions to the Fund on behalf of its bargaining unit employees

Contributions – Payments made to the Fund by contributing employers on behalf of their employees

Cosmetic – Treatment or surgery to improve or preserve physical appearance

Covered; Covered under the Plan – A term used to indicate that a person is eligible to receive the benefits from this Fund which apply to his status as an employee or a dependent under the Schedule of Benefits for the \$300, \$500 and \$1,000 PPO Deductible and Co-Pay Plans

Durable medical equipment – Equipment that:

1. Can withstand repeated use
2. Is primarily and customarily used for medical purpose and is not generally useful in the absence of an injury or illness
3. Is not disposable or non-durable

Emergency – A medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in his health being in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ

Employer – The NECA/IBEW Family Medical Care Plan defines an “employer” as a person, firm, association, partnership or corporation that:

1. Is bound by a collective bargaining agreement or other written agreement with a Union or the Trustees, or has a collective bargaining relationship with a Union or the Trustees, that requires payment of contributions to the Fund on behalf of its eligible employees
2. Is a Union or local Association chapter that has agreed to make contributions to the Fund on behalf of its eligible employees or
3. Is the Board of Trustees, or the board of trustees of any jointly sponsored trust fund between a Union and a local Association chapter, who has agreed to make contributions to the Fund on behalf of its eligible employees

The specific employer for the plans described in this booklet is Kansas City Power & Light Company or Great Plains Energy Incorporated.

Experimental or investigative – A treatment, procedure, facility, equipment, drug, device or supply will be considered to be experimental or investigative if it falls within any one of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient’s medical condition

2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized
3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is experimental or investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical experts of their choosing.

Fund – The NECA/IBEW Family Medical Care Trust Fund

Home health agency – A public agency or private organization (or a subdivision of such agency or organization) which meets all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes of its patients
2. It has policies (established by a group of professional personnel associated with the agency or organization) governing the services which it provides
3. It provides for the supervision of its services by a doctor or a registered professional nurse
4. It maintains clerical records on all of its patients
5. It is licensed according to the applicable laws of the state in which the patient receiving the treatment lives and of the locality in which it is located or in which it provides services and
6. It is eligible to participate in Medicare

Hospice – A public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization must:

1. Be eligible to participate in Medicare
2. Have an interdisciplinary group of personnel that includes the services of at least one doctor and one R.N
3. Maintain clerical records on all patients
4. Meet the standards of the National Hospice Organization and
5. Provide the following services, either directly or under other arrangement: nursing care, homemakers and home health aides, medical social services, counseling services and/or psychological therapy, physical, occupational and speech therapy, and palliative care

Hospital – An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services or
- An institution for exceptional or handicapped children

Medically necessary – Only those services, treatments or supplies provided by a hospital, a doctor, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's injury or sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the individual's injury, disease or sickness, including premature birth, congenital defects and birth defects
2. Are appropriate according to generally accepted standards of good medical practice

3. Are not mainly for the convenience of the patient, doctor, hospital or other provider
4. Are not experimental or investigative and
5. Are the most appropriate services, supplies or level of services required to provide safe and adequate care. When applied to confinement in a hospital or other facility, this means that the covered person needs to be confined as an inpatient due to the nature of services rendered or due to the person's condition, and that the person cannot receive safe and adequate care through outpatient treatment.

The fact that the treating doctor finds that the treatment is medically necessary is not binding on the Trustees.

Mental or nervous disorder (mental/ nervous disorder)

– A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of whether such condition, disease or disorder has causes or origins which are organic, physiological, traumatic or functional

Physician; Doctor – A legally qualified doctor or surgeon who is a Doctor of Medicine (M.D.) a Doctor of Osteopathy (D.O.), or a Doctor of Chiropractic (D.C.), provided that any such individual renders treatment only within the scope of his license and specialty

Plan; Benefit Plan; Plan of Benefits – The self-funded program of health and welfare benefits provided by the NECA/IBEW Family Medical Care Trust Fund. When used in this booklet, the term Plan specifically refers to the benefits provided to participants in the \$300, \$500 and \$1,000 PPO Deductible Plans and the Co-Pay Plan.

Reasonable and customary charge – The maximum allowable charge to be considered a covered expense under this Plan. The amount of a reasonable and customary (or usual and customary) charge is determined by comparing a charge with the charges made by persons with similar professional training and experience in the locality concerned (zip code area in which the service is performed) for comparable services and supplies provided to persons of similar age, sex, and medical and dental condition.

Skilled nursing facility – An institution, or a distinct part of an institution, which complies with all licensing and other legal requirements and which, to be approved for the purposes of this Plan, meets all of the following criteria:

1. It is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist the patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. It provides 24-hour-a-day supervision by one or more doctors or one or more R.N.s responsible for the care of its inpatients, it provides 24-hour-a-day nursing services by licensed nurses under the supervision of an R.N., and it has an R.N. on duty at least eight hours a day.
3. Every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hospital.
4. It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.
5. It has a utilization review plan.
6. It has a transfer agreement with one or more hospitals.
7. It is eligible to participate under Medicare.
8. It is not, other than incidentally, an institution which is a place for rest, for custodial care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

Substance abuse – Alcoholism, alcohol abuse, drug addiction, drug abuse or any other type of addiction to, abuse of or dependency on any type of drug, narcotic or chemical (except nicotine)

TMJ – Temporomandibular joint syndrome, craniomandibular disorders and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves, and other tissues related to that joint. For the purposes of the Plan, the term TMJ includes all of these conditions.

Trustees – The individuals responsible for the operation of the NECA/IBEW Family Medical Care Plan in accordance with the terms of the Trust Agreement, together with such Trustees' successors. Trustees appointed by the Association are Employer Trustees; Trustees appointed by the Unions are Union Trustees.

Union – Any local union affiliated with the International Brotherhood of Electrical Workers, AFL-CIO, which has entered into a collective bargaining agreement requiring contributions to the Fund. The plans described in this booklet are for employees represented by IBEW Locals 412, 1464 and 1613.



**For More Information:
Who is a Dependent?**

Please see page **A-3** for a definition of dependent.

Special Plan Features

Your Blue Card PPO Network

Most hospitals and physicians participate in the national Blue Card network. Your preferred provider (PPO) network is the national Blue Card PPO network through Blue Cross Blue Shield of Georgia (your “home plan”), an independent licensee of the Blue Cross and Blue Shield Association. The Blue Card network links individual Blue Cross Blue Shield (BCBS) PPO networks to provide you with access to the largest health care network in America.



For More Information: Blue Cross Blue Shield of Georgia Customer Service

You can reach customer service representatives by calling Blue Cross Blue Shield of Georgia Customer Service at 866-304-1881. Representatives are available to assist you Monday through Friday between 6 a.m. and 6 p.m. Central Time (CT)

If you use BCBS PPO network providers, you will receive the PPO (in-network) benefits shown on the Schedule of Benefits.

Participants in the Co-Pay Plan must use PPO providers or no Plan benefits are payable.

Your Blue Cross ID Card

Your BCBS ID card gives you access to BCBS network providers throughout the United States. The PPO-in-a-suitcase logo tells providers that you are part of the Blue Card PPO program. The three-letter alpha prefix that precedes your subscriber number on your ID card identifies Blue Cross and Blue Shield of Georgia (BCBSGA) as your home plan.

Preferred and Participating Providers under the PPO Plans

There are two types of health care professionals in the Blue Card PPO program:

1. Preferred Providers (PPO Providers) are part of the regular PPO network. They file claims for you, and your benefits are generally higher when you use their facilities and services. Participants in the Co-Pay Plan must use PPO providers in order to receive benefits from the Plan.
2. Participating Providers are non-PPO providers who have agreed to perform services at discounted rates for Blue Card PPO members. Typically, you would go to a participating provider if there are no PPO health care professionals in your area who can provide the medical care you need. Participating providers will also file your claims for you.



For More Information: To Find a Provider

To find a provider, call BCBS Network Access at 800-810-BLUE (2583) or visit www.bcbsga.com.

Pre-admission Certification

Pre-admission certification is a requirement for both in-network and out-of-network hospitalization benefits. For pre-certification, call 800-722-6614.

Pre-admission certification is not a guarantee of payment. Admissions are approved only when the appropriateness of the inpatient setting can be substantiated. Actual payment is dependent upon the person’s meeting the Plan’s eligibility rules.

Pre-admission certification is the responsibility of the PPO hospital or physician. Participating non-PPO providers will usually obtain pre-admission certification for you, but it is your responsibility to see that certification has been obtained.

If your admission is determined not to be medically necessary, all charges for that admission and related physician charges will be denied.

Your Sav-Rx Prescription Drug Program

The Plan provides its prescription drug benefits through a program administered by Sav-Rx. You can use your Sav-Rx card to purchase short-term or acute prescription drugs (such as antibiotics or pain relievers) from any participating retail pharmacy. Your co-pay amounts are shown on your Schedule of Benefits. See page **B-10** for more information about prescription drug coverage.



For More Information: Sav-Rx Customer Service

You can reach customer service representatives by calling Sav-Rx at 866-233-IBEW (4239) or visiting www.savrx.com. Representatives are available to assist you Monday through Friday between 6 a.m. and 6 p.m. Central Time (CT)

There is also a mail order feature allowing you to save even more money on your long-term and maintenance prescription drugs. You can order up to a 90-day supply of each prescription medication, with refills every 90 days, if allowed by your doctor. The discounts are usually greater through the mail order pharmacy.

Wal-Mart and Sam's Club are not part of your network, and the Plan will not cover drugs purchased from their pharmacies.



Important Note: If Your Spouse Has Coverage

If your spouse has coverage under another health plan, she must follow the rules of her prescription drug plan first and then file a claim with Sav-Rx for consideration of the remaining charge. The same applies to prescription drugs for any children for whom your spouse's plan pays primary benefits.

Cost of Coverage

You and the Company share of the cost of your medical coverage. Your contribution amount is determined by collective bargaining agreements between the Company and the Unions. Members of Local 1613 may use Flex Dollars to pay for this coverage.



Schedule of Medical Benefits for the PPO Deductible Plans

Benefit for the PPO Deductible Plans

Benefits are payable only for covered expenses. Covered expenses do not include amounts in excess of allowable charges, or charges for treatment that is not medically necessary. All benefits are subject to the maximum benefits and limitations stated below and to all Plan conditions and exclusions. All benefits and limitations shown are per covered person unless specifically stated otherwise.

Maximum Benefit Payable per Lifetime			
Per person	\$1,000,000*		
Limitations apply to certain types of benefits—see Special Benefits and Limitations, starting on page B-8 .			
Calendar Year Deductibles			
	\$300 PPO Deductible Plan	\$500 PPO Deductible Plan	\$1,000 PPO Deductible Plan
Per person	\$300	\$500	\$1,000
Per family	\$600	\$1,000	\$2,000
Deductibles apply to in- and out-of-network expenses combined.			
Coinsurance (Payment Percentages) per Calendar Year			
BCBS PPO expenses	90%		
Out-of-network expenses	60%		
Out-of-pocket Limits per Calendar Year			
	\$300 PPO Deductible Plan	\$500 PPO Deductible Plan	\$1,000 PPO Deductible Plan
Per person	\$1,000	\$2,000	\$3,000
Per family	\$2,000	\$4,000	\$6,000
Once a person's out-of-pocket limit is met, most covered medical expenses are paid at 100% during the remainder of the year. Deductibles do not count toward out-of-pocket limits, nor do out-of-pocket payments for mental health and chiropractic expenses. Expenses for mental health and chiropractic treatments will not be paid at 100% even if the person's out-of-pocket limit has been met.			

*All combined benefits paid under the PPO Deductible and/or Co-Pay Plan apply to the \$1,000,000 per person lifetime maximum.

Special Benefits and Limitations

Normal deductible and coinsurance percentages apply unless otherwise stated.

Wellness Exams	
Maximum benefit payable at 100% per calendar year, not subject to calendar year deductible	\$300
See page B-13 for a list of covered wellness expenses. Immunizations are excluded. Covered wellness expenses in excess of the annual maximum are covered under the regular PPO Deductible Plans provisions, subject to deductibles and coinsurance.	
Mental Health (Mental/Nervous Disorders & Substance Abuse)	
Maximum allowable days/visits per calendar year:	
Inpatient	30 days
Partial inpatient and intensive outpatient	30 days
Outpatient/office	20 visits
Chiropractic Care	
Allowable visits per calendar year	20 visits
Physical/Occupational Therapy	
Allowable visits per calendar year	20 visits
Speech Therapy (To Restore Speech After Accident or Illness)	
Allowable visits per calendar year	20 visits
TMJ/Jaw Disorders	
Lifetime maximum for all surgical and non-surgical treatment combined	\$1,000
Skilled Nursing Facility	
Allowable inpatient days per calendar year	60 days
Home Health Care	
Allowable visits per calendar year	120

Prescription Drug Program for the PPO Deductible Plans

You pay the following co-pays directly to the participating retail or mail order pharmacy:

	Retail	Mail
Generics	25% (\$10 minimum)	\$30
Brands	25% (\$20 minimum)	\$60

Wal-Mart and Sam's Club are not in your network.

"Generic drugs" are those with multiple manufacturers. You will have to pay the brand name co-pay for a generic drug sold by only one or two companies. See page **B-20** for information about covered and excluded drugs.

Schedule of Medical Benefits for the Co-Pay Plan

Medical Benefit for the Co-Pay Plan

Benefits are payable only for covered expenses rendered by PPO providers. The only exception is for hospital or urgent care facility and ambulance services, rendered due to an emergency. Covered expenses do not include amounts in excess of allowable charges, or charges for treatment that is not medically necessary. All benefits are subject to the maximum benefits and limitations stated below and to all Plan conditions and exclusions. All benefits and limitations shown are per covered person unless specifically stated otherwise.

The Co-Pay Plan only covers services rendered by BCBS PPO providers.

Maximum Benefit Payable per Lifetime	
Per person	\$1,000,000*
Calendar Year Deductible	
Not applicable	
Coinsurance	
Payable by the Plan after you pay your applicable co-pay amounts	100%
Out-of-pocket Limit	
Not applicable	
Co-pay Amounts and Limitations	
Inpatient hospital facility charges for room and board (semi-private and special care units) and ancillary charges	\$100 per day up to \$1,000 per admission
Hospital emergency room facility fees	\$50 per visit
Outpatient hospital or surgical facility when surgery is performed	\$100 per visit
Outpatient hospital facility – non-surgical/non-emergency	\$0
Urgent care facility (waived if admitted)	\$30 per visit
Professional (doctors') services	
Inpatient hospital (doctors' medical/surgical care, radiologist, pathologist, anesthesiologist)	\$0
Outpatient hospital (doctors' medical/surgical care, radiologist, pathologist, anesthesiologist)	\$0
Office visits:	
Primary care physician (PCP) or ob/gyn	\$15 per visit
Specialist, consultant or referral	\$30 per visit
Other office services (X-ray, lab, allergy treatment, second opinion), after payment of office visit co-pay shown above	\$0
Independent diagnostic facility (X-rays, labs, MRIs, etc.)	\$0

*All combined benefits paid under the PPO Deductible and/or Co-Pay Plan apply to the \$1,000,000 per person lifetime maximum.

Co-pay Amounts and Limitations (continued)	
Wellness exams, including immunizations	\$15/\$30 per visit
Mental health (mental/nervous disorders & substance abuse):	
Inpatient facility charges (30 days allowed per calendar year)	\$100 per day up to \$1,000 per admission
Partial inpatient/intensive outpatient facility charges (30 days allowed per calendar year)	\$90 per day up to \$900 per treatment
Outpatient/office (20 visits allowed per calendar year)	\$30 per visit
Chiropractic (20 visits allowed per calendar year)	\$30 per visit
Physical/occupational therapy (20 visits allowed per calendar year)	\$30 per visit
Speech therapy (20 visits allowed per calendar year)	\$30 per visit
Skilled nursing facility, inpatient (60 visits allowed per calendar year)	\$0
Home health care (120 visits allowed per calendar year)	\$0
Hospice	\$0
Durable medical equipment	\$0
Ambulance	\$0
TMJ (maximum benefit payable is \$1,000 lifetime)	\$15/\$30 per visit

Prescription Drug Program for the Co-Pay Plan

You pay the following co-pays directly to the participating retail or mail order pharmacy:

	Retail	Mail
Generics	\$8	\$16
Preferred brands	\$18	\$36
Non-preferred brands	\$36	\$72

Wal-Mart and Sam's Club are not in your network.

"Generic drugs" are those with multiple manufacturers. You will have to pay the brand name co-pay for a generic drug sold by only one or two companies. See page **B-20** for information about covered and excluded drugs.

PPO Deductible Plans

Calendar Year Deductibles

Individual Deductible

Your deductible amount depends on your benefit plan. Each calendar year you must pay your deductible out of your own pocket before benefits are payable for your remaining expenses.

This deductible is based on an accumulation period of a calendar year, and you must satisfy a new deductible each year.

Only covered medical expenses can be used to satisfy a deductible.

Prescription drug co-pays do not apply to deductibles under the PPO Deductible Plans.

Family Deductible

After two or more persons in your family have had amounts applied to their individual deductibles that together equal the amount of the family deductible for your benefit plan for a particular calendar year, your family deductible will have been satisfied for that year, and no further individual deductibles will be required of you or your eligible dependents for the rest of that calendar year.

Coinsurance (Plan Payment Percentages)

The Plan pays the following percentages for covered medical expenses after satisfaction of the individual or family calendar year deductible each year:

PPO expenses	90%
Out-of-network (non-PPO) expenses	60%

Covered expenses for out-of-network hospital or urgent care facility treatment, and ambulance services, are payable at 90% if the treatment is due to a medical emergency.

The coinsurance percentages described above do not apply to prescription drugs; refer to the Prescription Drug Program section for information about prescription drug benefits.

Out-of-pocket Limit

The amount of your out-of-pocket limit is determined by your benefit plan.

If your annual combined 10% and 40% coinsurance amounts for covered medical expenses total the amount of the out-of-pocket limit for your plan, the Plan payment percentage will be 100% for the covered medical expenses you incur during the remainder of the calendar year.

Calendar year deductibles and prescription drug co-pays do not apply to out-of-pocket limits, nor do out-of-pocket coinsurance payments for chiropractic care or mental health treatment (substance abuse or mental/nervous disorders). Chiropractic and mental health expenses, and prescription drug charges will not be paid at 100% if your out-of-pocket limit was previously satisfied.

Maximum Benefits

A maximum benefit is the most the Plan will pay for a person for a particular type of treatment during a calendar year, the person's lifetime or, in the case of the \$1,000,000 lifetime maximum under the Plan, for treatment of all injuries and sicknesses during his lifetime. Maximums apply to each eligible family member separately, and do not start over if the person's eligibility is interrupted, or if his status changes—for example, if he changes to a different PPO Deductible Plan or to the Co-Pay Plan.

Lifetime Maximum for the PPO Deductible Plans

A \$1,000,000 maximum applies to all benefits combined paid on your behalf under the PPO Deductible and/or Co-Pay Plan. It applies to all treatment and all injuries and sicknesses during your lifetime.

Other Maximums and Limitations

The Plan's other maximums and limitations are shown on the Schedule of Benefits. Any amounts paid toward these separate maximums also apply to your lifetime maximum.

Covered Medical Expenses

Covered medical expenses are the actual charges incurred for the following types of services and supplies which are medically necessary. Except where specifically stated otherwise, the services and supplies must be required in connection with the treatment of a person's injury or sickness. The amount payable is subject to the maximum benefits and limitations shown on the Schedule of Benefits and to all other limitations and exclusions that apply. Only the amount of a charge that is considered an allowable charge is considered a covered medical expense.

1. Hospital services and supplies:

- a. Daily room and board, if semi-private or ward accommodations are used, and general duty nursing care, excluding professional services of doctors, private duty nurses or any individual nursing care, regardless of what it is called. Charges for intensive care or cardiac care units are also covered. If you are admitted to a hospital that has only private rooms, covered charges are based on the hospital's most prevalent room rate.
- b. Other hospital services and supplies furnished to a person which are medically necessary and required for treatment of the person's medical condition

2. Freestanding medical facilities – Services provided by licensed ambulatory surgical center services, urgent care centers, immediate care facilities and clinics

3. Surgery by a physician. A surgical assistant's fees will also be covered subject to the coverage and fee guidelines established by Blue Cross Blue Shield of Georgia.

4. Anesthetics and their administration by a physician

5. Doctors' professional services rendered either in or out of a hospital for medical care and treatment

6. Chiropractic care – Up to 20 visits per calendar year for the medically necessary services and supplies provided by a chiropractor for treatment of a non-occupational injury or sickness, including diagnostic X-rays, laboratory tests and imaging services

7. Professional services by other covered providers –

Professional medical services provided by the following types of licensed providers when the services are within the Plan's normal covered expense provisions and are rendered within the scope of each such individual's license and specialty, and if payment would have been made under this Plan to a doctor for the same services:

- a. An advanced practice nurse (a registered nurse with a Master's or better degree who is licensed to practice in a clinical setting, for example, an N.P., L.N.P., C.N.P., C.N.S. or C.R.N.A.)
- b. A licensed clinical psychologist, a licensed clinical social worker, or a clinical specialist psychiatric nurse (for mental/nervous disorders and substance abuse only)
- c. A physician's assistant (P.A.)
- d. A surgical assistant
- e. A registered nurse first assistant
- f. A licensed midwife (for pregnancy-related services only)
- g. A doctor of dentistry (D.D.S.)
- h. A podiatrist (D.P.M.) and
- i. A doctor of optometry (O.D.)

8. X-ray, laboratory examinations, and diagnostic imaging and tracing services (such as EKGs, MRIs, computerized scans, sonograms, mammograms, etc.), including services of radiologists and pathologists

9. Chemotherapy and radiation, radioisotope and nuclear medicine therapy

10. Physical and occupational therapy (other than speech therapy) provided on an outpatient basis up to 20 visits per calendar year for physical and occupational therapy combined, as follows:

- a. Physical therapy rendered by a registered physical therapist, or a licensed physical therapy assistant working under the supervision of the physical therapist on an inpatient or outpatient basis, provided the therapy is recommended by the attending doctor
- b. Occupational therapy prescribed by a physician and performed by an accredited occupational therapist, or licensed occupational therapy assistant working under the supervision of the occupational therapist. The therapy must provide task-oriented therapeutic activities designed to significantly improve or restore physical functions lost or impaired as a result of a disease, or injury; or to relearn daily living or performance skills or compensatory techniques in order to improve the level of independence. Driver training is not covered, nor are any services related to learning disabilities, developmental delays, mental retardation, brain damage not caused by accidental injury or illness, minimal brain dysfunction, or dyslexia.

11. Cardiovascular rehabilitation therapy that is rendered through a supervised medical cardiac rehabilitation program prescribed by a physician within six months after an acute cardiovascular incident for a patient with modifiable coronary risk factors or poor exercise tolerance

12. Speech therapy to restore speech abilities lost due to an illness or a non-occupational accident. Covered expenses are limited to 20 visits per person per calendar year.

13. Wellness exams – An annual routine physical examination for an employee or spouse, including diagnostic tests such as pap tests, mammograms, prostate specific antigen tests (PSAs), colorectal cancer screenings, EKGs, stress tests and hearing tests.

The maximum benefit payable at 100% (no deductible) is \$300 per person per calendar year. Covered wellness expenses in excess of \$300 are payable under the regular provisions of the PPO Deductible Plans, subject to your deductible and coinsurance. Immunizations are not covered.

Co-Pay Plan: The Co-Pay Plan pays covered wellness expenses and immunizations at 100% after your \$15 (PCP or ob/gyn physician) or \$30 (specialist) office visit co-pay.

14. Family planning services, including physician's office visits, diagnostic tests, contraceptive devices (Depo-Provera, intrauterine devices and diaphragms) provided by in the physician's office, vasectomies and other sterilization procedures. These services are only covered for employees and dependent spouses; they are not covered for children. Over-the-counter products are not covered.

15. Breast reconstructive surgery on the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas

16. Dialysis treatment

17. Diabetic treatment – Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional counseling for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the physician

18. Ambulance – Local service to a hospital in connection with care for a medical emergency or if otherwise medically necessary. The Plan also covers your transfer from one hospital to another, and air ambulance, if medically necessary. Note: Services by an out-of-network ambulance provider will be covered on the same basis as a PPO provider in the case of an emergency (as defined on page **B-10**).

19. Mental or nervous disorders and substance abuse

treatment in an approved facility and/or by a covered provider as follows:

- a. **Hospital inpatient treatment** – When treatment is rendered as an inpatient, covered expenses include the hospital’s daily room and miscellaneous charges, including diagnostic X-rays and laboratory work, up to 30 days per calendar year
- b. **Partial inpatient/intensive outpatient treatment** – The Plan covers up to 30 days of partial inpatient and/or intensive outpatient treatment per calendar year, which is defined as treatment provided at a facility for at least three hours but less than twelve hours per day
- c. **Outpatient or office treatment** – The Plan covers up to 20 outpatient and/or office visits each calendar year
- d. **Residential treatment for substance abuse by a state-licensed alcohol/drug rehabilitation facility** – Covered on the same basis as a hospital inpatient confinement

Prescription drugs for mental/nervous disorders are payable under the Prescription Drug Program.

20. Pregnancy expenses, including medical expenses for miscarriage, abortion, prenatal care, and delivery in a hospital, birthing center or at home. Routine well-newborn nursery care and pediatric visits during the initial hospital confinement are also covered. The Plan covers pregnancy-related expenses for employees and their dependent spouses only.

Note About Benefits: Pregnancy benefits are payable like any other covered condition, and the normal deductibles and co-pays apply. For the Co-Pay Plan, office visit co-pays must be paid if the physician does not include prenatal care in the charge for delivery but makes separate charges for those visits. The newborn baby’s hospital charges are usually billed as part of the mother’s bill, and will therefore be paid as part of the mother’s claim. If a hospital bills separately for the baby, either because the baby is ill or because it is their billing practice, the bills will be processed as claims for two separate individuals, and deductibles and co-pays will be assessed accordingly.

Note About Length of Maternity Confinements: An eligible female, and her newborn infant, are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. (The attending provider may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) Benefits are payable for the covered medical expenses incurred by an eligible female during the prescribed time periods, subject to the applicable deductibles, coinsurance and maximum benefits shown on the Schedule of Benefits.

- 21. Certain infertility-related services** – Diagnostic testing to determine the cause of a person’s infertility, and surgical or medical treatment to treat the underlying medical cause of the infertility. Services to promote conception, including but not limited to the following, are NOT covered: 1) hormone therapy; 2) artificial intrauterine insemination; or 3) the implanting of a fertilized egg, gamete or zygote by any means, including but not limited to in vitro fertilization, gamete intrafallopian transfer or zygote intrafallopian transfer.
- 22. Obstructive sleep apnea treatment**, subject to medical necessity and the coverage guidelines established by BCBS (treatment of snoring without sleep apnea is not covered)
- 23. Cochlear implants** when medically necessary and appropriate for a person with severe-to-profound sensorineural hearing impairment who can obtain limited benefit from a conventional hearing aid, up to one per person per lifetime
- 24. Organ/tissue/bone marrow transplants** as described in the Benefits for Transplants section starting on page **B-17**

25. Home health care – up to 120 visits per calendar year (a visit consists of up to four hours of care), for part-time or intermittent nursing care provided by a home health agency, subject to the following requirements:

- a. The services and supplies must be provided by or through a home health agency as defined in the Definitions section
- b. A program of home nursing care must be established and approved in writing by the patient's doctor within seven days after an inpatient hospital stay
- c. The doctor must certify that the home nursing care is for the same or related condition for which the patient was hospitalized and that proper and medically necessary treatment of the patient's condition would require hospital confinement in the absence of the services and supplies provided as part of the program of home nursing care and
- d. The home health care program must be pre-certified

Covered home health care services – The following services are covered by the Plan:

- a. Visits by an R.N. or L.P.N.
- b. Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy
- c. Visits to render services and/or supplies of a licensed medical social services worker when medically necessary to enable the patient to understand the emotional, social, and environmental factors resulting from or affecting the patient's illness
- d. Visits by a home health nursing aide when rendered under the direct supervision of an R.N.
- e. Nutritional guidance when medically necessary
- f. Administration of prescribed drugs
- g. Oxygen and its administration

26. Skilled nursing facility care, including room and board and medically necessary services and supplies for up to 60 days per person per calendar year, subject to all the following requirements:

- a. A doctor must certify that the confinement and nursing care are necessary for the patient's recuperation from an injury or sickness
- b. The patient must require continuous 24-hour-a-day nursing care
- c. The confinement must be provided in a facility which meets the Plan's definition of a skilled nursing facility

27. TMJ treatment and treatment for other jaw disorders, including hospital and doctors' services, and other medically necessary services and supplies provided for or in connection the treatment. The maximum payable is \$1,000 per lifetime for all treatment. Jaw surgery performed due to tumors, fractures or accidental injury is not subject to the \$1,000 maximum and is payable the same as any other covered procedure.

28. Durable medical equipment – Rental charge up to the purchase price of the equipment. The equipment must be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition.

The equipment must meet all the following criteria:

- It is related to the patient's physical disorder.
- It is appropriate for in-home use.
- It can stand repeated use.
- It is manufactured solely to serve a medical purpose.
- It is not merely for comfort or convenience.
- It is normally not useful to a person not ill or injured.
- It is ordered by a physician.
- The physician certifies in writing the medical necessity for the equipment. The physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing medical necessity of any item.

29. Prosthetic appliances and devices to improve or correct conditions resulting from accidental injury or illness and that are ordered by a physician. Covered prosthetic devices include: artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); orthotics; external breast prostheses used after breast removal. Exclusions include but are not limited to penile implants and corrective shoes.

30. Medical supplies, such as:

- a. Drugs and medicines which may only be legally dispensed by a registered licensed pharmacist according to a doctor's written prescription which includes the name of the drug, and certain diabetic supplies not requiring a doctor's prescription. Refer to Prescription Drug Program on page **B-20** for more information about obtaining prescription drugs.
- b. Whole blood (if not donated or replaced) or blood plasma and the administration of such substances
- c. Bandages, surgical dressings, casts, splints, trusses, crutches and orthopedic braces
- d. Surgical supplies, including the first charge incurred for surgical supplies required to aid any impaired physical organ or part in its natural body function
- e. Oxygen and rental of the equipment for the administration of oxygen

31. Hospice services as follows, when provided by an organization meeting the Plan's definition of a hospice to an eligible person who is terminally ill (medical prognosis indicates a life expectancy of six months or less).

- a. Nursing care by an R.N. or L.P.N. and services of home health aides (such services may be furnished on a 24-hour basis during a period of crisis or if the care is necessary to maintain the patient at home)
- b. Chaplaincy and medical social services, counseling services and/or psychological therapy by a social worker or a psychologist
- c. Physical and occupational therapy and speech language pathology
- d. Short-term inpatient care to provide respite care, palliative care or care in periods of crisis. The maximum allowable number of respite care days is eight per lifetime.

32. Dental treatment, limited to:

- a. Treatment of accidental injury to sound natural teeth, including the initial replacement of such teeth and any necessary dental X-rays, provided the first treatment is received within twelve months of the accident causing the injury
- b. Treatment of fractures and dislocations of the jaw, and cutting procedures in the oral cavity other than for extractions, repair or care of the teeth, dentures or gums, or TMJ, when provided by a qualified oral surgeon
- c. General anesthesia and associated hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:
 - A patient who is age 7 or younger
 - An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder or
 - An individual who has sustained extensive facial or dental trauma (other than for a work-related injury)

The services listed above are the only dental-related procedures covered under the PPO Deductible Plans. The only other benefits payable by the Plan for dental procedures, including oral surgery and removal of impacted teeth, are provided under the provisions of the Dental Benefit.

Benefits for Transplants

A “transplant” means a procedure or series of procedures by which an organ or tissue is either removed from the body of one person (called a “donor”) and implanted in the body of another person (called a “recipient”); or removed from and replaced in the same person’s body (called a “self-donor”).

Covered Transplants

In order to be covered, a transplant must be a medically appropriate transplant of one of the following organs or tissues only, and no others:

1. Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session
2. Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, including covered donor costs, but only if required in the treatment of one of the following conditions:
 - a. Non-Hodgkin’s lymphoma, intermediate or high grade Stage III or IVB
 - b. Hodgkin’s disease (Lymphoma), Stages IIIA, IIIB, IVA, or IVB
 - c. Neuroblastoma, Stage III or Stage IV
 - d. Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support
 - e. Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds
 - f. Metastatic breast cancer that has not been previously treated with systemic therapy, is currently responsive to primary systemic therapy, or has relapsed following response to first-line treatment
 - g. Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse
3. Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but

only if required in the treatment of one of the following:

- a. Aplastic anemia
- b. Acute leukemia
- c. Severe combined immunodeficiency exclusive of acquired immune deficiency syndrome (AIDS)
- d. Infantile malignant osteoporosis
- e. Chronic myelogenous leukemia
- f. Lymphoma (Wiscott-Aldrich syndrome)
- g. Lysosomal storage disorder
- h. Myelodysplastic syndrome

Pre-Certification Requirement

All transplant procedures must be pre-certified for type of transplant and be medically appropriate according to criteria established by the Plan. The pre-certification requirements are a part of the benefit administration of the Plan and are not a treatment recommendation. The actual course of medical treatment the patient chooses remains strictly a matter between the patient and his physician.

Your physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, the recipient and the transplant surgeon must meet required medical selection criteria as defined by Blue Cross Blue Shield of Georgia.

Live Donors

If the transplant involves a living donor, covered donor costs are as follows:

- If a patient receives a transplant and the donor is also covered under this Plan, payment for the recipient and the donor will be made under each individual’s coverage
- If the donor is not covered under this Plan, benefits will be limited by any payment which might be made under any other hospitalization coverage plan
- If the participant is the donor and the recipient is not covered under this Plan, benefits will be limited by any payment which might be made by the recipient’s hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

General Provisions and Definitions

“Covered donor costs” means all costs, direct and indirect (including administration costs), incurred in connection with medical services required to remove the organ or tissue from either the donor’s or the self-donor’s body; preserving it; and transporting it to the site where the transplant is performed.

In treatment of cancer, the term “transplant” includes any chemotherapy and related courses of treatment which the transplant supports.

Benefits for anti-rejection drugs are payable under the Prescription Drug Program.

Covered services include certain services and supplies not otherwise excluded in this SPD booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including antirejection drug treatment) and transplant related chemotherapy.



A Closer Look: Individual Case Management

The Trustees of the NECA/IBEW Family Medical Care Plan may authorize coverage of services, supplies or treatment settings not normally covered by the Plan on the basis that, in the opinion of the Trustees, such treatment is cost effective for the Plan and clinically appropriate for the individual. The Trustees may rely on the opinion of a health care professional who is qualified to render advice on the issue as to whether a service or supply not normally covered by the Plan is medically necessary, medically appropriate and cost-effective for the Plan in a particular case. Any alternative services covered under this provision shall be specific to the individual case and shall in no event set a precedent with respect to other similar claims.

Co-Pay Plan

The Co-Pay Plan covers a wide range of hospital and professional services provided by PPO providers.

No benefits are provided for treatment rendered by facilities or medical professionals who are not in the Blue Cross PPO network. The only exception is for hospital or urgent care facility and ambulance services rendered due a medical emergency.

Co-pays

The co-pay is the flat dollar amount you pay for certain expenses. The Plan has a lower co-pay for services received from a primary care physician (PCP) or gynecologist/obstetrician, and a higher co-pay for services rendered by a specialist.

Your co-pay amounts are shown on the Co-Pay Plan Schedule of Benefits that starts on page **B-9**. Once you pay your co-pay for a service, the plan pays 100% of the remainder.

Maximum Benefits

A \$1,000,000 maximum applies to all combined benefits paid on your behalf under the PPO Deductible and/or Co-Pay Plan. It applies to all treatment and all injuries and sicknesses during your lifetime.

Other maximums and limitations, which are shown on your Schedule of Benefits, apply to certain types of services. Any amounts paid toward these separate maximums also apply to your lifetime maximum under the PPO Deductible Plan.

Maximums apply to each eligible family member separately, and do not start over if the person's eligibility is interrupted, or if his status changes—for example, if he changes from the Co-Pay Plan to a PPO Deductible Plan.

Covered Medical Expenses

The Co-Pay Plan covers the same medical expenses as the PPO Deductible Plans. Those expenses are described on pages **B-12 – B-16**. The only exceptions are as follows:

- 1. Wellness exams** – The Co-Pay Plan covers an annual routine physical examination for an employee or spouse, including diagnostic tests such as pap tests, mammograms, prostate specific antigen tests (PSAs), colorectal cancer screenings, EKGs, stress tests and hearing tests. These expenses are covered at 100% after your \$15 (PCP or ob/gyn physician) or \$30 (specialist) office visit co-pay.
- 2. Immunizations** for adults and children are covered under the Co-Pay Plan.

Prescription Drug Program for the PPO Deductible and Co-Pay Plans

Packets containing prescription drug cards and additional information about your prescription drug program are sent to all participants when they first become eligible for benefits.

Your Prescription Drug Co-Pays

Your prescription drug co-pay amounts are shown on the Schedule of Benefits for your plan. Your prescription drug co-pays do not apply to your deductible or out-of-pocket limit under the PPO Deductible Plans.

Note that the co-pays for generic drugs apply to drugs with multiple manufacturers. You will have to pay the brand name co-pay for a generic drug sold by only one or two companies. Contact Sav-Rx for information about specific drugs.

Drug Card Program

Your Sav-Rx drug card is recognized at most pharmacies nationwide. Most of the major pharmacy chains are in the network.

You pay your co-pay amount directly to the participating pharmacy—there are no claims to file. You can get up to a 30-day supply at one time. Your co-pays do not apply to your deductibles or out-of-pocket limit under the PPO Deductible Plans.

Wal-Mart and Sam's Club are not in your network. No benefits will be paid for drugs purchased at these chains.

You should use the retail drug card program only for short-term prescription drugs such as antibiotics or pain relievers. Your out-of-pocket costs will usually be lower if you use the mail order program for your long-term prescription drug needs.

Mail Order Pharmacy

When you order your covered prescription drugs through the Sav-Rx mail order pharmacy, you pay your co-pay amount directly to the mail order pharmacy. You can receive up to a 90-day supply of each prescription or refill, and your medications will be delivered to your home, postage paid.

When Your Spouse Has Other Coverage

If your spouse has coverage under another health plan, she must follow the rules of her prescription drug plan first. A claim can then be filed with Sav-Rx for payment consideration of any amount not paid by her plan under the PPO Deductible Plans. This same process must be followed for any children for whom your spouse's plan pays primary benefits.

Covered Prescription Drugs

Covered drugs and medications under the Prescription Drug Program are the same as those covered under the PPO Deductible Plans, and the Exclusions and Limitations section starting on page **B-21** apply to this program. For example, the Plan does not cover over-the-counter (non-prescription) drugs; experimental/investigative drugs; growth hormones for short stature; vitamins; or drugs for infertility, obesity, sexual dysfunction or smoking cessation, even if you have a doctor's prescription. Exceptions:

- The \$300, \$500 and \$1,000 PPO Deductible Plans cover prescription vitamins that treat a covered condition, prescription fluoride, and prescription erectile dysfunction drugs (such as Viagra)—up to six tablets per month.
- Participants in the \$300, \$500 and \$1,000 PPO Deductible Plans may purchase respiratory therapy devices and ostomy supplies through the Prescription Drug Program.
- The Co-Pay Plan covers special infant formula for treatment of inborn errors of metabolism.

Injectables and specialty drugs may require pre-authorization by Sav-Rx.

Exclusions and Limitations

No payment will be made by this Plan for loss sustained as a result of, or for charges incurred for or as a result of, any of the following:

1. Treatments, care, services or supplies that are not medically necessary (as defined in the Definitions section)
2. Under the PPO Deductible Plans, any amount in excess of the allowable charge; or with respect to the other benefits by provided the Plan, any charge or portion of a charge that is determined to be in excess of the reasonable and customary charge
3. Cosmetic treatment or surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue), or surgery to correct prior cosmetic surgery. This exclusion applies to breast reductions, reshapings and enhancements.
 Exceptions: This exclusion does not apply to:
 - a. Cosmetic surgery for the correction of defects incurred through traumatic injuries sustained as a result of an accident within one year of the surgery
 - b. The correction of congenital defects or
 - c. Breast reconstruction following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance
4. Experimental or investigative treatment, care, services, supplies, procedures or facilities
5. Obesity, morbid obesity, or any overweight condition. The Plan will, however, cover medically necessary bariatric surgery that has been pre-authorized by BCBSGA
6. Immunizations (except under the Co-Pay Plan)
7. Developmental delays, including charges for development and neuroeducational testing or treatment, hearing therapy, therapy for learning disability, communication delay, perceptual disorders, sensory deficit, developmental disability and related conditions, or for other special therapy not specifically included as a covered expense elsewhere in this booklet, whether or not such disorder is the result of an injury or sickness

Note: The Plan does cover medically necessary, non-experimental treatment of attention deficit disorders (ADD/ADHD).

8. Reversal of, or attempts to reverse, a previous elective sterilization
9. Pregnancy or a pregnancy-related condition of any person other than a female employee or the spouse or domestic partner of an employee
10. Infertility, including but not limited to hormone therapy, artificial insemination, or any other direct attempt to induce or facilitate fertility or conception. (The Plan does cover the initial diagnostic tests to determine the underlying cause of the infertility.)
11. Sex transformations or transsexual surgery
12. Sexual dysfunction or impotency of any kind, including any complications arising from such conditions or treatments. This exclusion applies to erectile dysfunction drugs (except as provided for participants in the \$300, \$500 and \$1,000 PPO Deductible Plans under the Prescription Drug Program), and penile implants, regardless of the person's physical or mental condition.
13. Marriage or family counseling
14. LASIK surgery, or any other surgical or laser procedures to correct nearsightedness, farsightedness or astigmatism
15. Hearing aids
16. Over-the-counter drugs or medicines which are drugs that are not legally required to be dispensed by a registered pharmacist according to the written prescription of a doctor (except for certain non-prescription diabetic supplies)
17. Nutritional supplements, food supplements or vitamins, except as specifically stated under the Prescription Drug Program
18. Growth hormone therapy or any treatment for growth hormone deficiency or short stature
19. Snoring
20. Excessive sweating
21. Orthoptics or vision training

- 22.** Travel or transportation, whether or not recommended by a doctor, unless specifically listed as a covered medical expense
- 23.** Physical therapy for chronic pain
- 24.** Rehabilitative therapy or any other type of therapy if either the prognosis or history of the person receiving the treatment or therapy does not indicate to the Trustees that there is a reasonable chance of improvement
- 25.** Organ and tissue transplants unless preapproved by BCBS and performed through the BCBS human organ transplant program
- 26.** Artificial organs
- 27.** Smoking cessation services or supplies, including but not limited to medications (prescription or non-prescription) and therapy or counseling of any type
- 28.** Individual or private nursing care unless specifically listed as a covered medical expense
- 29.** Rental or purchase of any durable medical equipment other than as specifically provided in the Covered Medical Expenses section, including but not limited to equipment that is not used solely for therapeutic treatment of a single individual's injury or illness. The following items related to durable medical equipment are also excluded:
- Air conditioners, humidifiers, dehumidifiers, or purifiers
 - Arch supports and orthopedic or corrective shoes (unless custom-made and medically necessary)
 - Heating pads, hot water bottles, home enema equipment or rubber gloves
 - Sterile water
 - Deluxe equipment, such as motordriven chairs or beds, when standard equipment is adequate
 - Rental or purchase of equipment if you are in a facility which provides such equipment
 - Electric stair chairs or elevator chairs
 - Physical fitness, exercise or ultraviolet/tanning equipment
 - Residential structural modification to facilitate the use of equipment
 - Other items of equipment which do not meet the listed criteria
- 30.** Any of the following items or items of a similar nature or purpose, regardless of intended use:
- Blankets, mattresses, pillows or covers for these items, even if orthopedic or hypo-allergenic
 - Communication devices
 - Continence aids (either anal or urethral)
 - Devices or implants to simulate natural body contours
 - Emergency alert equipment
 - Exercise equipment
 - Health club memberships
 - Scales
 - Swimming pools
 - Thermometers
 - Whirlpools, saunas or Jacuzzis
 - Wigs
- 31.** Alternative medical treatments, including, but not limited to, hypnotism, biofeedback, holistic medicine, acupuncture, massage therapy, rolfing, music therapy, hippotherapy, health education, homeopathy, reiki, myofractional therapy, sleep therapy and programs intending to provide personal fulfillment or harmony
- 32.** Personal convenience items such as telephones, TVs, cosmetics, newspapers, magazines, laundry, guest trays or beds or cots for guests or other family members, or any other personal comfort items or items that are not medically necessary
- 33.** Home health care charges for: a) food, housing, homemaker services, sitters, child care or home-delivered meals; b) any non-skilled level of care, or any services and/or supplies which are not included in the home health care plan as described; c) any services for any period during which the patient is not under the continuing care of a physician; d) convalescent or custodial care where the patient has spent a period of time for recovery of an illness or surgery and where skilled care is not required; e) services that are only for aid in daily living, i.e., for the convenience of the patient; f) dietitian services; g) maintenance therapy; or h) dialysis treatment, or purchase or rental of dialysis equipment

- 34.** Skilled nursing facility services for: a) any period of confinement after the patient reaches the maximum level of recovery possible and no longer requires other than routine care; b) care that is primarily custodial, or that does not require definitive medical or 24-hour-a-day nursing service; c) mental illness including drug addiction, chronic brain syndromes and alcoholism, unless there is a specific medical condition that requires care in a skilled nursing facility; or d) a patient with senile deterioration, mental deficiency or retardation, who has no medical condition requiring care
- 35.** Military service-connected injuries or sicknesses
- 36.** Genetic testing unless the result of the test will directly impact the treatment being delivered to a patient who has a diagnosed medical condition
- 37.** Surrogacy or surrogate fees. This exclusion applies to, but is not limited to, charges in connection with: a) the medical or other expenses of a surrogate who carries and delivers a child on behalf of a person covered under this Plan or b) a female employee's or dependent's carrying and delivering a child for someone else. Any child born of a covered person acting as a surrogate mother will not be considered a dependent of the surrogate mother or her spouse. This exclusion does not apply to complications of pregnancy incurred by a surrogate who is an eligible employee or eligible dependent under this Plan.
- 38.** Court-ordered treatment or classes
- 39.** Accidental bodily injury, sickness or disease for which benefits are or may be payable in whole or in part under any workers' compensation act or any occupational diseases act or any similar law
- 40.** Education, training or room and board while a person is confined in an institution which is primarily a school or institution of learning or training
- 41.** Special education, regardless of the type or purpose of the education, the recommendation of the attending doctor or the qualifications of the individual providing the education. This applies to special education or instruction for a learning disabled or handicapped child. (This exclusion does not apply to diabetic education for a person diagnosed with diabetes mellitus.)
- 42.** Custodial care, which is care designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called (unless the care is provided to a person under an approved hospice care program).
- 43.** Care or treatment rendered to you or a dependent which is provided by a person who is a relative in any way to you or to the dependent receiving the care or who ordinarily lives in your home or in the home of the dependent receiving the care
- 44.** Services or supplies provided while a person is confined in an institution which is primarily a place of rest, a place for the aged, or a nursing home (unless provided during an approved confinement in a facility that meets the definition of a skilled nursing facility)
- 45.** Treatment, care, services, supplies or procedures provided while a person is confined in a hospital operated by the U.S. Government or its agencies, provided, however, that if charges are made by a Veterans Administration (V.A.) hospital which claims reimbursement for the "reasonable cost" of care furnished by the V.A. for a non-service-related disability, to the extent required by law such charges will be considered covered medical expenses to the extent that they would have been considered covered medical expenses had the V.A. not been involved.
- 46.** Charges incurred by an eligible family member which you or the family member are not legally required to pay. This includes any portion of a provider's fee or charge which is ordinarily due from the patient but which has been waived. If a provider routinely waives (does not require the participant to pay) a deductible or an out-of-pocket amount, the claims administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- 47.** Completing of claim forms (or any forms required by the Plan for the processing of claims) by a doctor or other provider of medical services or supplies
- 48.** Bodily injury, disease or sickness caused by any act of war, whether war is declared or undeclared, any act of international armed conflict or any conflict involving the armed forces of any international body, or insurrection

- 49. Services or supplies furnished, paid for or otherwise provided due to past or present service of any person in the armed forces of a government
- 50. Treatments, care, services or supplies which are not recommended, ordered or approved by the attending doctor
- 51. Unless specifically stated otherwise, any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a specific sickness, illness or accidental bodily injury
- 52. Any care or treatment of a person once the person has already received Plan benefits totaling the maximum benefit for that type of care and treatment as specified on the Schedule of Benefits
- 53. Injury or sickness for which you or an eligible dependent, whether or not a minor, have a right to recover payment from a third party, except to the extent provided in the Plan's subrogation rules
- 54. Injury or sickness resulting from or occurring during a crime committed by the patient
- 55. Services or supplies provided to a person who is not covered under the Plan
- 56. Charges which would not have been made if this Plan did not exist
- 57. Services or supplies required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement, or which are required by law
- 58. Services, treatment or supplies which were ordered before the person's effective date of coverage or which are performed or provided after the date a person's eligibility terminates

The above is not an all-inclusive listing of excluded services and supplies. It is only representative of the types of services and supplies for which no payment is made and of the types of situations in which loss may be sustained or in which expenses may be incurred for which no payment is made.



How to File Claims

Medical

Hospitals and doctors will usually file your claim for you. If you need to submit a claim yourself, send it to your local BCBS plan.

Blue Cross PPO providers throughout the country will file your claims for you. The Fund's home Blue Cross plan, Blue Cross Blue Shield of Georgia (BCBSGA), will make payments for medical claims on the Fund's behalf.

When visiting a Blue Cross PPO provider, all you need to do is show your ID card. You will be responsible for any coinsurance amounts, in addition to any services that are not covered by the Fund or not approved by BCBS.

When your provider submits your claim to the local BCBS plan, it is important that the alpha prefix from your ID card is included. This prefix is the key to timely and accurate claims processing.

If you need to submit a claim yourself, send itemized bills to your local BCBS plan (the BCBS plan in the provider's state). For example, in the Kansas City area, send your claims to:

**Blue Cross and Blue Shield of Kansas City
(BCBSKC)**

P.O. Box 419169

Kansas City, MO 64141-6169

Your local BCBS plan will transmit the claim to this Plan's home plan (BCBSGA). Be sure to include your BCBS alpha prefix, and your group and individual identification numbers.



Important Note: Examinations

The Trustees have the right to have a doctor examine a person for whom benefits are being claimed, to ask for an autopsy in the case of a death and to examine any and all hospital or medical records relating to a claim.

Prescription Drug

Co-pays are your responsibility. Do not submit claims for co-pays.

There are no claims to file when you use the Plan's prescription drug program (unless another group plan is the primary payor for the person's claims). You pay your co-pay shares directly to the participating retail or mail order pharmacy.

Coordination of Benefits (COB)

If you or your dependents are covered by another medical plan, the benefits/coverages are coordinated between this Plan and the other plan.

For information about coordination of benefits, please refer to the General Information section of this book.

Imputed Income

The Internal Revenue Service (IRS) has ruled that if an employee receives health benefits for a domestic partner or the domestic partner's legally dependent child(ren), the employee must pay FICA, federal income and state income (unless otherwise permitted by state law) taxes on the domestic partner's health coverage over the amount paid for the employee's own coverage. This amount may be added to gross income and taxed accordingly. If the domestic partner is a legal tax dependent under IRC Section 152, imputed income may not apply.

Employees on an approved leave of absence, who pay their portion of the employee contribution schedule by a method other than payroll deduction, will be obligated to pay the amounts due to FICA tax and income tax withholding on imputed income. Income withholding tax rates will be calculated in accordance with the employee's specific W-4.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your private health information.

In addition, certain provisions of HIPAA are intended to improve the availability and portability of health care coverage for workers and their families when they change or lose jobs. For example, if your coverage under the Deductible or Co-Pay Plans ends, you will receive a "certificate of creditable coverage" which may help you avoid all or part of any pre-existing condition restriction which might apply to you under new coverage.

For information on your rights under HIPAA, please refer to the General Information section of this book.

Continuing Medical Coverage under COBRA

Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, you and your dependents may be eligible to temporarily extend your group medical coverage if you lose coverage due to certain qualifying events.

For information on your rights and benefits under COBRA, please refer to the General Information section of this book.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For information about your rights and protections under ERISA, please refer to the General Information section of this book.



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Dental Coverage

The dental plans for employees represented by IBEW Locals 412, 1464 and 1613 are described in this section.



Important Note: Pronouns Used in this Dental Coverage Section

Wherever the term “you” or “your” is used in this booklet, it means an eligible employee. And, to avoid awkward wording, male personal pronouns are used to refer to employees. Feminine pronouns are used when referring to spouses. Whenever a personal pronoun is used in the masculine gender, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine.

Important Dental Coverage Terms

There are certain dental terms that have specific meaning under the Plan. This section explains those terms to help you better understand your benefits. Note: A benefit is not necessarily covered because a term appears in this definition’s section.

Please note that references to “dependent” or “spouse” throughout this Dental Coverage section include a qualifying domestic partner according to the definition in the Plan Participation section of this book.

Allowable charge – The maximum covered charge for a service rendered or supply furnished by a health care provider that will be considered for payment. You will be responsible for amounts in excess of the allowable charge even if the allowable charge is less than some determinations of what is reasonable and customary. Allowable charge limitations apply to out-of-network services only.

Association – The National Electrical Contractors Association, Inc. (NECA)

Calendar year; Year – The twelve-month period starting on January 1 of any year and ending on December 31 of that year

Claims administrator – The dental claims administrator is MetLife Dental.

Collective bargaining agreement – The negotiated labor agreement between a Union and an employer or Association requiring the employer or Association to make contributions to the Fund on behalf of its bargaining unit employees

Contributions – Payments made to the Fund by contributing employers on behalf of their employees

Cosmetic – Treatment or surgery to improve or preserve physical appearance

Covered; Covered under the Plan – A term used to indicate that a person is eligible to receive the benefits from this Fund which apply to his status as an employee or a dependent under the Schedule of Benefits

Emergency – A medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in his health being in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ.

Employer – The NECA/IBEW Family Medical Care Plan defines an “employer” as a person, firm, association, partnership or corporation that:

1. Is bound by a collective bargaining agreement or other written agreement with a Union or the Trustees, or has a collective bargaining relationship with a Union or the Trustees, that requires payment of contributions to the Fund on behalf of its eligible employees
2. Is a Union or local Association chapter that has agreed to make contributions to the Fund on behalf of its eligible employees or
3. Is the Board of Trustees, or the board of trustees of any jointly sponsored trust fund between a Union and a local Association chapter, who has agreed to make contributions to the Fund on behalf of its eligible employees

The specific employer for the plans described in this booklet is Kansas City Power & Light Company or Great Plains Energy Services Incorporated.

Fund – The NECA/IBEW Family Medical Care Trust Fund

Reasonable and customary charge – For dental services, “reasonable and customary” means the least of:

- The amount charged by the dentist for a covered service
- The usual amount charged by the dentist for dental services which are the same as, or similar to, the covered service or
- The usual amount charged by other dentists in the same geographic area for dental services which are the same as, or similar to, the covered service

TMJ – Temporomandibular joint syndrome, craniomandibular disorders and other conditions of the joint linking the jaw bone and the skull, along with the complex of muscles, nerves and other tissues related to that joint. For the purposes of the Plan, the term TMJ includes all of these conditions.

Trustees – The individuals responsible for the operation of the NECA/IBEW Family Medical Care Plan in accordance with the terms of the Trust Agreement, together with such Trustees’ successors. Trustees appointed by the Association are Employer Trustees; Trustees appointed by the Unions are Union Trustees.

Union – Any local union affiliated with the International Brotherhood of Electrical Workers, AFL-CIO, which has entered into a collective bargaining agreement requiring contributions to the Fund. The plans described in this booklet are for employees represented by IBEW Locals 412, 1464 and 1613.



**For More Information:
Who is a Dependent?**

Please see page **A-3** for a definition of dependent.

Cost of Coverage

You and the Company share of the cost of your dental coverage. Your contribution amount is determined by collective bargaining agreements between the Company and the Unions. Members of Local Union 1613 may use Flex Dollars to pay for this coverage.

Your Dental PPO Network

MetLife administers the Plan's dental benefits. In addition to handling your dental claims, MetLife has a network of dentists—called the MetLife Preferred Dentist Program (PDP)—who have agreed to accept MetLife's Maximum Allowed Charge as payment in full. However, you do not have to use MetLife dentists to receive dental benefits. The same benefit levels will be provided for both in-network and out-of-network dental services. But you will save money using PDP dentists because of lower fees.

You do not need any authorization from MetLife or the NECA/IBEW Family Medical Care Plan's Fund Office to choose a dentist.

See page **C-4** for more information about your dental PPO network.



For More Information: MetLife Customer Service

You can reach customer service representatives by calling MetLife Customer Service at 800-942-0854. You'll need to refer to group account number 304133. Representatives are available to assist you (Monday through Friday between 7 a.m. and 10 p.m. Central Time). You also may log on to www.metlife.com/mybenefits for more information.

Schedule of Dental Benefits

Deductible Per Calendar Year (does not apply to Type I services)			
Per person			\$50
Per family			\$150

Maximum Benefit per Calendar Year			
	Local 412	Local 1464	Local 1613
Per person	\$1,000	\$1,500	\$1,500

Payment Percentage of Covered Charges	
Type I services	100%
Type II services	90%
Type III services	70%

See page **C-5** for a list of covered dental services.

Members of Locals 412 and 1464 have the option of enrolling in employee-only basic dental coverage ("Type I"). Under this option, only the services listed as Type I services on page **C-5** are covered.

Dental Benefit

The Plan's dental benefits are provided through MetLife—MetLife handles all dental claims and administers a preferred provider network of dentists that provides negotiated fee discounts to Plan participants.

Your Dental PPO Network

This dental plan gives you access to dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the maximum allowed charge for such service.

Maximum allowed charge means the lesser of: 1) the amount charged by the dentist; or 2) the maximum amount which the in-network dentist has agreed with MetLife to accept as payment in full for the dental service.

This means you may be able to reduce your out-of-pocket costs by using an in-network dentist. To find a participating dentist, visit www.metlife.com/mybenefits or call 800-942-0854.

However, the Plan pays benefits for covered services performed by either in-network dentists or out-of-network dentists. You are always free to receive services from any dentist.

You do not need any authorization from MetLife or the Fund Office to choose a dentist. You do not have to sign up for services from a particular dentist, you can change dentists at any time, and you can receive services from more than one dentist during a year.

Annual Dental Deductible

Each calendar year you must pay the individual deductible amount shown on the Schedule of Benefits out of your own pocket before benefits are payable for your remaining expenses. The dental deductible is based on an accumulation period of a calendar year, and you must satisfy a new deductible each year. Only covered dental expenses can be used to satisfy a deductible.

The deductible does not apply to Type I services.

After three or more persons in your family have had amounts applied to their individual dental deductibles that together equal the amount of the family deductible shown on the Schedule of Benefits for a particular calendar year, your family dental deductible will have been satisfied for that year, and no further individual deductibles will be required of you or your eligible dependents for the rest of that calendar year.

Calendar Year Maximum Benefits

There is a limit on the amount the Plan will pay each calendar year for your dental expenses. The amount that applies to you is shown on the Schedule of Benefits.

The maximum applies even if your eligibility is interrupted, or if you change from one plan to another.

Covered Dental Expenses

Covered dental expenses are the reasonable and customary charges you or your eligible dependents incur for the following services and supplies which are necessary for treatment of a dental condition.

For in-network dental expenses, your benefit will be based on the covered percentage of the maximum allowed charge. For out-of-network dental expenses, your benefit will be based on the covered percentage of the reasonable and customary charge.

Type I Services (100%, no Deductible)

1. Routine oral examinations and prophylaxis (scaling and cleaning of teeth), up to two per calendar year
2. Emergency palliative treatment
3. Dental x-rays, including full mouth x-rays (once in a period of 3 calendar years), supplementary bitewing x-rays (up to two sets per calendar year), and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment
4. For dependent children under age 19 (only):
 - a. Topical application of fluoride, twice per calendar year
 - b. Space maintainers that replace prematurely lost teeth
5. Sealants on permanent molars and bicuspid, no more than once every three years to age 14
6. Simple tooth extractions
7. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth

Type II Services (90% after Deductible)

1. Pin retention for fillings, and crown buildups
2. Crowns (on single teeth)
3. Treatment of periodontal and other diseases of the gums and tissues of the mouth, including root planing, gingival curettage, surgery on the gums or teeth-supporting tissues, apicoectomy, and scaling. Up to four cleanings (periodontal prophylaxis) are covered per year, two of which will count toward the two regular cleanings allowed by the Plan
4. Endodontic treatment, including pulpotomy, pulp caps and root canal therapy
5. Oral surgery, including pre- and post-operative care

6. Alveoplasty
7. General anesthetics when medically necessary and administered in connection with a covered oral surgical procedure
8. Extractions (other than simple extractions which are considered Type I services)
9. Injection of antibiotic drugs by the attending dentist

Type III Services (70% after Deductible)

1. Inlays, onlays and gold fillings when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration
2. Initial installation of fixed or removable bridgework (including inlays and crowns as abutments)
3. Initial installation of partial or full removable dentures (including precision attachments and any adjustments during the six-month period following installation)
4. Repair or cementing of crowns, inlays, onlays, bridgework, implants or dentures, or relining or rebasing of dentures
5. Replacement of an existing partial or full removable denture, fixed bridgework, an inlay or an onlay by a new denture, bridgework, inlay or onlay, or the addition of teeth to an existing partial removable denture, but only if satisfactory evidence is presented that:
 - a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
 - b. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture; or
 - c. The existing denture, bridgework, inlay or onlay cannot be made serviceable and at least five years have elapsed prior to its replacement.

Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.
6. Tooth implants, but no more than one per tooth position every five years (60 months)
7. Oral appliances such as bruxers and nightguards

Exclusions and Limitations

In addition to the exclusions and limitations shown below, exclusions and limitations listed in the Medical section of this book also apply to dental coverage, if applicable. See page B-21 for a listing of exclusions and limitations that may apply.

No dental benefits are payable for:

1. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist. The Plan also covers services performed by a denturist who is licensed as a denturist in the state in which the services are performed.
2. Services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
3. Orthodontics
4. The replacement of a lost, missing or stolen removable prosthetic device unless no benefits were paid by this Plan for that prosthetic device
5. Any duplicate prosthetic device or any other duplicate appliance
6. Oral hygiene, dietary instruction or a plaque control program
7. Tooth re-implantation at the same tooth position unless the prior implant is more than five years (60 months) old
8. Occlusal adjustments
9. Treatment of conditions related to the temporomandibular jaw joint (TMJ)
10. Treatment for opening of vertical dimension
11. Services or supplies received as a result of dental disease, defect or injury due to war, declared or undeclared, or any act of war or aggression
12. Dental care or services paid for or furnished by or at the direction of any governmental agency, but only to the extent paid for or furnished
13. Dental procedures that are covered medical expenses
14. Treatment incurred while a person is not eligible for dental benefits
 - a. For full or partial dentures, treatment is considered incurred when the impression is taken for the appliances
 - b. Root canal therapy is considered incurred when the tooth is opened
 - c. Fixed bridgework, crowns and other gold restorations are considered incurred when the tooth is first prepared

Additional Provisions Governing Dental Benefits

Extension of Dental Benefits

Dental benefits will be available for a person for 31 days after his eligibility terminates for covered dental expenses incurred for:

1. Fillings, bridgework, crowns or gold restorations, provided the tooth was prepared while the person was eligible for dental benefits or
2. Full or partial dentures, provided the impression for the appliance was taken while the person was eligible for dental benefits or
3. Endodontic treatment, provided the tooth was opened for root canal therapy while the person was eligible for dental benefits

Predetermination of Benefits Procedure

If the dentist's charges will be \$200 or more, your claim should be submitted to MetLife for predetermination of benefits before the work is started.

If you don't request a predetermination, you can just submit your claim after the dental work is done. However, you may be confronted with a large unexpected out-of-pocket cost.



Important Note:

A predetermination of benefits does not guarantee payment of dental benefits. Coverage is valid only upon determination of eligibility.

Alternate Courses of Treatment

If MetLife determines that a service, less costly than the covered service the dentist performed, could have been performed to treat a dental condition, benefits will be paid based upon the less costly service if such service: 1) would produce a professionally acceptable result under generally accepted dental standards; and 2) would qualify as a covered service.

How to File a Dental Claim

Claims should be submitted to MetLife—the dentist will usually file the claim electronically. If you need to file a claim yourself, send it to:

MetLife Dental Claims

P.O. Box 981282
El Paso, TX 79998-1282

Be sure to include your Social Security number and your group account number (304133).

You will receive your benefit payment explanations directly from MetLife, and any questions you have about your claim should be directed to MetLife.

Coordination of Benefits (COB)

If you or your dependents are covered by another employer's dental plan, the benefits/coverages will be coordinated between the IBEW dental coverage and the other plan.

For information about coordination of benefits, please refer to the General Information section of this book.

Imputed Income

The Internal Revenue Service (IRS) has ruled that if an employee receives health benefits for a domestic partner or the domestic partner's legally dependent child(ren), the employee must pay FICA, federal income and state income (unless otherwise permitted by state law) taxes on the domestic partner's health coverage over the amount paid for the employee's own coverage. This amount may be added to gross income and taxed accordingly. If the domestic partner is a legal tax dependent under IRC Section 152, imputed income may not apply.

Employees on an approved leave of absence, who pay their portion of the employee contribution schedule by a method other than payroll deduction, will be obligated to pay the amounts due to FICA tax and income tax withholding on imputed income. Income withholding tax rates will be calculated in accordance with the employee's specific W-4.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your private dental information.

For information on your rights under HIPAA, please refer to the General Information section of this book.

Continuing Dental Coverage under COBRA

Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, you and your dependents may be eligible to temporarily extend your group dental coverage if you lose coverage due to certain qualifying events.

For information on your rights and benefits under COBRA, please refer to the General Information section of this book.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

For information about your rights and protections under ERISA, please refer to the General Information section of this book.



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Vision Benefits for Local 1613 Only

The Company offers an optional vision benefit administered by Vision Service Plan (VSP) that provides coverage for members of Local 1613 and their eligible dependents. The Plan offers you the choice of using vision providers who are part of the Plan's network or providers outside the network. However, when you use providers who participate in the network, you may pay less out of pocket because VSP providers charge discounted rates as part of their membership in the VSP network.

Important Vision Benefit Terms

There are certain terms that have specific meaning with respect to vision benefits. This section explains those terms to help you better understand your vision benefits.

Please note that references to "spouse" or "dependent" throughout this Vision Benefit section include a qualifying domestic partner according to the definition in the Plan Participation section of this book.

Additional discount – You can receive a 20% discount toward the purchase of non-covered materials from any VSP provider when a complete pair of glasses is received. Also, you are entitled to a 15% discount off of a contact lens exam provided by a VSP provider.

Benefit authorization – Verification of coverage and benefits that a VSP provider obtains from VSP before providing you with services. If benefit authorization is not obtained before services are provided, benefits will be paid at the non-VSP provider level.

Benefit period – The calendar year (January 1 through December 31)

Co-pay – A dollar amount you pay to your provider for certain services and eyewear that are not fully covered by the Plan

Eyewear – Eyeglass lenses, frames and/or medically necessary contact lenses

Frequency – Plan frequency is how often you are eligible to receive services. Frequency is usually every 12 or 24 months under the Plan.

Non-covered materials – Eyewear not covered by the Plan

Non-VSP provider – An optometrist, optician, ophthalmologist or other licensed eye care service provider who is not a participant in the VSP network of providers

Ophthalmologist – A doctor of medicine who specializes in ophthalmology

Orthoptics – Treatment of defective visual habits, defects in binocular vision or muscular imbalance by reeducation of visual habits, exercise and visual training

Optometrist – A licensed professional who practices optometry

Plan allowance – The maximum dollar amount for frames

Usual and customary fees – The fee typically charged for a service in a particular geographic area

Visually necessary – Services or materials that are medically or visually necessary to restore or maintain visual acuity and health and for which there are no other less expensive professional alternatives available

VSP provider – A licensed optometrist or ophthalmologist who is a member of VSP's network of providers

Cost of Coverage

You pay the cost of your vision benefit coverage. The cost of your coverage is determined by the coverage tier you select. You may use Flex Dollars or pre-tax pay reduction, or a combination of both to pay for this coverage. See the Plan Participation section of this book for more information about Flex Dollars.

How the Vision Benefits Work

KCP&L offers a comprehensive vision care program to help cover the cost of eye exams, frames, lenses and contact lenses. When you need vision care or services, you may use a VSP provider or a non-VSP provider. When you use VSP providers, you receive a higher level of benefits than you receive when you visit a non-VSP provider because VSP providers provide coverage to you and your eligible dependents at negotiated discounted rates.



For More Information: Who is a Dependent?

Please see page **A-3** for a definition of dependent.

When You Visit a VSP Provider

When you use a VSP provider, you pay the following co-pays for covered services:

- \$10 for a vision exam
- \$25 for eyewear

VSP pays your remaining charges according to coverage and frequency guidelines outlined in the Schedule of Benefits on page **D-3**. You do not need to complete a claim form if you use a VSP provider—the provider files your claims.

VSP also features extra discounts when you use VSP providers:

- Non-covered materials are available at a 20% discount when a complete pair of glasses is dispensed.
- A 15% discount on professional services is available for a contact lenses exam.
- These discounts are applied to the VSP provider's usual and customary fees and are available for 12 months following the initial covered exam. Professional judgment applies when evaluating prescriptions written by another provider. A VSP provider may request a discounted additional exam.

For a list of limitations that apply to discounts, please refer to the What's not Covered section on page **D-4**.



A Closer Look: How to Find a VSP Provider

To receive a list of VSP providers, log on to the VSP Web site at www.vsp.com or call VSP at 800-877-7195. There is no charge for this information.

If You Visit a Non-VSP Provider

The Plan also covers services you receive from non-VSP providers. At the time of service, you must pay the bill and then submit an itemized statement to VSP. You will be reimbursed from VSP according to the Schedule of Benefits for non-VSP providers as described on page **D-3**. Services are subject to the same frequency restrictions and co-pays as those received through a VSP network doctor.

Schedule of Benefits

Following is a summary of your benefits. The Schedule of Benefits lists the vision care services, supplies and coverage amounts that you and your eligible dependents can receive under the Plan.

Benefits	Frequency of Benefits	VSP Provider	Non-VSP Provider
		After the applicable co-pay (\$10/exam; \$25/eyewear)	
Exam Includes appropriate examination of visual functions and prescription of corrective eyewear	Once every year**	Plan pays 100%*	Plan pays 100%*
Lenses (for complete set)			
Single vision	Once every year**	Plan pays 100%*	Plan pays up to \$45*
Bifocal			Plan pays up to \$65*
Trifocal			Plan pays up to \$85*
Lenticular			Plan pays up to \$125*
Lens Option Progressive lenses	Once every other year**	Plan pays 100%*	\$85 (no co-pay)
Frames	Once every other year**	Plan pays 100%, up to \$120*	Plan pays up to \$47*
Contact Lenses			
Visually necessary	Once every year**	Plan pays 100%*	Plan pays up to \$210*
Elective – additional discount applies to VSP provider's usual and customary fees for elective contact lens evaluation and fitting	If you obtain contact lenses, you will not be eligible to receive lens and frame benefits during the current benefit period, and your future eligibility for spectacle lenses and frames will be determined as if they were received in the current benefit period.	Plan pays up to \$120 (no co-pay)	Plan pays up to \$105 (no co-pay)

* Less the co-pay

** Beginning with the first day of the benefit period (January to December)

Eligible Expenses

Benefits for lenses and frames include reimbursement for the following necessary professional services:

- Prescribing and ordering proper lenses
- Assisting in frame selection
- Verifying accuracy of finished lenses
- Proper fitting and adjustments of frames

- Subsequent adjustments to frames to maintain comfort and efficiency
- Progress or follow-up work as necessary

For additional information about eligible services and supplies under the Plan, please refer to the Schedule of Benefits.

What's not Covered

Some vision services are not covered by the Plan. These include but are not limited to:

Patient Options

The Plan is designed to cover vision needs, not cosmetic materials. The Plan will pay the basic lens charges and you will be responsible for any additional costs for the following extras:

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Exclusions

In addition, there are no vision benefits under the Plan for professional services or materials associated with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a $\pm .50$ diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under the Plan, that are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
- Costs for services and/or materials above Plan allowances
- Services and/or materials not indicated in the Schedule of Benefits

Discount Limitations

There are also limitations that apply to the additional discount provided under the Plan:

- Discounts do not apply to vision care benefits obtained from non-VSP providers
- The 20% discount applies to complete pairs of glasses only
- Discounts do not apply if prohibited by the manufacturer
- Discounts do not apply to sundry items such as contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames

How to File a Vision Claim

VSP Provider

In most cases, when you receive services from a VSP provider, your claims will be filed by your provider directly with VSP's Claim Office:

Vision Service Plan Insurance Company
3333 Quality Drive
Rancho Cordova, CA 95670

Non-VSP Provider

If you visit a non-VSP provider, typically, you must pay the full cost for services up front. To request reimbursement, log on to www.vsp.com and access the online Out-of-Network Reimbursement Form on the "Members" page of the Web site or send the following information to VSP:

- An itemized receipt listing the services you received
- The name, address and phone number of the non-VSP provider
- Your employee ID number or last four digits of your Social Security number
- Your name, phone number and address
- The name of your Company that provides your VSP coverage
- The patient's name, date of birth, phone number and address
- The patient's relationship to the covered member (such as "self," "spouse," "child")

Please keep a copy of the information and mail the originals to the following address:

VSP
Attn: Out-of-Network Claims
P.O. Box 997105
Sacramento, CA 95899-7105

You have 180 days from the date you incurred the charge to submit a claim. When the claim has been filed properly, it will be reviewed and you will be notified in writing or electronically of the approval or denial within 30 days after receipt of the claim. However notification may be extended an additional 15 days if an extension is required due to circumstances beyond the control of VSP.

For information about claims determination timeframes and appeal procedures, please refer to the General Information section of this book.



For More Information

You can reach member service representatives by calling VSP at 800-877-7195. Representatives are available to assist you between 7 a.m. and 9 p.m. Central Time (CT), Monday through Friday, and between 8 a.m. and 4:30 p.m. CT Saturday. You also may log on to www.vsp.com for information.

Coordination of Benefits (COB)

If you or your dependents are covered by another employer's vision plan, the benefits/coverages may be coordinated between this Plan and the other plan. For information about coordination of benefits, please refer to the General Information section of this book.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your private vision information.

For information on your rights under HIPAA, please refer to the General Information section of this book.

Continuing Vision Coverage under COBRA

Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, known as COBRA, you and your dependents may be eligible to temporarily extend your group vision coverage if you lose coverage due to certain qualifying events. For information on your rights and benefits under COBRA, please refer to the General Information section of this book.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information on your rights and protections under ERISA, please refer to the General Information section of this book.

Reimbursement Accounts

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Included in this section is information about the Medical Reimbursement Account which is available to members of Local 1613, but is not available to members of Locals 412 and 1464. References to the Medical Reimbursement Account are intended only for members of Local 1613.

Reimbursement Accounts

Reimbursement accounts offer tax savings for medical, dental, vision and dependent care expenses. KCP&L offers a Dependent Care Reimbursement Account to all bargaining unit employees and a Medical Reimbursement Account to members of Local 1613. When you enroll in the Medical Reimbursement Account and/or the Dependent Care Reimbursement Account, you elect how much you would like to contribute using salary deferrals. Then, when you or your dependents incur eligible expenses during the Plan Year, you can receive tax-free reimbursements from your account(s).

If you are a member of Local 1613, your contributions may be offset by Flex Dollars, depending on your other benefits elections (see the Plan Participation section of this book for more information about Flex Dollars).

PayFlex administers the Medical and Dependent Care Reimbursement Accounts. By registering at www.mypayflex.com, you can access:

- Express Claims Service to file claims online
- Your account balance, claim and transaction history
- Claim and direct deposit forms
- Lists of eligible and ineligible expenses
- Frequently asked questions

To speak with a PayFlex customer service representative, call 800-284-4885 between 7:00 a.m. and 7:00 p.m. Central Time (CT), Monday through Friday and Saturday between 9:00 a.m. and 2:00 p.m. CT.



It's the Law:

You may contribute to either the Medical Reimbursement Account or Dependent Care Reimbursement Account or to both. The accounts are separate; therefore, you cannot use the

Medical Reimbursement Account to pay for eligible dependent care expenses, and you cannot use the Dependent Care Reimbursement Account to pay for eligible medical, dental or vision care expenses.



Important Note: Domestic Partners and your Reimbursement Accounts

Because domestic partners are generally not considered eligible dependents by the Internal Revenue Service, you may not use the Medical

Reimbursement Account or the Dependent Care Reimbursement Account for any expenses you incur on behalf of your domestic partner or your domestic partner's children unless they qualify as your dependents for federal tax purposes and under the terms of this Plan.

Important Reimbursement Accounts Terms

There are certain terms that have specific meaning under the Medical and Dependent Care Reimbursement Accounts. This section explains those terms to help you better understand your benefits.

Dependent care expenses – Amounts paid or incurred by you for household services (that can be attributed to the care of a dependent) or for the care of a dependent, either inside or outside of your home, to enable you to be gainfully employed for any period in which you have one or more dependents. Expenses for care provided by your own spouse or child under the age of 19, or for care provided by an individual who can be claimed as a dependent on your or your spouse's income tax return, will not be considered eligible dependent care expenses.

When care is provided outside of your home and the person or facility provides care for more than six individuals, expenses will be considered dependent care expenses eligible for reimbursement if the person or facility complies with all applicable laws and regulations of any state or local government and the benefits are provided for the care of your dependent child under the age of 13 or any other dependent who regularly spends at least eight hours each day in your household.

Grace period – The period from January 1 through March 15 following the end of each Plan Year

Household services – Expenses paid for ordinary and usual services necessary to maintain your household. The expenses must be for the care of a dependent. For example, amounts paid for the services of a cook may be reimbursed if a part of those services are provided to your dependent and allow you to be gainfully employed. Expenses will not be reimbursed for the services of a chauffeur, bartender or gardener.

Plan – The Great Plains Energy Incorporated Cafeteria Plan and Dependent Care Reimbursement Program for Employees Represented by Local Unions 412 and 1464 and The Great Plains Energy Incorporated Cafeteria Plan and Reimbursement Programs for Management Employees and Employees Represented by Local Union 1613

Plan Year – The calendar year (January 1 to December 31)



For More Information: Who Are Spouses and Dependents?

Please see page **A-3** for definitions of spouse and dependent.

How the Medical Reimbursement Account Works

The Medical Reimbursement Account allows you to set aside tax-free dollars to help cover the cost of medical expenses not covered by your medical, dental or vision plans.

If you enroll in the Medical Reimbursement Account, a PayFlex Card will be mailed directly to your home address on file. When you use the card to pay for qualified health care expenses, your Medical Reimbursement Account will be automatically debited to pay for eligible expenses. You can use the card at qualifying merchant locations, including places such as physician and dental offices, pharmacies and vision providers.

Although you do not need to complete claim forms when using the PayFlex Card, documentation of your expenses may be required in order to meet IRS guidelines. Therefore, you should keep copies of all receipts and itemized statements throughout the Plan Year. In some cases, you could receive a letter from PayFlex requesting the documentation and you will be required to submit this information to substantiate the expenses according to IRS regulations. For example, PayFlex may require you to submit an itemized receipt listing the merchant name, name of the item or product, date of the purchase and the amount. You must comply with IRS guidelines by using the card only for qualifying expenses and providing appropriate documentation upon request.

Your Contributions

The maximum contribution you may make to your Medical Reimbursement Account each Plan Year is \$5,000. Contributions are made using deferrals from your pay and Flex Dollars that have been allocated to your account over the course of the entire Plan Year.



Important Note: Qualified Medical Child Support Orders

A qualified medical child support order may require a child to be covered under the Medical Reimbursement Account. For information on qualified medical child support orders, please refer to the General Information section of this book.



It's the Law: Use It, or Lose It!

Dollars you set aside in your Medical Reimbursement Account may only be used to reimburse you for eligible medical expenses you incur during the Plan Year in which they are contributed or during the grace period following the Plan Year, so plan your contributions carefully. Dollars do not roll over from year to year—any dollars in your account at the end of the grace period for each Plan Year will be forfeited. You can submit a claim until April 30 after the Plan Year for which the expense is incurred.

Your Reimbursements

You may be reimbursed for eligible expenses for an amount that is more than the current balance in your Medical Reimbursement Account, but no reimbursement (either alone or in combination with other reimbursements from your account balance for that year) may be more than the total amount you have elected to contribute to your Medical Reimbursement Account for the year.

For example, let's say you elect to set aside \$3,000 in your Medical Reimbursement Account for the year. In March, you incur \$1,500 in expenses. You can receive reimbursement for the full \$1,500—even though only about \$500 has been deducted from your pay and/or Flex Dollars at that point.

Later in the year, you incur \$2,000 more in expenses. You can only be reimbursed for \$1,500 of the \$2,000, because you cannot be reimbursed for more than the \$3,000 you elected to contribute to your Medical Reimbursement Account for the year.



Important Note: Medical Expenses

A medical expense is considered incurred when the service or supply is provided, not when you are billed or pay for the expense.

Eligible Expenses

When you have an eligible expense that is not paid by your medical, dental or vision plans, you should submit a claim for reimbursement from your Medical Reimbursement Account. Your account may be used to pay for any medical expenses considered tax deductible by the Internal Revenue Service (IRS), except for health insurance premiums. Generally, eligible medical expenses include deductibles and co-pays for yourself and your dependents under the medical, dental and vision plans, as well as certain other expenses.

The following are eligible medical expenses when they are incurred by you or your dependents and neither you nor your dependents are reimbursed for the expenses from another health plan:

- Acupuncture services related to the diagnosis, cure, mitigation, treatment or prevention of disease
- Ambulance services
- Chiropractors' fees
- Cosmetic surgery – only if directly related to a congenital abnormality, a personal injury from an accident or trauma or a disfiguring disease
- Dental treatment
- Diagnostic services, including laboratory and x-ray services
- Eye glasses and contact lenses
- Hospital services
- Insulin
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings and hearing aids
- Nurses' fees
- Operations
- Over-the-counter drugs that are legally purchased, such as antacids, allergy medicine, pain relievers and cold medicine
- Oxygen equipment and oxygen
- Physicians' fees
- Prescription drugs
- Psychiatric care
- Psychologists' fees
- Surgical fees



For More Information:

For a complete list of eligible medical expenses, refer to IRS Publication #502, "Medical and Dental Expenses," available on the IRS Web site at www.irs.gov, by calling 800-TAX-FORM (800-829-3676) or by visiting your local IRS office. You also may find the information at www.mypayflex.com.

What's not Eligible for Reimbursement

Some services and supplies are not covered by your Medical Reimbursement Account. For example, health insurance premiums may not be reimbursed from your account. In addition, expenses for toiletries (for example, toothpaste), cosmetics (for example, face cream) or items for general good health (for example, vitamins and nutritional supplements) are not covered.



A Closer Look: Cosmetic Surgery

Cosmetic surgery is not eligible for reimbursement from the Medical Reimbursement Account unless it directly relates to a congenital abnormality, a personal injury from an accident or trauma or a disfiguring disease.

How the Dependent Care Reimbursement Account Works

The Dependent Care Reimbursement Account helps you pay for care for your dependents while you (and your spouse, if you are married) work. It also is available to help you with expenses that you incur while your spouse looks for work or attends school. If you have eligible dependents—such as children under age 13, or a spouse or parent who is incapable of self-care—you can use the Dependent Care Reimbursement Account to set aside tax-free money to pay for care.

Your Contributions

Contributions to your Dependent Care Reimbursement Account will be made using any contributions from your pay (including Flex Dollars for Local 1613) that have been allocated to your account each pay period, plus contributions left in your account from previous pay periods.

The total amount of your dependent care benefits during any Plan Year may not be more than:

- Single – \$5,000
- Married – The lesser of:
 - \$5,000 if you file federal income taxes jointly
 - \$2,500 if you file taxes separately or each spouse participates in a dependent care reimbursement account
 - You or your spouse's total earned income

If your spouse is a full-time student or physically or mentally incapable of caring for himself or herself and lives with you for more than half the year, your spouse is assumed to have earned income of \$250 per month if you have one dependent, or \$500 per month if you have two or more dependents. When you decide how much you would like to contribute to your Dependent Care Reimbursement Account, be careful not to exceed these single and married limits.

Contributions for highly compensated employees, as defined by the IRS, are subject to special contribution limits. Generally, highly compensated employees are those whose annual earnings are greater than the applicable IRS limit for the previous year (employees who earned more than \$110,000 in 2009 will generally be considered highly compensated employees for 2010). We will notify you if these limits apply to you.



It's the Law: Use It, or Lose It!

Dollars you set aside in your Dependent Care Reimbursement Account may only be used to reimburse you for dependent care expenses you incur during the Plan Year in which they are contributed or during the grace period following the Plan Year, so plan your contributions carefully. Dollars do not roll over from year to year—any dollars in your account at the end of the grace period for each Plan Year will be forfeited. You can submit a claim for reimbursement until April 30 after the Plan Year for which the expense is incurred. For example, a claim incurred in January 2010 that is to be paid from your remaining 2009 account balance (on account of the grace period) must be filed by April 30, 2010. If the same claim is to be paid from your 2010 account balance, you have until April 30, 2011 to file your claim.



A Closer Look: Using the Dependent Care Reimbursement Account Can Save You Money

Here is an example of how the Dependent Care Reimbursement Account can save you money. Let's assume you earn \$60,000 a year. This year, you expect to pay \$2,500 for child care. The following chart shows how you could save \$721 by using the Dependent Care Reimbursement Account.

	WITH the Dependent Care Reimbursement Account	WITHOUT the Dependent Care Reimbursement Account
Salary	\$60,000	\$60,000
Dependent Care Reimbursement Account Contribution	\$2,500	\$0
Taxable Income	\$57,500	\$60,000
Taxes		
Federal	\$5,044	\$5,460
FICA	\$3,565	\$3,720
State	\$3,450	\$3,600
Take-home Pay	\$45,441	\$47,220
Amount to Pay for Child Care	\$0	\$2,500
Net Pay	\$45,441	\$44,720
Savings from using the Dependent Care Reimbursement Account	\$721	

*This example assumes three withholding allowances (self, spouse and child) and is based on the federal tax schedule for the 2009 tax year, 6% Missouri state income tax and 6.2% FICA.

Your Reimbursements

When you incur an eligible expense, you should file a claim to be reimbursed from your Dependent Care Reimbursement Account. You receive reimbursement from your account for eligible expenses incurred during the Plan Year you contribute to the account or during the grace period following the Plan Year.

Your reimbursements may not be more than the amount in your account. For example, you cannot be reimbursed for a dependent care expense of \$1,000 if you have only

\$500 in your account. In this case, \$500 in expenses would be reimbursed from your account when the claim is filed, and the remaining \$500 would be paid as funds become available in your account.



Important Note: Dependent Care Expenses

A dependent care expense is considered incurred when the dependent care is provided, not when you are billed or pay for the expense.

Eligible Expenses

Dependent care expenses that can be reimbursed from your account include amounts paid or incurred by you for household services or for the care of your dependent that allow you to work. These expenses may be for care or services received inside or outside of your home.

Household services include expenses paid for ordinary and usual services to maintain your household and that are related to the care of your dependent. For example, amounts paid for a cook may be reimbursed if a part of the services are provided to your dependent so you can work. Expenses will not be reimbursed for the services of a chauffeur, bartender or gardener.

Some examples of eligible dependent care expenses include, but are not limited to:

- Care at a licensed nursery school, day camp (not overnight camp), day care facility for children or dependent adults and sometimes pre-school (if your child is under the age of kindergarten and if the schooling and the cost of care cannot be separated)
- Private sitter (does not include babysitting which allows you and/or your spouse to participate in social or recreational activities, even if they are work related)
- Care at a dependent day care center or child care center
- A housekeeper, au pair or nanny who provides care for a dependent
- Practical nursing care for an incapacitated spouse or parent

Expenses for care provided outside of your home by a person or in a facility that provides care for more than six people will be eligible for reimbursement only if the person or facility complies with all applicable laws and regulations of any state or local government. In addition, the benefits must be provided for the care of your dependent child under the age of 13 or any other dependent who is physically or mentally incapable of caring for himself or herself, for whom you provide over half of their financial support for the year or who resides with you for over half the year.



For More Information:

For a complete list of dependent care expenses, refer to IRS Publication #503, "Child and Dependent Day Care Expenses," available on the IRS Web site at www.irs.gov, by calling 800-TAX-FORM (800-829-3676) or by visiting your local IRS office.

You may also find the information at www.mypayflex.com.

What's not Eligible for Reimbursement

Examples of expenses that are not eligible for reimbursement through your Dependent Care Reimbursement Account include, but are not limited to:

- Dependent care expenses paid to an individual who you or your spouse can claim as a dependent on your federal income tax return, or who is your spouse or child under age 19
- Babysitters who are required for reasons other than you and your spouse's absence due to work
- Entertainment, food or clothing
- Tuition for parochial school
- Overnight camp
- Full-time care in a custodial or residential nursing home
- Transportation
- Activity fees
- Expenses for household services such as chauffeurs, bartenders or gardeners

Tax Considerations

Tax Effects on Medical Expenses

If you pay for expenses through the Medical Reimbursement Account, you may not also take a tax deduction for those expenses. You only are eligible for the tax deduction if your health care expenses are not reimbursed by a health plan or medical reimbursement account and they are more than 7.5% of your adjusted gross income.

Effect on Social Security Benefit

When you contribute to the Medical Reimbursement Account and/or Dependent Care Reimbursement Account, the amount of your Social Security benefit may be affected slightly. This is because the amount of your Social Security benefit is, in part, dependent upon your taxable income. Because your contributions to the Medical Reimbursement Account and Dependent Care Reimbursement Account generally are not included in your taxable income, you will not pay Social Security taxes on those contributions. As a result, the amount of your Social Security benefit may be affected.

Tax Benefits Available for Dependent Care Expenses

Many people find it necessary to pay for the care of their children or other dependents so that they can work outside of the home. If you are in this situation, you may be eligible for certain tax benefits. It may be possible to exclude a portion of the dependent care expenses you incur (through the Dependent Care Reimbursement Account) from your taxable income. Or, you may receive a credit against your federal income taxes that is equal to a portion of the expenses. Although these two options are calculated in different ways, they are both subject to essentially the same eligibility requirements. In addition, dependent care expenses under both options are limited to the earned income of you or your spouse, whichever is smaller.

Although you may take advantage of only one tax benefit option for each dollar of dependent care expenses, you may choose one of the above options for a portion of your dependent care expenses, and the other option for the

remainder. This is especially true if your (and your spouse's) total earned income is between \$35,000 and \$43,000 during the year.

Which Is Better For You?

How do you know which option to choose? Usually, you can rely on the following general rules; however, to be certain, you should seek the advice of your tax advisor:

- If your (and your spouse's) total earned income is about \$35,000 to \$39,000, you have only one dependent, and you incur less than \$3,000 in dependent care expenses, then claiming the tax credit will likely provide you greater tax benefits.
- If your (and your spouse's) total earned income is between \$12,000 and \$15,000, then claiming the tax credit will likely provide you greater tax benefits.
- In most other cases, use of the dependent care exclusion will likely provide greater tax benefits.



A Closer Look: Tax Credit

If you find that taking the tax credit is the best option for your situation, you take the credit on your federal income taxes based on your eligible dependent care expenses during the year. The

amount of expenses that you can apply toward a tax credit depends on how many dependents you have:

- One dependent: \$3,000
- More than one dependent: \$6,000



For More Information:

To learn more about the federal tax credit and whether contributing to the Dependent Care Reimbursement Account or taking the tax credit is the best option for you, you should consult a tax advisor.

How to File a Reimbursement Account Claim

Medical Reimbursement Account Claims

You may access your Medical Reimbursement Account in two ways:

1. By using your PayFlex Card to pay for eligible expenses at health care related merchants and retail merchants who have implemented an inventory information approval system (IIAS) or
2. By submitting a claim to PayFlex online using the online Express Claims process or using a paper claim form. Claim forms are available through the All About page through the KCP&L intranet or on **www.payflex.com**.

When submitting your claim, you must include a receipt or bill indicating the type of expense you have incurred, the date of the expense, the provider of services and the amount of the expense. Acceptable documentation includes:

- An Explanation of Benefits (EOB), provided to you by your insurance provider
- An itemized receipt that shows the date of purchase or service, amount of purchase or service, description of item or service, name of merchant or service provider, and name of patient
- Prescription drug receipt containing the necessary information
- Over-the-counter items must be clearly described on the receipt

If you use your PayFlex card to pay for an expense, PayFlex will notify you if you need to submit any documentation. While in some instances you may not be required to submit documentation after the fact, it is a good idea to save any itemized receipts or other documentation you receive when using your card. If you do not submit this documentation within the time frame allowed, your PayFlex card may be suspended until PayFlex receives the required documentation.

Dependent Care Reimbursement Account Claims

You may submit Dependent Care Reimbursement Account claims online using Express Claims at **www.payflex.com**

or by completing a paper claim form and mailing or faxing it along with itemized documentation to PayFlex.

Claims should be submitted following the completed dates of service. When submitting your claim, you must include a receipt or bill indicating the type of expense you have incurred, the date of the expense, the provider of services and the amount of the expense. Acceptable documentation includes:

- A completed dependent day care claim form with dates of service, name of dependent, amount requested and day care provider's name and signature. The claim form can be used as an itemized statement if your day care provider provides this information and signs the form where indicated.
- A completed dependent day care claim form and an itemized statement from your day care provider. The itemized statement must include the provider's name, your dependent's name, as well as the specific dates day care services were provided and the cost of care.

Completed paper claim forms and itemized receipts for both Medical and Dependent Care Reimbursement Accounts may be mailed or faxed to PayFlex at:

PayFlex Systems USA, Inc.

P.O. Box 3039
Omaha, NE 68103-3039
800-284-4885
Fax: 402-231-4310

Note: Because domestic partners are generally not considered eligible dependents by the Internal Revenue Service, you may not use the Medical Reimbursement Account or Dependent Care Reimbursement Account for any expenses you incur on behalf of your domestic partner or your domestic partner's children unless they qualify as your dependents for federal tax purposes and under the terms of the Plan.

For information about claims determination timeframes and appeal procedures, please refer to the General Information section of this book.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Under the federal regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan is required to protect the confidentiality of your private health information related to your Medical Reimbursement Account.

For information on your rights under HIPAA, please refer to the General Information section of this book.

Continuing Medical Reimbursement Account Coverage under COBRA

Under provisions of the Consolidated Omnibus Reconciliation Act of 1985, known as COBRA, you may be eligible to temporarily extend your Medical Reimbursement Account participation through the end of the Plan Year if you lose coverage due to certain qualifying events. You may not continue participation in the Dependent Care Reimbursement Account under COBRA. For information on your rights and benefits under COBRA, please refer to the General Information section of this book.

Your Rights under ERISA

As a participant in the Medical Reimbursement Account, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information about your rights and protections under ERISA, please refer to the General Information section of this book.

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Life and Accident Benefits

Each of the Life and Accident benefits provided by KCP&L are designed to help protect you and your family's standard of living, if you or one of your dependents die or are seriously injured. For some of the benefits, KCP&L provides a basic level of coverage at no cost to you; other benefits require you to make contributions for coverage.

You are eligible to participate in the following Life and Accident benefits:

- Basic Life Insurance
- Supplemental Life Insurance
- Dependent Life Insurance
- Basic Accidental Death & Dismemberment (AD&D) Insurance (Locals 412 and 1464 only)
- Supplemental Accidental Death & Dismemberment (AD&D) Insurance (Local 1613 only)
- Dependent Accidental Death & Dismemberment (AD&D) Insurance (Local 1613 only)
- Business Travel Accident Insurance
- Survivor Benefit Plan

You may cover eligible dependents under Dependent Life Insurance and Dependent AD&D Insurance.

The Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance and AD&D Insurance coverage are insured by MetLife. Business Travel Accident Insurance is insured through CIGNA (Life Insurance Company of North

America). The Survivor Benefit Plan is self-funded by KCP&L. This means benefits under the Survivor Benefit Plan are paid from the Company's general assets.

Some of the life insurance benefits require that evidence of insurability be presented to MetLife, for example, if you want to enroll for coverage that is above a specific dollar amount or if you enroll for coverage more than 31 days after you or your dependents become eligible for the coverage. More information about evidence of insurability requirements is available throughout this Life and Accident section.



Important Life and Accident Terms

There are certain terms that have specific meaning with respect to the Life and Accident benefits. This section explains those terms to help you better understand your Life and Accident benefits.

Please note that references to “spouse” and “dependent” throughout this Life and Accident Benefits section include a qualifying domestic partner according to the definition in the Plan Participation section of this book.

Annual earnings – The gross annual rate of pay paid to you by the Company in cash for performing the duties required of your job. Bonuses, overtime pay, earnings for more than 40 hours per week, and other cash and non-cash compensation are not included.

Beneficiary – The person or persons you name to receive your benefits if you die. In the case of your covered dependents, you are the beneficiary.

Brain damage – Permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. This damage must manifest itself within 30 days of the covered accident, require a hospitalization of at least five days and persist for 12 consecutive months after the date of the covered accident.

Child/children – For a definition of child/children, refer to the Plan Participation section of this book.

Child care center – A facility which:

- Operates and is licensed according to the law of the jurisdiction where it is located and
- Provides care and supervision for children in a group setting on a regularly scheduled and daily basis

Coma – A state of deep and total unconsciousness from which the comatose person cannot be aroused

For Life/AD&D benefits, this state of unconsciousness must begin within 30 days of the accidental injury and continue for seven consecutive days.

For Business Travel Accident Insurance, the coma must begin within 30 days of the covered accident, continue for 60 consecutive days and must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of a treatment of a covered injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that covered accident.

Company – Any of the Great Plains Energy Incorporated or Kansas City Power and Light Companies

Covered accident – A sudden, unforeseeable event that results, directly and independently of all other causes, in a covered injury or covered loss and meets all of the following conditions:

- Occurs while you are insured under the applicable insurance policy
- Occurs under one of the conditions of coverage specified in the policy schedule of benefits
- Is not contributed by disease, sickness, or mental or bodily infirmity and
- Is not otherwise excluded under the terms of the applicable insurance policy

Covered injury – Any bodily harm, independent of disease or bodily infirmity that results, directly and independently of all other causes, from a covered accident

Dependent – For a definition of dependent, refer to the Plan Participation section of this book.

Evidence of insurability – To determine a person’s insurability for coverage, evidence of good health may be required.

Hemiplegia – The total paralysis of the upper and lower limbs on one side of the body

Imputed income – The cost of any KCP&L-provided life insurance in excess of \$50,000 is considered taxable, “imputed” income.

Injury – Injury to the body

Loss of hearing – For Life/AD&D benefits, the entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following accidental injury

For Business Travel Accident Insurance, loss of hearing means the total and permanent loss of hearing in one ear. The loss of hearing must be irrecoverable by natural, surgical or artificial means.

Loss of sight – For Life/AD&D benefits, it means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.

For Business Travel Accident Insurance, it means the total and permanent loss of sight in one eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech – The entire and irrecoverable loss of speech that continues for six consecutive months following accidental injury

Loss of thumb and index finger of same hand – For Life/AD&D benefits, it means the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of thumb and index finger of the same hand or loss of four fingers of the same hand – For Business Travel Accident Insurance, it means the complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Paralysis – For Life/AD&D benefits, it means the loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.

For Business Travel Accident insurance, it means the total loss of use. A physician must determine the paralysis to be complete and irreversible at the time the claim is submitted.

Paraplegia – The total paralysis of both lower limbs or both upper arms

Passenger car – Any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Physician – For Life/AD&D benefits, it means a person licensed to practice medicine in the jurisdiction where such services are performed. The physician must be acting within the scope of that license and be certified and/or registered if required by such jurisdiction. The term does not include:

- You
- Your spouse
- Any member of your immediate family including your and/or your spouse’s:
 - Parents
 - Children (natural, step or adopted)
 - Siblings
 - Grandparents
 - Grandchildren

For Business Travel Accident Insurance, it means a licensed practitioner of the healing arts acting within the scope of his or her license and rendering care and treatment to you that is appropriate for the condition and locality. The term does not include:

- You
- A parent, sibling, spouse or child of either you or your spouse
- A person living in your household
- A person employed or retained by KCP&L or
- A person providing homeopathic, aroma-therapeutic or herbal therapeutic services

Quadriplegia – The total paralysis of both upper and lower limbs

School – An institution of higher learning, including, but not limited to, a university, college or trade school

Seat belt – Any restraint device that:

- Meets published United States Government safety standards
- Is properly installed by the car manufacturer and
- Is not altered after the installation

This term also includes any child restraint device that meets the requirements of state law.

Sickness – For Business Travel Accident Insurance, it means a physical or mental illness, including pregnancy.

Spouse – For a definition of spouse, refer to the Plan Participation section of this book. For purposes of this Life and Accident benefits section, the definition of spouse includes a qualified domestic partner, as defined in the Plan Participation section.

Supplemental restraint system – For Business Travel Accident Insurance, an air bag that inflates upon impact for added protection to the head and chest areas

Terminally ill – A person whose life expectancy is six months or less

Totally disabled/total disability – For Life/AD&D benefits, it means you are unable to perform the material and substantial duties of your regular job and of any other job for which you are fit by education, training or experience.

For Business Travel Accident Insurance, it means either:

- Inability, due to a covered accident, by you to perform the material and substantial duties of your occupation during the first 12 months after the end of the benefit waiting period. After this time period, total disability means the inability to perform the material and substantial duties of any occupation for which you are qualified by reason of education, training or experience or
- Inability by you to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance

Uniplegia – The total paralysis of one upper or one lower limb

War – Declared or undeclared war, or act of war, insurrection, rebellion or riot

Cost of Coverage

You and the Company share the cost of your Life and Accident benefits coverage. The amount you must pay is determined by the coverage you select.

The Company provides Basic Life insurance at no cost you and offers you the opportunity to purchase Supplemental Life Insurance. The Company also provides Basic AD&D and Dependent Life Insurance to members of Locals 412 and 1464. Members of Local 1613 may purchase Supplemental AD&D Insurance and Dependent Life Insurance.

How the Life and Accident Benefits Work

Your Life and Accident benefits are an important part of your total rewards at KCP&L. Each of the available Life and Accident coverage options offer benefits that work together to provide you and your family financial security if you or your dependents are seriously injured or die.

Basic Life Insurance

To help protect your family if you should die, KCP&L provides you with Basic Life Insurance coverage as follows:

If your age is:	Your Basic Life Insurance is an amount equal to:
Less than 55	2.5 times your annual earnings; maximum of \$60,000
55 to 64	2 times your annual earnings; maximum of \$50,000
65 or older	1.33 times your annual earnings; maximum of \$50,000

Note: Effective January 1, 2010, members of Local 1464 will receive Basic Life insurance equal to their annual earnings, rounded to the next highest \$1,000.

Your beneficiary(ies) receives your Basic Life Insurance benefit amount if you die while covered for Basic Life Insurance benefits.

Your Basic Life Insurance coverage amount is based on your annual earnings as of January 1 each year. Your coverage amount adjusts during the year with any changes to your annual earnings.



A Closer Look: Imputed Income

Imputed income is an amount that reflects premiums paid on KCP&L-provided life insurance greater than \$50,000. The IRS requires you to pay income taxes on the cost of coverage above

this amount. If your Basic Life (and Supplemental Life) Insurance coverage is greater than \$50,000, you will have imputed income added to your gross pay. Each pay period, taxes will be withheld from your paycheck based on that amount.

Supplemental Life Insurance

You have the option to purchase Supplemental Life Insurance coverage. This insurance is in addition to your Basic Life Insurance coverage amount. You pay for this coverage with after-tax dollars through automatic payroll deduction. The maximum supplemental life insurance you can purchase is \$250,000. Effective January 1, 2010, there is no maximum dollar amount for members of Local 1464.

Coverage levels are as follows:

Option	Amount of Insurance
1	1 times annual earnings
2	2 times annual earnings
3	3 times annual earnings
4	4 times annual earnings

Your coverage is rounded to the next highest \$1,000. For example, if your annual earnings are \$85,500, Option 1 would be Supplemental Life Insurance coverage of \$86,000.

You may increase your coverage level by one option during each open enrollment period. You may also increase your coverage by one option if you experience a qualifying status change event.

Your cost for Supplemental Life coverage is based on your coverage amount and your age as of January 1 and adjusts during the year with changes to your earnings and/or age.

Your Supplemental Life Insurance coverage begins on the first day in which:

- You enroll.
- You meet the eligibility requirements and
- You meet any evidence of insurability requirement.

Life Insurance coverage is delayed if you are not actively at work on the day your insurance is scheduled to begin. Instead, coverage begins the first day you are actively at work and meet the requirements listed above.

Basic AD&D and Company-provided Dependent Life Insurance are available only to members of Locals 412 and 1464; Supplemental and Dependent AD&D Insurance are available only to members of Local 1613.

Evidence of Insurability

You may elect coverage up to two times your annual earnings without providing evidence of insurability when you are initially eligible for coverage. You must provide evidence of insurability to the satisfaction of MetLife before the coverage is effective in the following circumstances:

- For amounts over two times your annual earnings that you elect when you are initially eligible
- If you do not elect coverage when you are initially eligible, for any amount you elect later

If you elect coverage when you are initially eligible to do so, you may increase your coverage by one times your annual earnings (limited by the maximum dollar amount) during annual open enrollment periods without evidence of insurability. The insurance amount is increased when evidence is satisfactory to MetLife, you are actively at work and you receive written approval from MetLife.

Will Preparation and Estate Services

While your Supplemental Life Insurance coverage is in effect, you will be eligible for Will Preparation and Estate Resolution Services through Hyatt Legal Services, a MetLife affiliate.

Will Preparation services enable you and your spouse to have a will prepared free of charge through Hyatt Legal Services. If you choose to have a will prepared by another attorney, you must pay for the services directly, but you will be reimbursed for such services up to the amount of having the service provided by Hyatt Legal Services.

If you die while your Supplemental Life Insurance coverage is in effect, certain probate services will be made available to your estate through Hyatt Legal Services. If such services are provided to your estate by another attorney, your estate must pay for the services directly, but will be reimbursed up to the amount of having the services provided by Hyatt Legal Services. For more detailed information about these services, you may contact the provider, Hyatt Legal Plans, Inc. by phone at 800-821-6400.

Accelerated Death Benefit Payment

The accelerated death benefit pays a portion of your Basic Life and Supplemental Life Insurance benefit before your death, if a physician determines you are terminally ill due to any injury or sickness which is expected to result in death within six months.

The accelerated benefit amount is up to 80% of your Basic Life Insurance amount and up to 80% of your Supplemental Life Insurance coverage amount. MetLife will pay the accelerated benefit in one sum unless you or your legal representative selects another payment mode.

Your right to receive an accelerated death benefit is subject to the following terms:

- You must choose this option in writing in a manner that satisfies MetLife.
- You must provide proof to MetLife (to its satisfaction) that your life expectancy is six months or less—including certification by a physician.
- Your Basic Life Insurance must not be assigned to another person.
- Accelerated death benefits will be made available to you on a voluntary basis only.

Accelerated death benefit payments may also be available for your spouse (Local 1613 only) if he or she is covered under Dependent Life Insurance and meets the same eligibility requirements as described above. The maximum accelerated death benefit for your spouse is 80% of your spouse's coverage amount under Dependent Life Insurance up to \$24,000. For more information on Dependent Life Insurance, see the following section.

The amount of life insurance payable and any premiums you pay for coverage will be reduced by the accelerated death benefit payment.

Dependent Life Insurance

Locals 412 and 1464

The Company provides Basic Dependent Life Insurance at no cost to you as follows:

For your spouse	\$ 5,000
For each of your children	\$ 2,000

Local 1613

You have the option to purchase Dependent Life Insurance coverage for your spouse and eligible dependent children. You pay for this coverage with after-tax dollars through automatic payroll deduction. You are the beneficiary for all Dependent Life Insurance.

If you and your spouse both work for the Company, you may each be covered as an employee, but not as a dependent. In addition, eligible children may only be covered by one parent for Dependent Life Insurance. You may not both cover them as dependents.

You may choose Dependent Life Insurance from the following options:

Option 1

For your spouse	\$ 10,000
For each of your children	\$ 4,000

Option 2

For your spouse	\$ 20,000
For each of your children	\$ 8,000

Option 3

For your spouse	\$ 30,000
For each of your children	\$ 10,000

Note: Your Dependent Life Insurance cannot exceed 100% of your Supplemental Life Insurance.

When Dependent Life Insurance Coverage Begins

Dependent Life Insurance coverage begins on the first day in which all of the following requirements are met:

- You enroll.
- The person you cover is your qualified dependent.
- You meet the eligibility requirements.
- You have Basic Life Insurance coverage through KCP&L.
- Your dependent meets any evidence of insurability requirement.
- You are actively at work.
- The insurance is part of the group insurance policy.

You must enroll for coverage and agree to pay the required contributions. KCP&L will tell you the amount which must be paid, if any.

Dependent Life Insurance coverage under the Plan is delayed if your dependent is confined for medical care or treatment at home or elsewhere. Once your dependent is released from care or confinement, coverage begins. However, coverage for your newborn child is not delayed if the child is your first qualified dependent or the child becomes a qualified dependent while you are insured for Dependent Life Insurance for any other qualified dependent.

Evidence of Insurability

You must provide evidence of insurability (to the satisfaction of MetLife) to enroll your spouse for Dependent Life Insurance:

- More than 90 days after eligibility for coverage
- If you re-elect coverage after any insurance has ended because you did not pay the required contribution
- If a previous evidence of insurability requirement is not met. (The evidence must have been required for the person to be covered as your dependent and the insurance must have been through a MetLife insurance policy with the Company.)

Evidence of insurability is not required for a dependent child if you enroll within 90 days of your dependent child becoming eligible. If you request coverage more than 90 days after your dependent child becomes eligible, evidence of insurability will be required. Coverage becomes effective when evidence is satisfactory to MetLife, you are actively at work and you receive written approval from MetLife. In addition, if at the time you elect or increase Dependent Life Insurance coverage, your dependent is confined at home under a physician's care, receiving or applying to receive disability benefits from any source or hospitalized, coverage will not take effect until the date your dependent is no longer confined, receiving or applying to receive disability benefits or hospitalized.



**Important Note:
Change in Family Status**

It is important to inform KCP&L when you first acquire a dependent. You should also contact KCP&L for the following Dependent Life Insurance changes:

- Your dependent is no longer eligible for coverage.
- Your marital status changes for reasons of marriage, divorce, legal separation, annulment or death of a spouse.
- Your number of dependents changes for reasons such as birth, adoption or placement for adoption, or death.

Basic, Supplemental and Dependent AD&D Insurance

Basic AD&D Insurance (Locals 412 and 1464 only)

Basic AD&D Insurance coverage pays you a benefit if you suffer an accidental loss. KCP&L provides a basic AD&D benefit equal to the amount of your Basic Life Insurance.

The basic AD&D benefit is paid if you die as a result of a covered injury; benefits payable for accidental injury other than death are a percentage of the basic AD&D amount as shown on the chart on page **F-9**.

Benefits for accidental injury are payable only if:

- You sustain a covered injury.
- Your loss results directly from the covered injury and from no other cause and
- You suffer a loss within 365 days after the covered accident. But, if the loss is due to coma, that loss:
 - Begins within 30 days of the covered accident and
 - Continues for seven consecutive days

In addition, loss of life will be presumed if your body is not found within one year of the disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.



Important Note: Information for Residents of Certain States

Some states have specific requirements that change the provisions of the Life Insurance and AD&D Insurance under the coverage described in this Summary Plan Description. If you live in one of these states, those requirements apply to your coverage. Please see the insurance certificate posted on the All About page through the KCP&L intranet for more information.

Supplemental and Dependent AD&D Insurance (Local 1613 only)

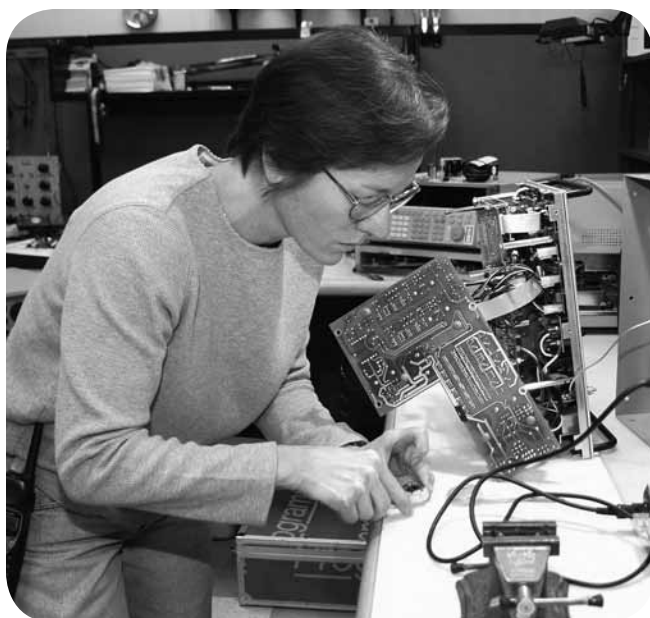
You have the option of purchasing Supplemental AD&D Insurance coverage for yourself and Dependent AD&D Insurance coverage for your dependents.

For You

You may purchase additional AD&D coverage of \$25,000 or in multiples of \$50,000—up to a maximum of \$250,000.

For Your Dependents

You may purchase AD&D coverage for your dependents of \$25,000 or in multiples of \$50,000—up to a maximum of \$250,000.



Schedule of Benefits for Basic, Supplemental and Dependent AD&D

The AD&D amount payable depends on the type of loss.

Loss	Percent of Your Insurance Amount
<ul style="list-style-type: none"> • Loss of life • Loss of any combination of hand, foot or sight of one eye • Loss of speech and loss of hearing • Paralysis of both arms and both legs • Brain damage 	100%
<ul style="list-style-type: none"> • Loss of an arm permanently severed at or above the elbow • Loss of a leg permanently severed at or above the knee 	75%
<ul style="list-style-type: none"> • Loss of a hand permanently severed at or above the wrist but below the elbow • Loss of a foot permanently severed at or above the ankle but below the knee • Loss of sight in one eye • Loss of speech or loss of hearing • Paralysis of both legs • Paralysis of the arm and leg on either side of the body 	50%
<ul style="list-style-type: none"> • Loss of thumb and index finger of the same hand • Paralysis of one arm or one leg 	25%
<ul style="list-style-type: none"> • Coma 	1% per month beginning on the seventh day of the coma for the duration of the coma, up to 60 months



A Closer Look: Limitation Per Accident

All benefits are subject to the Limitation Per Accident, which means no more than 100% of your AD&D Insurance benefit in effect at the time of an accident will be paid for all losses resulting from that accident. For example, if you were to lose sight in both your eyes and one hand due to the same accident, your benefit would be 100% of your insurance amount—not 150%. This limit does not apply to the benefits shown in the “Additional Benefits” section beginning on page **F-10**.

Basic AD&D and Company-provided Dependent Life Insurance are available only to members of Locals 412 and 1464; Supplemental and Dependent AD&D Insurance are available only to members of Local 1613.

Additional Benefits

In certain circumstances, when benefits are paid for accidental death, additional benefits may be paid under applicable Basic, Supplemental or Dependent AD&D coverage as follows:

Additional Benefits for Basic, Supplemental and Dependent AD&D Insurance	Amount Payable
<p>Seat Belt</p> <p>This additional benefit is only payable if you or a covered dependent sustains a covered accident that results in loss of life while driving or riding in a passenger car and wearing a seat belt which was properly fastened. In addition, your use of a seat belt at the time of the injury must be verified in an official report of the covered accident or certified in writing by investigating officials.</p>	<p>An amount equal to the lesser of:</p> <ul style="list-style-type: none"> • The greater of \$1,000 or 10% of the full Basic, Supplemental or Dependent AD&D Insurance amount (as applicable) • \$25,000
<p>Air Bag</p> <p>This additional benefit is only payable if you or a covered dependent sustains a covered accident that results in loss of life while driving or riding in a passenger car with an air bag, riding in a seat protected by an air bag and wearing a seat belt which was properly fastened. In addition, officials investigating the accident must certify that the seat belt was properly fastened and that the passenger car in which you were traveling was equipped with air bags.</p>	<p>An amount equal to the lesser of:</p> <ul style="list-style-type: none"> • The greater of \$1,000 or 5% of the full Basic and Supplemental or Dependent AD&D Insurance amount (as applicable) • \$10,000
<p>Hospital Confinement</p> <p>This additional benefit is only payable if you are confined in a hospital as a direct result of a covered accident and is independent of other causes.</p> <p>This benefit is paid on a monthly basis beginning on the 5th day of confinement, for up to 12 months of continuous confinement. It will be paid on a pro-rata basis for any partial month of confinement.</p> <p>Benefits are payable only for the first period of confinement that qualifies for payment.</p>	<p>An amount for each full month of hospital confinement equal to the lesser of:</p> <ul style="list-style-type: none"> • 1% of the Supplemental AD&D Insurance amount (as applicable) • \$2,500
<p>Spouse Education</p> <p>This additional benefit only applies if you suffer loss of life. An additional benefit for tuition reimbursement is payable for your spouse if he or she:</p> <ul style="list-style-type: none"> • Was enrolled as a full-time student in an accredited school on the date of your death and • Enrolls in an accredited school as a full-time student within 12 months after the date of your death <p>Proof of continued enrollment of your spouse as a full-time student during the academic year may be required by MetLife.</p>	<p>An amount equal to tuition charges incurred for a period of up to 1 academic year, not to exceed:</p> <ul style="list-style-type: none"> • An academic year maximum of \$5,000; an overall maximum of 3% of your Supplemental AD&D Insurance amount. If this benefit is in effect on the date you die and there is no Spouse who could qualify for it, a benefit of \$1,000 will be paid to your beneficiary in one sum.
<p>Child Education</p> <p>This additional benefit only applies if you suffer loss of life. An additional benefit for child education is payable for each dependent child who, on the date of your death, is:</p> <ul style="list-style-type: none"> • Enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level or • At the 12th grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school <p>Proof of the child's continuing enrollment as a full-time student may be required by MetLife.</p>	<p>An amount equal to the tuition charges incurred for a period of up to 4 consecutive academic years, not to exceed:</p> <ul style="list-style-type: none"> • An academic year maximum of \$10,000 • An overall maximum of 20% of your Supplemental AD&D Insurance amount. If there is no dependent child eligible for this benefit on the date you die, a benefit of \$1,000 will be paid to your beneficiary.

Additional Benefit for Basic, Supplemental and Dependent AD&D Insurance	Amount Payable
<p>Child Care</p> <p>This additional benefit only applies if you suffer loss of life.</p> <p>This additional benefit is payable for each dependent child under age 12 who:</p> <ul style="list-style-type: none"> • Is enrolled in a child care center on the date of your death or • Becomes enrolled at a child care center within 12 months after the date of your death <p>Proof of your child's continued enrollment in a child care center during the period for which a benefit is claimed may be required by MetLife.</p>	<p>An amount equal to charges incurred at a child care center for a period of up to 4 consecutive years, not to exceed:</p> <ul style="list-style-type: none"> • An annual maximum of \$5,000 • An overall maximum of 12% of your Supplemental AD&D Insurance amount <p>If there is no dependent child eligible for this benefit, a benefit of \$1,000 will be paid to your beneficiary.</p>
<p>Common Disaster</p> <p>This additional benefit is only payable for your spouse's loss of life if you and your covered spouse are injured in the same covered accident and die within 365 days as a result of injuries in the covered accident.</p>	<p>An amount equal to the difference between:</p> <ul style="list-style-type: none"> • The Basic or Supplemental AD&D Insurance amount payable under the coverage for your loss of life and • The Dependent AD&D Insurance amount payable under the coverage for your spouse's loss of life
<p>Common Carrier</p> <p>This additional benefit is payable only if you or a covered dependent die as a result of a covered accident while traveling in a common carrier. A common carrier means a government-regulated entity that is in the business of transporting fare paying passengers.</p>	<p>An amount equal to the Basic, Supplemental AD&D Insurance or Dependent AD&D Insurance amount (as applicable)</p>

Business Travel Accident Insurance

KCP&L provides Business Travel Accident Insurance benefits through Life Insurance Company of North America at no cost to you. This insurance protects you and your family from financial loss resulting from a covered accident occurring while you are traveling on Company business.

Business Travel Accident benefits are subject to all applicable conditions and exclusions if you suffer a covered loss caused by a covered accident which occurs when you travel:

- On business for KCP&L and
- In the course of the business of KCP&L and
- On a trip authorized in advance by KCP&L and
- Away from the premises of KCP&L or for a short stay away from KCP&L's premises in a city to which you are permanently assigned

Coverage for business travel is not provided during any of the following:

- Normal commuting between your home and place of work
- Travel to another location where you are expected to be assigned for more than 60 days
- Any activity not authorized, organized or reimbursable by KCP&L
- Any activity by you that is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this policy and you perform before, during or after covered travel
- While you are driving any vehicle or private passenger automobile for pay or hire
- While you are performing job duties during work hours in a work area that is in a residence. This work arrangement must be specified in a written telecommuting agreement between you and KCP&L.

Principal Sum

The Business Travel Accident coverage amount (principal sum) is \$200,000. The maximum amount paid by Life Insurance Company of North America is \$2,500,000 per accident. For example, if 20 employees are eligible for a Business Travel Accident Insurance claim under one accident, each person would receive \$125,000 rather than \$200,000 (\$2,500,000 maximum ÷ 20 employees).



Important Note:

Business Travel Accident Insurance does not cover commuting between your home and place of work, or activities not related to KCP&L business.



Schedule of Benefits

If you have an accident while traveling on KCP&L business that results (within 365 days of the covered accident) in any of the following losses, Life Insurance Company of North America will pay the amount indicated below. If the accident results in more than one of these losses, only the loss with the largest benefit amount will be payable.

Covered Loss	Benefit
Loss of life	100% of the principal sum
Loss of two or more hands or feet	100% of the principal sum
Loss of sight of both eyes	100% of the principal sum
Loss of one hand or one foot and sight in one eye	100% of the principal sum
Loss of speech and hearing (in both ears)	100% of the principal sum
Quadriplegia	100% of the principal sum
Paraplegia	75% of the principal sum
Hemiplegia	50% of the principal sum
Uniplegia	25% of the principal sum
Coma	<ul style="list-style-type: none"> • Monthly benefit • Number of monthly benefits • When payable • Lump sum benefit • When payable
	<ul style="list-style-type: none"> • 1% of the principal sum • 11 • At the end of each month during which the covered person remains comatose • 100% of the principal sum • Beginning of the 12th month
Loss of one hand or foot	50% of the principal sum
Loss of sight in one eye	50% of the principal sum
Loss of speech	50% of the principal sum
Loss of hearing (in both ears)	50% of the principal sum
Severance and reattachment of one hand or foot	25% of the principal sum
Loss of thumb and index finger of the same hand	25% of the principal sum
Loss of all four fingers of the same hand	25% of the principal sum
Loss of all the toes of the same foot	20% of the principal sum

Permanent Total Disability

You receive 100% of the principal sum after 12 months of continuous disability. Any benefits payable for permanent and total disability are in addition to any other accidental death and dismemberment benefits payable to you.

To be eligible for the permanent and total disability benefits, at the time of the covered accident you must be employed with KCP&L and you must be either:

- Performing your regular duties on a full-time basis during one of KCP&L's scheduled work days, either at one of the Company's usual places of business or at another location you are required to travel to for business or
- On a scheduled holiday, vacation day or period of KCP&L-approved leave of absence other than sick leave, only if you were performing your regular duties as described above on the preceding workday.

The permanent and total disability benefit is paid to you if the total disability results from, and is within the time period shown in the Schedule of Benefits, of a covered accident. To qualify for benefits, you must remain totally disabled during the benefit waiting period shown in the Schedule of Benefits. At the end of the benefit waiting period, you must be expected to remain disabled, as certified by a physician, for the rest your life.

Life Insurance Company of America will pay a single lump sum benefit equal to the amount shown in the Schedule of Benefits, minus any accidental dismemberment benefit paid for the covered loss causing the total disability.

Seat Belt and Air Bag Benefit

The Business Travel Accident policy provides a seat belt and air bag benefit in addition to the principal sum. This benefit includes:

- Seat belt benefit – 10% of the principal sum, up to a maximum of \$10,000
- Air bag benefit – 5% of the principal sum, up to a maximum of \$10,000
- Default benefit – \$1,000

The seat belt benefit paid is subject to all applicable conditions and exclusions when your death results from a

covered accident while wearing a seat belt and operating or riding as a passenger in a private passenger automobile. An additional air bag benefit is provided if you were also positioned in a seat protected by a properly-functioning and properly deployed air bag.

Verification of proper seat belt usage at the time of the covered accident as well as proper inflation of the air bag upon impact must be a part of the official police report or certified, in writing, by the investigating officer(s) and submitted with your claim to Life Insurance Company of North America.

Exposure and Disappearance Coverage

Life Insurance Company of North America will pay benefits under this policy (subject to all applicable conditions and exclusions), if you suffer a covered loss from a covered accident that causes your unavoidable exposure to the elements after the forced landing, sinking, stranding or wrecking of a vehicle.

If you disappear and are not found within one year after the wrecking, sinking or disappearance of your vehicle, it will be presumed that your death resulted from a covered accident.

The travel or trip must have been authorized in advance by KCP&L.

Benefits If You Are Age 70 or Older

If you are age 70 or older, the Business Travel Accident benefit is a percentage of the principal sum as shown below:

Age at Date of Loss	Percentage of Principal Sum Payable
70 but less than 75	82.5%
75 but less than 80	57.5%
80 but less than 85	37.5%
85 or over	20%

For example, if you are age 75 and eligible for \$200,000 in Business Travel Accident Insurance, the Business Travel Accident benefit pays \$115,000 (57.5% of \$200,000) for a covered loss of life.

Survivor Benefit Plan

KCP&L provides a \$10,000 survivor benefit to your beneficiary upon your death. The beneficiary under the Survivor Benefit Plan is the same as the beneficiary you have designated to receive your Basic Life Insurance benefit.

The survivor benefit is paid to your beneficiary as soon as possible after your death. You cannot receive your survivor benefit before your death. This survivor benefit is fully taxable to your beneficiary when payment is made.

Designating Your Beneficiary

You will be asked to name a beneficiary or beneficiaries when you become covered for Life and AD&D benefits. You may name anyone as your beneficiary and you may change your beneficiary at any time by written notice without the consent of a beneficiary. You may change your beneficiary designation at the All About page through the KCP&L intranet. For assistance with changing a beneficiary, you may also contact the HR Service Center.

Life Insurance Beneficiaries

Life Insurance benefits will be paid to the person you most recently named as long as that person is living on the date of the claim. If you do not name a beneficiary or the beneficiary is not living, life insurance benefits will be paid in the following order:

- Your spouse, if living
- Your surviving children in equal shares
- Your surviving parents in equal shares
- Your surviving siblings in equal shares
- Your estate

AD&D Insurance Beneficiaries

AD&D benefits are payable to you with these exceptions:

- Benefits for spouse education payable because of your loss of life will be paid to your spouse, if living, or your spouse's estate.
- Benefits for child care expenses or child education payable because of your loss of life or your spouse's loss of life that are unpaid at your death will be paid to your child or, if your child is a minor or incompetent to receive payment, to the child's guardian.
- Benefits for any other of your losses that are unpaid at your death or become payable on account of your death will be paid to your beneficiary.
- If you are not living, benefits for any other dependent's losses are payable to the dependent who suffered the loss. If that dependent is not living, the benefits will be paid to that dependent's estate.

Business Travel Accident Insurance Beneficiaries

If you die while benefits are payable to you, the insurance company may make direct payment to your first surviving of the following:

- Spouse
- Child or children
- Parents
- Siblings
- Estate

What's not Covered

Life Insurance

There are no coverage exclusions under Basic Life Insurance for any loss of life.

Under Supplemental Life Insurance, if you commit suicide within one year from the date your coverage became effective and MetLife determines that, when you enrolled for such coverage, you intended to commit suicide, no benefits are payable. Your beneficiary will receive a refund of any premiums paid by you for your coverage.

Under Dependent Life Insurance, if a dependent commits suicide within one year from the date coverage became effective and MetLife determines that, when the dependent was enrolled for such coverage, he or she intended to commit suicide, no benefits are payable. You will receive a refund of any premiums paid for such coverage.

The suicide limitation under Supplemental Life Insurance and Dependent Life Insurance also applies to any increases in coverage. Benefits will be limited to the amount in effect prior to the date the increased coverage became effective and any premiums paid for the increase in coverage will be refunded.

AD&D Insurance

Certain losses are not covered under AD&D Insurance. For example, AD&D benefits (Basic, Supplemental and Dependent) are not payable if injury or death results from:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Infection, other than pyogenic infection that results from an accidental bodily injury, or bacterial infection that results from the accidental ingestion of contaminated substances
- Suicide or attempted suicide while sane
- Intentionally self-inflicted injury while sane, or while insane if it is not attempted suicide
- For any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident
- Service in the armed forces of any country or international authority, except the United States National Guard
- Any incident related to:
 - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger
 - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight
 - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation
 - Travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere
- Committing or attempting to commit a felony
- The voluntary intake or use by any means of:
 - Any drug, medication or sedative, unless it is:
 - Taken or used as prescribed by a physician
 - An "over the counter" drug, medication or sedative taken as directed
 - Alcohol in combination with any drug, medication or sedative
 - Poison, gas or fumes
- War, whether declared or undeclared; or act of war, insurrection, rebellion or riot

Business Travel Accident Insurance

In addition to any benefit-specific exclusion, benefits will not be paid for any covered injury or covered loss which directly or indirectly, in whole or in part, is caused by or results from any of the following:

- Intentionally self-inflicted injury, suicide or any attempt thereat while sane
- Commission or attempt to commit a felony or an assault
- Commission or active participation by you in a riot, insurrection or terrorist act
- Declared or undeclared war or act of war
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface:
 - Except as fare-paying passenger on a regularly scheduled commercial or charter airline
 - Being flown by you or in which you are a member of the crew
 - Being used for:
 - Crop dusting, spraying or seeding, giving and receiving flying instructions, fire fighting, sky writing, sky- or hang-gliding, racing endurance tests, stunt or acrobatic flying or
 - Any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on)
 - An ultra-light or glider
 - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent
 - Being used for the purpose of parachuting or skydiving
 - Designed for flight above or beyond the earth's atmosphere
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, including exposure to viral, bacterial or chemical agents, except for any bacterial infection resulting from an accidental bodily injury or accidental ingestion of a contaminated substance
- Travel in any aircraft owned, leased or controlled by KCP&L or any of its subsidiaries or affiliates. An aircraft will be deemed to be 'controlled' by KCP&L if the aircraft may be used as the Company wishes for more than 10 straight days, or more than 15 days in any year
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage
- A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which you have been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

- Employed or retained by KCP&L
- Living in your household
- A parent, spouse or child of either you or your spouse

How Payment is Made

Life and AD&D Insurance

Your Life and AD&D benefits are typically paid to a beneficiary in one lump sum. However, other payment arrangements may be available upon request when you file your claim.

Business Travel Accident Insurance

All benefits are paid in a single lump sum. Benefits for loss of life are payable according to the beneficiary and claims provisions. All other policy proceeds (unless otherwise stated) are payable to you or your estate. If any payee of benefits is a minor or otherwise legally incompetent, the insurance company will pay benefits to the person designated as the legal guardian or conservator.

If Life Insurance Company of North America pays benefits to the estate or person who is incapable of giving a valid release, then a \$1,000 payment may be made to a relative by blood or marriage if the insurance company believes this person is entitled to the benefit. Any payment in good faith will fully discharge and release the insurance company from liability.

Survivor Benefit Plan

Survivor benefits are paid to the beneficiary in a single lump sum by KCP&L.

How to File a Claim

Life and AD&D Insurance

MetLife must receive written proof of loss for any claim for life, or AD&D insurance made under the Plan. This proof must cover the nature and extent of the loss. It must be given to MetLife within 90 days after the loss date. If any Plan provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each period must be provided within 90 days. You may contact MetLife at the following address:

Metropolitan Life Insurance Company

Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
800-638-6420

A claim is not valid unless proof is furnished within the time limit, or as soon as reasonably possible.

When Benefits Are Paid

Benefits are paid when MetLife receives written proof of loss. But, if the Plan provides that benefits are payable at equal intervals of one month or less, MetLife will not have to pay benefits more often.

Physical Exam and Autopsy

At its expense, MetLife has the right to examine the person whose loss is the basis for the claim. MetLife may do this as often as is reasonable while the claim is pending. In addition, MetLife has the right to arrange an autopsy in case of accidental death, if it is not forbidden by law.

Legal Action

No action at law or in equity may be brought on the Plan until 60 days after written proof is provided. No action may be brought on the Plan more than three years after proof of loss is required.

Business Travel Accident Insurance

The insurance company must receive written or authorized electronic/telephonic notice within 31 days after a covered accident, or as soon as reasonably possible, but no later than 15 months after the date of loss. If written or authorized electronic/telephonic notice is not given in that timeframe, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice may be given at the home office of Life Insurance Company of North America in Philadelphia, Pennsylvania or at another place that the insurance company designates, and it may be given to the insurance company's authorized agent.

Life Insurance Company of North America

1601 Chestnut Street
Philadelphia, PA 19192-2235

The notice should include KCP&L's name, the policy number ABL 626896, and your name and address.

Life Insurance Company of North America will send you a claim form once it receives written notice. If a claim form is not sent within 15 days after the insurance company receives notice, the proof requirements will be met by submitting written or authorized electronic proof of the nature and extent of the claimed loss. This information must be sent within the required timeframe.

Proof of Loss

Written or authorized electronic proof of loss, satisfactory to Life Insurance Company of North America, must be given within 90 days after a covered loss occurs. If benefits are payable as periodic payments and each payment is contingent on continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which the insurance company is liable. If written or authorized electronic notice is not given within that timeframe, no claim will be invalidated or reduced if it is shown that the notice was given as soon as reasonably possible. Written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

When Benefits are Paid

The insurance company will pay benefits under this policy for any loss (except those with a periodic payment provision) immediately upon receipt of written or authorized electronic proof of the loss. All accrued benefits for loss (subject to written or electronic proof of loss) will be paid monthly unless otherwise specified. Any unpaid balance at the termination of liability will be paid immediately when the insurance company received satisfactory proof of loss, unless otherwise stated in the policy.

Physical Examination and Autopsy

Life Insurance Company of North America, at its own expense, has the right and opportunity to examine you when and as often as may be reasonably required while a claim is pending. The insurance company also may make an autopsy in case of death where it is not forbidden by law.

Legal Action

No legal action can be brought to recover benefits less than 60 days after satisfactory proof of loss has been furnished. No action will be brought after the expiration of the applicable statute of limitations from the time proof of loss is required.

Survivor Benefit Plan

For information about filing a claim for survivor benefits, contact the HR Service Center:

KCP&L HR Service Center

P.O. Box 418679
Kansas City, MO 64141-9679
816-276-5555

hrrservicecenter@kcpl.com

Waiver of Premium

If you become totally disabled before you reach age 60 and continue to be totally disabled for six consecutive months, you may qualify to continue the following coverage at no cost:

- Basic Life Insurance in effect when your total disability began
- Supplemental Life Insurance in effect for at least 12 months prior to the date you were totally disabled

Waiver of premium coverage may continue until the earliest of:

- Your death
- The date your total disability ends
- The date you do not provide proof of total disability as required

- The date you refuse to be examined by MetLife's physician as required
- The date you reach age 65

To qualify for waiver of premium, you must contact MetLife within 90 days after becoming disabled and provide proof of your disability satisfactory to MetLife. MetLife will determine if you qualify for waiver of premium and will notify you in writing of their determination. If approved, you may be required to provide proof of your continuing total disability to MetLife from time to time.

After your eligibility for waiver of premium continuation ends, you may be eligible to port or convert your coverage. Please see the Portability section on pages **F-20** to **F-22** and Converting to an Individual Policy section on page **F-24**.

Portability

In certain situations, portability allows you to continue some of your life and AD&D coverage after your coverage through the Company ends. You may apply for portability benefits if any of the following coverage ends:

- Supplemental Life Insurance
- Dependent Life Insurance
- Supplemental AD&D Insurance
- Dependent AD&D Insurance

To be eligible for portability benefits the following tests must be met:

- Coverage must end for reasons other than:
 - Your employment terminates
 - You are no longer eligible for coverage under the Plan
 - The end of portable plan coverage for all employees, unless such coverage is replaced by similar insurance under another group insurance policy issued to the Company or its successor
 - The policy ends, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Company or its successor.



Important Note:

If you or your dependents' coverage ends for any of the above reasons and you are not eligible to port your coverage, you may be eligible to convert your coverage to an individual policy. For more information see the Converting to an Individual Policy section in this book.

If you die, your spouse has the right to apply for portability coverage if he or she:

- Is covered for Dependent Life Insurance or Dependent AD&D Insurance on the date your Basic Life Insurance or Supplemental AD&D Insurance coverage ends
- Is not confined for medical care or treatment at home or elsewhere on the date your Basic Life Insurance or Supplemental AD&D Insurance coverage ends

In addition, your spouse has the right to apply for Dependent Life Insurance and Dependent AD&D Insurance portability coverage for a qualified child if:

- Your spouse applies and becomes covered for portability benefits.
- The dependent child is under age 25 and solely depends on you for support and maintenance.
- The dependent is covered under Dependent Life Insurance or Dependent AD&D Insurance on the day your Life Insurance or Supplemental AD&D Insurance coverage ends.
- The dependent is not confined for medical care or treatment at home or elsewhere on the day your Basic Life Insurance coverage ends.

If you divorce, your spouse has the right to apply for Dependent Life Insurance and Dependent AD&D Insurance portability coverage if:

- Dependent Life Insurance coverage on your spouse ends due to divorce.
- Your spouse is not confined for medical care or treatment at home or elsewhere on the day Dependent Life Insurance or Dependent AD&D Insurance ends.

Application Period

If you or your dependent wishes to port your Supplemental Life, Supplemental AD&D, Dependent Life or Dependent AD&D Insurance coverage, you must complete and submit a request form to MetLife within the application period as described below:

- If you receive written notice of your option to port your insurance within 15 days of the date your coverage ends, the application period begins the date your coverage ends and expires 31 days after that date.
- If you receive written notice of your option to port your insurance more than 15 days after the date your coverage ends, but within 91 days of the date, the application period begins the date your coverage ends and expires 45 days after the date of the notice.

Portability Amounts

For You

	Minimum Portability Amount	Maximum Portability Amount*
Supplemental Life Insurance	\$10,000 Supplemental Life Insurance	Supplemental Life Insurance that is the lesser of: <ul style="list-style-type: none"> Your total Supplemental Life Insurance in effect on the date you elect to port \$2 million
Supplemental AD&D Insurance	\$10,000 Supplemental AD&D Insurance	Supplemental AD&D Insurance that is the lesser of: <ul style="list-style-type: none"> Your Supplemental AD&D Insurance in effect on the date you elect to port \$1 million

* The amount shown is the portability coverage available without evidence of insurability. However, you may apply for increased coverage with evidence of insurability.

If your Supplemental Life Insurance and/or Supplemental AD&D Insurance ends due to the end of your group policy or an amendment of the policy to end your right to port your insurance, the maximum amount of insurance you may port is the lesser of:

- The amount of your portability-eligible insurance that ends under the group policy minus the amount of life insurance for which you become eligible under any group policy issued to replace the ending group policy
- \$10,000

For Your Spouse

	Minimum Portability Amount	Maximum Portability Amount*
Dependent Spouse Life Insurance		
When you port Dependent Life Insurance for your spouse along with your Supplemental Life Insurance	\$2,500 Dependent Life Insurance for your spouse	Dependent Life Insurance for your spouse that is the lesser of: <ul style="list-style-type: none"> Your total Dependent Life Insurance for your spouse in effect on the date you elect to port \$250,000
When you port only Dependent Life Insurance for your spouse	\$10,000 Dependent Life Insurance for your spouse	Dependent Life Insurance for your spouse that is the lesser of: <ul style="list-style-type: none"> Your total Dependent Life Insurance for your spouse in effect on the date you elect to port \$250,000
Dependent Spouse AD&D Insurance		
When you port Dependent AD&D Insurance for your spouse along with your Supplemental AD&D Insurance	\$2,500 Dependent AD&D Insurance for your spouse	Dependent AD&D Insurance for your spouse that is the lesser of: <ul style="list-style-type: none"> Your total Dependent AD&D Insurance for your spouse in effect on the date you elect to port \$250,000
When you port only Dependent AD&D Insurance for your spouse	\$10,000 Dependent AD&D Insurance for your spouse	Dependent Life Insurance for your spouse that is the lesser of: <ul style="list-style-type: none"> Your total Dependent Life Insurance for your spouse in effect on the date you elect to port \$250,000

* The amount shown is the portability coverage available without evidence of insurability. However, your dependent or former dependent may apply for increased coverage with evidence of insurability.

Basic AD&D and Company-provided Dependent Life Insurance are available only to members of Locals 412 and 1464; Supplemental and Dependent AD&D Insurance are available only to members of Local 1613.

If your Supplemental Life Insurance and/or Supplemental AD&D Insurance or if your spouse's Dependent Life Insurance and/or Dependent AD&D Insurance ends due to the end of your group policy or an amendment of the policy to end your right to port your insurance, the maximum amount of insurance you may port is the lesser of:

- The amount of your portability-eligible insurance that ends under the group policy minus the amount of life insurance for which you become eligible under any group policy issued to replace the ending group policy
- \$10,000

For Your Children

	Minimum Portability Amount	Maximum Portability Amount*
Dependent Child Life Insurance	\$1,000 Dependent Life Insurance for your children	Dependent Life Insurance for your children that is the lesser of: <ul style="list-style-type: none"> • Your total Dependent Life Insurance for your children in effect on the date you elect to port or • \$25,000
Dependent Child AD&D Insurance	\$1,000 Dependent AD&D Insurance for your children	Dependent AD&D Insurance for your children that is the lesser of: <ul style="list-style-type: none"> • Your total Dependent AD&D Insurance for your children in effect on the date you elect to port or • \$25,000

* The amount shown is the portability coverage available without evidence of insurability. However, your dependent or former dependent may apply for increased coverage with evidence of insurability.

If your Supplemental Life Insurance and/or Supplemental AD&D Insurance or if your children's Dependent Life Insurance and/or Dependent AD&D Insurance ends due to the end of your group policy or an amendment of the policy to end your right to port your insurance, the maximum amount of insurance you may port is the lesser of:

- The amount of your portability-eligible insurance that ends under the group policy minus the amount of life insurance for which you become eligible under any group policy issued to replace the ending group policy
- \$10,000

Assignment of Benefits

Life and AD&D Insurance

You may be able to assign Life and AD&D benefits as a gift or viatical assignment.

Any rights, benefits or privileges related to your assigned coverage will transfer to the assignee(s).

This includes any right you have to choose a beneficiary or to convert to another insurance contract. The insurance company does not decide if an assignment does what it is intended to do. To confirm an assignment, a copy must be filed with the insurance company.

If an assigned amount of insurance is payable when you die, but there is no designated beneficiary, payment is made to the assignee if living, or the estate of the assignee (if the assignee is not living). It will not be payable as stated in beneficiary rules.

Business Travel Accident Insurance

To confirm an assignment of your Business Travel Accident Insurance, a signed copy of this policy (from you or any irrevocable beneficiary) must be filed with the insurance company. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this policy for you remains in force.

This insurance may not be levied on, attached, garnished or otherwise taken for a person's debts unless contrary to law.

Survivor Benefits Plan

These benefits may not be assigned.

Imputed Income

The Internal Revenue Service (IRS) has ruled that if an employee receives life or accident insurance benefits for a domestic partner or the domestic partner's legally dependent child(ren), the employee must pay FICA, federal income and state income (unless otherwise permitted by state law) taxes on the domestic partner's coverage over the amount paid for the employee's own coverage. This amount may be added to gross income and taxed accordingly. If the domestic partner is a legal tax dependent under IRC Section 152, imputed income may not apply.

Employees on an approved leave of absence, who pay their portion of the employee contribution schedule by a method other than payroll deduction, will be obligated to pay the amounts due to FICA tax and income tax withholding on imputed income. Income withholding tax rates will be calculated in accordance with the employee's specific W-4.

Converting to an Individual Policy

You may convert the following coverage to an individual policy (without evidence of insurability) if group coverage ends:

- Basic Life Insurance
- Supplemental Life Insurance
- Dependent Life Insurance

To convert to an individual policy, your coverage must end because:

- Your employment ends
- You are no longer eligible for coverage
- The Plan is changed or ends and you have been covered for five years

If you or your dependent wishes to convert your Life Insurance coverage, you must complete and submit a request form to MetLife within the application period as described below:

- If you receive written notice of your conversion privilege within 15 days of the date your coverage ends, the application period begins the date your coverage ends and expires 31 days after that date.
- If you receive written notice of your conversion privilege more than 15 days after the date your coverage ends, but within 91 days of the date, the application period begins the date your coverage ends and expires 45 days after the date of the notice.

The individual policy must not be more than your insurance amount when group coverage ends. If it ends because all KCP&L life insurance is no longer offered, the total individual insurance amount available to you may not be more than the lesser of the following:

- The total insurance amount ending, reduced by the group life insurance amount from any insurance company for which you are or will become eligible for within the next 31 days
- \$10,000

Your premium is based on MetLife's rate for the form and amount of insurance, and your class of risk and age at that time. Coverage is effective 31 days after you are no longer insured.

If you die within 31 days of the date your coverage ends, death benefits may be payable to your beneficiary.

Your Rights under ERISA

As a participant in the Life and Accident benefits, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information on your rights and protections under ERISA, please refer to the General Information section of this book.

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Disability Benefits

Your KCP&L disability benefits provide important financial protection if a sickness or injury prevents you from working. Long-Term Disability benefits are provided under the Great Plains Energy Incorporated Employee Welfare Benefit Plan. Depending on the nature of the sickness or injury, you may also be eligible for benefits through Workers' Compensation.

Important Disability Terms

There are certain terms that have specific meaning with respect to the Long-Term Disability benefits. This section explains those terms to help you better understand your benefits.

Active service – Any scheduled work day at KCP&L when either of the following conditions are met:

- You are performing your regular occupation on a full-time basis at KCP&L, or at a location to which KCP&L business requires you to travel.
- The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

You are also in active service on a day which is not one of KCP&L's scheduled work days only if you were in active service the preceding scheduled work day.

Claims administrator – The claims administrator is CIGNA.

Consumer Price Index (CPI-W) – The Consumer Price Index for urban wage earners and clerical workers published by the U.S. Department of Labor

Covered earnings – Your basic wage or salary as reported by KCP&L for work performed just before the date your disability begins. Initially, covered earnings are determined on the date you apply for disability coverage. A change in covered earnings is effective on the date of the change. It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation. Any increase in your covered earnings will not be effective during a period of continuous disability.

Disability/disabled – For the first 24 months of Long-Term Disability payments, you are considered disabled if you are unable to perform the material and substantial duties of your regular occupation and unable to earn 80% or more of your indexed earnings from working in your regular occupation solely due to injury or sickness. After 24 months of Long-Term Disability payments, you are considered disabled if, due to injury or sickness, you are unable to perform the material and substantial duties of any occupation for which you are, or become qualified based on education, training or experience. In addition, you must be unable to earn 60% or more of your indexed earnings.

Disability earnings – Any wage or salary for work performed for any employer during your disability, including commissions, bonus, overtime pay or other extra compensation

Elimination period – The period of time which you must be continuously disabled before Long-Term Disability benefits begin

Good cause – A medical reason preventing participation in the rehabilitation plan. Satisfactory proof of good cause must be provided to the claims administrator.

Indexed earnings – During the first 12 months for which Long-Term Disability benefits are payable, indexed earnings are equal to your covered earnings. After 12 months, indexed earnings are your covered earnings plus an increase on each anniversary date of the date disability payments started. The increase is the lesser of 10% of your indexed earnings during your preceding year of disability, or the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury – Any accidental loss or bodily harm that results directly and independently from all other causes from an accident

Insurability requirement – You satisfy the insurability requirement for an amount of coverage on the day CIGNA agrees in writing to accept you as insured for that amount. To determine your acceptability for coverage, CIGNA will require you to provide evidence of good health and may require it be provided at your expense.

Optimum ability – The greatest extent of work you are able to do in your regular occupation during the first 24 months that Long-Term Disability benefits are payable. After 24 months of Long-Term Disability benefits, it is the greatest extent of work you are able to do in any occupation based on education, training or experience.

Your ability to work is based on medical evidence you submit, consultation with your physician and evaluation of your ability to work by up to three independent experts, if this is required by the claims administrator. The independent experts must be licensed, registered or certified, as required by the laws of the state in which the evaluation is made. They must also act within the scope of that license, registration or certificate.

Physician – A licensed doctor practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for your condition and locality. “Physician” does not include you, your spouse, your immediate family (including parents, children, siblings or spouses of any of your immediate family—whether the relationship is by blood or marriage) or a person living in your household.

Plan – The Great Plains Energy Incorporated Employee Welfare Benefit Plan

Proof of loss – Written, electronic or telephonic proof to substantiate your claim for Long-Term Disability benefits

Pro rata share – The proportion of the total benefit that the amount payable under one policy—without other insurance—bears to the total benefits under all policies

Regular occupation – The occupation you routinely perform at the time your disability begins. In determining your regular occupation, CIGNA considers the duties of your occupation as it is normally performed in the general labor market nationally; not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation plan – A written plan designed to enable you to return to work. A rehabilitation plan must consist of one or more of the following phases:

1. Rehabilitation under which CIGNA may provide, arrange or authorize education, vocational or physical rehabilitation or other appropriate services
2. Work, which may include modified work and work on a part-time basis

The rehabilitation plan may allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

Retirement plan – A defined benefit or defined contribution plan sponsored or funded by Great Plains Energy Incorporated. It does not include:

- An individual deferred compensation agreement
- A profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan
- Employee savings plan (including thrift, stock option or stock bonus plan)
- Individual retirement account
- 401(k) plan

Sickness – A physical or mental illness

Cost of Coverage

Locals 412 and 1464

You do not pay for Long-Term Disability coverage—KCP&L covers the full cost of your Long-Term Disability coverage.

Local 1613

You do not pay for Basic (50%) Long-Term Disability coverage—KCP&L covers the full cost. However, if you wish to purchase Supplemental Long-Term Disability coverage, you must pay for the additional coverage through after-tax payroll deductions (effective January 1, 2010, payroll deduction for Supplemental Long-Term Disability will be deducted on a pre-tax basis).

How Long-Term Disability Benefits Work

To help ensure financial security for you and your family if you are disabled for an extended period of time, KCP&L provides Long-Term Disability benefits. Long-Term Disability benefits are administered by CIGNA and are designed to help you during periods of long-term sickness or injury by replacing a portion of your lost income.

After an elimination period, you may be eligible for Long-Term Disability benefits if you continue to be disabled, and you are under the care of a licensed physician. You must file a claim for benefits and, if your claim is approved by CIGNA, Long-Term Disability benefits begin on the 91st or 181st day of your disability, as described below.

Locals 412 and 1464

After an elimination period of 180 days, the Long-Term Disability benefits provide a monthly disability income equal to $66\frac{2}{3}\%$ of your monthly covered earnings up to a maximum benefit of \$5,000 per month.

Local 1613

After an elimination period of 180 days, Basic Long-Term Disability benefits provide a monthly disability income equal to 50% of your monthly covered earnings up to a maximum benefit of \$2,000 per month.

You have the option to purchase Supplemental Long-Term Disability coverage which, combined with your Basic Long-Term Disability coverage, equals $66\frac{2}{3}\%$ of your monthly covered earnings to a maximum benefit of \$2,667 per month. In addition, you may choose a 90-day elimination period for 50% or $66\frac{2}{3}\%$ Long Term Disability coverage.



Important Note:

If you elect to purchase Supplemental Long-Term Disability benefit coverage after your initial election, you will be required to meet CIGNA's insurability requirement before your coverage goes into effect. In addition, coverage at any level may be subject to pre-existing condition limitations, even if your coverage was previously approved by CIGNA. For more details, please see Pre-existing Condition Limitation on page **G-7**.

Maximum and Minimum Benefits

The maximum and minimum Long-Term Disability benefits paid monthly are:

	Elimination Period (calendar days)	Maximum Benefit	Minimum Benefit
Locals 412 and 1464 66 ² / ₃ %	180 days	\$5,000 per month	The greater of \$50 or 15% of your monthly benefit before any reductions for other income benefits
Local 1613			
Option 1: (50%)	180 days	\$2,000	The greater of \$50 or 15% of your monthly benefit before any reductions for other income benefits
Option 2: (50%)	90 days	\$2,000	
Option 3: (66 ² / ₃ %)	180 days	\$2,667	
Option 4: (66 ² / ₃ %)	90 days	\$2,667	

Long-Term Disability benefits are paid at regular intervals of not less than once per month. Any balance that is due and unpaid at the end of the disability period will be paid at that time.



A Closer Look: The Elimination Period

The elimination period is a period of continuous disability which must be satisfied before you are eligible to receive Long-Term Disability benefits.

The elimination period for Long-Term Disability benefits is 180 days for Locals 412 and 1464. The elimination period for Local 1613 Long-Term Disability is also 180 calendar days unless you choose the 90-day elimination period. During the elimination period, you may be eligible to receive sick leave benefits per your collective bargaining agreement.

Payment of Benefits

Long-Term Disability benefits are paid to you. If you die and have remaining unpaid disability benefits, the claims administrator may pay you:

- Spouse*
- Mother
- Father
- Children
- Brothers or sisters
- Estate executors or administrators

If you or someone to whom your benefits are payable is not validly able to receive them, the claims administrator may make payment to the legal guardian. If the legal guardian makes no request, the claims administrator has the option to make payment to the person or institution with responsibility for custody and support.

The claims administrator also may reduce the amount payable by any overpayment of benefits that is due and outstanding at the time of your death.

*Note: Domestic partners are not eligible to receive these benefits.

Other Income Benefits

Long-Term Disability benefits may be reduced by any other income benefits you are eligible to receive, such as:

- Any amounts received (or assumed to be received*) by you or your dependent under:
 - The Canada and Quebec Pension Plans
 - The Railroad Retirement Act
 - Any local, state, provincial or federal government disability or retirement plan or law payable for injury or sickness provided as a result of employment with KCP&L
 - Any sick leave or salary continuation plan offered by KCP&L
 - Any work loss provision in mandatory “No Fault” automobile insurance
- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because you are entitled to such benefits
- Any retirement plan benefits funded by KCP&L
- Any disability income proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for disability, and contains the same or similar provision for reduction because of other insurance, CIGNA pays for the pro rata share of the total claim.
- Any amounts received (or assumed to be received*) by you or your dependents under any workers’ compensation, occupational disease, unemployment compensation law or similar state or federal law payable for injury or sickness arising out of work with KCP&L—including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because you are entitled to Long-Term Disability benefits.

**CIGNA assumes you and your dependents (if applicable) are receiving other benefits for which you are eligible from other income benefits. CIGNA reduces your disability benefits by the other income benefits estimated as payable to you and your dependents. CIGNA waives this assumption (except for*

disability earnings for work you perform while benefits are payable) if you:

- *Provide satisfactory proof of application for other income benefits*
- *Sign a reimbursement agreement*
- *Provide satisfactory proof that all appeals for other income benefits have been made (unless CIGNA determines that further appeals are not likely to succeed) and*
- *Submit satisfactory proof that other income benefits were denied*



Important Note: Social Security Assistance

The claims administrator may help you in applying for Social Security Disability Income (SSDI) Benefits, and may require you to file an appeal, if a reversal of a prior decision is possible. Your disability benefits may be reduced if you do not cooperate or participate in the SSDI assistance program.

Recovery of Overpayment

The claims administrator has the right to recover any benefits that are overpaid. Some of the ways in which an overpayment may be recovered include:

- Request for a lump sum payment of the overpaid amount
- Reduction of any Long-Term Disability benefits payable
- Use of an available collection process

The minimum benefit amount, as listed on page **G-4**, does not apply if Long-Term Disability benefits are reduced in order to recover any overpayment. If an overpayment is due when you die, any benefits payable will be reduced to recover the overpaid amount.

Physical Examination and Autopsy

The claims administrator has the right to have a physician examine you (as frequently as may be needed) if a claim is pending. Also, if you die, the claims administrator may require an autopsy, unless prohibited by law. In each of these circumstances, the claims administrator is responsible for all physical examination or autopsy expenses.

Return to Work Incentive

During any month in which you have disability earnings, the return to work incentive applies.

During the first 24 months for which Long-Term Disability benefits are payable, the Long-Term Disability benefit amount payable to you under the return to work incentive is calculated as follows:

- Step 1:** Your gross disability benefit and disability earnings are added together
- Step 2:** The sum of Step 1 is compared to your indexed earnings
- Step 3:** If the sum from Step 1 exceeds 100% of your indexed earnings, then the indexed earnings amount is subtracted from the Step 1 amount
- Step 4:** Your gross disability benefit is reduced by the difference from Step 3, as well as by other income benefits and the calculation for optimum ability
- Step 5:** If the sum from Step 1 does not exceed 100% of your indexed earnings, your gross disability benefit is reduced by other income benefits and the calculation for optimum ability

After Long-Term Disability benefits are payable for 24 months, the Long-Term Disability benefit amount payable to you under the return to work incentive is the gross disability benefit reduced by:

- Other income benefits
- The calculation for optimum ability and
- 50% of disability earnings

If the claims administrator determines you are able to work under a modified work arrangement and you refuse to do so without good cause, no disability benefits are paid and your coverage ends.

The "calculation for optimum ability" is the earnings you could earn if working at optimum ability, minus your disability earnings.

If You Become Disabled Again

If you recover from your disability, return to work and then become disabled again, you still are entitled to Long-Term Disability benefits if:

- The disability results from the same or related causes as a prior disability for which benefits were payable
- After receiving disability benefits, you return to work in your regular occupation for less than six consecutive months and
- You earn less than the percentage of indexed earnings that would still qualify you to meet the definition of disability/disabled during at least one month

If you are later disabled for any reason, and you are eligible for coverage under another group disability plan, it is treated as a new elimination period. And, if your current disability is not related to your previous disability, it is treated as a new claim and you must complete another elimination period.

What's not Covered

CIGNA does not pay Long-Term Disability benefits if your disability is caused by any of the following:

- Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane
- War or any act of war, whether declared or undeclared
- Active participation in a riot
- Commission of a felony
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to injury or sickness otherwise covered by the policy

In addition, you are not eligible for Long-Term Disability benefits for disability when you are incarcerated in a penal or corrections institute.

Limitations

Long-Term Disability benefits are limited to a maximum of 24 months for a disability caused or contributed to by any one or more of the following conditions:

- Alcoholism
- Anxiety disorders
- Delusional (paranoid) disorders
- Depressive disorders
- Drug addition or abuse
- Eating disorders
- Mental sickness
- Somatoform disorders (psychosomatic sickness)

If you are confined in a hospital for more than 14 consecutive days before you reach your 24-month lifetime maximum benefit, the period of confinement does not count against your lifetime limit. The confinement must be for the appropriate care of any of the above named conditions.

Pre-existing Condition Limitation

CIGNA does not pay Long-Term Disability benefits for any disability caused by, contributed to or resulting from a pre-existing condition. The pre-existing condition limitation applies to any new or increased benefits (for example, if you are a member of Local 1613 and you increase your Long-Term Disability coverage from 50% to 66 $\frac{2}{3}$ % of covered earnings). This limitation does not apply to a disability that begins at least 12 months after your coverage effective date or the effective date of any added or increased benefits.



A Closer Look: Pre-existing Condition

A pre-existing condition is any sickness or injury for which you incurred expenses, received medical treatment, care or services (including diagnostic measures), or took prescribed drugs or medicines within 3 months before your most recent effective date of Long-Term Disability coverage or increase in coverage.

Rehabilitation During Disability

If the claims administrator determines that you are a suitable candidate for rehabilitation, you may be required to participate in a rehabilitation plan. The claims administrator pays for rehabilitation plan expenses.

During the first 12 months of disability (including your elimination period), you may be required to participate in a rehabilitation plan only for your regular occupation. After 12 months, you may be required to participate in a rehabilitation plan for any occupation based upon your education, training, experience and income at the time you became disabled. You may voluntarily participate in any other plan recommended or approved by the claims administrator. The claims administrator has the right to approve your rehabilitation plan participation and to approve a program as a rehabilitation plan. As needed, the claims administrator will work with you, KCP&L, your physician and others to perform the assessment, develop a rehabilitation plan and discuss return to work opportunities.

If you fail to fully cooperate in all required phases of the rehabilitation plan and assessment without good cause, no disability benefits are paid and Long-Term Disability coverage will end.

Conversion Privileges

If your Long-Term Disability coverage ends because you are no longer employed by KCP&L, or you are laid off or on an uninsured leave of absence, you may be eligible to convert your coverage to an individual policy.

You must have been eligible for Long-Term Disability coverage and actively at work for at least 12 consecutive months to be eligible for conversion privileges. If you apply for conversion insurance within 31 days after your Long-Term Disability coverage ends, the conversion insurance is effective on the date your Long-Term Disability coverage ends. If you apply after 31 days, you are required to provide satisfactory evidence of good health at your own expense to the claims administrator. Conversion insurance is effective on the date the claims administrator agrees in writing to insure you. You must apply for conversion insurance within 62 days after Long-Term Disability coverage ends.

The conversion plan benefits are those in effect at the time you apply. The premium is based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following conditions apply:

- You are retired or age 70 or older.
- You are not in active service because of disability.
- The policy is canceled for any reason.
- You are no longer in a class of eligible employees, but are still employed by KCP&L.

Survivor Benefit

Your spouse or children may receive a survivor benefit if you die while receiving Long-Term Disability benefits. The survivor benefit equals 100% of the sum of the last full monthly disability benefit payable to you, plus the amount of any disability earnings by which the benefit had been reduced for that month. A single lump sum payment equal to three monthly survivor benefits is payable.

The survivor benefit is paid to your spouse (domestic partners are not eligible to receive this benefit), or if you do not have a spouse, to your surviving children or stepchildren in equal shares. To be eligible to receive survivor benefits, your children or stepchildren must be under age 21 and chiefly dependent upon you for support. If you do not have a spouse or any children, the survivor benefit is paid to your estate. Please see the Plan Participation section of this book for definitions of spouse and children.



How to File a Long-Term Disability Claim

If your disability continues for 180 calendar days (or 90 calendar days if you are a member of Local 1613 and you elect coverage Option 2 or 4), you may be entitled to Long-Term Disability benefits. You need to provide written notice of your claim (or by any other electronic/telephonic means authorized by the claims administrator) to:

CIGNA

CIGNA Group Insurance
Paper Intake Team
12225 Greenville Avenue
Suite 1000
Dallas, TX 75243
800-36CIGNA (800-362-4462)

<http://dmswebintake.group.cigna.com>

The claim must be provided to the claims administrator within 31 days after a covered loss or as soon as reasonably possible in order to prevent a delay in the start of your Long-Term Disability benefits. Your claims notice should include KCP&L's name, the policy number FLK-960145, and your name and address.

Once the claims administrator receives notice of your claim, forms will be sent to you for filing a proof of loss claim. If the claims administrator does not send claim forms within 15 days after receiving notice of your proof of loss, the requirements can be met by submitting written (or electronic/telephonic) proof of your loss. Your written (or electronic/telephonic) proof must be provided to the claims administrator within 90 days after the date of the loss for which a claim is made. If proof is not given within the 90-day period, the claim will not be invalidated or reduced if it is shown that it was given as soon as was reasonably possible. Proof authorized by the claims administrator must be given no more than one year after the 90-day period. If the proof is provided to the claims administrator outside of these time limits, the claim will be denied. These time limits do not apply for lack of legal capacity.

The claims administrator may periodically require that you present written (or electronic/telephonic) proof that your loss continues. This information must be provided to the claims administrator within 30 days of the request.

For information about claims determination timeframes and appeal procedures, please refer to the General Information section of this book.

When Benefits End

Long-Term Disability benefits continue until the earliest of the following dates:

- The date you earn (from any occupation) more than the percentage of indexed earnings applicable at that time
- The date the claims administrator determines you are not disabled
- After a maximum of 24 months if your disability is contributed to or due to one of the conditions listed in the Limitations section on page **G-7**.
- The later of your Social Security Normal Retirement Age or the Maximum Benefit Period (as shown in the table in this section)
- The date you die
- The date you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment
- The date you no longer receive appropriate care
- The date you fail to cooperate with the claims administrator in administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may begin again if you begin to fully cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

Your Age on Date Disability Begins	Your Maximum Benefit Period
Age 62 or under	Your 65th birthday or the date the 42nd monthly benefit is payable, if later
Age 63	The date the 36th monthly benefit is payable
Age 64	The date the 30th monthly benefit is payable
Age 65	The date the 24th monthly benefit is payable
Age 66	The date the 21st monthly benefit is payable
Age 67	The date the 18th monthly benefit is payable
Age 68	The date the 15th monthly benefit is payable
Age 69 or older	The date the 12th monthly benefit is payable

Note: Your normal retirement age is your retirement age under the Social Security Act, where retirement age depends on your year of birth.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information on your rights and protections under ERISA, please refer to the General Information section of this book.



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Pension Plan

The Great Plains Energy Incorporated Joint Trusteed Retirement Plan (the “Pension Plan” or “Plan”) is a defined benefit plan that contributes to your financial security in retirement. The Plan provides a benefit based on your age, years of service and pay.

Important Pension Plan Terms

Certain terms have specific meaning under the Pension Plan. This section explains those terms to help you better understand your benefits.

Actuarial equivalent – For determining Plan benefits, calculations made to produce approximately equal present values among the Plan’s different forms of payment, based on certain interest rate and mortality assumptions as required by the Plan and the Internal Revenue Code

Affiliate – With respect to Great Plains Energy Incorporated:

- Any corporation that is a member of a controlled group of corporations that includes Great Plains Energy Incorporated
- Any trade or business (whether or not incorporated) that is under common control with Great Plains Energy Incorporated and
- Any member of an affiliated service group that includes Great Plains Energy Incorporated

Agreement – The February 6, 2007, Agreement and Plan of Merger among Aquila, Inc., Great Plains Energy Incorporated, Gregory Acquisition Corp., and Black Hills Corporation

Aquila Plan – The Aquila, Inc. Restated Retirement Income Plan, as in effect on the closing date, which was merged into the Great Plains Energy Incorporated Management Pension Plan on December 31, 2008

Base compensation – Your basic salary or wages for services performed for the Company (or the union, if it is your employer). Base compensation is computed on an annual basis by multiplying 2,088 by your hourly rate in effect as of October 1 of each year of service. Base compensation does not include any amounts of additional compensation;

bonuses; premium or overtime pay; contributions by the Company or union to the Plan; or any other fringe benefit. Base compensation includes your pre-tax contributions to the Company’s 401(k) Savings Plan, as well as pre-tax elective contributions to any cafeteria plan offered by the Company.

Board of trustees – The board appointed jointly by the Company and IBEW Locals 412, 1464 and 1613 to administer the Plan. The board of trustees may delegate certain functions at its discretion to external service providers or to internal departments or individual employees of the Company.

Closing date – The closing date of the Agreement, which was July 14, 2008

Combined service – If you were an active employee of Aquila, Inc., IBEW Local 814 or IBEW Local 695 on the day before the closing date of the Agreement, service with Aquila, Inc. (or with IBEW Local 814 or 695) will be combined with service while an employee of the Company (or union, if it is your employer) for purposes of determining whether your benefit under the Plan is vested. There may be other circumstances in which your service under the Aquila Plan will be considered for vesting purposes. Contact the Benefits Department for details.

Company – Great Plains Energy Incorporated or Kansas City Power & Light Company

Early retirement date – The first day of the month after an eligible employee retires from the Company after reaching age 55, but before his or her normal retirement date

Eligible retirement plan – An Individual Retirement Account (IRA), individual retirement annuity or a qualified trust that accepts an eligible rollover distribution. In the case of a distribution to a beneficiary who is not a surviving spouse, this definition is limited to an IRA or individual retirement annuity that is subject to the distribution restrictions and other tax rules that apply to inherited IRAs. Certain 403(b) plans and certain 457(b) plans maintained by governmental employers also are eligible retirement plans.

Employee – Any person employed by the Company who is a union member or an employee of a union

Final average monthly salary – A fraction of your total base compensation, determined as follows:

- If you retire before age 62: One sixtieth (1/60) of your base compensation paid during the five years in which your base compensation was the highest
- If you retire between ages 62 and 64: One forty-eighth (1/48) of your base compensation paid during the four years in which your base compensation was the highest
- If you retire at age 65 or after, or if you are age 57 or older and have at least 30 years of credited service with the Company: One thirty-sixth (1/36) of your base compensation paid during the three years in which your base compensation was the highest

For purposes of determining your final average salary, the years in which your compensation was highest need not be consecutive.

Frozen Aquila benefit – A transferred Aquila employee's accrued benefit under the Aquila Plan, determined as of the day immediately prior to the closing date

Hour of service – Each hour for which you are paid, or are entitled to payment by the Company (or union, if you are employed by the union), including any periods during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), lay-off, jury duty, military duty, leave of absence, or periods for which back pay is awarded. No more than 501 hours of service will be credited for any single continuous period when you perform no duties.

You receive at least 190 hours of service for each calendar month in which a contribution is due to the Plan on your behalf.

Married – One man and one woman joined in a legal union as husband and wife

Normal retirement date – For benefits accrued under the Plan, the first day of the month after your 65th birthday

One-year break in service – You will have a one-year break in service for each Plan Year (October 1 - September 30) after September 30, 1976, in which you have fewer than 500 hours of service for vesting. A one-year break in service generally does not occur if you are absent from work for any of the following reasons:

- Pregnancy
- Birth of a child
- Placement of a child with you for adoption
- Caring for a child immediately after a birth or placement with you for adoption

In this case, you will be credited with the hours of service that otherwise would have been credited if you were not absent. If the board of trustees is not able to make a determination of the hours otherwise credited, eight hours of service per normal workday of absence will be credited, as long as the total number of hours credited is not more than 501. The hours will be treated as hours of service in the Plan Year when the absence begins, if this will prevent you from having a one-year break in service. Otherwise, the hours of service will be credited in the following Plan Year.

Pension benefit – Any benefit payable to an eligible participant under the Plan

Pension starting date – The first day of the month for which a pension benefit is payable under the Plan. The date when benefits actually begin to be paid may be later than the pension starting date

Plan Year – The 12 consecutive months beginning October 1 and ending September 30 of each year

Union or unions – Any or all of Local Union Numbers 412, 1464, and 1613, International Brotherhood of Electrical Workers (AFL-CIO)

Vested – Refers to your right to receive a pension benefit under this Plan

Vested deferred retirement – If your employment with the Company and its affiliates (or the union which is your employer) ends before the first day of the month after your normal retirement date and you are not eligible to receive an early retirement benefit, or you elect to defer commencement of your pension benefit until a later date, you will be eligible to receive a vested deferred retirement benefit if you have five or more years of credited service as of the date of your termination of employment

Year of credited service – For purposes of determining years of credited service for vesting purposes, generally service with an affiliate and your combined service is considered.

However, when determining years of credited service for purposes of calculating your normal retirement benefit, only hours of service for the Company (or the union which is your employer) will count—and then only after you have completed six months of service with the Company or union. For example, if you are hired on January 1st your service which will count toward determining the amount of your pension will only be considered after June 30th (six months after your hire date). Combined service will be recognized for purposes of satisfying this six-month period.

In addition, if you have fewer than five years of credited service and you experience five or more consecutive one-year breaks in service, you may lose credited service accrued before the break.

Your years of credited service are calculated depending on when you performed your service.

For service after October 1, 1972, your years of credited service are determined by calculating your hours of service during the Plan Year. You receive a full year of credited service for each Plan Year in which you have 1,000 or more hours of service, one-half of a year of credited service for each Plan Year in which you have at least 500 but less than 1,000 hours of service, and no year of credited service if you have less than 500 hours of service in a Plan Year.

Special rules may apply for service earned before October 1, 1976. Contact the Benefits Department if you think you may be affected by those rules.

The Plan will not take into account more than 30 years of credited service.

Cost

The Company (or the union if you are an employee of the union) pays the full cost of the Pension Plan.

How the Pension Plan Works

You may have a choice of when to receive your benefit under the Plan, depending on your personal situation.



It's the Law: When Distribution Must Begin

Generally, you must begin to receive your vested benefit from the Plan as of April 1 of the calendar year after the year you reach age 70½. For more information, see the Minimum Distribution Requirements section on page **H-11**.

Normal Retirement

Payment of your benefit will begin on your normal retirement date (provided you have properly applied for your benefit), unless you remain employed by the Company or any of its affiliates (or the union which is your employer) after that date. If you continue your employment after your normal retirement date, you will continue to be eligible to accrue additional years of credited service under the Plan (up to a maximum of 30 total years of credited service), and payment of your normal retirement benefit will begin on the first day of the month immediately after the date your retirement begins (provided you have properly applied for your benefit).

Early Retirement

A “subsidized” early retirement benefit means that, even after the reduction in your benefit amount for early retirement, the present value of the benefit you receive is higher than the actuarial equivalent of your normal retirement benefit.

You are eligible for a subsidized early retirement benefit if:

- You are an employee of the Company or union on the last day of the month before your early retirement date and
- You are at least age 55, but you have not reached age 65

Payment of your early retirement benefit will begin on your early retirement date (provided you have properly applied

for your benefit). Your early retirement date is the first day of the month after the date you retire under the Plan, on or after your 55th birthday but before your normal retirement date. For example, if you retire at age 58 on October 12, 2009, your early retirement date is November 1, 2009.

Early retirement benefits are calculated using the same formula as normal retirement benefits. However, if you elect early retirement and start receiving payments before age 62, your monthly benefit will be reduced. That’s because when benefits start early, they are expected to be paid over a longer period of time than benefits beginning at age 62. There is no reduction to your early retirement benefit if you begin receiving it at age 62 or later.

If you elect to retire on or after the first day of the month after your 55th birthday, but before the first day of the month after your 62nd birthday, your early retirement benefit will be reduced by 3% per year, or one-quarter of 1% per month for each month your retirement date precedes the first day of the month after your 62nd birthday.

In addition, you may be eligible for an unreduced early retirement benefit as early as age 57 if you have at least 30 years of credited service.



A Closer Look: Examples of Early Retirement

Let’s say you are age 59 and you have earned a normal retirement benefit of \$2,200 per month, based on 20 years of credited service. You decide to retire and elect an early retirement benefit payable beginning on the first day of the month after you reach age 59. This is 36 months before your 62nd birthday, so your normal retirement benefit is reduced by 9% (one-quarter of 1% per month times 36 months = 9%), or \$198. Your early retirement benefit, paid in the form of a single life pension, is \$2,002 a month ($\$2,200 - \$198 = \$2,002$).

If you had retired at age 62, your normal retirement benefit would not have been reduced on account of your age, even though you would not have reached your normal retirement date at the time you retired.

Vested Deferred Retirement— Termination Benefit

You are eligible for a vested deferred retirement benefit if:

- Your employment with the Company and its affiliates (or the union which is your employer) terminates before you reach age 55 and
- You have five or more years of credited service as of the date of your termination.

Vested deferred retirement benefits are calculated using the same formula as normal or early retirement benefits, whichever is applicable.

Payment of a vested deferred retirement benefit can start on your normal retirement date without being reduced. You also may request that your vested deferred retirement benefit begin earlier.

If you begin your vested deferred retirement before age 62 but on or after your early retirement date, your benefit amount will be reduced as described in the “Early Retirement” section on page **H-4**.

Termination Benefit

If you are eligible for a vested deferred retirement benefit you may receive some, and in some cases all, of your benefit immediately upon termination of your employment. If you so elect with the consent of your spouse, the benefit payable to you immediately may be paid in a lump sum or as a monthly benefit. If you elect the benefit to be paid in the form of a monthly pension, such amount will be reduced actuarially to reflect early commencement of your benefit. See page **H-10** for information about the lump sum option.

Qualified Preretirement Survivor Annuity

If you die after you are vested, but before benefits begin, the Plan may provide a monthly annuity benefit to your surviving spouse.

Payments

The payments to a surviving spouse depend, in part, on when you die. If you die after reaching age 55, payments are generally equal to the amounts that would have been payable as the survivor’s portion of a 50% joint and survivor annuity, that is, 50% of the amount that would have been payable during your lifetime (or its actuarial equivalent) if you had retired with an immediate qualified joint pension benefit on the day before your death. Depending on your age and employment status at the time of your death, benefits would be calculated as described in the Early Retirement, Normal Retirement or Vested Deferred Retirement section (as applicable) on pages **H-4 and H-5**. If you die after reaching age 55, payment of the qualified preretirement survivor annuity will begin on the first day of the month after your death (although actual benefit distribution may begin at a later date), or as of the first day of any later month.

If you die before age 55, your spouse will receive a benefit calculated as if you had not died, but had instead left employment on the day you died, then lived until age 55, retired with a qualified joint pension, and died the next day. Payments to your spouse in this case will be delayed until you would have been eligible for Early Retirement, and will not be as large as they would have been had you been working during the period between your death and the date you would have been eligible for Early Retirement.

There is a supplemental survivor’s annuity for the surviving spouses of certain employees who died before August 23, 1984. If you are such a surviving spouse, please contact the Benefits Department to find out if you are eligible.

Payment of a qualified preretirement survivor annuity will continue until your surviving spouse dies.

If the lump sum actuarial equivalent of your spouse’s benefit is \$5,000 or less, then your spouse will be eligible to receive an immediate lump sum payment. Otherwise, the benefit is paid as a monthly amount for the life of your spouse. For more information about the immediate lump sum payment, please see Automatic Rollovers on page **H-11**.

Death Benefit

If you die with at least five years of credited service and while still employed by the Company, its affiliates or the union, your beneficiaries may be entitled to elect a special lump sum death benefit.

Generally, the amount of this special lump sum death benefit is equal to three-quarters (3/4) of your benefit under the Plan. However, special rules apply under a group annuity contract issued by Manufacturers Life Insurance Company (Group Contract No. GA 6700) with respect to service before October 1, 1989. If you were a participant in the Plan prior to October 1, 1989, please contact the Benefits Department for additional information on the amount of the death benefit.

If you are married when you die, your surviving spouse will be your beneficiary for purposes of this death benefit. In that case, your spouse will receive the Qualified Preretirement Survivor Annuity in lieu of this death benefit unless he or she elects to receive the death benefit instead. If your surviving spouse elects the death benefit, the Qualified Preretirement Survivor Annuity will be reduced to reflect his or her receipt of the death benefit.

If you are not married when you die, your beneficiary for purposes of the death benefit will be the person or persons you designate in writing on a form approved by the board of trustees.

Note that if you die after your pension payments begin, the form in which you elected to have your pension paid will determine the death benefit, if any, paid to your beneficiaries.

Vesting

To receive a benefit under the Plan, you must be vested. You are vested after the earlier of the date you complete five or more years of credited service or when you reach age 55. If your employment ends before you are vested, you will not be eligible to receive a benefit under the Plan. If you have five or more consecutive one-year breaks in service before you are fully vested, some or all of your vesting credit earned before the break may be lost.


How Your Benefit Is Calculated

The Plan provides a retirement benefit based on your age, years of credited service and final average monthly salary. The maximum normal retirement benefit you can receive is equal to 50% of your final average monthly salary.

The formula for your monthly single life retirement benefit is:

<p>1²/₃% of Your Final Average Monthly Salary (measured over 3, 4 or 5 years, depending on your age at retirement or if you qualify for the age 57/30 year pension)</p>	X	<p>Your Years of Credited Service (up to a maximum of 30 years)</p>
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You may begin receiving your retirement benefit before your normal retirement age subject to applicable retirement adjustments discussed in the “Early Retirement” section on page **H-4**.



Important Note:
Frozen Aquila benefit
If you are eligible to receive benefits accrued under the Aquila Plan, such benefits will be paid from the Great Plains Energy Incorporated Management Pension Plan.

GPE Retirement Planning Tool (RPT)

The GPE RPT Web site will help shed some light on your retirement options to help you reach your financial goals. This modeling tool will help you jump-start your planning, review what you already have, and weigh options for possible changes.

Access the tool 24 hours a day, seven days a week, from any computer to:

- Find retirement forms.
- Estimate your future benefits under the Plan (including any frozen Aquila benefit) and 401(k) Plan.
- Evaluate different payment scenarios (i.e., lump sum, lifetime annuity, survivor annuity, etc.).
- Evaluate various possible retirement dates.
- Determine if you’re on the right track with your savings.
- Get answers to commonly asked questions.
- Access a directory and utilize links to other resources.

Go to **www.my-retirementplan.com/gpe** and complete the easy registration process for first-time users:

1. Use your eight-digit login number: 0 + your seven-digit employee number (e.g., 03456789).
2. Enter the last four digits of your Social Security number.
3. Enter your two-digit month and two-digit year of birth (e.g., June 1959 = 0659).
4. When prompted, create a new password, as well as security questions/responses using the guidelines provided.

Once you have successfully registered your account, you will be redirected to the main page to log on. If you have trouble accessing the Web site, contact the HR Service Center 816-276-5555, or via e-mail at **hrrservicecenter@kcpl.com**.

Final Average Monthly Salary

Your final average monthly salary is determined as follows.

If you retire:	Then your final average monthly salary is determined by:
Before reaching age 62	The 5 years* your base compensation was highest
On or after reaching age 62 but before reaching age 65	The 4 years* your base compensation was highest
On or after reaching age 65	The 3 years* your base compensation was highest
At age 57 with 30 or more years of credited service	The 3 years* your base compensation was highest

* For purposes of determining your final average salary, the years in which your compensation was highest need not be consecutive.

Credited Service

If your employment terminates before you are vested, you will forfeit all your rights to benefits under the Plan if you never return to work for the Company, any of its affiliates or the union. If you do return, whether you lose the benefits you had accrued when you left will depend upon whether the number of your consecutive one-year breaks in service equals or exceeds five.

Transfers and Reassignments

If you leave the collective bargaining units or one of the unions and become employed by the Company (or an affiliate) in a management position, some special rules apply. If at the time you leave the collective bargaining units you have a benefit under the Plan which is not yet vested, your service in a management position will count under this Plan for purposes of vesting.

However, your management service will not count under this Plan for purposes of increasing your benefits under this Plan. In other words, your benefit under this Plan will be based only on your years of credited service and your final average monthly salary as of the date you left the collective bargaining units or the union which was your employer.

If you have accrued benefits under both the Great Plains Energy Incorporated Management Pension Plan and the Great Plains Energy Incorporated Joint Trusteed Retirement Plan, you will make separate elections for the benefits under each plan and will receive separate payments.

How Your Benefit Is Paid

The Plan offers you a variety of payment options. When you retire, you may select the one that best fits your personal financial situation.

For purposes of this section, your spouse is a person of the opposite sex who is your husband or wife on the first day of the month in which you are eligible to receive your pension benefits, even though benefits may not be paid until a later date.

Normal Forms of Payment

Your normal form of payment depends on your marital status on the date your payments begin.

Payment Form	Highlights
Single Life Pension	<ul style="list-style-type: none"> • If you are unmarried, your pension benefit will be paid as a single life pension, unless you elect an optional form of payment. • You will receive a monthly benefit for your lifetime. • Your payments will end on the first day of the month in which you die.
Qualified Joint Pension	<ul style="list-style-type: none"> • If you are married, your pension benefit will be paid as a qualified joint pension, unless you elect an optional form of payment with the written consent of your spouse. • You will receive a monthly benefit for your lifetime, and after your death, your spouse will receive a monthly benefit equal to 50% of your benefit for the rest of his or her life. If you retire and survive your spouse, no change will be made to your pension after the death of your spouse. • Payments will end on the first day of the month in which the last of you or your spouse dies. • The qualified joint pension will be the actuarial equivalent of the single life pension otherwise payable to you.



Important Note: Waiver of the Qualified Joint Pension

If you are married and elect a form of payment other than the qualified joint pension, your spouse must consent during the election period in writing on a form authorized by the Board of Trustees and witnessed by a notary public or a Plan representative.

Optional Forms of Payment

You may elect one of these optional forms of payment instead of the single life pension or the qualified joint pension by filing a written application with the board of trustees or their designee:

- 60-month or 120-month Life and Term-Certain Annuity
- 25%, 33 $\frac{1}{3}$ %, 66 $\frac{2}{3}$ %, 75% or 100% Joint and Survivor Annuity
- Level Income Option
- Lump-Sum Payment

For details about these options, see the chart on page **H-10**.

If you are married, you must include your spouse's written consent to your election and acknowledgement of its effect. Your spouse's consent must be in writing, using a form authorized by the board of trustees, and witnessed by a notary public or a Plan representative. With your spouse's consent, you may also designate a contingent beneficiary other than your spouse.

The total of the retirement benefits expected to be paid to you and your beneficiary under any of these optional forms will be the actuarial equivalent of the single life pension otherwise payable to you.

Optional Forms of Payment

Payment Option	Highlights
Life and Term-Certain Annuity	The Life and Term-Certain Annuity provides a retirement benefit payable for your life, with a minimum of 60 or 120 monthly payments guaranteed. Any guaranteed payments which remain payable after your death will be paid to your contingent beneficiary for the balance of such period.
Joint and Survivor Annuity	The Joint and Survivor Annuity provides a retirement benefit payable for life. You will receive a monthly benefit for as long as you live. If your contingent beneficiary is living when you die, he or she will receive payments of 25%, 33 $\frac{1}{3}$ %, 66 $\frac{2}{3}$ %, 75%, or 100% of your benefit amount for as long as he or she lives.
Level Income Option	If you begin receiving an early retirement benefit before becoming eligible for an Old-Age Insurance Benefit under the Social Security Act, you may request the level income option. This option adjusts the amount of your early retirement benefit so that an increased amount will be paid from the Plan before you become eligible for an Old-Age Insurance Benefit and a reduced amount after you become eligible. This adjustment allows you to receive, from this Plan and under the Social Security Act, an approximately level retirement income.
Lump-Sum Payment	<p>The amount of a lump sum payment will depend on a number of factors, including your age and the Plan's mortality and interest rate assumptions. Interest rate and mortality assumptions are generally determined by federal law. A special rule applies under the Plan, however, for participants who terminate employment on or after October 1, 2008.</p> <p>If you terminate employment between October 1, 2008, and September 30, 2010, you will receive an amount that is the greater of:</p> <ul style="list-style-type: none"> • The lump sum calculated using the mortality table in effect prior to October 1, 2008, and the interest rate on 30-year Treasury securities in effect for the month of July immediately preceding the Plan Year in which the lump sum is paid (referred to as the "GATT factors") or • The lump sum calculated using the interest rate required by Section 417(e)(3) of the Internal Revenue Code, as published by the IRS for the month of July immediately preceding the Plan Year in which the lump sum is paid, and the "applicable mortality table" determined as of the first day of the Plan Year in which the lump sum is paid (referred to as the "PPA factors"). <p>If you terminate on or after October 1, 2010, the calculation will change. From that point on, participants who elect a lump sum will receive an amount that is the greater of:</p> <ul style="list-style-type: none"> • The lump sum that is based on your years of credited service and final average monthly salary as of September 30, 2010, calculated using the GATT factors or • The lump sum that is based on all of your years of credited service and final average monthly salary under the Plan at your pension starting date, calculated using the PPA factors <p>Note that in computing the value of a lump sum, the value of the special subsidy that applies to annuity payments made to those who qualify for the age 57 with 30 years of service benefit is taken into account, as is the rule that three years of compensation is averaged for such participants.</p> <p>If your employment terminates after you reach age 65, you may elect, in addition to other options that apply, to receive either a full or a partial lump sum distribution. A partial lump sum will represent about three quarters ($\frac{3}{4}$) of the value of your normal retirement benefit. The portion of your benefit that you receive as a series of annuity payments will be reduced to reflect your receipt of a portion of your benefit in a lump sum.</p> <p>These lump sum options do not apply to any annuity contracts purchased by the Plan prior to September 30, 1989, from the Metropolitan Life Insurance Company. Any benefits payable to you under those contracts will reduce the amount of the otherwise applicable lump sum.</p> <p>If you were a participant in the Plan prior to October 1, 1989, the amount of your lump sum will be based partly on the lump sum formula contained in an annuity contract issued by the Manufacturers Life Insurance Company (Group Contract No. GA6700). You will be furnished with additional information about the lump sum options available to you at the time you retire.</p>

You may elect, change or revoke your payment option by filing a new election in writing with the board of trustees or its designee before your benefits begin. You cannot elect, change or revoke your payment option or your choice of beneficiary after your benefit payments begin. If your contingent beneficiary is your spouse and you die after electing your benefit but before your retirement, your spouse will receive the greater of the preretirement survivor annuity or the survivor benefit you elected. Otherwise, your election will be voided if you or your contingent beneficiary dies before your retirement. Additionally, a divorced spouse will not be entitled to benefits under the Plan, except in cases of qualified domestic relations orders or if you designate your divorced spouse as your contingent beneficiary after the divorce. See page **H-14** for more information about qualified domestic relations orders.

If you terminate your employment with the Company (or the union, if it is your employer) and the actuarial equivalent of your vested benefit is \$5,000 or less, you will receive an immediate lump sum distribution. For more information, please see Automatic Distributions and Rollovers on page **H-11**.

Direct Rollovers

If you elect a lump sum form of payment you have the option to have any portion of it paid directly to an eligible retirement plan. You also have this option if you terminate your employment and receive a lump sum cash distribution because the actuarial equivalent of your vested benefit is \$5,000 or less. This is called a “direct rollover” of an “eligible rollover distribution.” An eligible rollover distribution is all or a portion of the balance of your benefit except for:

- Any distribution that is one in a series of payments made for your life (or life expectancy) and/or your beneficiary’s life or for a period of 10 years or more
- Any distribution required on account of you reaching age 70½ and
- The portion of any distribution that is not included in gross income

An eligible rollover distribution includes a lump sum death benefit payment made on behalf of a beneficiary who is not your spouse to an inherited IRA. Contact the HR Service Center for more information about the distribution restrictions and other tax rules applicable to “inherited IRAs.”

For example, if you receive payment of your benefits in a lump sum, you can direct the Plan to transfer those benefits to another qualified retirement plan (such as an IRA or another pension plan), if the plan allows for these types of transfers. If you do not direct the Plan to make a direct rollover of your lump sum benefit, the benefit will be paid directly to you and the Plan will be required by federal law to withhold a portion of the distribution for taxes.

Automatic Distributions and Rollovers

The Plan pays a mandatory distribution in the form of a lump sum payment or direct rollover when your benefit is less than \$5,001. If your benefit is \$1,000 or less, it will be paid as a lump sum unless you or another person eligible to receive the distribution elects to have it rolled in to an IRA. If your benefit is over \$1,000 but less than \$5,001, the Plan pays the distribution as a direct rollover to an individual retirement account at an institution selected by the board of trustees, unless you or another person eligible to receive the distribution elect to have the distribution paid to an eligible retirement plan or to receive it directly in cash.

The IRA custodian selected by the board of trustees to receive such an automatic rollover is Commerce Bank. The distribution will be invested in an investment product designed to preserve principal and to provide a reasonable rate of return and liquidity. Fees and expenses associated with the IRA will be your responsibility and will be allocated against your IRA account balance. These fees and expenses will be comparable to those the custodian charges for other IRAs.

Minimum Distribution Requirements

You must begin to receive your vested benefit as of April 1 of the calendar year after the year you reach age 70½. This is true even if you continue to work for the Company, one of its affiliates or the union after you reach age 70½. Under these circumstances, you will be entitled to any additional benefits you accrue due to your continued employment. Your pension payment will be increased by the amount of any additional accrued benefits.

Reemployment After You Begin Receiving Your Benefit Payments

If you retire and are later reemployed, you may begin to earn additional benefits under the Plan. If you had begun to receive pension benefits under the Plan prior to your normal retirement date and are later reemployed, the benefits you earn during your period of reemployment may be paid in a different form from the benefits you earned during your first period of employment. On the other hand, if you begin to receive pension benefits under the Plan on or after your normal retirement date, the benefits you earned during any later period of reemployment will automatically be paid in the same form in which you were receiving your benefits at the time you returned to work. In these circumstances, you will not be permitted to change your election and receive the benefits you earned during your period of reemployment in a form different from the form in which you were receiving your benefits at the time you returned to work.

Applying for Your Pension

To begin receiving your pension benefit, you must file a claim on the form provided by the Human Resources Department. The board of trustees conducts periodic reviews to verify that claim decisions have been made according to the Plan Document and that the Plan's provisions have been applied consistently across similar claims.

Filing a Pension Claim

You may obtain a claim form from the HR Service Center or from the Retirement Planning Tool site at www.my-retirementplan.com/gpe. Once you have completed the form, return it to:

KCP&L

Benefits Department

P.O. Box 418679

Kansas City, MO 64141-9679

Telephone: 816-276-2323

For information about claims determination timeframes and appeal procedures, please refer to the General Information section of this book.

Limitations on Benefits

The Plan contains provisions that are required under federal tax laws and which set an upper limit on the amount of the benefit that may be earned by any one participant, as well as a limit on the amount of a participant's base compensation that may be taken into account in determining the benefits provided under the Plan. These limits are adjusted from time to time by the Internal Revenue Service and the U.S. Treasury Department to reflect changes in the cost of living. If a participant's benefit accrued under the Plan would otherwise exceed these limits, the benefit will be reduced to the extent necessary to ensure that the Plan complies with these limits. You will be notified if your benefit is subject to either of the limits. If you are concerned about this issue, you should refer to the Plan document for a detailed explanation of these rules.

Pension Benefit Guaranty Corporation

Your benefits under the Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the Plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under the Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits
- Disability benefits if you become disabled before the Plan terminates
- Certain benefits for your survivors

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates
- Some or all of the benefit increases and new benefits based on Plan provisions that have been in place for fewer than five years at the time the Plan terminates
- Benefits that are not vested because you have not worked long enough for the Company or union
- Benefits for which you have not met all of the requirements at the time the Plan terminates
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in a monthly early retirement benefit greater than your monthly benefit at the Plan's normal retirement age
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay

Even if certain benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, contact the Plan Administrator or the PBGC. Inquiries to the PBGC should be addressed to:

PBGC

Technical Assistance Division
1200 K Street NW, Suite 930
Washington, DC 20005-4026

The PBGC also can be reached by calling 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll free at 800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's Web site at www.pbgc.gov.



Important Note: Insurance for Plan Benefits

Your benefits under this Plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if the Plan terminates. Because the PBGC insures only pension plans, none of KCP&L's other benefit programs are insured by the PBGC.

Assignment of Benefits

Your benefit under the Plan cannot be assigned or transferred by you or your beneficiary to anyone else. In addition, your benefit cannot be subject to attachment, garnishment or other legal process, except through a qualified domestic relations order. No attempted assignment or transfer of any Plan benefit will be recognized.

Qualified Domestic Relations Orders (QDROs)

Under certain circumstances, a court may award all or part of your benefit under the Plan to a present or former spouse, child, or other dependent through a Qualified Domestic Relations Order (QDRO). For more information about QDROs, see the General Information section of this book.

Military Leave

The federal law known as the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA) provides certain rights if you are absent from work on account of “qualified military service” and then timely return to employment. Upon your reemployment after a period of qualified military service, the Plan will credit you with 40 hours of service for each complete week of qualified military service and eight hours of service for each day in any partial week of such service, up to a maximum of five years of credited service. Hours of service credited under this rule are offset by any hours of service credit to which you are otherwise entitled for the same week or day. If you received a distribution of all or part of your accrued benefit in connection with your qualified military service before you become reemployed, you may repay the withdrawn amount when you become reemployed.

For more information on your rights and benefits under USERRA, contact the HR Service Center at 816-276-5555.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information about your rights and protections under ERISA, please refer to the General Information section of this book.

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401(k) Savings Plan

The Great Plains Energy Incorporated 401(k) Savings Plan ("the Plan") is a defined contribution plan that consists of elective contributions and Company matching contributions. It is designed to help you save and invest for retirement by allowing you to make pre-tax contributions to the Plan. The Company matches your contributions to the Plan, up to a certain percentage of your compensation.

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of the securities offered under the Plan or determined if this document, or any other materials that serve as portions of the prospectus, is truthful or complete. Any representation to the contrary is a criminal offense.

Note: References to "spouse" and "dependent" throughout this 401(k) Savings Plan section of the book do not include domestic partners.

Important 401(k) Savings Plan Terms

There are certain terms that have specific meaning under the Plan. This section explains those terms to help you better understand your benefits.

Account balance – Your total Plan account balance, including your elective contributions, Company matching contributions, investment earnings, rollovers and any transferred amounts from another plan

Beneficiary – The person or persons you select to receive payment of your account balance in the event of your death

Company – Great Plains Energy Incorporated or Kansas City Power & Light Company

Company match – Contributions the Company makes to the Plan based on the amount of elective contributions you contribute during a Plan Year

Compensation – Your straight-time pay and shift differential pay (if applicable) while a participant. In addition, overtime pay equal to two and one-half times straight-time pay will be included in the compensation of a Local 1464 member during any pay period he or she works overtime sufficient to earn an unpaid earned rest period. Compensation does not include overtime (other than as described for Local 1464 members), bonuses, commissions or other payments made under another Company benefit plan.

Highly compensated employee – An employee who performs service for the Company during a year and who receives compensation during the preceding year that is greater than the applicable IRS limit or who was a 5% owner during the preceding year or the current year. The IRS limit is available on the Internet at www.irs.gov or by calling JPMorgan Retirement Plan Services at 800-345-2345.

Hour of service – Each hour for which you are paid or entitled to payment from the Company for the performance of duties. It also includes the period of time in which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. No more than 501 hours of service will be credited for any period in which you perform no duties.

Investment earnings – Income earned on your account balance in the Plan

Lump sum – One single payment consisting of your entire account balance

Married – One man and one woman joined in a legal union as husband and wife

One-year break in service – You will have a one-year break in service for each Plan Year (January 1 – December 31) after September 30, 1976, in which you have fewer than 500 hours of service. A one-year break in service generally does not occur if you are absent from work for any of the following reasons:

- Pregnancy
- Birth of a child
- Placement of a child with you for adoption
- Caring for a child immediately after a birth or placement with you for adoption

In this case, you will be credited with the hours of service that otherwise would have been credited if you were not absent. If the Plan Administrator is not able to make a determination of the hours otherwise credited, eight hours of service per normal workday of absence will be credited, as long as the total number of hours credited is not more than 501. The hours will be treated as hours of service in the Plan Year when the absence begins, if this will prevent you from having a one-year break in service. Otherwise, the hours of service will be credited in the following Plan Year.

Participant – Any employee who is eligible to participate in the Plan or a former employee, alternate payee or beneficiary who is entitled to receive benefits from the Plan

Payroll period – The time period in which your salary is earned and you are paid by the Company

Permanent and total disability – A physical or mental incapacity that prevents you from performing one or more of the essential duties of your occupation as determined by the Company's long-term disability insurer

Plan Year – The calendar year (January 1 – December 31)

Pre-tax – Contributions you make to the Plan before taxes are withheld from your paycheck.

Retirement date – The date you elect to retire on or after your 65th birthday

Rollover – An amount transferred to this Plan from an Individual Retirement Account (IRA), a previous employers' retirement savings plan, a 403(b) plan or a 457(b) plan which you may "roll over" into your Plan account without any federal income tax liability. You (or your beneficiary) also may be able to roll over your account balance under this Plan into another tax-qualified arrangement if your employment with the Company ends for any reason.

Tax-deferred – The money in your Plan account is not taxed until you receive a distribution from the Plan.

Trust – The Trust established to hold assets of the Plan for the exclusive benefit of Plan participants.

Trustee – An entity that administers the Trust and handles contributions, plan investments and distributions to and from the Plan. The Trustee for the Plan is JPMorgan Chase Bank N.A.

Vesting – Refers to your right to receive Company matching contributions allocated to your account balance when you receive a distribution

Year of service – A Plan Year during which you complete at least 1,000 hours of service

How to Enroll

You may enroll or make participation changes at any time following your date of hire at the JPMorgan Retirement Plan Services Web site at <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345.

If you are eligible to participate in the Plan and have not made an affirmative election to participate or not to participate in the Plan, the Company will automatically enroll you 30 days after the later of your hire date or the date you receive an automatic enrollment notice from JPMorgan Retirement Plan Services. You will be enrolled at an employee contribution rate of 6% of your annual compensation. You may choose not to participate or change your election to contribute less or more of your annual compensation at any time. In addition, if you are automatically enrolled in the Plan, you may withdraw your contributions within the first 90 days after your automatic enrollment. Any Company matching contributions made during this period will be forfeited.

Naming Your Beneficiary

A beneficiary is someone you choose to receive your account balance if you die. If you are married and name someone other than your spouse as beneficiary, your spouse must consent by signing a notarized statement waiving his or her right to your account balance.



For More Information: Who Is a Spouse?

Please see page **A-3** for a definition of spouse.

If you die and you did not designate a beneficiary, or if your designated beneficiary does not survive you, your account balance will be paid to the first of the following survivors:

- Spouse
- Descendants, per stirpes
- Parents
- Brothers and sisters
- Estate

You can change your beneficiary at any time. In fact, it is a good idea to update this information on a regular basis, especially if you have married, divorced or had children since you last designated your beneficiaries. A form to change your beneficiary is available on the All About page through the KCP&L intranet.

Why It Is Important to Contribute to the Plan

1. **Company match** – For every one dollar you contribute to the Plan—up to the first 6% of compensation—the Company contributes an additional 50 cents after you have completed one year of employment.
2. **Reduction in current taxes** – Pre-tax contributions to the Plan reduce your current federal income taxes; you defer taxes until you receive the money.
3. **Saving is easy** – Through convenient payroll deductions, you can defer a portion of your compensation in the Plan (up to IRS limits and Plan limits).
4. **Contributions grow tax-deferred** – Investment earnings (or losses) on your contributions and the Company match are tax-deferred while they remain in your account.
5. **Flexible investment options** – You have a choice of investment options to invest your contributions and the Company match.
6. **Portability** – When you terminate employment with the Company, you can roll over your account balance to an Individual Retirement Account (IRA) or another qualified employer-sponsored retirement plan (if the IRA or other plan accepts rollovers).
7. **Account access** – Even though the Plan encourages long-term saving for retirement, loans and hardship distributions are available.

How the Plan Works

Under federal law, your Plan contributions are required to be held in a Trust for safekeeping. The Company match is also held in a Trust. You choose how to invest your contributions, including any rollover contributions, and the Company match among a variety of investment options.

Employee Contributions—Salary Deferrals

You may contribute, on a pre-tax basis, from 2% to 40% in whole percentages of your compensation to the Plan—up to the annual IRS maximum limit. This limit is available on the Internet at www.irs.gov or by calling JPMorgan Retirement Plan Services at 800-345-2345 (see page **I-6** for the limits effective for 2009). Your contributions are fully vested when they are made. In other words, 100% of the contributions you make to the Plan are always yours.

You make contributions to the Plan that are deducted from your pay check before taxes are withheld. You pay no federal, or, in most cases, state and local income taxes, on your contributions, which lowers your current taxable income. You will, however, have to pay tax on these contributions (and any investment earnings on these contributions) when you receive a distribution from the Plan. Be sure to check state and local tax laws to determine the impact on your taxes, or consult with a tax advisor.

To begin contributing to the Plan or change your contribution percentage or fund elections, log on to <https://www.retireonline.com> or call JPMorgan Retirement Plan Services at 800-345-2345. Your change will be effective as soon as administratively possible, which is generally one to two pay periods. You may change your contribution percentage as often as you like.

Flex Dollars (Local 1613 Only)

If you have Flex Dollars left after funding your other KCP&L benefits elections, your elected contributions to the Plan will be partially or fully offset by your remaining Flex Dollars. See the Plan Participation section of this book for more information about Flex Dollars.



It's the Law: Catch-up Contributions

If you are age 50 or older anytime during the calendar year and you make the maximum contribution to the Plan, you also may make a pre-tax "catch-up" contribution (up to IRS limits). The maximum catch-up contribution you may make in 2009 is \$5,500. (However, keep in mind that your total contribution including catch-up contributions are limited to 40% of your compensation.) This amount may increase periodically for cost-of-living adjustments. Note that catch-up contributions are not matched by the Company. If you would like to make a catch-up contribution, log onto <https://www.retireonline.com> or call 800-345-2345 and increase your contribution percentage from your paycheck. The system will automatically stop deductions when you reach the maximum. The maximum contribution to the Plan and the catch-up contribution limit are available on the Internet at www.irs.gov or by calling a JPMorgan Retirement Plan Services Representative at 800-345-2345.

Company Matching Contributions

The Company provides a contribution to your account that is in addition to your contribution. For every dollar you contribute to the Plan, up to 6% of your compensation, the Company contributes an additional 50 cents beginning with the first payroll period after your first anniversary of employment with the Company.

The Company match is made to your account each payroll period in which you make an employee contribution and are eligible to receive the Company match.

Example

If you contribute 6% of your compensation—the amount needed to receive the full Company match—the total contributions for one year would be as follows, depending on your compensation. For purposes of this example, three compensation levels have been assumed.

Your Compensation	Your 6% Pre-Tax Contribution	50% Company Match	Total Contributions
\$50,000	\$3,000	\$1,500	\$4,500
\$75,000	\$4,500	\$2,250	\$6,750
\$100,000	\$6,000	\$3,000	\$9,000

If you contribute at least 6% of your compensation during the Plan Year but less than 6% in one or more payroll periods during the year, the Company will contribute an additional amount following the end of the Plan Year that is equal to the difference between the match on 6% of your compensation and the amount of Company match you received during the year.



JPMorgan's retireonline.com Web site

You have 24-hour access to your retirement plan account at <https://www.retireonline.com> where you can:

- Enroll.
- Review plan information.
- Check your account balance.
- Change your investment choices.
- Increase your contributions.
- Access a wealth of investor education and interactive planning tools.
- View and print your quarterly and on-demand statements.

When accessing the Web site for the first time, enter your Social Security number as your Username. When you first log on, your temporary Password is the last four digits of your Social Security number and the MM/DD/YY of your date of birth.

Example: For someone with a Social Security number of 000-00-1234 and a birth date of November 1, 1975, the Username would be 000001234 and the temporary password would be 1234110175.

Once you have accessed your account, you will be prompted to create your own personalized Username and Password. A Username and Password that you create will be easier to remember. After you create your own Username, you will no longer need to use your Social Security number to log on to www.retireonline.com.

If you have trouble accessing the Web site, contact JPMorgan at 800-345-2345.

Because of this Plan's tax advantages, your contributions are subject to the following limits:

- You may contribute no more than the IRS maximum on a pre-tax basis to this Plan (combined with your contributions to any other tax-qualified 401(k) savings plan). The limits for 2009 are \$16,500 if you are under age 50 and \$22,000 if you will be age 50 or older in 2009. These limits may change at the beginning of each calendar year. The IRS publishes the limits at www.irs.gov or you can contact JPMorgan at 800-345-2345.
- If your contributions from your KCP&L paychecks reach the IRS limit during the calendar year, your contributions will be suspended for the remainder of the year. Your contributions automatically resume on the following January 1, unless you elect otherwise.
- The amount of your compensation that may be used to calculate any contribution is capped at \$245,000 a year, subject to adjustment from time to time by the IRS.
- Your contributions and Company matching contributions may be subject to further limits if you are a highly compensated employee. Contributions made by and on behalf of highly compensated employees may be limited by special non-discrimination rules required by the Internal Revenue Code. These rules are complex, and the way in which contributions may be limited is described in greater detail in the Plan Document. If your contribution is limited by these rules, you will be notified.
- There are IRS limits on the combined maximum amount you and the Company can contribute to your account in a Plan Year (\$49,000 in 2009).

Remember, the IRS limits described above are subject to adjustment from time to time by the U.S. Treasury Department and may change annually. The limits are available on the Internet at www.irs.gov or by calling a JPMorgan Retirement Plan Services Representative at 800-345-2345.



**It's the Law:
Contributions After Military Leave**

If you return to work after a military leave of absence and you elect to make up any contributions you would have made if you had been working for the Company during your leave, the Company will credit you with the corresponding Company matching contributions.

Vesting

Vesting means earning a non-forfeitable right to contributions made to your account. You are always 100% vested in your own contributions and any rollover contributions to the Plan as well as any investment gains on your contributions.

The Company matching contribution is subject to vesting. You become vested in any Company matching contributions and any associated earnings as follows:

Years of Service	Percentage
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6	100%

You automatically become 100% vested in your Company matching contributions upon your retirement date, death or permanent and total disability.

You receive vesting credit for each Plan Year during which you complete one year of service. Years of service completed before you begin participating in the Plan or any period in which you are on a qualified military leave of absence count for vesting purposes.

If you leave the Company before becoming fully vested, you forfeit the Company matching contributions that are not vested. Forfeitures remain in your account until they are applied by the Company to reduce future Company matching contributions for other participants or (effective beginning July 1, 2009) pay the reasonable expenses of administering the plan. If you are rehired before incurring five consecutive one-year breaks in service, the forfeited amount will be restored to your account.

If you receive a distribution of the vested portion of your Company match before you incur five consecutive one-year breaks in service, the non-vested portion of your account will be forfeited in the year you receive the distribution.

If you receive a distribution of your vested account balance and you are later rehired before incurring five consecutive one-year breaks in service, the forfeited portion of your Company matching contributions will be reinstated if you repay the full amount of your distribution before the fifth anniversary of your return to employment.

Assignment of Benefits

Your Plan account, or your rights to a distribution from it, cannot be assigned to anyone, including voluntary and involuntary assignments for the benefit of creditors, garnishments, attachments and similar procedures. This also means you cannot use your Plan account as collateral for a loan, except loans from the Plan itself.

The exception is if the Plan receives a Qualified Domestic Relations Order (QDRO) that entitles a qualified individual (as determined by law) to all or a portion of your account balance. For more information about QDROs, see the General Information section of this SPD.



Important Note: Possible Limitations or Losses to Your Plan Benefit

In certain situations, your Plan benefit may be lost or substantially reduced, including the following situations:

- The investment selections you make and general market conditions create a loss.
- Investment changes or other types of transactions are temporarily suspended (typically, you will be notified before such a suspension).
- The Plan cannot pay your benefit (for example, in the case of a mandatory cash out from your account), because the Company does not have your current address.
- The Plan is required to pay out a portion of your account balance under the terms of a QDRO.
- The Company reduces its contributions or terminates the Plan.

Investment Options and Risks

You may invest your contributions and Company matching contributions in a variety of investment funds offered through JPMorgan Retirement Plan Services. Please note that if you do not make an investment election, your employee contributions will be invested in the American Century LIVESTRONG Fund based on the year closest to the year you will become age 65 and Company matching contributions will be invested in Great Plains Energy common stock. You may elect to diversify all or a portion of these investments into the other investment options available under the Plan at any time.

Investment Risks

Investment results depend on fund or stock performance. Typically, different types of funds have different levels of risk. The amount of risk you are willing to bear is up to you. Before making any investments, you should read all the materials about your investment options through the Plan and consider contacting a financial advisor or accountant who can help you decide which investments might best work with your savings goals. A listing of investment options offered is available in the insert accompanying this book, which is expressly incorporated

and made part of this SPD. Information about the Plan's investment options is also available at <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345.

Please keep in mind that none of the investment funds offered through the Plan is insured by any government agency. Also, the Company does not make any guarantee with respect to the funds—any investment option could incur a loss.

It is important to create a retirement savings strategy, familiarize yourself with the investment funds and then make your investment decisions. Over time, as your personal situation and tolerance for investment risk change, you may wish to choose different funds. You are responsible for your Plan investments—neither the Company nor the Plan Trustee monitors your investment choices or has responsibility for any decisions you make that may result in investment gains or losses.

JPMorgan will provide you with certain information about your investment options, including prospectuses, description of funds and information about any fees that may be charged. The following information about the Plan's investment options is available at <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345:

- A description of the annual operating expenses of each investment fund (such as investment management fees) and the aggregate amount of such expenses expressed as a percentage of average net assets of the investment fund, which may reduce your return in the investment fund
- Copies of any prospectuses, financial statements, fund reports and any other materials relating to the investment funds (to the extent such information is provided to the Plan)
- A list of assets in each investment fund and the value of each asset, as well as the name of the contract issuer, the rate of return on fixed rate investment contracts and the contract's term
- Information concerning the value of shares or units in each investment fund, as well as the past and current investment performance of each investment fund (net of expenses)
- The value of shares or units in investment funds held in your accounts

Changing Investment Funds

You may change your investment fund elections at any time by visiting <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345.

Transferring Account Balances

The Plan allows you to change future investments for your existing account balances. To transfer account balances from one investment fund to another, log on to <https://www.retireonline.com> or call JPMorgan at 800-345-2345. All investment changes must be made in whole percentages.



Important Note: When Changes Are Effective

Except for changes to investments in Company stock, changes to your investment elections made by 3 p.m. Central Time (CT) on any given business day will be in effect the next business day (or the second business day if the transaction involves Company stock). If you call after 3 p.m. CT, your change would not be effective until the second business day (or the third business day if the transaction involves Company stock). For example, if you call at 4 p.m. CT on Wednesday, your non-Company stock changes will process overnight on Thursday and will be in effect as of Friday morning.

Accessing Your Account

The Plan is designed to help you save money for your retirement, but the Plan provides a loan feature which allows you to borrow money from your account before your retirement under special circumstances. You should consult with a tax advisor before obtaining a loan from the Plan.

Loans

Payments of both principal and interest are credited to your account through payroll deduction when you take a loan. In a sense, you pay yourself back. Loans are not subject to taxation—unless you default on your loan (please refer to Loan Repayments on this page). All costs and expenses in connection with obtaining the loan—including processing fees, taxes, recording fees, filing fees and attorneys' fees—are prepaid by you or deducted from your loan amount. Each loan must be evidenced by a promissory note payable to the Plan.

Eligibility

You are eligible to apply for a loan while you are employed at the Company and participating in the Plan. Your loan application will be reviewed to determine whether you are eligible to receive a loan, as well as whether you qualify for the amount requested. If your loan is granted, you will receive a clear statement of the charges involved in the transaction.

Loan Limitations

The minimum loan you may take from the Plan is \$1,000. The maximum loan you may take is the lesser of:

- \$50,000, reduced by the highest outstanding balance of loans to you from the Plan during the 12-month period ending on the day before the new loan is made or
- 50% of your vested account balance

Outstanding loans from the Plan are limited (at any one time) to a total of two loans.

Loan Repayments

Loans for the purpose of purchasing your principal residence must be repaid within 15 years; all other loans must be repaid within 60 months. You may also repay a loan in full, without penalty, at any time. Any outstanding loan must be paid in full at the time your account balance is distributed to you or your beneficiary.

If you do not repay your outstanding loan balance, you will be in default. If you do not make the overdue payments by the last day of the quarter after the quarter in which you defaulted, your loan will be treated as a distribution, reported to the IRS as taxable income and subject to any applicable penalties. Loans that are treated as a distribution will nevertheless be considered outstanding for other purposes, including calculating the maximum amount of any subsequent loan.

Interest Rates

Effective July 1, 2009, all loans from the Plan will be charged interest equal to the prime lending rate established by the Federal Reserve on the first business day of the month in which your loan application is received by the Administrative Committee, plus two percentage points. Contact JPMorgan at 800-345-2345 for information about current loan interest rates.

Loan Application Process

To request a loan from the Plan, log on to <https://www.retireonline.com> or call JPMorgan at 800-345-2345. If your loan is approved, your check will be mailed to you as soon as administratively possible.

Hardship Withdrawals

You can withdraw money from your account balance while you are still employed by the Company, if you have a financial hardship. The amount you may withdraw is limited to the vested value of your account balance (not including any investment income from your pre-tax contributions or catch-up contributions) minus any previous hardship withdrawals. Hardship withdrawals are taken pro rata from your account balance.

A hardship withdrawal may only be made on account of an immediate and heavy financial need to pay for one of the following:

- Medical expenses incurred by you, your spouse or your dependent that would qualify as deductible on an individual federal income tax return
- Costs related to the purchase of your principal residence (not mortgage payments)
- Payment of tuition and related educational fees for the next 12 months of post-secondary education for you, your spouse or your dependents

- Payment necessary to prevent eviction from, or foreclosure on the mortgage of, your principal residence
- Payments for burial or funeral expenses for a deceased parent, spouse, child or dependent (as specified in the Internal Revenue Code) or
- Expenses to repair damage to your principal residence (that qualify for a casualty deduction under the Internal Revenue Code)

To qualify for a withdrawal because of financial hardship, you cannot have any other source available for the money. When you make a hardship withdrawal, you will not be permitted to make pre-tax contributions to the Plan for six months after you receive the withdrawal.

The minimum amount of any hardship withdrawal is \$500.



For More Information: Who Is a Dependent?

Please see page **A-3** for a definition of dependent.

Distributions from Your Account

You may take a distribution of the vested portion of your Plan account when you reach age 59½ or when your employment with the Company ends. However, be aware that your distribution is taxable. Please see Tax Information on page **I-14** for more information about the tax implications of receiving distributions from the Plan. Also, see the information about rollovers on page **I-13** for information about how to avoid taxable distributions when withdrawing your account balance from the Plan.

If your employment ends for any reason, you can receive your vested account balance which includes your contributions, any rollover amount, Company matching contributions and any investment returns associated with these amounts.

An exception is if the Plan receives a Qualified Domestic Relations Order (QDRO) that entitles a qualified individual (as determined by law) to all or a portion of your account balance. In this case, when your distribution is made, your account will be reduced by the amount required by the QDRO. For more information about QDROs, see the General Information section of this SPD.

You have the choice to receive your payment as a single lump sum or in monthly or annual installments if your vested account balance is more than \$1,000—excluding rollovers. Your account balance will be paid to you in annual installments over five years if you do not make an election. Effective July 1, 2009, you may also elect to receive partial distributions from your account.

If your vested account balance is \$1,000 or less—excluding rollovers—it will be distributed in a lump sum as soon as possible after your termination.

Deferring Distribution

Tax considerations or other factors may influence how you receive a distribution from the Plan. You may want to take an immediate distribution of your Plan account when your employment ends or defer receipt until a later date. However, you may not delay distribution beyond the April 1 following the calendar year in which you reach age 70½ or, effective July 1, 2009, the date you retire, whichever is later.

There are some other details you should know about distributions from the Plan:

- Distributions may not extend beyond the later of the life or life expectancy of you and your spouse or beneficiary.

- If you die after your benefit distribution begins, but before your account is fully distributed, the balance will be distributed as soon as administratively possible.

Age 59½

After you reach age 59½, you may withdraw all or any portion of your vested account balance—even if you are still employed with the Company. The minimum amount of any withdrawal on account of reaching age 59½ is \$500.

Death Benefits

Your account balance is payable to your surviving spouse or beneficiary if you die. Please see Naming Your Beneficiary on page **I-3** for more information about beneficiaries. If your account balance is \$5,000 or less—excluding any rollover amount—a lump sum payment will be made to your spouse or beneficiary as soon as administratively possible. If your account balance is more than \$5,000, your spouse or beneficiary can elect to receive a single lump sum, a series of substantially equal monthly or annual installments, or any other fixed amount made available by the Trustee.

Upon notification of your death, the Benefits Department will provide information to JPMorgan. Distribution of death benefits will begin no later than one year after the end of the Plan Year in which you die. Benefits are paid as follows:

- If your spouse or beneficiary elects a lump sum payment within 60 days of receiving notice of the right to elect a lump sum or installments, the Trustee will convert the value of your account to cash and pay the account balance as of the date which coincides or immediately precedes your death.
- If your spouse or beneficiary elects installments within 60 days of receiving notice of the right to elect a lump sum or installments, payments will begin as soon as administratively possible.
- If your spouse or beneficiary does not elect a lump sum or installments within 60 days of receiving notice, then your account balance will be distributed in annual installments over a three-year period.

Special Great Plains Energy Stock Provisions—Cash Dividend Distributions

Dividends that you may receive from Great Plains Energy stock invested in the Employee Stock Ownership Plan (ESOP) component of the Plan are allocated to your account based on the number of shares held in the account as of the dividend record date. These dividends will be automatically reinvested in Great Plains Energy stock, unless you or your beneficiary elects to receive the dividends in cash. Dividends may be paid in cash if you meet the following requirements:

- You or your designated beneficiary elect a cash distribution of the dividend paid for Great Plains Energy stock shares allocated to the ESOP portion of your employee contribution account as of the dividend record date
- You are fully vested in Company matching contributions, and you elect a cash distribution of the dividend paid for Great Plains Energy stock shares in your matching contribution account

Once made, the election continues unless otherwise modified or revoked. You or your beneficiary will be able to change a dividend election at least once a year at <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345.

Any dividends you elect to receive as a cash distribution are taxable income to you.

After the Plan Trustee receives a cash dividend election, a cash payment equal to the dividend amount paid for Great Plains Energy stock will be allocated to your Plan account for the quarter. Payment is made as soon as administratively possible after the Plan Trustee receives dividend payment from Great Plains Energy Incorporated, but no later than 90 days after the end of the Plan Year in which the dividend may be allocated to your account.

Rollovers

Payments from the Plan may be eligible to be rolled over into an IRA or another tax-qualified employer sponsored retirement plan. Some examples of plans that typically accept rollovers include IRAs and qualified employer plans that are similar to the GPE 401(k) Plan.

For an employer plan to be an eligible retirement plan for your rollover from this Plan, the plan must specifically accept rollover contributions. Not all employer plans accept rollover contributions.

There is some additional information you should know about rollovers:

- If you would like to roll over your distribution to another retirement plan, you must complete the transfer within 60 days of the date you receive the distribution, or you will be required to pay taxes on the distribution.
- If you roll over your distribution directly to a rollover IRA or another qualified retirement plan, you will avoid the IRS withholding tax. (See Requesting a Direct Rollover.)
- Be sure that the Plan Trustee or IRA custodian receiving your rollover is willing to accept the payment. This must be done before you request a payment from the Plan.

Requesting a Direct Rollover

You can choose a direct rollover of all or any portion of a Plan payment that is an eligible rollover distribution. In a direct rollover from the Plan, the eligible rollover distribution is paid with a check from the Plan made out jointly to you and to the IRA or your new employer's Plan.

Non-spousal Beneficiaries

A single sum lump sum may be paid as a direct rollover on behalf of a beneficiary who is not your spouse to an inherited IRA. Contact a JPMorgan Retirement Plan Services Representative by calling 800-345-2345 for more information about the distribution restrictions and other tax rules applicable to inherited IRAs.

Keeping Track of Your Account

Your Plan account is maintained in your name. The value of your account is adjusted at the close of each business day to reflect the current market value of the investment accounts in which your funds are invested. This means the balance in your account increases or decreases each business day by your share of investment gains or losses, dividends, etc.

Quarterly Statements

Each calendar quarter (after the quarter ends), you will receive a statement from the Plan. This statement tells

you how much your account was worth at the end of the previous quarter, how much money you contributed and the amount of investment earnings or losses that were allocated to each of your investment accounts. The statement will also show how much the Company contributed in Company matching contributions.

You may check your account balance at any time at <https://www.retireonline.com> or by calling JPMorgan at 800-345-2345.

Tax Information

In most cases, distributions from the Plan must be reported as taxable income on your federal, state and local income tax returns. You are responsible for paying all applicable taxes on any distributions.

Under current tax law, the Company is required to withhold 20% of the taxable portion of any distribution you receive from the Plan. To continue deferring taxes and avoid withholdings on your payment, you can make a direct rollover as described on page **I-13**. You also have 60 days to make a rollover on your own after receiving a distribution from the Plan, but the Company would be required to withhold 20% for income taxes even though no taxes may be due. In this case, you would have to make up the difference from your own savings.

If you receive a distribution from the Plan before reaching age 59½, you may be subject to an excise tax equal to 10% of the taxable portion of your distribution. This additional tax will not apply to:

- Distributions made because your employment with the Company ends after you reach age 55
- Distributions made to a beneficiary after your death
- Distributions made after you are determined to be disabled or
- Distributions of dividends paid on Company stock that you elect to receive in cash

Payments from the Plan must begin by April 1 of the following year in which you reach age 70½ or, effective July 1, 2009, your retirement date if later. If you roll over a distribution to an IRA, keep in mind that payments from IRAs must begin by April 1 of the year following the year in which you reach age 70½. If you do not receive the minimum required distribution for your post 70½ years, a federal penalty tax is imposed equal to 50% of the minimum required distribution that you failed to have distributed.

Since income tax rules governing the Plan are complex, we encourage you to consult with a professional tax advisor before taking a distribution. You can also find more specific information on the tax treatment of payments from qualified employer retirement plans in IRS Publication 575, "Pension and Annuity Income," and IRS Publication 590, "Individual Retirement Arrangements (IRAs)." These publications are available from your local IRS office, by calling 800-TAX-FORM or at **www.irs.gov**.



How to File a Claim

You or your beneficiary may file a claim for benefits from the Plan. To file a claim, contact <https://www.retireonline.com> at 800-345-2345. For information about claims determination timeframes and appeal procedures, please refer to the General Information section of this book.

Military Leave

The federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 (as amended) provides certain rights if you are absent from work on account of “qualified military service” and then timely return to employment. Upon your return to employment, you may make elective contributions and (if eligible) catch-up contributions for the period you were absent from work on account of your qualified military service. For more information on your rights and benefits under USERRA, contact the HR Service Center at 816-276-5555.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For information on your rights and protections under ERISA, please refer to the General Information section of this book.

Other Important Information

As of January 1, 2009, there were 5,910 Plan participants, and approximately 3,200 employees eligible to participate. To date, Great Plains Energy has registered 10,276,442 shares of its common stock without par value, and an indeterminate number of interests in the Plan, for issuance under the Plan.

Where You Can Find More Information

Great Plains Energy files annual, quarterly and current reports, and proxy statements and other information with the Securities and Exchange Commission (the “SEC”) through the SEC’s Electronic Data Gathering, Analysis and Retrieval system and these filings are publicly available through the SEC’s website <http://www.sec.gov>. You may read and copy such material at the SEC’s Public Reference Room at 100 F Street, N.E., Washington, D.C. 20549. You may obtain

information on the operation of the Public Reference Room by calling the SEC at 800-SEC-0330.

Great Plains Energy filed a registration statement with the SEC under the Securities Act of 1933, as amended (Securities Act), relating to the Great Plains Energy common stock and interests offered pursuant to the Plan. This document constitutes part of a prospectus covering these securities. The registration statement contains additional information about Great Plains Energy and its securities. The SEC allows Great Plains Energy to omit certain information included in the registration statement from this prospectus. You may inspect and copy the registration statement at the SEC’s Public Reference Room.

The SEC allows Great Plains Energy to “incorporate by reference” into this prospectus the information we file with it. This means that Great Plains Energy can disclose important information to you by referring you to the documents containing the information. The information Great Plains Energy incorporates by reference is considered to be included in and an important part of this prospectus and should be read with the same care. Information that Great Plains Energy or the Plan files later with the SEC that is incorporated by reference into this prospectus will automatically update and supersede this information. Great Plains Energy is incorporating by reference into this prospectus the following documents that it has filed with the SEC and any subsequent filings Great Plains Energy or the Plan makes with the SEC under Sections 13(a), 13(c), 14 or 15(d) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”) (excluding information deemed to be furnished and not filed with the SEC) until the offering of the securities described in this prospectus is completed:

- Great Plains Energy’s Annual Report on Form 10-K for the year ended December 31, 2008, filed with the SEC on February 27, 2009
- Great Plains Energy’s Quarterly Report on Form 10-Q for the quarter ended March 31, 2009, filed with the SEC on May 11, 2009
- Great Plains Energy’s Quarterly Report on Form 10-Q for the quarter ended June 30, 2009, filed with the SEC on August 5, 2009
- Great Plains Energy’s Current Reports on Form 8-K dated January 27, 2009, and filed January 28, 2009; February 10, 2009, (Item 8.01 only) and filed with the SEC on February 10, 2009; February 9, 2009, and filed with the SEC on February 13, 2009; March 6, 2009, and filed with the SEC on March 12, 2009; March 18, 2009, (Item 8.01 only) and filed with the SEC on March 19, 2009; March 19, 2009, and filed with the SEC on March 24, 2009; April 16, 2009, and filed with the SEC on April 22, 2009; April 21, 2009, and filed with the SEC on April 21, 2009; May 11, 2009, (reporting Items 8.01 and 9.01) and filed with the SEC on May 11, 2009; May 12, 2009, and filed with

the SEC on May 19, 2009; May 22, 2009, and filed with the SEC on May 22, 2009; May 22, 2009, and filed with the SEC on May 27, 2009; June 4, 2009, and filed with the SEC on June 8, 2009; June 10, 2009, and filed with the SEC on June 11, 2009; June 11, 2009, and filed with the SEC on June 16, 2009; June 18, 2009, and filed with the SEC on June 18, 2009; July 9, 2009, and filed with the SEC on July 13, 2009; and July 24, 2009, and filed with the SEC on July 30, 2009

- The Annual Report on Form 11-K for the Plan for the year ended December 31, 2008
- The information under the caption “Description of Common Stock” in Great Plains Energy’s Registration Statement on Form S-3 (Registration No. 333-159131), filed May 11, 2009 and
- All documents filed with the SEC by Great Plains Energy or the Plan pursuant to Sections 13(a), 13(c), 14, or 15(d) of the Exchange Act after the date of this document and prior to the filing of a post-effective amendment which indicates that all the securities offered have been sold or which deregisters all securities then remaining unsold

You have the right to obtain a copy of all documents filed by Great Plains Energy or the Plan pursuant to Sections 13(a), 13(c), 14 or 15(d) of the Exchange Act and that are incorporated by reference in this prospectus. You also have the right to obtain a copy of all other documents required to be delivered to you pursuant to Rule 428(b) of the Securities Act. These copies will be provided to you without charge. You may make an oral or written request for copies to:

Great Plains Energy
Benefits Department
P.O. Box 418679
Kansas City, MO 64141-9679
816-556-2200

In addition, we will deliver to all participants in the Plan who do not otherwise receive such material, copies of all reports, proxy statements and other communications distributed to our shareholders generally.

Resale Restrictions

If you are not an “affiliate” of Great Plains Energy, you may resell shares of Great Plains Energy common stock acquired under the Plan, subject to the terms of any applicable lock-up agreement or other specific resale restrictions. If you are an “affiliate” of Great Plains Energy, you may resell Great Plains Energy common stock acquired under the Plan only in compliance with all of the provisions of Rule 144 of the Securities Act, other than the holding period requirement, or pursuant to a separate registration for the sale of such shares. We have not filed a reoffer prospectus as a part of the registration statement covering the Plan. Resales by affiliates are also subject to any applicable lock-up agreement or other specific resale restrictions.

An “affiliate” of the Company is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the Company. Executive officers and directors of the Company may be deemed to be affiliates for this purpose.

All transactions in Great Plains Energy securities, including transactions under the Plan, are subject to laws governing trading in securities while in possession of material nonpublic information about Great Plains Energy, as well as the provisions of the Code of Ethical Business Conduct and the Great Plains Energy Securities Trading (“Insider Trading”) Policy.

Voting Rights

When you are permitted to exercise any voting, tender, exchange or similar ownership rights on Great Plains Energy common stock held in the Plan, you will receive proxy, tender or exchange materials along with further instructions. You must exercise these rights by giving your instructions to the Trustee. If you do not provide voting instructions, the Trustee will, if directed by the Plan administrator or Great Plains Energy, vote your shares in the same ratio in which the total shares with respect to which timely instructions were received were voted. The Trustee will tender or exchange any shares in accordance with your instructions; however, the Trustee will not tender any shares in the absence of your instructions. Your instructions are held by the Trustee in confidence and will not be released to anyone, including officers or employees of the Company.



Other Benefits

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Other Benefits

KCP&L provides a number of other valuable benefits to employees, including the:

- Employee Assistance Program
- Education Assistance Program
- Vacation Purchase (Local 1613 only)
- Dollars to Scholars Program
- Wellness Program

Employee Assistance Program

KCP&L makes an Employee Assistance Program (EAP) available to you and your dependents. The program allows you to receive assistance and short-term counseling for personal life situations. The EAP is a voluntary program that provides confidential services. The EAP is available at no cost to you and your dependents.

How the EAP Works

When you call the EAP, a professional counselor will provide confidential assistance for:

Counseling and resources

- Stress
- Family difficulties
- Depression and anxiety
- Chemical dependency
- Crisis situations
- Any other personal or family concern

Work/life resources

- Child care providers and needs
- Elder care resources and programs
- Health and wellness resources
- Other work/life balance concerns



For More Information: Using the EAP

You can access the EAP by calling LifeMatters at 800-634-6433, 24 hours per day, seven days per week or by logging on to www.neas.com. The Web site offers education information, self-serve

options and interactive tools. When you go to the Web site, select "Login" and enter GPE1 as the company password.

Financial consultation with a certified financial counselor

- Budgeting
- Credit report review or correction
- Information on mortgages, loans and other financial arrangements
- Debt management and consolidation
- College or retirement planning

Legal consultation with an attorney

- Consumer law
- Traffic citations
- Family law
- Estate planning
- Other personal law issues

The EAP provides assessment, referrals and up to six paid counseling sessions in a calendar year for you and your dependents. In the event your EAP provider determines that a problem requires long-term attention or specialized care, the provider may refer you or your dependent to a non-EAP provider for further counseling.

Services received from the EAP are governed by the Health Insurance Portability and Accountability Act (HIPAA)—a federal regulation that establishes requirements on how plans may use and disclose protected health information about you. For more information on HIPAA, please see page **K-3** of the General Information section of this book.

Vacation Purchase (Local 1613 Only)

Employees represented by Local 1613 have the option to purchase up to 120 hours of vacation, in addition to 80 hours provided by KCP&L. The cost of any purchased vacation time may not exceed your annual Flex Dollars and will be deducted in equal installments over the course of the Plan Year (January 1 – December 31).

How the Vacation Purchase Works

If you choose to purchase additional vacation during Open Enrollment, you must purchase your additional vacation time for the following year in eight-hour increments, up to a maximum of 120 hours. Purchased vacation must be paid from your Flex Dollars and may not be purchased through payroll deduction from your pay.

Your election for additional vacation days is not automatic and does not continue from year to year; therefore, if you want additional vacation time, you must elect to purchase it each year during the open enrollment period. Your vacation election remains in effect for the full year unless you experience a status change event. Please see page **A-8** of the Plan Participation section of this book for information on status changes.

The balance of your vacation account does not roll over from year to year. If you have vacation time remaining in your account at the end of the year, you will forfeit the unused days.



For More Information: Vacation Purchase

To receive answers to your questions about the Vacation Purchase, contact the HR Service Center at 816-276-5555 or hrrservicecenter@kcpl.com.

Wellness Program

The Wellness Program provides reimbursement when you purchase a membership and participate in regular exercise programs through a qualifying local fitness facility.



Important Note: Schedule a Physical

Before participating in the Wellness Program, you should schedule a physical examination with a physician.

How the Wellness Program Works

Full-time employees can be reimbursed up to \$150 per year. Part-time employees can be reimbursed up to \$90 per year. The amount of your reimbursement will be added to your paycheck as taxable income.

You may only be reimbursed once per calendar year. To maximize your reimbursement, retain your membership receipts or canceled checks and submit them when they total \$150 if you are a full-time employee or \$90 if you are a part-time employee.

If you participate in more than one qualifying facility, you may submit any combination of receipts from those facilities up to the full-time and part-time reimbursement maximums.

If you have a family membership for your facility or fitness program, you may only be reimbursed for the portion of the total fee that represents your individual membership cost.



A Closer Look: What Qualifies for Reimbursement?

Human Resources determines the facilities and fitness programs in your area that qualify for reimbursement. Fitness programs must be conducted by a qualified instructor.

- Examples of qualifying facilities include the YMCA, Gold's Gym, Bally Health & Racket Club, Curves and 24-Hour Fitness.
- Examples of qualified fitness programs include martial arts and aerobics.

Expenses such as court fees, pool fees, golf fees, bowling fees or locker fees are not reimbursable expenses. In addition, exercise equipment purchases are not reimbursable.

How to Participate

To participate, you must complete the "Wellness Program Waiver" form, which releases KCP&L from liability for any claims that may arise from, or occur as a result of, your participation in the Program. Then, submit your completed waiver to the HR Service Center with proof of payment.

Then, at any time during the following year, you may send a copy of your membership receipt or a canceled check for fees indicating continuation of your membership to the HR Service Center. Your request for reimbursement must be made within one year of the effective date of your membership.



For More Information: Wellness Program

For more information about the Wellness Program, contact the HR Service Center at 816-276-5555 or hrservicecenter@kcpl.com.

Education Assistance Program

The Education Assistance Program provides reimbursement for your tuition costs and class-specific fees for degree programs or individual courses.

How the Education Assistance Program Works

The Education Assistance Program provides reimbursement for business- or KCP&L-related degree programs or individual courses of study through accredited colleges or universities, with prior approval. The Company recognizes the North Central Association of Colleges & Schools, The Higher Learning Commission as the accrediting organization. Schools and programs with other accreditation (such as Distance Education and Training Council) would not likely qualify. If the degree program or course is not related to a fundamental business area, there is no benefit under the Plan. The degree program must be directly related to your job, to a job in your line of progression or to a job to which you could promote or laterally transfer.

The Education Assistance Program reimburses tuition costs and class-specific fees, including engineering, lab and computer fees, up to a maximum of \$5,250 per calendar year. Books, activity fees and other institutional fees are not eligible for reimbursement.

After successfully completing a course, you will be reimbursed as follows:

- 100% of tuition costs with a grade of A
- 85% of tuition costs with a grade of B
- 70% of tuition costs with a grade of C
- 70% of tuition costs where no grade is given (i.e., pass/fail classes)
- 70% of cost for CLEP tests

In addition, the Education Assistance Program will reimburse 100% of class preparation and examination fees for state licensure as a Professional Engineer or Certified Public Accountant. Other certification programs and continuing education units (CEUs) are not reimbursable.

The Education Assistance Program will reimburse you for more than one bachelor's or master's degree with prior approval from HR. Additionally, Ph.D. programs require special executive approval.



Important Note: Things to Keep in Mind

Participation in the Education Assistance Program is completely voluntary. Keep in mind:

- Courses should be scheduled to avoid conflicts with your job.
- Time devoted to your program or course will not be considered time worked for KCP&L.
- KCP&L cannot guarantee promotion or transfer if you participate in the Education Assistance Program.



A Closer Look: Prior Approval Is Required

In order to receive reimbursements, you must receive prior approval from Human Resources of your degree program or individual course of study before enrolling in the program or course. Degree programs or individual courses should be submitted to the HR Service Center for prior approval to ensure eligibility for reimbursement once the course is completed.

Degree Programs

If you wish to pursue a degree program, you must meet with an academic advisor from the accredited college or university of your choice. The "Participation in Approved Degree Program" form (#802H014A) must be completed with both required and elective courses listed. It must be signed by you, your supervisor and an academic advisor from the college, and then submitted to the HR Service Center for approval, before enrolling in the program. The form is available on the All About page through the KCP&L intranet.

Individual Courses

If you wish to take an individual course that is not part of an approved degree program, you must complete and submit the “Application for Job-related Course Status” form (#802H055). This form must be signed by you and your supervisor and then submitted to the HR Service Center for approval, before enrolling in the class. The form is available on the All About page through the KCP&L intranet.



A Closer Look: Common Degree Programs

Examples of degree programs typically covered by the Education Assistance Program include:

- Accounting
- Business Administration
- Communication
- Computer Science
- Economics
- Electronics Technology
- Finance
- Human Resources
- Information Technology
- Marketing

Prepayment Process

If you have approval for a degree program or individual course of study, you may apply for tuition prepayment. This prepayment is an interest-free loan provided to you. Your payments will be deducted from your paychecks in equal installments throughout the duration of the course(s).

To apply for prepayment, go to the All About page through the KCP&L intranet and click on “Self Service” then “Course Prepayment.” Or, complete the “Education Assistance Program Reimbursement Application” form and return it to the HR Service Center. The form is available from the All About page through the KCP&L intranet. Generally, application for prepayment of tuition must be received for approval at least two weeks before the enrollment deadline for the course.

Tuition Reimbursement Process

You can apply for tuition reimbursement after successfully completing a course. To apply for reimbursement, go to the All About page through the KCP&L intranet and click on the box titled “All About You,” log onto the HRIS system using your network user ID and password, then click on “Request Tuition Reimbursement.” Or, complete the “Outside Course Completion Report” form and return to the HR Service Center. The form is available on the All About page through the KCP&L intranet. Please include a phone number where

you can be reached during business hours or a message can be left in case of questions.

Your proof of payment can be any of the following:

- Copy of your cancelled check
- Credit card receipt
- Debited transactions from online banking
- Payment receipt from college

A standard breakdown of the school’s credit hour rates and customary fees is not considered proof of payment.

You must submit documentation for tuition reimbursement no later than six months after the date you complete the program or course. For example, if you complete a class on May 15, you have until November 15 to submit documentation for reimbursement. Incomplete reimbursement applications will be deleted from the active file after this six-month period has expired.

It is your responsibility to make sure all documentation is received by the HR Service Center in a timely manner. To ensure the timely processing of tuition reimbursement applications and requests, please follow these guidelines:

- Applications for tuition prepayment should be received for approval two weeks before your enrollment in the course.
- To be reimbursed during a particular pay period, all required documentation for tuition reimbursement must be received by the last day of the pay period. Any requests for reimbursement received after that day will be processed for the next pay period.

Any reimbursement requests received after December 15 will be counted against the following year’s maximum.



For More Information: Education Assistance Program

For more information on the Education Assistance Program, contact the HR Service Center at 816-276-5555 or hrservicecenter@kcpl.com.

Dollars to Scholars Program

The Dollars to Scholars Program is a college scholarship program for eligible dependent children of KCP&L employees. The program is administered by Scholarship America, a national not-for-profit organization that encourages private sector participation in education by offering administrative support. Please see page **A-3** of the Plan Participation section for eligibility requirements for dependent children.

How the Dollars to Scholars Program Works

The Dollars to Scholars Programs is available to children of KCP&L employees who are students in post-secondary educational programs. The Program grants up to 25 awards of \$2,000 each year to the applicants deemed to have the strongest combination of abilities, skills and accomplishments.

To apply, students must complete an online application and submit an applicant appraisal and transcript by mail. The application period is December 15 through February 1. Once the application period begins, students can access the online application at **www.scholarshipamerica.org/kcpl**. All materials must be postmarked before the submission deadline or the application will be considered incomplete. There is a limit of two awards per student.

Scholarship America sends congratulatory letters to student recipients with a return mailer for verifying enrollment. The announcement occurs annually in March, roughly 45 days after the application deadline.

Payment

Scholarship payment is made in two equal checks, sent in August and December, allowing the student to apply an amount to each semester. Each check is made payable to the school for the student's account and is sent to the student's permanent address.

Generally, the scholarship is not taxable as long as it is used for qualifying expenses such as tuition, books and fees. However, recipients should consult with their tax advisors to determine whether or not it is taxable in their circumstances.



For More Information: Dollars to Scholars

For additional information, contact Scholarship America at 507-931-1682. Ask for the Program Manager for the GPE Dollars to Scholars Program.



A Closer Look: The Selection Process

Scholarship America and a team of trained evaluators familiar with the program features and criteria review and score all applications.

The selection process takes into account:

- Past academic performance and future potential
- Leadership and participation in school and community activities
- Work experience
- Statement of career and educational aspirations and goals
- Unusual personal or family circumstances and
- An outside appraisal

Financial need is not considered.

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General Information

The individual sections of this book summarize highlights of the Great Plains Energy Incorporated (“the Company” or “KCP&L”) benefit plans for employees represented by IBEW Locals 412, 1464 and 1613. The information provided in each section is taken from original benefit plan documents and written in summary form. Specific coverage options may vary by bargaining agreement and some benefits may not be available to employees represented by one or more Locals. The summaries do not attempt to cover every detail. Complete details can be found only in the formal plan documents, which govern the operations of the plans.

These materials are intended to be the Summary Plan Descriptions (SPDs) required under the Employee Retirement Income Security Act of 1974 (ERISA). If there is a conflict between the summaries and the respective plan documents, the terms of the plan documents will govern.

If you wish to read plan documents and related insurance agreements, they may be reviewed at the Benefits Department, or you may request copies by contacting the HR Service Center at 816-276-5555 or hrservicecenter@kcpl.com. A reasonable charge may be made to cover the cost of production of the materials.

References throughout this book to KCP&L are intended to include Great Plains Energy Incorporated and its subsidiaries and affiliates as applicable.

This section of the book includes information about the administration of the plans and your rights under ERISA.



Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Plan Administration and Funding

Plan Administrator

Except as shown in the chart below, Great Plains Energy Incorporated is the Plan Administrator for the benefits described in this book. However, general administration of these Plans is handled by an Administrative Committee composed of members appointed by the Chief Executive Officer (CEO). The Administrative Committee administers the Plans in accordance with the terms of the Plans. The Administrative Committee has the power to construe any ambiguity, supply any omission or reconcile any inconsistencies in the Plan documents.

Plan	Plan Administrator
Medical, Prescription Drug and Dental plans	The Board of Trustees of the NECA/IBEW Family Medical Care Trust Fund
Basic Life, AD&D and Dependent Life Insurance	The Board of Trustees of the Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan
Pension Plan	The Board of Trustees of the Great Plains Energy Incorporated Joint Trusteed Retirement Plan.

Named Fiduciary

Except as shown in the following chart, the named fiduciary of each Plan described in this book is the Administrative Committee.

Plan	Named Fiduciary
Medical, Prescription Drug and Dental plans	The Board of Trustees of the NECA/IBEW Family Medical Care Trust Fund
Basic Life, AD&D and Dependent Life Insurance	The Board of Trustees of the Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan
Pension Plan	The Board of Trustees of the Great Plains Energy Incorporated Joint Trusteed Retirement Plan
401(k) Savings Plan	<ul style="list-style-type: none"> The Administrative Committee is the named fiduciary with respect to the management, operation and administration of the 401(k) Savings Plan. The Trustee is the named fiduciary with respect to the management and investment of the Trust Fund.

Whenever the term “named fiduciary” is used in the 401(k) Savings Plan, the term refers exclusively to the person designated as having the responsibility for the function for which the term is being used and not to any other persons designated as named fiduciaries for other functions. It is intended that the 401(k) Savings Plan constitutes a plan described in Section 404(c) of ERISA, and according to Section 404(c), the fiduciaries of the 401(k) Savings Plan may be relieved of liability for losses resulting from investment instructions given by any participant or beneficiary.

Claims Administrator

For some Plans, Great Plains Energy Incorporated has delegated authority to insurance companies or other service providers to administer benefit claims. The claims administrators for all the benefit plans are listed on page **K-28**.

Source of Funding for the Plans

KCP&L's health and welfare plans are either self-insured or fully insured. Under self-insured plans, KCP&L pays benefits out of its own funds. However, an insurance company or other service provider may be retained to administer claims for benefits under the self-insured health and welfare plans. Under fully-insured health and welfare plans, the insurance company pays the benefit. Premiums are typically based on administrative costs, claims experience, expected future losses and the number of employees covered.

The chart below summarizes the self-insured and fully insured KCP&L health and welfare benefit plans.

KCP&L Health and Welfare Benefit Plans	
Self-Insured	Fully-Insured
Medical Plan	Vision Insurance (Local 1613 only)
Prescription Drug Plan	Life and Accident Insurance
Dental Plan	Long-Term Disability Insurance
Medical Reimbursement Account (Local 1613 only)	Business Travel Accident
Dependent Care Reimbursement Account	
Survivor Benefit Plan	

The name and address of each insurance company and administrator appear on page **K-28**.

All contributions to the Pension Plan are made by KCP&L and are actuarially determined. Contributions are kept in trust.

KCP&L has no right to, or interest in, contributions made to the Pension Plan. However, if a contribution is made by mistake, it may be returned within one year after payment. In addition, to the extent that part or all of a contribution is not allowed as a deduction under Internal Revenue Code Section 404, it may be returned within one year after the disallowance. The Pension Plan does not permit employee contributions.

Contributions to the 401(k) Savings Plan are made in part by participants in the form of pre-tax salary deductions, and in part by KCP&L in the form of matching contributions.

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established federal requirements to:

- Improve the availability and portability of health care coverage for workers and their families when they change or lose jobs and
- Provide administrative simplification of the health care industry through national standards for conducting electronic administrative and financial health care transactions, such as enrollment, eligibility inquiries, referrals and health care claims along with privacy and security requirements for personal health information

Certificate of Creditable Coverage

Employers are required to provide a certificate of prior health care coverage when enrollees lose coverage. A certificate is to be provided to:

- An individual who loses coverage and is entitled to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- An individual who loses coverage but is not entitled to elect COBRA continuation coverage and
- An individual who has elected COBRA continuation coverage when COBRA continuation ends

The certificate is also provided upon your request within 24 months after your coverage ends. Your request must include:

- The name of the person for whom the certificate is requested
- The name of the employee, if the person referred to above is a dependent
- The address to which the certificate should be mailed
- If the request is made on behalf of another person, evidence of the authority of the person, making the request to receive the certificate and
- The requester's signature

You should use this certificate if you become covered under a new health plan that has pre-existing condition limitations. As long as you have not had a break in coverage of 63 days or more, your new plan will be required to reduce the length of time you have to wait for coverage to begin for the pre-existing condition, by the period of time that you were covered under a prior plan.

To request a certificate of creditable coverage, contact Blue Cross Blue Shield of Georgia at 866-304-1881.

Your Privacy Rights under HIPAA

The HIPAA Privacy Rule places restrictions on when KCP&L may have access to certain health care information about you—known as Protected Health Information (PHI). Generally, PHI is information from which your individual identity can be discerned, that is transmitted or maintained in any form (for example, electronic, paper or oral) and that is created or received by a provider, health plan or health care clearing house.

In accordance with HIPAA, your health plan agrees not to use or disclose your PHI for purposes other than:

- For treatment, payment or health care operations
- As permitted or required by law or
- As authorized by you

You will receive a Notice of Privacy Practices that describes the Plans' policies, practices and your rights with respect to your PHI under HIPAA.

Contact Information

For assistance, or to obtain a copy of the Notice of Privacy Practices applicable to your medical, prescription drug, and dental benefits provided under the NECA/IBEW Family Medical Care Plan, you may contact:

CompuSys, Inc.

5837 Highway 41 North
Ringgold, GA 30736
877-937-9602 or 706-937-9600
706-937-9601 (FAX)

To obtain a copy of the Notice of Privacy Practices applicable to other group health plan benefits, you may contact:

HR Service Center

KCP&L
P.O. Box 418679
Kansas City, MO 64141-9679
Telephone: 816-276-5555
E-mail: hrrservicecenter@kcpl.com

How Your Protected Health Information May Be Used

The Plans may disclose PHI to the Company only upon receipt of a certification that Plan documents have been amended to incorporate the following provisions agreed to by the Company:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Company creates, receives, maintains or transmits on behalf of the Plan
- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law
- Ensure that any agents, including subcontractors, to whom the Company provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Company with respect to PHI—including the implementation of reasonable and appropriate security measures to protect electronic PHI
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Company unless authorized by you
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for, and any security incident, of which the Company becomes unaware
- Make PHI available to an individual in accordance with HIPAA's access requirements
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA
- Make available the information required to provide an accounting of disclosures
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA
- If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosure to those purposes that make the return or destruction feasible) and
- Ensure that adequate separation between the Plan and the Company is established and supported by reasonable and appropriate security measures with respect to electronic PHI
- Access to and disclosure of PHI is limited to only those Company employees who need PHI to perform administration functions for the Plan. This includes any employee who receives protected health information relating to payment under health care operations of, or other matters pertaining to, the Plan. Access to and use and disclosure of PHI will be limited to only those employees of the Company and members of the Administrative Committee and/or Board of Trustees who have a need for the PHI in conjunction with their performance of plan administration functions for the Plan, including any employee who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

If the persons described above do not comply with the conditions described above, the Company will take appropriate actions—including possible disciplinary actions.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your dependents (called “qualified beneficiaries”), may be eligible to temporarily extend group health care coverage under the Medical, Prescription Drug, Dental and Vision Plans and under the Medical Reimbursement Account and Employee Assistance Plan. Although the right to COBRA coverage does not extend to domestic partners, or children of domestic partners, the Plans will provide continuation coverage to such individuals on the same terms and conditions as described below. Both you and your dependents should take the time to read this section carefully. Your rights and obligations under the law are summarized below.

In general, to elect continued coverage, you and your dependents must have been covered under the health care plan(s) on the day before the event that caused coverage to end (called the “qualifying event”). However, any child born to or placed for adoption with you, the covered employee, while you are covered through COBRA may be covered under the health care plan(s) you elect (as long as the child is eligible) and will be treated as a qualified beneficiary.



A Closer Look: Enrolling Children in COBRA

To enroll your child in COBRA, you must notify the HR Service Center within 60 days of the date of the birth, adoption or placement for adoption, and

pay the required cost. Coverage will be effective back to the date of the birth, adoption or placement. If you do not enroll your child within 60 days, you may not elect COBRA for that child.

COBRA Qualifying Events

You may elect continued coverage if:

- You are an active employee represented or employed by IBEW Locals 412, 1464 and 1613 covered by one of KCP&L’s health care plans, and you lose coverage because:
 - Your employment terminates (for reasons other than your own gross misconduct) or
 - Your hours of employment are reduced below the minimum required to maintain your eligibility

- You are a covered spouse or domestic partner of a covered employee, and you lose coverage because:
 - Your spouse or domestic partner dies
 - Your spouse’s or domestic partner’s employment terminates for reasons other than his or her gross misconduct
 - Your spouse’s or domestic partner’s hours of employment are reduced below the minimum required to maintain your eligibility or
 - You are divorced or legally separated from your spouse or your relationship with your domestic partner ends
- You are a covered dependent child of a covered employee, and you lose coverage because:
 - The covered employee dies
 - The covered employee’s employment terminates for reasons other than his or her gross misconduct
 - The covered employee’s hours of employment are reduced below the minimum required to maintain your eligibility
 - The covered employee divorces or legally separates or a domestic partner relationship ends or
 - You no longer qualify as an eligible child under the terms of the plan

If you do not return to work at the end of an FMLA leave, the qualifying event occurs on the last day of your leave.

If you or your dependents purchase continued coverage, it will be the same as the coverage you lost. However, if KCP&L changes the plans covering active employees, those changes also will apply to your continued coverage.



For More Information:

If you have questions about COBRA, you should contact the HR Service Center at 816-276-5555, hrservicecenter@kcpl.com or HR Service Center, KCP&L, P.O. Box 418679, Kansas City, MO 64141-9679.

COBRA Eligibility

When the qualifying event is divorce, legal separation or the end of a domestic partner relationship, or a dependent child no longer being eligible for coverage, you or your dependents must inform KCP&L within 60 days of the date of the event. If notice is not provided within 60 days of the qualifying event, you may not elect continuation coverage. This notice must be sent to:

Attention: KCP&L HR Service Center

P.O. Box 418679

Kansas City, MO 64141-9679

If the qualifying event is the covered employee's death, termination of employment or reduction in hours of employment, KCP&L will notify the Plan Administrator within 30 days of the date coverage ends.

If you are eligible to continue coverage under COBRA, you will receive an application for continued coverage within 14 days after KCP&L is notified of a qualifying event.

Special COBRA rights, including a second opportunity to elect COBRA, apply to employees who have been terminated or who have experienced a reduction of hours and who qualify for trade adjustment assistance under the Trade Act of 1974. If you believe you might qualify for assistance under the Trade Act of 1974, contact the KCP&L Benefits Department.



Important Note: Report Qualifying Events

To notify KCP&L of a qualifying event, contact the HR Service Center at 816-276-5555 or hrservicecenter@kcpl.com.

Electing COBRA Coverage

You and/or your covered dependents have 60 days from the later of the day you receive notice of your COBRA election rights and the day your regular coverage ends to return your written COBRA election to the HR Service Center. You will lose your rights to elect continuation coverage if you do not elect continuation coverage within the 60-day period. You do not have to provide evidence of good health to elect continuation coverage.



A Closer Look: Individual Rights

Each qualified beneficiary has the right to make his or her own election of COBRA coverage. For example, you may choose to continue coverage for yourself, and your spouse may waive coverage. However, you may elect COBRA on behalf of your spouse and child(ren).

Coverage During the Election Period

It is important to elect COBRA coverage and make the required premium payments as soon as possible after receiving notice of your right to elect COBRA coverage. As of the date coverage is terminated, you and your covered dependents will not have any coverage until COBRA coverage is properly elected and the required premiums have been paid. This means no claims will be paid during the election period. In order to receive uninterrupted coverage, you should elect coverage and make the required premium payments as soon as possible after receiving your notice of continuation coverage. Once a completed election form is received and all required premiums are paid, coverage becomes retroactive to the date coverage was terminated. However, if you initially waive COBRA coverage and decide to elect it within the 60-day election period, your coverage becomes retroactive to the date of the election.



A Closer Look: Changing Coverage

During annual enrollment, you will have the same rights as similarly situated active bargaining unit employees to change your coverage option(s). If the addition of a dependent will result in a higher applicable premium, COBRA rates will reflect the higher amount.

COBRA Continuation Period

If you or your dependents would lose coverage because of your termination of employment or reduction in work hours, you and your dependents may apply for continuation of coverage for up to 18 months from the date of that event.

For all other qualifying events (divorce, legal separation, your death, your dependent child's loss of dependent status), your dependents may apply for COBRA continuation coverage for up to 36 months from the date of that event.

Second Qualifying Events

If your spouse or dependent elects COBRA continuation coverage after your termination of employment or reduction in hours, and during the 18 months of continuation coverage he or she experiences a second qualifying event, your spouse or dependent may elect a total of 36 months of COBRA continuation coverage, rather than only 18 months. The applicable second qualifying events are: your divorce, legal separation or the end of a domestic partner relationship, your death or your dependent child's loss of dependent status under the health benefit option. This 36-month period will be determined by adding an additional 18 months to the original 18-month coverage period. Should this situation arise, dependents will be given another opportunity to elect or decline continued coverage for the remainder of the 36-month period.

To receive this additional coverage, you or your family members must notify the Benefits Department within 60 days of the second qualifying event. This notice must be sent to:

Attention: KCP&L HR Service Center

P.O. Box 418679

Kansas City, MO 64141-9679

Medicare

If you become entitled to Medicare and later lose coverage under the Plan due to your termination of employment or reduction in work hours, your spouse or dependent may elect COBRA coverage until the later of:

- 36 months from the date you became entitled to Medicare or
- 18 months from the date of your termination of employment or reduction of hours in employment

In no case will any cumulative period of continuation coverage extend beyond 36 months.

Disability

If you or your dependent is disabled on the date of your termination of employment or reduction in work hours or within the first 60 days of your or your dependent's COBRA coverage, you may elect up to an additional 11 months of COBRA coverage, for a total of 29 months. The cost of coverage may be higher during these last 11 months than during the initial 18 months.

The determination of disability must be made by the Social Security Administration, and must be issued within the initial 18 months of continuation coverage. To purchase the additional 11 months of continuation coverage, you or your dependent must contact the Benefits Department within 60 days after the later of the date of your termination of employment or reduction in work hours or the date of the disability determination by the Social Security Administration. This notice must also be made within the initial 18-month COBRA continuation coverage period. This notice must be sent to:

Attention: KCP&L HR Service Center

P.O. Box 418679

Kansas City, MO 64141-9679

If the Social Security Administration determines that the person is no longer disabled, you or your dependent must contact the Plan Administrator within 30 days after the determination date. This notice must be sent to the Plan Administrator at the address above. Your or your dependent's right to the 11-month extension of continuation of coverage will terminate as of the first day of the month that begins more than 30 days after the Social Security Administration's determination is issued.

Medical Reimbursement Account (Local 1613 only)

Generally, you may only continue coverage under the Medical Reimbursement Account for the remainder of the plan year after a qualifying event if you have a positive account balance on the date of the qualifying event. This means that if the maximum benefit available under the Medical Reimbursement Account for the remainder of the plan year is less than the maximum the plan could require as payment for the remainder of that year in order to maintain coverage under the Medical Reimbursement Account, you will not be offered COBRA continuation coverage.

The plan year begins on January 1 and ends on the following December 31. For example, if you enroll in the Medical Reimbursement Account on January 1, 2009, and then are terminated on June 11, 2009, you may elect to continue coverage under the Medical Reimbursement Account until December 31, 2009, as long as coverage does not end earlier (as provided in "When COBRA Coverage Ends" on page **K-9**). Once the plan year ends, you will have no further rights to continuation coverage.

Cost of Coverage Continuation

The monthly charge for continued coverage will be determined by the Plan Administrator, and will be the same for all similarly situated individuals electing the same type of coverage under COBRA. You or your covered dependents must pay the full coverage cost (your share plus KCP&L's share) plus a 2% administrative fee. If you or a dependent is disabled and is eligible for the 11-month extension of continuation coverage described above, then the COBRA premium will increase to 150% of the full cost of coverage.

Your contributions to the Medical Reimbursement Account must be made on an after-tax basis and will be subject to an additional 2% administrative fee. The 2% fee will not apply for the first 30 days of continued coverage if you are on an approved leave of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If you elect continued coverage, you must make payment for the period from the date your coverage would otherwise terminate. You have a 45-day grace period following the election date to pay your first COBRA premium. All COBRA payments are made on an after-tax basis. After this initial 45-day grace period, payments must be made by the first day of each month for which coverage is to be provided—subject to a 30-day grace period.

If you make a payment that is less than the amount due for that month's premium, and the shortfall is no more than the lesser of 10% of the premium or \$50, the Plan will notify you of the deficiency. To maintain your continued coverage, you must pay that deficiency within 30 days of the date the plan notifies you. If you do not pay the deficiency within that period, your COBRA continuation coverage will end and you will not be given the opportunity to reinstate coverage.

When COBRA Coverage Ends

Your COBRA coverage will end before the maximum coverage period expires if:

- KCP&L no longer provides group health coverage to any of its employees
- You do not make the required payment before the end of the 30-day grace period
- You or your covered dependent becomes entitled to Medicare
- In the case of a 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months) or
- You become covered under another group health plan (as an employee or otherwise) after the date you elect continuation of coverage, unless there is a pre-existing condition exclusion as explained below

If you become covered under another group health plan that excludes or limits coverage for pre-existing medical conditions, you may keep your COBRA coverage until the earlier of the date:

- The pre-existing medical condition exclusion ends or
- Your COBRA maximum coverage period ends

When COBRA coverage ends, you will be issued a certificate of creditable coverage by the Plan Administrator. This certificate will describe the period when you were a plan participant and the length of your COBRA coverage. If you (or your dependent, if applicable) participate in another group health plan within 63 days after your COBRA coverage ends, the new plan must reduce any pre-existing condition exclusion period by the length of your creditable coverage.



Important Note: Report Address Changes

To protect your family's rights, contact the HR Service Center at 816-276-5555 or hrrservicecenter@kcpl.com if your or a family member's address changes.

Claim Filing and Appeals

The chart on pages **K-14 and K-15** of this section lists the names, addresses and phone numbers of the trustee, insurer or claims administrator responsible for each of the plans. More details about filing claims are given in the sections related to the specific benefit plans. If you have a question about a claim, contact the appropriate administrator directly.

Medical, Prescription Drug and Dental Coverage

In order for the Plan to pay benefits, a claim must be filed with the claims administrator in accordance with the procedures described below. A claim can be filed by you, your eligible dependent or by someone authorized to act on behalf of you or your eligible dependent.

1. A claim is considered to have been filed on the date it is received at the correct claims office, even if the claim is incomplete. Claims are received during regular business hours, Monday through Friday.
2. A “claim” is a request for Plan benefits, normally because the claimant has incurred a health care expense. A request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense unless the Plan conditions payment on the receipt of prior approval. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a pharmacy.
3. Claims must be filed within twelve months from the date of service.
4. You may designate another person as your authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, such designations must be in writing.
 - Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you
 - A routine assignment of benefits so that the Plan will pay the provider directly is not a designation of the provider as your authorized representative
 - Designation of a person as an authorized representative does not grant that person the rights of a beneficiary under this Plan

Claims Determination

Urgent care claims: If you have a health care claim that involves urgent care, you will be notified whether your claim is approved or denied within 72 hours after the Plan receives your claim. If you do not provide sufficient information in your claim, the Plan will notify you within 24 hours after it receives the claim of the additional information you need to submit and the deadline for providing this information. The deadline for providing the additional information will not be less than 48 hours after you are notified. In this instance, you will be notified of the claim determination within 48 hours after the earlier of:

- The Plan’s receipt of the additional information or
- The deadline for submitting the additional information

Notification may be provided orally or in writing. If you are notified orally, you will receive a formal written notice within three days after the oral notice.

An urgent care claim is any pre-service claim for health care in which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or
- In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim



Important Note: Medical Reimbursement Account Claims

The timeframes for urgent care, concurrent care and pre-service claims and appeals do not apply to Medical Reimbursement Account claims.

Concurrent care decisions: Special rules apply where the Plan has approved an ongoing course of health care treatment for either a specific period of time or a specific number of treatments. A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial (except for plan amendment or termination). In this case, the Plan will notify you in advance so you can appeal the decision before the benefit is reduced or terminated.

You may request to extend the course of treatment beyond the approved time period or number of treatments. If this involves urgent care, the Plan will notify you whether your request has been approved or denied within 24 hours of receiving your request, as long as you make your request at least 24 hours before the approved time period or number of treatments expires.

Pre-service claims: A pre-service health care claim is any request for approval of a benefit where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (for example, pre-certification). The Plan will notify you whether a pre-service claim is approved or denied within 15 days of receiving your claim.

The original 15-day period to respond to your claim may be extended for another 15 days if you are notified that the extension is necessary due to matters beyond the control of the Plan, and you are notified before the end of the original 15-day period. The notice will explain the reason for the extension and when the Plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to provide. In this event, you have 45 days from the date you receive the notice to provide the additional information.

If you fail to follow the Plan procedures for filing a pre-service claim, you will be notified that you did not follow the procedures and you will be provided with an explanation of the proper procedures. You will be notified within five days after the original claim is filed. This timeframe will be 24 hours in the case of an urgent care situation. The notification can be oral, unless you request written notification.

Post-service claims: Post-service health care claims, including Medical Reimbursement Account claims and Vision claims, refer to health care claims that cannot be categorized as urgent care claims or pre-service claims. The Plan will notify you whether a post-service claim has been denied within 30 days of receiving your claim. This period may be extended for another 15 days if you are notified that the extension is necessary due to matters beyond the Plan's control, and you are notified before the end of the original 30-day period. The notice will explain the reason for the extension and when the Plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to provide. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

Disability claims: In the case of a disability claim (including a claim for disability under the Pension Plan or life and accidental death insurance), the Plan will notify you of a denial no later than 45 days after receipt of your claim. The period may be extended by the Plan for up to 30 days if it decides that an extension is necessary because of matters beyond its control. You will be notified of this extension before the end of the initial 45-day period, including the reasons for the extension and the date by which the Plan expects to make a decision.

If, before the end of the first 30-day extension period, the Plan determines that a decision cannot be made within that time, the extension period may be extended up to another 30 days. The Plan will notify you before the end of the first 30-day extension period if a second extension is necessary. The extension notice will explain the standards by which entitlement to a benefit is based, unresolved issues that prevent a claim decision and the additional information needed to resolve the issues. You will be given at least 45 days to provide the specified information.

For all other claims: The Plan Administrator, claims administrator, or insurer, as appropriate, will decide a claim within 90 days after it is received (though an extension of up to 90 days may be taken if special circumstances require an extension of time for claim processing). If a time extension is required for processing your claim, written notice will be given to you before the end of the initial period. The extension notice will indicate the special circumstances requiring a time extension and the date by which a final decision will be made.

You will receive written or electronic notification if your claim is denied. The notice will include:

- The specific reasons for the denial
- Reference to the Plan provisions on which the decision is based
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including your right to bring a civil action in federal court following a claims denial on appeal
- If applicable, a statement that any rule, guideline, protocol or other similar criterion that was used to make the adverse determination and reference to the actual specific rule, guideline, protocol or similar criterion is available free of charge upon request or
- An explanation of the scientific or clinical judgment for the determination, if a denied claim is based on medical necessity or experimental treatment or similar exclusion or limit, or a statement that the explanation is available free of charge upon request

For a claim denial involving an urgent care claim, a description of the expedited review process applicable to such claims also will be included in the notice.

If you have any questions about a denied claim, you should contact the Plan Administrator.

Appealing a Denied Claim

For Medical, Dental, Prescription Drug, and Vision claims, there is a two-level appeal process. For all other claims, follow the first level of appeal only.

First Level of Appeal

For Medical, Dental, Prescription Drug and Vision

claims: You (or your authorized representative) will have 180 days after receiving notice that your claim is denied to appeal the decision in writing to the claims administrator or insurer, as appropriate. Your request should include the employee's name, the member identification number, the covered person's name and date of birth, the provider's name and the claim number. You also may submit written comments or supporting documentation concerning the claim. You have the right to review, during normal working hours, any documents that are pertinent to your denial.

In the case of a denied urgent care claim, you may request an expedited appeal by calling or writing the claims administrator. All necessary information regarding the appeal, including the decision, will be transmitted by telephone, fax or other prompt method. You will be notified of the appeal decision as soon as possible, taking into account medical requirements, but no later than 72 hours after the claims administrator receives your request.

You will be notified of the first-level appeal decision for a pre-service claim within a reasonable period that is appropriate for your medical condition, but no later than 15 days after the Plan receives your request for review.

You will be notified of the first-level appeal decision for a post-service claim within 30 days after the Plan receives your request for review.

For Medical Reimbursement Account claims: You (or your authorized representative) will have 180 days after receiving notice that your claim is denied to appeal the decision in writing to the Administrative Committee. You may review documents pertinent to the appeal and submit issues and comments in writing to the Administrative Committee. The Administrative Committee will decide your appeal within 60 days after it is received.

For Disability claims: You have the right to appeal the decision, if your claim is denied. You (or your duly authorized representative) must make a written request for appeal to the Plan within 180 days from the date you receive the denial. If you do not make this request within that timeframe, you will have waived your right to appeal.

Once your request has been received by the Plan, a full and fair review of your claim will take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Plan will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Plan has 45 days from the date it receives your request to review your claim and notify you of its decision. Under special circumstances, the Plan may require more time to review your claim. If this happens, the Plan must notify you in writing that its review period has been extended for an additional 45 days.

In deciding an appeal, if a denial is based in whole or in part on a medical judgment, the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The review on appeal will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether the advice was relied upon in making the benefit determination. The chosen health care professional consulted for the review on appeal will not be connected to, or the subordinate of, any individual involved in the initial claim denial.

For all other claims: If your claim for benefits is denied, or if you do not receive a response to your claim within the appropriate timeframe, you (or your authorized representative) may appeal your denied claim in writing. The appeal must be made in writing within 60 days of the receipt of written notice of denial. You may submit any written comments, documents, records and any other information

relating to your claim with your appeal. Upon written request, you also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Utilizing individuals not involved in the initial benefit determination, the Plan will conduct a full and fair review of the information in the claim file and any new information submitted to support the appeal. The review will not give any special consideration to the initial benefit determination.

You will be given a notice of the decision with respect to your appeal within 60 days. The Plan makes the decision based on the facts and the pertinent provisions of the Plan. Special circumstances can require an extension of time for reviewing the claim. In this case, the Plan will provide you with written or electronic notice of the extension before the end of the initial 60-day period. The extension notice will indicate the special circumstances, and the date by which the Plan expects to make its decision. The Plan can take an additional 60 days to review your claim, or a total of 120 days from the day your appeal was received.

Second Level of Appeal

For Medical, Dental, Prescription Drug and Vision claims only: If you disagree with the decision of the initial appeal to your claim, you have the right to a second-level appeal. Within 180 days after receipt of the claim administrator or insurer's response to the initial appeal, you may submit a second appeal to the Board of Trustees of the NECA/IBEW Family Medical Care Plan (or to the insurer, in the case of a vision appeal) along with pertinent documentation. The Board of Trustees of the NECA/IBEW Family Medical Care Plan (or the insurer, in the case of a vision appeal) will communicate its final determination to you.

You will be notified of the second-level appeal decision for a pre-service claim within a reasonable period that is appropriate for your medical condition, but no later than 15 days after the Plan receives your request for review of your denied claim.

You will be notified of the second-level appeal decision for a post-service claim within 30 days after the Plan receives your request for review of your denied claim.

Appeals Denial Notice

If your appeal is denied, you will be notified electronically or in writing by the claims administrator, insurer, or the Benefits Department, as appropriate. This notice will include:

- The specific reasons for the denial
- Reference to Plan provisions on which the decision is based
- Your right to request access to or copies of all information relevant to your claim, upon request and free of charge and
- Your right to bring a civil action in federal court
- A statement that any rule, guideline, protocol or other similar criterion that was used to make the adverse determination and reference to the actual specific rule, guideline, protocol or similar criterion is available free of charge upon request or
- An explanation of the scientific or clinical judgment for the determination, if a denied claim is based on medical necessity or experimental treatment or similar exclusion or limit, or a statement that the explanation is available free of charge upon request

If the Plan fails to follow the claims appeals procedures as outlined above, you will have the right to bring a civil action in federal court.

You or your representative may not bring any lawsuit against the Plan or a representative or fiduciary of the Plan after one year from the later of the date your claim is first filed or the date the Plan decides your claim (or decides your appeal if you file an appeal with the appeal timeframes).



Important Note: Authorized Representative

Your authorized representative may act on your behalf in pursuing a benefit claim or appeal of a claim denial. The Benefits Administration

Department may require that you verify in writing the authority of your representative to act on your behalf.

Claims Filing Summary

Name of Plan	Address	Telephone Number/Web site
Medical Plan	Blue Cross Blue Shield of Georgia (BCBSGA) P.O. Box 9907 Columbus, GA 31908-7368	866-304-1881 customer service www.bcbsga.com
Prescription Drug Plan	Sav-Rx 224 North Park Avenue Fremont, NE 68025	866-233-IBEW (4239) www.savrx.com
Dental Plan	MetLife P.O. Box 981282 El Paso, TX 79998-1282	800-942-0854 customer service www.metlife.com/mybenefits
Vision Plan (Local 1613 only)	In-network: Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 Out-of-network: Vision Service Plan Insurance Company P.O. Box 997105 Sacramento, CA 95899-7105	800-877-7195 www.vsp.com

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Claims Filing Summary (continued)

Name of Plan	Address	Telephone Number/Web site
Medical Reimbursement Account (Local 1613 only)	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039	800-284-4885 www.payflex.com
Dependent Care Reimbursement Account		
Basic Life Insurance	Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 800-638-6420	800-638-6420
Supplemental Life Insurance		
Dependent Life Insurance		
Basic Accidental Death & Dismemberment (AD&D) (Locals 412 and 1464 only)		
Supplemental Accidental Death & Dismemberment (AD&D) (Local 1613 only)		
Dependent Accidental Death & Dismemberment (AD&D) (Local 1613 only)		
Business Travel Accident Plan	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235	816-276-5555
Survivor Benefit Plan	HR Service Center KCP&L P.O. Box 418679 Kansas City, MO 64141-9679	816-276-5555
Long-Term Disability	CIGNA Group Insurance Paper Intake Team 12225 Greenville Avenue Suite 1000 Dallas, TX 75243	800-36CIGNA (800-362-4462) http://dmswebintake.group.cigna.com
Pension Plan	KCP&L Attention: Employee Benefits P.O. Box 418679 Kansas City, MO 64141-9679	816-276-5555
401(k) Savings Plan	J.P. Morgan Retirement Plan Services 9300 Ward Parkway Kansas City, MO 64114	800-345-2345 www.retireonline.com

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Leaves of Absence

Family and Medical Leave Act of 1993

You may have a right to continue group health plan coverage, including Medical, Prescription Drug, Dental, Vision and Medical Reimbursement Account coverage, for yourself and your dependents during a period when you are on a leave of absence authorized under the Family and Medical Leave Act (FMLA).

In order to continue your health coverage during your leave, you must pay your portion of the cost of the coverage.

If you are on a paid leave, your contributions for health coverage will be made in the same manner as if you were not on leave. For example, if you made your contributions through payroll deduction before your leave, you will continue making contributions through payroll deduction during your paid leave. In the case of an unpaid leave, you must make your contributions for health coverage during the same timeframe as if you were not on leave. Your contributions during an unpaid leave can be made by personal check.

You have the option to not continue your coverage during your leave. In this situation, your coverage and your dependents' coverage will end on the last day of the month for which your contributions are applicable. If you elect to continue coverage during your leave, coverage will continue until the earliest of:

- The date you notify KCP&L that you do not plan to return to work for KCP&L at the end of your leave
- The date your employment with KCP&L ends because you failed to return to work at the end of your leave
- The last day of the month for which you paid the required contributions for coverage. You will have a 30-day grace period in which to make the contributions and your coverage will not end unless a contribution is not made for at least 15 days after you receive written notice that your payment is overdue or
- The date KCP&L terminates the Plan

If you are on leave and do not continue your coverage during your leave, your coverage can be reinstated when you return from leave. Coverage will begin as of the first day you return to active status with KCP&L, and you and your dependents will receive the same coverage you had before your leave.

If you continued your coverage during your leave, but you did not return to work for KCP&L at the end of your leave, KCP&L will have the right to recover from you any contributions made by KCP&L toward your and your dependents' coverage during your leave, unless the reason you do not return to work for KCP&L after your leave is due to the continuation, recurrence or onset of a serious health condition which would otherwise entitle you to another FMLA leave or other circumstances beyond your control. For purposes of your health coverage, you will be considered to have returned to work for the Company only if you return to work for at least 30 calendar days.



Important Note: Other Benefits during an FMLA Leave

During an FMLA leave, your contributions for KCP&L benefits other than for health care will be automatically deducted through payroll deduction if sufficient funds are available during your paid leave. If sufficient funds are not available to pay the cost of your other benefits, you will be billed for your cost of coverage.

Other Leaves of Absence

Medical, Prescription Drug, Dental and Vision

You may have a right to continue Medical, Prescription Drug, Dental and/or Vision coverage for yourself and your dependents when you are on an authorized leave of absence. For more information about your right to continued coverage during a leave, please contact the Plan Administrator.

Medical and Dependent Care Reimbursement Accounts and Vacation Purchase

You may not make pre-tax contributions to the Medical Reimbursement Account, Dependent Care Reimbursement Account and Vacation Purchase during an unpaid leave of absence. However, you may be able to continue your participation in these plans by contributing on an after-tax basis. You may also have the right to suspend your participation during your leave of absence and resume participation when you return to active employment.

Life Insurance and AD&D Insurance

You may be able to continue your and your dependents' life insurance and AD&D insurance coverage during an approved leave of absence from KCP&L.

Coverage may be able to be continued for up to six months during your leave. At the end of your leave or six months, whichever occurs first, your coverage and your dependents' coverage will be affected as follows:

- If you resume active work and are eligible for coverage, you and your enrolled dependents will continue to be insured through KCP&L.
- If you do not resume active work and are not eligible for coverage, your coverage will end unless your leave is continuing due to total disability. For more information, see the Life and Accident Plan section.

If your coverage ends, you may be able to convert insurance to an individual policy. See the Life and Accident Plan section for more information about conversion.

Business Travel Accident Plan

Your coverage under the Business Travel Accident Plan will not continue during your leave. Your coverage will end on your last day of active service with KCP&L and will be reinstated on your first day of work with KCP&L after your leave of absence.

Survivor Benefit Plan

Your coverage under the Survivor Benefit Plan will continue during your leave.

Long-Term Disability

If your Long-Term Disability coverage ends because you are on a leave of absence, you may be eligible for conversion insurance. To be eligible, you must have been insured under KCP&L's Long-Term Disability Plan and actively at work for at least 12 consecutive months.

If you apply for conversion insurance within 31 days after your coverage under the Long-Term Disability Plan ends,

your conversion insurance will be effective as of the date your insurance under the Plan ends. If you apply more than 31 days after your coverage under the Plan ends, you will be required to provide satisfactory evidence of good health at your own expense. Conversion insurance will be effective on the date CIGNA agrees in writing to insure you. You must apply for conversion insurance within 62 days after your coverage through the Great Plains Energy Incorporated Long-Term Disability Plan ends. The benefits of the conversion plan will be those benefits offered at the time you apply. The premium will be based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following apply:

- You are age 70 or older.
- You are not in active service of KCP&L because of a disability.
- Your coverage is canceled for any reason.
- You are no longer eligible for coverage, but are still employed by KCP&L.

Your coverage may be reinstated if it ends because you are on a KCP&L-approved unpaid leave of absence. Your coverage may be reinstated only if reinstatement occurs within 12 weeks from the date coverage ends.

For your insurance to be reinstated, the following conditions must be met:

- You must meet the eligibility requirements.
- The required premium must be paid.
- A written request for reinstatement and a new enrollment form must be received by CIGNA within 31 days from the date you return to active status.

Your reinstated coverage is effective on the date you return to active status with KCP&L. If you did not fully satisfy your eligibility waiting period or pre-existing condition limitation before your coverage ended due to your unpaid leave of absence, you will receive credit for any time that was satisfied.

Pension Plan

During an approved leave of absence, you receive credit for each hour of service for which you are paid, or entitled to payment by KCP&L, including any periods of time during which no duties are performed. No more than 501 hours of service will be credited on account of any single continuous period when you perform no duties. However special rules may apply during a leave of absence covered by the Uniformed Service Employment and Reemployment Rights Act (USERRA); see page **K-19**.

401(k) Savings Plan

You may not contribute to your 401(k) Savings Plan account if you are not receiving pay—for example, during an unpaid leave of absence. If you are paying back a loan from the 401(k) Savings Plan and are on an unpaid leave of absence, you must continue to make your loan payments by personal or cashier's check at the times and in the amounts required by the promissory note.



Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act (USERRA) prohibits discrimination against you because of your service in the Armed Forces Reserve, the National Guard or other uniformed services (also called “military leave”). If the entire length of your military leave is 30 days or less, your benefits through KCP&L will continue as normal.

Medical, Prescription Drug, Dental, Vision and Medical Reimbursement Account

If you take a military leave, whether for active duty or for training, you and your covered dependents are entitled to continue Medical, Prescription Drug, Dental and Vision coverage for up to 24 months as long as you give KCP&L advance notice (with certain exceptions) of the leave. Continued coverage may also be available for your Medical Reimbursement Account. Coverage may end earlier than the full 24 months. For example, health coverage ends on the day after the date on which you fail to apply for or return to your position of employment, if the failure to apply or return ends your right to reemployment rights under federal law regarding uniformed service.

The coverage that you and your dependents are entitled to receive will be the same as that provided to employees and their dependents under the Plan. Except in connection with an annual enrollment period or under other circumstances that permit eligible employees to make changes, you and your dependents may continue only the type of coverage that you were receiving on the day before you first were absent from employment.

If the entire length of the leave is 30 days or less, your benefits will continue as normal and you will not be required to pay any more than the portion you paid before the leave. If the entire

length of the leave is 31 days or longer, your coverage will end at the end of the month in which the 31st day of your leave falls. After that, you and/or your covered dependents must pay the full coverage cost (your share plus KCP&L's share) plus a 2% administrative fee. If you are eligible to continue coverage under these rules, the Benefits Department will send you an application for continued coverage within 14 days after it has received notice, satisfactory to the Benefits Department, that you will be, or are, absent from employment for a period of Qualified Uniformed Service. If you wish to have coverage continued, you must complete the application and return it to the Benefits Department within 60 days from the later of the date it is sent to you or the date your coverage otherwise would terminate.

If you take a military leave, but your health coverage is terminated (for example, you do not elect the continued health care coverage or you fail to pay any required premium), you will be treated as if you had not taken a military leave upon your return to work for the purpose of determining your coverage under the Plan. When you return to work at KCP&L, the health coverage will not cover injuries or illness (as defined by the health plan) that are attributable to military service. However, there will be no waiting periods or pre-existing condition limitations upon your return to work.



Important Note: Out-of-network Deductible

The election, notice and payment provisions of COBRA also apply to coverage during a period of Qualified Uniformed Service. Please contact the Plan Administrator for complete details regarding military leave.

Reinstatement of Coverage

You have special protection if your coverage under each of the benefit options (not only health care coverage) terminates during a military leave and you are later reemployed with KCP&L and eligible for coverage. Generally, coverage is reinstated as though you had not taken military leave. So, any exclusions or waiting periods under a health benefit option, for example, generally will not apply to the extent that you had satisfied those requirements before taking military leave. However, KCP&L applies exclusions and waiting periods for cases of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of service in the uniformed service.

Pension Plan

You have certain rights if you are absent from work on account of military leave and then return to employment on a timely basis. Upon your reemployment after a period of military leave, KCP&L will credit you with 40 hours of service for each complete week of military leave and eight hours of service for each day in any partial week of the service, up to a maximum of five years of future service. Hours of service credited under this rule are offset by any hours of service credit to which you are otherwise entitled for the same week or day. Please note that periods of military service (taken in the aggregate) may not result in credit of more than five years of service (or another number of years or partial years as required by law).

If you are entitled to credit for military service, to determine the amount of your benefit, you will be deemed to receive the compensation you would have received if you were actively working for KCP&L and not on a military leave.

Notwithstanding any provisions of the Pension Plan to the contrary, contributions, benefits and service credit for military service will be provided according to section 414(u) of the Internal Revenue Code.

401(k) Savings Plan

If you return to employment after a period of qualified military service, you may make additional elective contributions to the Plan for the period that you were absent from work on account of the qualified military service. Such contributions must be made between your date of reemployment and the earlier of:

- Three times the period of military service or
- Five years

You may make contributions regardless of the limitations that would otherwise apply in the year the contribution is actually made. Instead, your elective contributions must satisfy the limitations in effect for the year in which your contribution relates.

Investment earnings and losses will not be credited on your contributions on account of military service for any period before your contributions are actually made. If you choose to make elective contributions, the Company will then make any Company matching contributions that you would have been eligible to receive if not for your qualified military service.

401(k) Savings Plan loan repayments will continue to be deducted from your paychecks while you are on military leave. If your pay is not sufficient to cover your loan repayments, you may remit your payments to the 401(k) Plan administrator at the times and in the amounts required by the promissory note.

Notwithstanding any provisions of this Plan to the contrary, contributions, benefits and service credit with respect to military service will be provided in accordance with Code Section 414(u).

You and KCP&L must supply information to the Administrative Committee within a timeframe the Committee considers necessary or advisable to administer the provisions of this section. In the absence of independent evidence from you that establishes your right to credit for military service, the Administrative Committee will be entitled to rely on information provided by KCP&L regarding your military service. The Administrative Committee may, but will not be required to, make an independent investigation of your rights to credit for military service.



For More Information:

For more information about military leave, contact the HR Service Center at 816-276-5555 or hrservicecenter@kcpl.com.

Qualified Domestic Relations Orders

Under certain circumstances, a court may award all or part of your benefit under the Pension Plan and/or 401(k) Savings Plan to a present or former spouse, child or other dependent (called an “alternate payee”) through a Qualified Domestic Relations Order (QDRO).

A QDRO is a court order, judgment or decree that:

- Is made under a state domestic relations law (including community property laws)
- Relates to child support, alimony payments or marital property rights and
- Creates or recognizes an alternate payee’s right to receive all or part of your benefits under the Plan

You and your beneficiaries can obtain, at no charge, a copy of the procedures governing QDROs by contacting the Plan Administrator or the Benefits Department.

Qualified Medical Child Support Orders

Federal law requires group health plans to honor Qualified Medical Child Support Orders (QMCSOs). In general, QMCSOs are orders from a state court or state administrative agency requiring a parent to provide medical support to a child, for example, in cases of legal separation or divorce.

A QMCSO may require the Plan to make health coverage available for your child even though, for income tax or Plan purposes, the child is not your dependent due to divorce or legal separation.

A copy of KCP&L’s QMCSO procedures is available from the HR Service Center or NECA/IBEW Family Medical Care Trust Fund Office free of charge, upon request.

Coordination of Benefits (COB)

Benefits are coordinated when both you and your spouse (and/or your dependent children) are eligible for benefits from this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim.

General COB Rules

1. Benefits are coordinated on all employee, retiree and dependent claims. COB applies only to medical, prescription drug and dental benefits.
2. The Claims Administrator may release or receive necessary information about your claim to or from other sources. You must furnish the Claims Administrator with any information they need to process your claim.
3. You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).
4. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield plans, motor vehicle insurance and blanket insurance plans. If you or your spouse are covered under another plan, you can contact the NECA/IBEW Family Medical Care Trust Fund Office to find out whether that plan fits the definition of a group plan.
5. Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A AND Part B of Medicare, even if he has not actually enrolled in both Parts.
6. When anyone in your family who is covered under another group health plan has a claim, be sure that you file claims with all plans and provide all required information about other coverage on all claim forms.
7. Benefits are paid under COB for allowable expenses, which are expenses that are eligible to be considered for reimbursement.
8. If there is a difference between the amount the primary plan allows and the amount allowable by this Plan, this Plan will coordinate its benefits using the higher amount. However, if the primary plan has a contract with the provider (HMOs and PPOs usually have such contracts with their providers), the combined payments of both plans will not be more than the primary plan's contract calls for. Exception: If both plans have a contract with the same provider, the allowable expense will be the higher of the two contracted or negotiated fees.
9. If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment or any other required notification or procedure of the other plan, including failing to file a claim on time.
10. If you and your spouse are both covered as employees under this Plan and one of you (or child who is a covered dependent of both of you) has a claim, the Plan will coordinate benefits on the claim (two claims must be submitted—one by you and one by your spouse).

Order of Benefit Payments

A plan that is required to pay its normal benefits on a claim before another plan pays its benefits is the primary plan, or pays first. The plan that makes payments based on the amount that is not paid by the primary plan is the secondary plan, or pays second. When a person who has a claim is covered under one or more other plans, this Plan will determine and pay its benefits in accordance with the first of the following rules that applies:

1. If a person is covered under another group plan that doesn't have COB rules, that other plan will pay its benefits first and this Plan will pay second.
2. When the other plan does have COB rules, the plan covering the person (for whom the claim is filed) as an employee will pay first, and the plan covering the person other than as an employee will pay second.
3. If a person who is covered under a plan as a retired worker is also covered under a plan covering the person as a dependent of an actively working spouse, the benefits of the plan covering the person as a retired worker will pay first, and the plan covering the person as a dependent will pay second. However, if the person is also entitled to Medicare, then the order of payment is reversed, so that the plan covering the person as a dependent will pay before the plan covering the person as a retired worker.
4. If a person who has COBRA coverage is also covered under another plan as an employee, retiree or dependent, the COBRA coverage is secondary.
5. On claims for children, the following rules apply:
 - a. The primary plan is the plan of the parent whose birthday is earlier in the year (called the "birthday rule") if:
 - The parents are married or
 - The parents are not separated (whether or not they ever have been married to each other) or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health coverage

If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

- b. If the parents are not married and not living together, or are separated or divorced and no court decree allocates responsibility for the child's health care expenses, the order of benefits for all possible plans is:
 - The plan of the custodial parent
 - The plan of the non-custodial parent
 - The plan of the spouse (if any) of the custodial parent and then
 - The plan of the spouse (if any) of the non-custodial parent
- c. If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, then the responsible parent's plan is primary. If the legally responsible parent does not have health coverage for the child, but his or her spouse does, the spouse's plan becomes primary.
- d. If a court awards joint custody without stating that one parent has primary responsibility for providing health care coverage, the birthday rule applies.

If the above rules still don't clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) for the longest period of time will pay first. The plan which has covered the person for the next longest period of time will pay second, and so on.

COB with Sub-plans

This rule will only apply if the Plan is secondary to another plan with a cost-shifting sub-plan rule.

If this Plan is secondary on a covered person's claim under its order of benefit determination rules, but the person's primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, without regard to whether the lesser benefits are payable under the terms of sub-plan or wrap-around provision, then such person will be deemed covered under this Plan's sub-plan. The maximum payable by this Plan for all claims incurred by a person covered under the sub-plan is \$1,000 per calendar year, or, if less, the amount payable after application of this Plan's coordination of benefits rules.

If the primary plan has a no-loss provision, and if the sum of the primary plan's sub-plan benefits, plus this Plan's sub-plan benefits, plus any additional benefits payable by the primary plan's regular benefit plan under its no-loss provision, is less than the sum of the benefits otherwise payable under this Plan's regular benefit plan, then this Plan's regular benefit plan will pay the difference.

If the primary plan lacks a no-loss provision or if the primary plan refuses to apply its no-loss provision after this Plan's secondary sub-plan benefits are paid, and if the sum of the primary plan's sub-plan benefits and this Plan's secondary sub-plan benefits is less than the sum of the benefits otherwise payable under this Plan's regular benefit plan, then this Plan's sub-plan may, if the Trustees in their sole discretion choose to do so and notwithstanding the otherwise applicable benefit limit under this Plan's sub-plan, "advance" an amount not in excess of the difference between the sum of the benefits previously paid under the primary plan's sub-plan and this Plan's sub-plan and the benefits otherwise payable under this Plan's regular benefit plan. In order for such an "advance" to be made, the participant or beneficiary must sign any documents the Trustees in their sole discretion deem necessary, including a subrogation or reimbursement agreement, an assignment of benefits or any other document necessary to effectuate recovery of the amount of the "advance" from the primary plan or any other source of payment, and agree to fully cooperate in obtaining such recovery. Any amount recovered for the claim from the primary plan or any other source of payment shall be forwarded to this Plan and offset against the amount of the "advance."

If the primary plan pays its normal benefits for the person's claim, that is, the benefits it would have paid if the person was not also covered under this Plan, then the person will be deemed covered under this Plan's regular benefit plan, and this Plan will coordinate its regular benefits as the secondary payer to the other plan.

COB with Medicare

Employees Continuing to Work After Age 65

If you continue to work for KCPL after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for him or her before Medicare pays unless it is legally permitted to pay second. If your spouse is covered under his or her own plan, your spouse's plan will pay first, this Plan will usually pay second, and Medicare will pay last.

Persons age 65 or older are also entitled to select Medicare as their primary coverage. To do so, they must decline all coverage under this Plan.

Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

Medicare-Eligible Persons Under 65

If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second.

Subrogation

If you or your dependent incurs medical expenses for injuries received in an accident for which, in the opinion of the Plan Administrator, a third party may be liable, the Plan Administrator may pay the amount of benefits that would otherwise be payable under the health plan. However, you must provide documentation if requested by the Plan Administrator.

If you do not provide required documentation, the Plan may withhold payment of benefits or deduct the amount from future claims.

The Plan will request repayment of the full benefit amount, if you received payment by:

- Settlement or judgment from or against a third party
- From any uninsured or insured insurance coverage
- Any other first party or third-party claim

If you refuse to repay the benefit amount, the Plan is entitled to recover payment through legal action and/or deduct the amount from future claims.

If you later recover any of the amounts listed above, the Plan is entitled to reimbursement of all benefits it paid in connection with the illness or injury. By accepting these benefits, you also assign to the Plan the right to file suit or take other action on your behalf to recover benefits paid or to be paid by the Plan, agree that the Plan has a lien on any such recoveries, promise to do anything the claims administrator or Plan Administrator requests you to do to assist its recovery efforts, and promise to do nothing to hinder any such efforts. You also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover any amounts from you, your dependents or your or their attorneys or agents.

While not affecting the Plan's right to receive the full amount of medical or dental benefits paid, the Plan may elect, in an appropriate case to pay a portion of the participant's or dependent's attorney's fees in exchange for the waiver of the terms of the common fund doctrine by the involved attorney and the participant or dependent. The Plan shall pay no legal costs or fees without receiving a recovery and then only within the terms of this provision.

In the event that an attorney is hired by or on behalf of the participant or dependent and the Plan is given notice and an opportunity to pursue its own subrogation recovery, the Plan shall not be required to hire an attorney. If the attorney

representing the participant or dependent nevertheless wishes to proceed, and creates a common fund in which subrogated amounts are paid, the Plan may agree to pay up to 10% to include legal fees, provided that the participant or dependent and the attorney waive any other payment or agreement to reduce recovery from the Plan including, but not limited to, any rights under the common fund doctrine. Said 10% shall also include any prorated portion of the cost of recovery. If the attorney representing the participant or dependent receives either a payment or an agreement to reduce recovery from the Plan (whether in the form of cash payment or reduction of the Plan's right to the full amount of benefits paid by the Plan), the attorney and the participant or dependent will be considered to have waived the common fund doctrine.

The Plan's right of subrogation is from the first dollar received by the participant or dependent and takes effect before the whole debt is paid to the participant or dependent.

If you, your dependents or your or their attorneys or agents fail to cooperate with the Plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you and your dependents will not be entitled to any further Plan benefits. The amount the Plan may recover under this section will not be reduced by any attorneys' fees you incur in recovering amounts on behalf of the Plan, nor will it be reduced if you fail to recover all of the amounts you are seeking.

Recovery of Overpayments

If your health benefits are paid by mistake, you must repay the mistaken payment to the Plan immediately. In addition to any other recovery rights it may have, the Plan has the right to recover the overpayment from any future benefits payable to you or dependents. If you or your dependents fail to cooperate with the Plan in securing repayment of benefits paid by mistake, you and your dependents will no longer be entitled to any further Plan benefits.

In addition, if an overpayment results from misrepresentations made by or on behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

Plan Continuation and Discretion

KCP&L intends to continue its benefit plans indefinitely, but subject to any restrictions or limitations in the applicable collective bargaining agreement, reserves the right to amend, suspend, discontinue or terminate the benefit plans, in whole or in part, with or without notice (as required by law) at any time and for any reason.

The Plan Administrator has the sole discretionary authority to determine eligibility for, and the amount of, benefits and to take any other actions with respect to questions arising in connection with the plans, including construction and interpretation of the terms of the plans. All decisions, determinations and interpretations of the Plan Administrator are conclusive and binding on all persons.

Top-Heavy Rules

The Pension Plan and 401(k) Savings Plan contain special rules that apply if the Plans should become "Top-Heavy." Generally, a Plan is top heavy if the benefits accrued by certain key employees of KCP&L amount to 60% or more of the benefits accrued by all employees of KCP&L.

If this should occur, federal law requires that an accelerated vesting schedule and minimum benefit accrual and contribution requirements become effective. It is highly unlikely that these Plans will ever become top heavy; however, if this should happen, you will receive more information about the effective provisions.

Required Legal Information

Under the Employee Retirement Income Security Act of 1974 (ERISA), each employee must be provided certain details about benefit plans. This information is listed in this section of this book. If you need additional information, please contact the Benefits Administration Department or your local U.S. Department of Labor office.

Plan Sponsor

Except as noted herein, the plans described in this book are sponsored by:

Great Plains Energy Incorporated

P.O. Box 418679
Kansas City, MO 64141-9679

The NECA/IBEW Family Medical Care Plan (which provides medical, prescription drug, and dental benefits) is sponsored by:

Board of Trustees

NECA/IBEW Family Medical Care Trust Fund
5837 Highway 41 North
Ringgold, GA 30736

A complete list of employers and the unions sponsoring the NECA/IBEW Family Medical Care Plan may be obtained by participants and beneficiaries upon written request to the Board of Trustees, and is available for examination by participants and beneficiaries, as required by DOL regulations 29 CFR §§ 2520.104b-1 and 2520.104b-30.

Plan Administrator

Basic Life, AD&D and Dependent Life Insurance:

Board of Trustees

Great Plains Energy Incorporated Joint Trusteed
Health and Welfare Plan
P.O. Box 418679
Kansas City, MO 64141-9679
816-556-2500

Pension Plan:

Board of Trustees

Great Plains Energy Incorporated Joint Trusteed
Retirement Plan
P.O. Box 418679
Kansas City, MO 64141-9679
816-556-2500

NECA/IBEW Family Medical Care Plan:

NECA/IBEW Family Medical Care Trust Fund

5837 Highway 41 North
Ringgold, GA 30736
877-937-9602

All Other Plans:

Great Plains Energy Incorporated

P.O. Box 418679
Kansas City, MO 64141-9679
816-556-2500

The Tax Identification number for Great Plains Energy Incorporated is 43-1916803.

The Tax Identification numbers for the union locals are as follows:

I.B.E.W. Local 412: 44-0296394
I.B.E.W. Local 1464: 44-0539884
I.B.E.W. Local 1613: 44-0540581

The Tax Identification number assigned to the NECA/IBEW Family Medical Care Plan is 75-3198514.

Collective Bargaining Agreements

The Joint Trusteed Retirement Plan and the Joint Trusteed Health and Welfare Plan are maintained pursuant to Article XIX, Section 4, of the collective bargaining agreement between the Company and Local Union 412; Article XIX, Section 4, of the agreement between the Company and Local Union 1464; and Article XIX, Section 4, of the agreement between the Company and Local Union 1613. Copies of the bargaining agreements may be obtained upon written request to the Plan Administrator, and are available for examination by participants and beneficiaries, as provided by law, by making a request to the Plan Administrator.

Plan Year

All records are kept on a Plan Year basis. The Plan Year begins January 1 and ends December 31 for all benefit plans except the Pension Plan. The Plan Year for the Pension Plan is October 1 through September 30.

Agent for Service of Legal Process

The agent for service of legal process is:

Basic Life, AD&D and Dependent Life Insurance:

Board of Trustees

Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan
P.O. Box 418679
Kansas City, MO 64141-9679

Pension Plan:

Board of Trustees

Great Plains Energy Incorporated Joint Trusteed Retirement Plan
P.O. Box 418679
Kansas City, MO 64141-9679

NECA/IBEW Family Medical Care Plan:

Board of Trustees

NECA/IBEW Family Medical Care Plan
5837 Highway 41 North
Ringgold, GA 30736

All Other Plans:

Great Plains Energy Incorporated Corporate Secretary

P.O. Box 418679
Kansas City, MO 64141-9679

Service of legal process may also be made on the Plan Administrator.

Plan Administration Summary

The chart below lists the common names of the KCP&L benefit plans, as well as other identifying information.

Common Name of Plan	Legal Plan Name	Plan Type	Plan Trustee (T), Insurer (I) or Claims Administrator (A)	Plan Number
Medical Plan	NECA/IBEW Family Medical Care Plan	Welfare plan providing medical expense benefits	(A) Blue Cross Blue Shield of Georgia (BCBSGA) P.O. Box 9907 Columbus, GA 31908-7368	501
Prescription Drug Plan	NECA/IBEW Family Medical Care Plan	Welfare plan providing prescription drug benefits	(A) Sav-Rx 224 North Park Avenue Fremont, NE 68025 866-233-IBEW (4239)	501
Dental Plan	NECA/IBEW Family Medical Care Plan	Welfare plan providing dental expense benefits	(A) MetLife P.O. Box 981282-1282 El Paso, TX 79998-1282	501
Vision Plan (Local 1613 only)	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare plan providing vision expense benefits	(I) Vision Service Plan Insurance Company 333 Quality Drive Rancho Cordova, CA 95670	540
Medical Reimbursement Account (Local 1613 only)	Great Plains Energy Incorporated Cafeteria Plan and Reimbursement Programs for Management Employees and Employees Represented by Local Union 1613	Welfare plan and fringe benefit providing reimbursement of health care expenses under Internal Revenue Code section 125	(A) PayFlex 10802 Farnam Drive Suite 100 Omaha, NE 68154	513
Dependent Care Reimbursement Account	Local 1613: Great Plains Energy Incorporated Cafeteria Plan and Reimbursement Programs for Management Employees and Employees Represented by Local Union 1613 Locals 412 and 1464: Great Plains Energy Incorporated Cafeteria Plan and Dependent Care Reimbursement Program for Employees Represented by Local Unions 412 and 1464	Fringe benefit plan providing reimbursement of dependent care expenses under Internal Revenue Code sections 125 and 129	(A) PayFlex 10802 Farnam Drive Suite 100 Omaha, NE 68154	Local 1613: 514 Locals 412 and 1464: 512
Basic Life Insurance	Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan	Welfare plan providing benefits in the event of death	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	501

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Common Name of Plan	Legal Plan Name	Plan Type	Plan Trustee (T), Insurer (I) or Claims Administrator (A)	Plan Number
Dependent Life Insurance	Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan	Welfare plan providing benefits in the event of a dependent's death	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	501
Supplemental Life Insurance	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare plan providing benefits in the event of death	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	540
Basic Accidental Death & Dismemberment (AD&D) (Locals 412 and 1464 only)	Great Plains Energy Incorporated Joint Trusteed Health and Welfare Plan	Welfare plan providing benefits in the event of accidental death or dismemberment	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	501
Supplemental Accidental Death & Dismemberment (AD&D) (Local 1613 only)	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare plan providing benefits in the event of accidental death or dismemberment	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	540
Dependent Accidental Death & Dismemberment (AD&D) (Local 1613 only)	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare plan providing benefits in the event of a dependent's accidental death or dismemberment	(I) Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166-0188	540
Business Travel Accident	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare benefit and fringe benefit providing benefits in the event of death while traveling on KCP&L business	(I) Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235	540
Survivor Benefit Plan	Great Plains Energy Incorporated Survivor Benefit Plan	Fringe benefit providing benefits to survivors in the event of death during employment at KCP&L	(A) KCP&L Attention: Employee Benefits P.O. Box 418679 Kansas City, MO 64141-9679	526
Long-Term Disability	Great Plains Energy Incorporated Employee Welfare Benefit Plan	Welfare plan providing income replacement benefits in the event of a long-term disability	(A) GPE Welfare Benefit Plan P.O. Box 418679 Kansas City, MO 64141-9679	540

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Common Name of Plan	Legal Plan Name	Plan Type	Plan Trustee (T), Insurer (I) or Claims Administrator (A)	Plan Number
Pension Plan	Great Plains Energy Incorporated Joint Trusteed Retirement Plan	Defined benefit plan	(A) KCP&L Attention: Employee Benefits P.O. Box 418679 Kansas City, MO 64141-9679 (T) Board of Trustees of the Joint Trusteed Retirement Plan	002
401(k) Savings Plan	Great Plains Energy Incorporated 401(k) Savings Plan	Defined contribution Plan. A component of the Plan is also known as an "Employee Stock Ownership Plan."	(A) JPMorgan Retirement Plan Services 9300 Ward Parkway Kansas City, MO 64114	006
Vacation Purchase (Local 1613 only)	Great Plains Energy Incorporated Cafeteria Plan and Reimbursement Programs for Management Employees and Employees Represented by Local Union 1613	Fringe benefit under Internal Revenue Code section 125	(A) KCP&L Attention: Employee Benefits P.O. Box 418679 Kansas City, MO 64141-9679	513

Board of Trustees of the Great Plains Incorporated Joint Trusteed Retirement Plan and Board of Trustees of the Great Plains Incorporated Joint Trusteed Health and Welfare Plan

Union Trustees	Employer Trustees
<p>Jerry Archer Business Manager IBEW Local No. 1613 6200 Connecticut Suite 105 Kansas City, MO 64120</p>	<p>Terry D. Bassham Executive Vice President, Finance and Strategic Development & Chief Financial Officer Kansas City Power & Light Company P.O. Box 418679 Kansas City, MO 64141-9679</p>
<p>Darrell L. McCubbins Business Manager IBEW Local No. 1464 6200 Connecticut Suite 105 Kansas City, MO 64120</p>	<p>Barbara B. Curry Senior Vice President, Human Resources & Corporate Secretary Kansas City Power & Light Company P.O. Box 418679 Kansas City, MO 64141-9679</p>
<p>Billy R. McDaniel Business Manager IBEW Local No. 412 6200 Connecticut Suite 105 Kansas City, MO 64120</p>	<p>William P. Herdegen Vice President, Transmission & Distribution Operations Kansas City Power & Light Company P.O. Box 418679 Kansas City, MO 64141-9679</p>

Vision Coverage, Supplemental and Dependent AD&D, the Medical Reimbursement Account, Flex Dollars and Vacation Purchase are available only to members of Local 1613.

Board of Trustees NECA/IBEW Family Medical Care Plan

Union Trustees	Employer Trustees
<p>Mr. Lindell Lee International Secretary-Treasurer International Brotherhood of Electrical Workers 900 Seventh Street, NW Washington, D.C. 20001</p>	<p>Mr. Geary Higgins Vice President, Labor Relations National Electrical Contractors Association 3 Bethesda Metro Center Suite 1100 Bethesda, MD 20814</p>
<p>Mr. Johnny M. Nickles Business Manager IBEW Local Union 1316 1046 Patterson Street P. O. Box 2565 Macon, GA 31203</p>	<p>Mr. Howard D. Hughes Vice President, NECA District 5 Hughes Electric Co., Inc. 814 Raleigh Street Fort Smith, AR 72901</p>
<p>Mr. Shane Roberts Business Manager IBEW Local Union 1925 402 Jackson Street Martin, TN 38237</p>	<p>Mr. Jerry Sims Governor East Tennessee Chapter, NECA District 3 Allied Electric & Control Systems 612 Lullwater Rd. Chattanooga, TN 37405</p>
<p>Mr. William M. ("Mike") Long Business Manager IBEW Local Union 1613 6200 Connecticut Avenue Suite 105 Kansas City, MO 64120</p>	<p>Mr. Kevin Tighe Manager North Florida Chapter NECA 4951-A Richard Street Jacksonville FL 32207</p>
	<p>Mr. Lawrence J. Moter, Jr. Manager Atlantic Coast Chapter NECA 2510 Grenoble Road Richmond, VA 23294</p>

Statement of ERISA Rights

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at KCP&L's offices and at other specified locations, such as worksites and union halls, all documents governing the Plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, by written request to the Plan Administrator, copies of documents governing the operation of the Plans, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and the current Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if ERISA requires one. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.
- Continue health care coverage for yourself, spouse or your dependents if you lose coverage under the Plan as a result of a qualifying event. You or your dependents have to pay for such coverage. Review this SPD and the documents governing the Plan for rules governing your COBRA continuation rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ends, if you request it before losing coverage or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. These people, 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 KCP&L, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension or welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 Plan Administrator.

If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if 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. However, before filing any suit, you must exhaust your administrative remedies under the Plan's claims procedure.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator by calling 816-276-5555.

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.

