Westar Legacy Union and Non-Union Turning 65

Medical Plan Information

Your Medicare eligibility date is the first day of the month in which you turn 65 (i.e. if your birthdate is June 15, your Medicare eligible June 1). If your birthdate falls on the first day of the month, your Medicare eligibility date falls back to the first day of the previous month (i.e. if your birthdate is June 1, your Medicare eligibility date would be May 1).

To enroll in a Medicare eligible plan, you must contact Via Benefits at **1-844-448-7296** or online, at **my.viabenefits.com/westarenergy**. Via Benefits will provide you with your HRA allocation amount during your enrollment session with a benefit advisor. In order to continue to receive an HRA allocation, you must enroll with Via Benefits. Via Benefits will be sending you information regarding the Medicare enrollment process.

Dental Plan Information (if applicable)

Evergy does not contribute toward the cost of dental coverage for Medicare eligible employees. Medicare eligible retirees and dependents are provided an opportunity to enroll in a fully-insured dental plan either through Via Benefits or directly with Delta Dental of Kansas. You can use the funds deposited into your HRA to reimburse yourself for dental plan premiums and costs. In order to enroll in Medicare Eligible Dental Coverage, please contact the plan provider directly:

Dental Providers

Via Benefits
(844) 448-7296
my.viabenefits.com/westarenergy

Delta Dental
(800) 234-3375
deltadentalks.com

If you are currently enrolled in Evergy's pre-65 dental plan through Delta Dental, your coverage will terminate on your Medicare eligibility date. If you are covering a non-Medicare eligible dependent(s), the dependent(s) will continue to maintain pre-65 dental coverage. Any premium payments will be stopped or adjusted accordingly on your behalf.

Evergy Medicare
Eligible Dental Coverage (Group #199)

DELTA DENTAL®

% Paid by DDPK	
100%	**1. DIAGNOSTIC:** Includes procedures to assist the dentist in evaluating the conditions existing and the dental care required: • Oral examinations: twice per calendar year. • Diagnostic x-rays: bitewings twice per calendar year for dependents under age 18 and once each twelve months for adults age 18 and over. • Full mouth x-rays: once each five years.
100%	**2. PREVENTIVE:** Provides for the following: • Prophylaxis: twice per calendar year. • Topical fluoride: twice per calendar year for dependent children under age 19. • Space maintainers for dependent children under age 9 and only for premature loss ofprimary molars. • Sealants: one per lifetime for dependent children under age 15 when applied only topermanent molars with no caries (decay) or restorations on any surface and with theocclusal surface intact.
50%	**3. ANCILLARY** Provides for an emergency examination by the dentist for the relief of pain when no otherservices are performed.
50%	**4. ORAL SURGERY:** Provides for extractions and other oral surgery including pre- and post-operative care.
50%	**5. REGULAR RESTORATIVE DENTISTRY:** Provides amalgam (silver) restorations; composite (white) resin restorations on anterior(front) teeth; and stainless steel crowns for dependents under age 12.
50%	**6. ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings.
50%	**7. PERIODONTICS:** Includes procedures for the treatment of diseases of the gums and bone supporting theteeth.
50%	**8. SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular RestorativeDentistry, provides for gold restorations and individual crowns.
50%	**9. PROSTHODONTICS:** Includes bridges, partial and complete dentures, including repairs and adjustments.
Not Covered	**10. ORTHODONTICS:** Orthodontic appliances and treatment.
Dependent:	Dependent children are covered till the end of the month in which they turn 26.
Maximum:	$1,000 per person per benefit period.
Deductible:	The deductible is $50 per person per benefit period, with a family maximum deductibleof $150. The deductible does not apply to Diagnostic or Preventive procedures.

RETIREE ONLY: **$33.30**
RETIREE + FAMILY: **$67.47**

Send completed forms to:
Delta Dental
PO Box 789769
Wichita, KS 67278

**This is a summary of benefits only. Please see certificate for limitations and exclusions.*

DELTA DENTAL

Enrollment/Change Form

Check One:

- ☐ New Application for Coverage
- ☐ Change Authorization
- ☐ Waiver of Coverage (complete Section (6) ONLY)

Section 1 EMPLOYEE INFORMATION: (Please Type or Print Legibly)

Add ☐ Terminate ☐	Social Security / ID Number:	Group Number: 199	Employer/Group Name: (Please do not abbreviate) EVERGY RETIREES

Employee Name: (First, Middle Initial, Last) — Male ☐ Female ☐

Home Address:	City:	State:	Zip Code:	Birth Date: (mm/dd/yy)

Single ☐ Married ☐	Hire Date: (mm/dd/yy)	Effective Date: (mm/dd/yy)	Type of Medical Coverage: Single ☐ Family ☐	Medical Carrier and Address:
	N/A			

Section 2 DEPENDENT INFORMATION: (List ONLY Eligible family members to be enrolled or affected by change)

Action:	Effective Date:	**Spouse** Name: (First, Middle Initial, Last)		Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		Male ☐ Female ☐	

NOTE: If natural parents are separated or divorced, indicate name of parent with custody or who is legally responsible for health benefits:

Action:	Effective Date:	**Dependent** Name: (First, Middle Initial) (Last Name, if different)	Male	Female	Birth Date:
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	
Add ☐ Terminate ☐	(mm/dd/yy)		☐	☐	

Section 3 OTHER INSURANCE INFORMATION: (Complete ONLY if requesting coverage for dependent[s])

	Spouse	Children
Are your dependents covered by another dental plan?	○ Yes ○ No	○ Yes ○ No
Are your dependents covered by another medical plan?	○ Yes ○ No	○ Yes ○ No

If YES, please provide spouse's Social Security #:_____

Spouse's employer:_____

Dental Carrier:

Address:

Medical Carrier:

Address:

Section 4 CHANGES: (Please mark all appropriate boxes that apply to change[s] you wish to make)

DELTA DENTAL MUST BE NOTIFIED OF CHANGES WITHIN 30 DAYS OF EVENT

DATE of EVENT:_____

☐ Name Change: From:_____ To:_____

☐ Adoption/Legal Custody of Child:

☐ Marriage: ☐ Divorce: ☐ Other:

Section 5 SIGNATURE/AUTHORIZATION:

I hereby apply for group dental coverage for which I am eligible and authorize the release of dental records to Delta Dental of Kansas, Inc.

Authorization/Signature for Enrollment/Change[s]:_____ Date:_____

Section 6 WAIVER OF COVERAGE: (Complete ONLY if you or your family are not enrolling for benefits)

This is to certify that I have been given the opportunity to apply for group dental insurance available to me through my employer, and I have decided that I:

- ☐ **Do not** want dental coverage for myself because:_____.
- ☐ **Do not** want dental coverage for my spouse and/or my children.

I understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be conditional upon the approval of Delta Dental of Kansas, Inc. and may be subject to waiting periods or limitations.

Authorization/Signature for Waiver of Coverage:_____ Date:_____

Printed-Employee Name: (First, Middle Initial, Last) _____ Social Security #:_____

(Please keep a copy for your records)

Dated: 7/19/06

Authorization Agreement for Automated Payments

COMPANY:
Delta Dental of Kansas, Inc.

I (we) hereby authorize Delta Dental of Kansas, Inc. hereinafter called COMPANY, to initiate debit entries to my (our) Checking ( ) Savings ( ) account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to debit same to such account.

Depository
Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Bank Routing No.: _____ Account No.: _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY has received written notification from me (or either of us) of its termination in such time and insuch manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s): _____ Medicare No.: _____

Date: _____ Signed: _____

Date to take out first payment: _____ _____
Month Year

A VOIDED CHECK MUST ACCOMPANY THIS FORM.