**A Plan Designed to Provide Security for Employees of**


# Ameren Dental Plan

for:

Management Employees
and
Employees Represented by a Collective Bargaining Agreement with:
AmerenCILCO and IBEW Local Union 51
UEC (Ameren Missouri) Callaway Energy Center, Unit 1
and UGSOA Local Union 11
Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 309
Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 649
Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702E – Illini
Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702S – Shawnee
Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702W – Great Rivers
Ameren Illinois (formerly AmerenIP) and IBEW Local 51 (IP)
Ameren Illinois (formerly AmerenIP) and IBEW Local 309 (IP)
Ameren Illinois (formerly AmerenIP) and IBEW Local 702 (IP)
Ameren Illinois (formerly AmerenIP) and Laborers Local 12 Counties (IP)
Ameren Illinois (formerly AmerenIP) and Pipefitters Local 101 (IP)
Ameren Illinois (formerly AmerenIP) and Pipefitters Local 360 (IP)
Ameren Illinois (formerly AmerenIP) and Laborers Local 459 (IP)
Ameren Illinois (formerly AmerenIP) and IBEW 51 MDF (IP)
Ameren Illinois (formerly AmerenIP) and Laborers Local 100 (IP)
AER Divestiture Employees

Administered by:
Delta Dental of Missouri

**ERISA Summary Plan Description.** This document constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 ("ERISA) § 102.

## Purpose

Ameren Corporation ("the Plan Sponsor") maintains the **Ameren Dental Plan**, a component of the **Ameren Employee Medical Plan** (the "Plan") to provide dental benefits to its eligible Employees, their Spouses, and other eligible Dependents. All references herein to the "Ameren Dental Plan" and the "Plan" refer to the Dental Program component of the Plan.

This booklet (including any subsequent supplements) constitutes the Summary Plan Description (SPD) for and outlines the provisions and benefits afforded under the Plan as of January 1, 2018. It replaces and supersedes all prior summary plan descriptions for the Plan.

The **Ameren Dental Plan** has been established on a noninsured basis; all liability for payment of benefits is assumed by Ameren. While Delta Dental of Missouri ("Delta Dental") administers the payment of claims, Delta Dental has no liability for the funding of the Plan.

While one of the functions of Delta Dental is to process claims according to the Plan provisions, all claims under the Plan are paid by Ameren and Ameren owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by Ameren Services.

The Administrative Committee of Ameren Services Company (the "Company") serves as Plan Administrator. The Plan Administrator has complete and sole discretion to construe or interpret all Plan provisions, to determine eligibility for benefits, to grant or deny benefits, and to determine the type and extent of benefits, if any, to be provided. The Plan Administrator's decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by the Plan Administrator, the Plan Administrator shall be deemed to have exercised its discretion properly unless it is proved duly that the Plan Administrator has acted arbitrarily and capriciously. The Plan Administrator has also delegated discretionary authority for the administration of dental benefit claims and appeals to Delta Dental.

The Plan shall be construed and administered to comply in all respects with applicable federal law.

As a participant in the Plan, Your rights and benefits are determined by the provisions of the Plan. This booklet briefly describes those rights and benefits. It outlines what You must do to be covered. It explains how to file claims. This SPD contains a brief description of the principal features of the Plan and is not meant to interpret, extend or change the provisions of the Plan in any way. A copy of the Plan document is on file with the Plan Administrator and is available to You, upon request and free of charge, at any time. The Plan document shall govern if there is a discrepancy between this SPD and the actual provisions of the Plan.

**DURATION OF THE PLAN**. Ameren Corporation hopes and expects to continue the **Ameren Dental Plan** in the years ahead but cannot guarantee to do so. The Company reserves the right to amend, modify, or terminate the Plan, and/or any benefits provided under the Plan at any time, with respect to all individuals.

**PLEASE READ THIS BOOKLET CAREFULLY**. We suggest that You start with a review of the terms listed in the DEFINITIONS Section. The meanings of these terms will help You understand the provisions of Your Plan. Terms defined in the DEFINITIONS section of this booklet are capitalized in this document.

## Ameren Benefits Center

The **Ameren Benefits Center** is Ameren's employee benefits customer call center. When You have questions about Your benefits, call the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), Option 2. The **Ameren Benefits Center** is available Monday through Friday from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

## www.myAmeren.com

Ameren Services maintains **www.myAmeren.com** where Plan participants can enroll, view, or make changes to elected benefit coverage through "Healthcare and Life Benefits". The website is generally available 24 hours a day, seven days a week.

**Note**: There may be short maintenance periods during which benefits information will not be available.

In order to maintain confidentiality of Your benefits information, a password is required for a Plan participant to view individual benefit information. If You have forgotten Your password, You can request a new password on the logon screen. Questions about Your benefits should be directed to the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637)**, Option 2**.**

If You do not have access to a computer or an HR Web Station, You can manage Your benefits by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637)**, Option 2**.**

# Ameren Dental Plan
# Table of Contents

**Section** **Page**


Purpose ..... 2
Ameren Benefits Center ..... 3
www.myAmeren.com ..... 3
Eligibility ..... 5
Enrollment Provisions ..... 7
Coverage Changes ..... 8
Cost of Coverage ..... 9
Coverage Identification Card ..... 10
Definitions ..... 10
Schedule of Benefits ..... 13
Deductible Amounts ..... 15
Maximum Benefits ..... 15
Covered Expenses ..... 15
Expenses Not Covered ..... 17
Coverage Limitations ..... 18
Coordination of Benefits ..... 18
Subrogation ..... 20
Payment of Benefits ..... 20
How to File a Claim ..... 20
Termination of Benefits ..... 22
COBRA Continuation – Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ..... 23
Continuation of Coverage under the Trade Act of 1974 ..... 26
Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA) ..... 27
Continuation of Coverage Under the Uniformed Services Employment & Re-Employment Rights Act of 1994 (USERRA) ..... 28
Privacy ..... 29
Claim and Appeal Procedures for Eligibility ..... 29
Claims Procedure and Appeals For Dental Benefits ..... 31
Miscellaneous ..... 33
Your Rights Under ERISA ..... 35
General Information About the Plan ..... 36

# Ameren Dental Plan

## Eligibility

### Employees

- You are eligible to participate in this Plan if You are classified by Ameren as:
- A regular full-time Employee represented by a collective bargaining agreement between:
  - Ameren Illinois (formerly AmerenCILCO) and IBEW Local Union 51; or
  - UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11; or
  - Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 309; or
  - Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 649; or
  - Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702E – Illini; or
  - Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702S – Shawnee; or
  - Ameren Illinois (formerly AmerenCIPS) and IBEW Local Union 702W – Great Rivers; or
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  - Ameren Illinois (formerly AmerenIP) and IBEW Local 702 (IP) ; or
  - Ameren Illinois (formerly AmerenIP) and Laborers Local 12 Counties ( IP) ; or
  - Ameren Illinois (formerly AmerenIP) and Pipefitters Local 101 (IP) ; or
  - Ameren Illinois (formerly AmerenIP) and Pipefitters Local 360 (IP) ; or
  - Ameren Illinois (formerly AmerenIP) and Laborers Local 459 (IP) ; or
  - Ameren Illinois (formerly AmerenIP) and IBEW 51 MDF (IP) ; or
  - Ameren Illinois (formerly AmerenIP) and Laborers Local 100 (IP) ; or
- a regular full-time Employee (1) whose employment was covered by the following collectively bargained agreement on the date the applicable business was divested or acquired[1] and (2) is receiving benefits under the Ameren Long Term Disability Plan.
  - AmerenEnergy Generating Company and IBEW Local Union 702 – Newton; or
  - AmerenEnergy Generating Company and IBEW Local Union 702 – Newton Clerical; or
  - AmerenEnergy Generating Company and IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville, and Grand Tower); or
  - AmerenEnergy Generating Company and IUOE Local Union 148 – Coffeen Clerical; or
  - AmerenEnergy Resources Generating Company and IBEW Local Union 51 (Duck Creek, and Edwards)

[1] AmerenEnergy Resources (AER) was divested to Illinois Power Holdings, LLC (commonly referred to as "Dynegy") effective December 2, 2013. The Grand Towers Power Plant was acquired by NAES Corporation effective February 1, 2014.

Employees who meet this criteria are considered "AER Divestiture Employees" for purposes of this SPD; or

- a full-time management Employee of Ameren; or
- a participant in the "Temporary Voluntary Reduced Hours Program".

You may complete the appropriate enrollment process, either by enrolling on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

## Dependents

If You enroll in the Plan, Your Dependents are also eligible for coverage, provided that You enroll them according to the appropriate procedures. You must be enrolled in the **Ameren Dental Plan** in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to Your:

1) Spouse;
2) Dependent Children who have not reached age 26;
3) Dependent Children who are not capable of self-sustaining employment due to a disability and are therefore dependent upon You for support, are eligible to continue their coverage under the Plan beyond age 26. Proof of the disability must be furnished to the Plan Administrator no later than 31 days after the date of the child's 26th birthday. A child is considered disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected either to result in death or last for a continuous period of not less than 12 months.

   Disabled Dependent Children who were not covered under the Plan upon attainment of their 26th birthday are not eligible for coverage.

   Disabled Dependent Children who are dropped from coverage after age 26 may not re-enroll in the future.

Proof of eligibility and Social Security numbers are required for enrollment. You are required to provide the Social Security number for each eligible Dependent you wish to cover. Social Security numbers are not required to enroll an eligible Dependent under six months of age. Please note that Dependents age six months or older are required to have a Social Security number on file.

**Important Note**: If proof of Dependent status is not provided in accordance with procedures determined by the Plan Administrator, your Dependent's coverage under the Plan will be terminated as of the stated required date You fail to provide the required proof of Dependent status.

A Spouse who works for Ameren and who is eligible as an Employee for coverage under another Ameren sponsored Dental or Dental/Vision Plan cannot be covered as Your Dependent under this Plan, whether or not they chose to enroll in the Plan for which they are eligible.

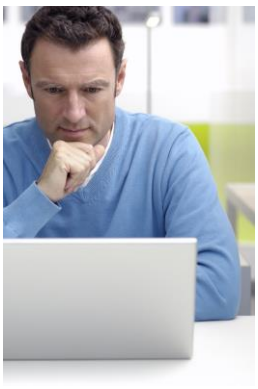
A Dependent Child under the age of 26 who is also an Ameren Employee and eligible for coverage under an Ameren sponsored Dental or Dental/Vision Plan as an Employee, can be covered as an Employee, or can be covered as the Dependent Child of another Ameren Employee, but cannot be covered as both an Employee and a Covered Dependent.

No person can be covered as a Dependent of more than one Employee. No person can be covered under more than one Ameren-sponsored dental plan at the same time.

## Enrollment Provisions

### Employees

In order to elect or waive coverage in the **Ameren Dental Plan**, You must complete the appropriate enrollment or waiver process, either on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). You must choose a coverage category. The coverage categories are:



- You Only
- You + Spouse
- You + Child(ren)
- You + Family
- Waive Coverage

Whether You become eligible for this Plan because You are a new Employee or because You have had a change in Your employment status (such as a transfer from temporary to regular, part-time to full-time or transfer from an ineligible Ameren union represented position to a management position), You must elect a coverage category and enroll eligible Dependents, or waive coverage, no later than thirty-one (31) days from the date of Your Enrollment Worksheet. Your coverage will be effective on Your eligibility date.

If You do not make a coverage election (including "Waive Coverage") during Your initial enrollment period, You will be defaulted to 'You Only' coverage and the applicable payroll deductions will be taken.

*__Important Note__: If You become eligible to participate in this Plan and were covered under another Ameren sponsored dental plan immediately prior to Your change in employment status, Your Covered Dependents will also become covered under this Plan if they were covered under the other Ameren sponsored dental plan. For example, if You transfer from union to management, Your Plan will change. Your Covered Dependents will also become covered under Your new dental Plan.

You must be at work on the day Your coverage is to become effective. If You are not at work on that day, Your coverage will not begin until You return to full-time work. If You are absent from work due to a health condition, You will be treated as if You are at work for purposes of determining Your effective date of coverage.

### Dependents

Coverage for Your eligible Dependents will generally begin on the same date as Your coverage begins if You enroll them at the time You enroll Yourself in the Plan. If You choose not to cover Your Spouse, or Child(ren) immediately, You can add that Dependent only during the Annual Enrollment Period, unless You qualify for a special enrollment right or You experience a change in status. (See COVERAGE CHANGES.)

## Coverage Changes

### Change in Status

Aside from the Special Enrollment Period, You may not change Your coverage in any way during the Plan Year unless there is a change in status that results in a gain or loss of eligibility for coverage. The change in coverage must be on account of and consistent with Your change in status. Qualifying changes in status as defined by the IRS include, but are not limited to:

- You get married, divorced or legally separated;
- You gain a Dependent through birth, adoption, placement for adoption, or marriage;
- You, Your Spouse, or Dependent Child becomes employed or loses a job;
- Your Spouse, or Dependent Child dies;
- You, Your Spouse, or Dependent Child changes from full-time to part-time work or vice versa;
- You, or Your Spouse commence or return from an unpaid leave of absence;
- Your Spouse, or Dependent Child experiences a significant change in dental coverage or cost under another employer's health plan.
- Your Dependent Child satisfies or ceases to satisfy the eligibility requirements.

You may also be entitled to make the appropriate coverage change if there is a change required pursuant to a Qualified Medical Child Support Order.

If You have a status change and want to enroll Yourself, or add a new Dependent, You must complete the appropriate enrollment process by either enrolling on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**) within 31 days of the event in order for the change in coverage to be retroactive to the date of the event. If notification is received later than 31 days after the event, You and/or the Dependent must wait until the next Annual Enrollment Period to enroll for coverage.

If You have a status change and want to drop coverage for Yourself or a Dependent, in most cases, the coverage will be terminated on the last day of the month in which the event occurred, provided You notify the **Ameren Benefits Center** within 31 days of the change in family status. In the event of the death of a Dependent, divorce, or legal separation, coverage will be terminated on the date of the event.

All enrollment and coverage changes due to a change in status event are subject to the approval of the Plan Administrator. Documentation of a change in status may be necessary to make a change in coverage. The Plan Administrator has the discretionary authority to determine whether a change in status has occurred in accordance with the IRS rules and regulations permitting a change.

### Special Enrollment Period

If coverage under the Plan was waived, You and/or Your eligible Dependents may enroll in the Plan only during the Annual Enrollment Period unless You and/or an eligible Dependent qualifies for a special enrollment period due to a loss of coverage or the acquisition of a new Dependent.

If You and/or an eligible Dependent were covered under another group dental plan (including COBRA continuation coverage) or had other dental insurance coverage at the time enrollment was waived, and have lost or will lose coverage under the other plan as a result of:

a) loss of eligibility (due to such reasons as death of a Spouse, divorce, legal separation, termination of employment or reduction in the number of hours of employment), or

b) cessation of the employer's contributions towards such coverage (regardless of whether You or an eligible Dependent lost eligibility for such coverage), or

c) exhaustion of COBRA continuation coverage,

You and/or an eligible Dependent must request enrollment within 31 days after the loss of coverage. Coverage will be effective as of the date coverage was lost.

If You acquire an eligible Dependent through marriage, birth, adoption, or Placement for Adoption while You are eligible for the Plan, You (if You waived coverage when You became eligible) and Your newly acquired eligible Dependent(s) may enroll within 31 days of the date of marriage, birth, adoption, or placement for adoption. In the case of the birth, adoption, or placement for adoption of a child, Your Spouse may also be enrolled as Your eligible Dependent if otherwise eligible for coverage. Coverage will be effective as of the date of marriage, birth, adoption, or placement for adoption (see ELIGIBILITY).

If You do not enroll Yourself or Your eligible Dependents during the 31-day special enrollment periods permitted above, enrollment is not permitted until the next Annual Enrollment Period.

### Annual Enrollment Period

You may add or drop coverage for You or Your Dependents during the Annual Enrollment Period which is normally held each November. Changes in coverage made during this period will be effective January 1 of the following year.

### Qualified Medical Child Support Orders

This Plan will also provide coverage to the extent required pursuant to a Qualified Medical Child Support Order (QMCSO), including National Medical Support Notices, as defined by ERISA § 609 (a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants can obtain, without charge, a copy of such procedures from the Plan Administrator.

## Cost of Coverage

The Company currently pays a portion of the cost of this coverage for You and Your Covered Dependents. You pay the remainder of the cost for You and/or eligible Dependent coverage through pre-tax payroll deductions from Your earnings.

Paying on a pre-tax basis means that Your premiums are deducted from Your paycheck before federal income, Social Security, and (in most cases) state taxes are withheld. The premiums are not included on Your W-2 form as taxable wages, so You lower Your taxable income.

The cost of coverage for Members is subject to change. Additionally, at any time an overpayment or underpayment of premiums by You for coverage under this Plan becomes known to the Plan, a correction will be required. Unless otherwise subject to IRS Section 125

rules, in the case of an overpayment, the overpaid premium amount will be refunded to You, or in the case of an underpayment, the underpayment of premiums will need to be paid by You to Ameren.

### Coverage of Certain Dependents May be Taxable

Dental coverage under the Plan for Your Spouse (including a same-sex Spouse) and eligible Dependent Children is generally not taxable for federal tax purposes.

### Children

Your eligible Covered Dependent Children and stepchildren may receive Ameren healthcare coverage on a tax-free basis for federal tax purposes until they reach age 26. Healthcare coverage provided to other children, such as a child for whom You have guardianship, may be provided on a tax-free basis for federal tax purposes only if the child meets the guidelines for being your qualified tax dependent for healthcare purposes.

If You cover a child under the **Ameren Dental Plan**, You are responsible for determining whether the child is eligible for tax-free coverage. It is recommended that You consult with Your tax advisor to determine if your covered child is eligible for tax-free coverage. If You determine that one or more of Your children is not eligible for tax-free employer provided healthcare coverage, You must contact the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

## Coverage Identification Card

Once You are enrolled in the Plan, You will be issued identification cards which provide information about Your dental coverage. You should carry the cards with You at all times and show them to Your provider when You go for any appointments.

## Definitions

Several words and phrases used to describe Your Plan are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

**Ameren** means Ameren Corporation and its subsidiaries.

**Claims Administrator** means any entity authorized by the Plan Administrator to administer claims for benefits under this Plan.

**Coinsurance** means the percentage of Covered Expenses either paid by the Plan or paid by You.

**Company** means Ameren Services Company, as agent for Ameren Corporation and its subsidiaries.

**Coordination of Benefits** means a provision that is intended to avoid claims payment delays and duplication of benefits when a Member is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

**Covered Dependent** means a Dependent who meets the Plan's eligibility requirements set forth in this Summary Plan Description and has been enrolled hereunder and whose coverage under the Plan is in effect.

**Covered Employee** means an Employee who meets the Plan's eligibility requirements set forth in this Summary Plan Description and has enrolled hereunder and whose coverage under the Plan is in effect.

**Covered Expenses** mean charges for the types of treatment or service listed under the Covered Expenses section to the extent the charges do not exceed the Maximum Plan Allowance.

**Covered Spouse** means a Spouse who meets the Plan's eligibility requirements set forth in this Summary Plan Description and has been enrolled hereunder and whose coverage under the Plan is in effect.

**Deductible** means a specified dollar amount of covered dental expenses that must be incurred by You or one of Your Covered Dependents before benefits will be payable under this Plan for all or part of the remaining Covered Expenses during the calendar year.

**Dependent** means Your Spouse or Dependent Child, if that Spouse or Dependent Child is not in the active services of any Armed Forces of any country and is not covered under this Plan as an Employee.

**Dependent Child** means: Your natural child; Your stepchild who resides with You; an adopted child; a child who has been placed with You for adoption; a child for whom You or Your Spouse have been appointed legal guardian or custodian by a court order; a child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan. In all cases, the child must depend upon You for more than half of his or her support and care. However, when a court recognizes a child as a QMCSO-child, the child will be considered Your eligible Dependent regardless of whether or not the child is living with You or receiving more than half of his or her support and care from You.

When a court or administrative order determines paternity and establishes upon You a duty to support Your natural child, the child will be considered Your eligible Dependent regardless of whether or not the child is living with You or receiving his or her main support and care from You.

**Employee** generally means any person who is classified by Ameren as a regular employee of Ameren. Employee does not include, however, any individual classified by the Company as an independent contractor, Temporary Referral Worker (TRW) unless otherwise expressly provided in a collective bargaining agreement, leased employee, an employee whose terms and conditions of employment are governed by a collective bargaining agreement unless the collective bargaining agreement provides for coverage under the Plan, any non-resident alien who receives no earned income from Ameren that constitutes income from sources within the United States, or an individual otherwise classified as an employee but who is a party to a written employment agreement with Ameren or an affiliated Company, whereby the employee agrees to and waives participation in the employee benefit plans sponsored by Ameren.

**Immediate Family** means a Member's Spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother, or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

**Maximum Plan Allowance** means the amount determined by the applicable Delta Dental plan as the allowed amount for a particular procedure, service or item for the particular dentist of service provider. The allowed amount for a particular dentist or service provider depends on its, his or her participation status (e.g., Delta Dental PPO Dentist, Delta Dental Premier Dentist or Non-Participating Dentist).

**Member** means a Covered Employee or Covered Dependent.

**Network Provider/In-Network Provider/Participating Dentist** means a dentist, or other provider who has agreed to participate in Delta Dental's Preferred Provider Organization (PPO) or Premier network program.

**Non-Network/Out-of-Network Provider/Non-Participating Dentist** means a dentist or service provider who does not have or participate under a participation agreement with a Delta Dental's PPO plan for rendering dental care and who has not agreed to accept payment based on the applicable Maximum Plan Allowance for a Delta Dental PPO dentist or a Delta Dental Premier dentist.

**Out-of-Pocket Expenses** means Covered Expenses for treatment or service for which no benefits are payable because of the Plan's Deductible, Copay, and Coinsurance provisions.

**Participating Dentist** means a dentist or service provider who has or participates under a participation agreement with a Delta Dental plan for rendering dental care and who has agreed to accept payment based on the applicable Maximum Plan Allowance for a Delta Dental PPO dentist or a Delta Dental Premier dentist.

**Plan** means **Ameren Dental Plan**.

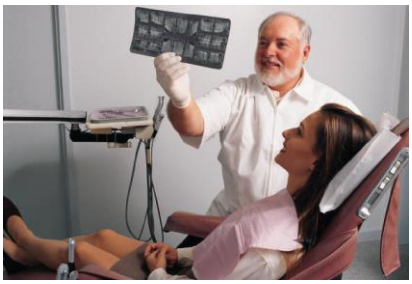
**Plan Administrator** means the Administrative Committee, or its delegate.

**Plan Year** means the period of time beginning at 12:00 A.M. on January 1 and ending on the following December 31 at 11:59 P.M. With respect to an individual Member's coverage, it does not begin before a Member's effective date and it does not continue after a Member's coverage ends.

**Spouse** means a person to whom the Employee is currently married by a marriage procedure which was solemnized by a person authorized by law to solemnize marriages. Spouse includes a same-sex spouse who is considered Your married Spouse for federal tax purposes pursuant to applicable Internal Revenue Service guidance. Spouse does not include common-law spouse (even if the state recognizes common-law marriages), ex-spouse, domestic partner, boyfriend, girlfriend or anyone else to whom the Employee is not currently married.

**You/Your** means an Employee who is eligible to participate in the dental Plan offered by the Company as set forth in this Summary Plan Description; however, in the context of receiving Plan benefits, You/Your is intended to refer to any Member.

## Schedule of Benefits



The Plan allows You to go to any dentist. However, Delta Dental offers access to large dentist networks – Delta Dental PPO and Delta Dental Premier.

### Advantages of Selecting a Participating Dentist

All Participating Dentists (Delta Dental PPO and Delta Dental Premier) have the necessary forms needed to submit Your claim. Delta Dental Participating Dentists will usually file Your claims for You and Delta Dental will pay them directly for Covered Expenses. Visit **www.deltadentalmo.com** to find out if Your dentist participates, or contact Delta Dental to receive, at no cost, a listing of Delta Dental PPO and Delta Dental Premier Participating Dentists in Your area. You are not responsible for paying the Participating Dentist any amount which exceeds the Delta Dental PPO or Delta Dental Premier Maximum Plan Allowance; whichever is applicable. You are only responsible for any non-Covered expenses, Deductible and Coinsurance amounts.

### Selecting Your Dentist

You may visit the dentist of Your choice and select any dentist on a treatment by treatment basis. It is important to remember Your Out-of-Pocket Expense costs may vary depending on Your choice. You have three (3) options:

### Delta Dental PPO Dentist

Delta Dental's PPO network consists of dentists who have agreed to accept payment based on the applicable PPO Maximum Plan Allowance and to abide by Delta Dental policies. This network offers You cost control and claim filing benefits.

### Delta Dental Premier Dentist

Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the applicable Premier Maximum Plan Allowance. This network also offers You cost control and claim filing benefits. However, Your Out-of-Pocket Expenses (Deductibles and Coinsurance amounts) may be higher with a Delta Dental Premier dentist based upon Your plan design.

### Non-Participating Dentist

If You go to a Non-Participating Dentist (a dentist not contracted with a Delta Dental plan), Delta Dental will make payment directly to You based on the applicable Maximum Plan Allowance for the Non-Participating Dentist. It will be Your obligation to make full payment to the dentist and file Your own claim.

The following chart shows how benefits are paid under each schedule.

| Plan Features | In-Network (PPO) | In-Network (Premier) | Out of Network |
|---|---|---|---|
| **Provider Selection** | **Delta Dental PPO Dentists** | **Delta Dental Premier Dentists** | **Non Participating Dentists** *Maximum allowed or the Dentist's charge (whichever is less)* |
| **Deductible (once every Plan year)**<br>• **Individual**<br>• **Family** | **$25**<br>**$75** | **$25**<br>**$75** | **$25**<br>**$75** |
| **Diagnostic and Preventive Services** *Includes office visits, exams, cleanings, x-rays, fluoride treatments* | **100% no Deductible** | **100% no Deductible** | **90% no Deductible** |
| **Basic Restorative Services** *Includes fillings, extractions, periodontics, endodontics, oral surgery, space maintainers, and sealants* | **90% (after Deductible)** | **80% (after Deductible)** | **70% (after Deductible)** |
| **Major Restorative Services** *Includes crowns, bridges, inlays, onlays and dentures* | **50% (after Deductible)** | **50% (after Deductible)** | **50% (after Deductible)** |
| **Orthodontia** *(no benefits within the first 12 months of coverage)* | **50%** | **50%** | **50%** |
| **Annual Maximum Benefits**<br>**Orthodontia Lifetime Maximum** | **$3000 per Covered Individual**<br>**$2000 per Covered Individual** | | |

## How to Receive Dental Benefits

Simply call the dental office and make an appointment. If You select a Delta Dental Participating (PPO or Premier) Dentist, he or she is required to complete and submit a claim for You at no charge. Show them Your coverage identification card and they will handle the rest.

## How to Verify Participation in Delta Dental Networks

In order to verify if Your dentist is a participant in the Delta Dental PPO or Delta Dental Premier network, You can:

- Simply ask Your dentist if he/she is a Delta Dental PPO or Premier Participating Dentist; or
- Visit Delta Dental's website at www.deltadentalmo.com and search the directory for a Delta Dental Participating Dentist; or
- Call Delta Dental's customer service department at **800.335.8266** or **314.656.3001**.

## Explanation of Benefits

An Explanation of Benefits (EOB) is an itemized list of services provided, dates of service, amount paid to the dentist according to the terms of the Plan and the balance owed by the patient. You can access and print an EOB from Delta Dental's website at any time after a claim is processed. In addition, if there is a balance due after a claim is processed, You will receive an EOB in the mail. If a Delta Dental PPO or Premier dentist bills You for an amount that is different from what the EOB indicates, contact Delta Dental customer service for assistance by calling **800.335.8266**, or e-mailing at **service@deltadentalmo.com**.

## Deductible Amounts

There is no Deductible required for preventive care. However, You must satisfy the Deductible specified by the Plan before basic and major restorative services will be paid. The Deductible amount for dental Covered Expenses each calendar year is $25 per person or $75 per family. The Plan will subtract the Deductible amount from Covered Expenses; then the Plan will pay for Covered Expenses as stated in this document.

## Maximum Benefits

There is an annual limit on the amount of benefits each covered person may receive from the **Ameren Dental Plan**. The maximum annual benefit (not including benefits for orthodontia) payable by this Plan is $3,000 per covered individual. The separate maximum lifetime benefit for orthodontia services is $2,000 per covered individual.

## Covered Expenses

The amount the Plan pays depends on the type of service You receive. Services fall into four categories:

- Diagnostic and Preventive
- Basic Restorative
- Major Restorative
- Orthodontia

### Diagnostic and Preventive Services

Diagnostic and Preventive services include:

1) oral examinations, twice in any twelve (12) month benefit period (includes all types);
2) emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain);
3) full mouth x-rays (once every three (3) years);
4) periapical x-rays as required;
5) bitewing x-rays as required;
6) topical application of fluoride, but not more than two (2) per calendar year;
7) dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any calendar year.

## Basic Restorative Services

Basic Restorative Services include:

1) Extractions – simple;
2) Restorative services using amalgam, synthetic porcelain, and plastic filling material. Composites on anterior (front) teeth only;
3) Space maintainers for prematurely lost teeth in children to age sixteen (16) – limited to initial appliance only unless an existing space maintainer cannot be made satisfactory, then a replacement will be covered only once in five (5) years – except for accidental injuries;
4) Endodontics – root canal filling and pulpal therapy (therapy for the soft tissue of a tooth);
5) Sealants – for Dependents to age nineteen (19), limited to caries-free occlusal surfaces of the permanent first and second molars, once in five (5) years;
6) Periodontics – treatment for diseases of the gums and bone supporting the teeth;
7) The giving of anesthesia in connection with covered dental care;
8) Dental implants, subject to review;
9) Oral Surgery, including removal of partially or fully impacted wisdom teeth.

## Major Restorative Services

Major Restorative Services include:

1) Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes, once in five (5) years. If an existing crown, jacket, labial veneer, inlay or onlay cannot be made satisfactory, a replacement will be covered only once in five (5) years – except for accidental injuries;
2) Prosthodontics – fixed bridges (once in five (5) years) if the existing bridge cannot be made satisfactory. Replacement of existing bridge not covered within the first year of coverage.
3) Repair of fixed bridge and denture;
4) Prosthodontics – complete or partial dentures (once in 5 years) if the existing denture cannot be made satisfactory. Replacement of existing denture not covered within the first year of coverage.

## Orthodontia Services

Orthodontic Care includes treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position.

The Plan does not pay benefits for Orthodontic Care expenses incurred within the first twelve (12) months after You or Your Dependent becomes covered under a dental Plan sponsored by Ameren.

Benefits will not be paid for repair or replacement of an orthodontic appliance.

If Your membership is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.

After completion of an orthodontic treatment plan, no further orthodontic benefits will be provided unless the lifetime maximum has not been reached.

## Expenses Not Covered

Just because a dentist recommends a type of treatment does not necessarily mean it will be covered under the Plan. The Claims Administrator, in its sole discretion, decides whether a dental service is covered and is necessary and appropriate. Contact Delta Dental for any questions about whether or not a procedure is covered.

No payment will be made for these expenses (this is not an exhaustive list):

1) Any services not specifically stated as Covered Expenses (including hospital or prescription drug charges);
2) Charges for complete occlusal adjustments, crowns for occlusal correction, nightguards, bruxism appliances, and bite therapy appliances;
3) Instructions in dental hygiene, dietary planning, or plaque control;
4) Supplies for dental care other than those used in a dentist's office and services rendered by a dentist which are beyond the scope of his/her license;
5) Services for which the participant, absent this coverage, would normally incur no charge, such as care rendered by a dentist to a member of his/her Immediate Family or the Immediate Family of his/her Spouse;
6) Services provided or paid for by any governmental agency or under any governmental program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act and its Amendments);
7) Dental care or supplies needed as a result of participation in the commission of an assault or felony;
8) Services for which coverage is available under Workers' Compensation or Employers' Liability Laws;
9) Diseases contracted or injuries or conditions sustained as a result of any act of war;
10) Dental care or supplies to the extent that they are payable under another Plan administered by the employer;
11) Consultations;
12) Diagnostic casts;
13) Services performed for cosmetic purposes or to correct congenital malformations;
14) Services related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws);
15) Replacement of dentures and other dental appliances that are lost or stolen;
16) Hypnosis;
17) Duplicate services provided by another group dental plan;

18) A dentist need not provide dental services which for any reason, in his/her professional judgment should not be provided. Charges for such services are not a Covered Expense;

19) Denture adjustments for the first six (6) months after the dentures are initially received;

20) Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of the complete dental procedure are considered components of, and included in the fee for, the complete procedure. Separate fees may not be charged by Participating Dentists;

21) Charges for multiple visit services that commenced prior to the membership effective date (including but not limited to prosthetics and orthodontic care);

22) Charges covered under a terminal liability or similar provision of a program being replaced by this program;

23) Services rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group;

24) Charges for duplication of radiographs;

25) Charges for temporary appliances;

26) Charges for experimental services or supplies;

27) Missed appointments or completion of claim forms;

28) Infection control, including sterilization of supplies and equipment.

## Coverage Limitations

If You receive care from more than one dentist for the same procedure, benefits will not exceed what would have been paid for one dentist for that procedure (including but not limited to prosthetics and root canal therapy).

If alternative treatments are available, the Plan shall be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the cost of an amalgam (silver) filling; or fixed bridges, in which case the benefits may be based on the cost of a removable partial denture.

## Coordination of Benefits

You or a Covered Dependent may be entitled to dental benefits from another source. If this is the case, dental benefits from the **Ameren Dental Plan** are coordinated with benefits from the other source so that the total amount reimbursed may be less than but does not exceed 100% of allowed expenses, as outlined in the section titled Schedule of Benefits.

*Another source of benefits* means:

- Any group, blanket, or franchise health coverage.
- A group contractual prepayment or indemnity plan.
- A health maintenance organization (HMO), whether group practice or individual practice association.
- A labor-management trusteed plan or a union income protection plan.

- An employer or multi-employer plan or employee benefit plan.
- A government program.
- Coverage required or provided by statute.

The **Ameren Dental Plan** does not coordinate benefits with any individually purchased coverage or public assistance program. The **Ameren Dental Plan** does not coordinate benefits with the **Ameren Employee Medical Plan**.

Part of the *allowed expense* must be covered under at least one of the programs covering You or Your Covered Dependent. When the program covers an expense incurred for care provided by a Network Provider, the allowed expense is limited to the payment that the provider agreed to accept.

If the Dental Plan is primary, its benefits are determined before those of another plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits.

If this Coordination of Benefits provision applies to benefits to which You or Your family members are entitled, the bills must first be filed with the primary carrier before being filed with the secondary carrier. A copy of the primary plan's explanation of benefits should be included with the secondary claim.

The Dental Plan determines its order of benefits by using the first of the following rules that applies:

- A plan that does not coordinate with other plans is always the primary plan.
- The plan that covers the person as an employee, Member, or subscriber (other than a dependent) is the primary plan; the plan that covers the person as a dependent is the secondary plan.
- The primary plan is the plan that covers the person as an employee who is neither laid off nor retired (or as that employee's dependent). The secondary plan is the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

In the case of a Dependent Child whose parents are not legally separated or divorced:

- The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the benefits of the plan that covered the parent the longer period of time is the primary plan; the plan that covered the parent the shorter time is the secondary plan.
- If the other plan has the male/female rule instead of the birthday rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

- If a Dependent Child whose parents are legally separated or divorced and who is covered by the plans of both parents has a claim, the primary payer is the plan covering the parent who is responsible for the child's health care under the terms of the court decree. In the absence of a court decree, the payment order is:

  — The plan of the natural parent with custody.

  — The plan of the spouse of the natural parent with custody.

  — The plan of the natural parent without custody.

If none of the above rules determine the order of benefits, the primary plan is the plan that covered an employee, member or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

## Subrogation

The Plan does not cover expenses that are or should be paid by other parties. When another party (such as an issuer of an automobile or liability insurance policy) is, or may be, obligated to pay for some or all of Your expenses, or a court orders or You agree to a settlement with another party to pay for Your expenses, the Plan is subrogated in Your right to recover from these other parties. You will be requested to complete an agreement to reimburse the Plan if some or all of the expenses are recovered from a third party. If You collect from another party, You must reimburse the Plan for any benefits You received from the Plan that have been paid by another party. If You, Your Dependents or the representative of either You or Your Dependents receives any form of recovery from a third party, that recovery is held in trust for the Plan.

## Payment of Benefits

If You receive services from a dentist who participates in the Delta Dental network, payment of benefits will be made directly to the dentist. When services are received from an Out-Of-Network Provider, reimbursement will be made directly to the Member by Delta Dental of Missouri for all Covered Expenses under the Plan.

If You, a provider or other person has been paid benefits under the Plan that are in excess of the benefits that should have been paid, or which should not have been paid under the provisions of the Plan, the Plan or the Claims Administrator may cause the deduction of the amount of the excess or improper payment from any present or future benefits payable to You, the provider or other person or to recover such amounts by any other appropriate method that the Plan or the Claims Administrator shall determine.

## How to File a Claim

The Plan Sponsor has contracted with Delta Dental to serve as the Claims Administrator. The Claims Administrator is responsible for: (1) initial determination of the amount of any benefits payable under the Plan, (2) prescribing claims procedures to be followed and the claim forms to be used by Participants, and (3) administration of claims appeals. However, the Plan Sponsor is ultimately responsible for providing Plan benefits.

Delta Dental Participating Dentists have agreed to file claims with Delta on Your behalf and benefits will be paid directly to them. You are only responsible for Your share of the bill. Delta Dental Participating Dentists can charge You only for Deductibles, Your Coinsurance, any amounts over Plan maximums, and any non-covered services.

Dentists who are not in a Delta Dental network do not promise to file a claim for You but may submit a standard ADA claim form and Delta Dental will make the benefit payment directly to You. Most dentists have the ADA form available; however, one can also be obtained by visiting **www.deltadentalmo.com**.

If You use a non-Delta Dental provider, You will need to send a claim to the address below:

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690
**800.335.8266**

Claims for dental Covered Expenses may be submitted in any amount for payment. You do not need a claim form in order to file a claim for reimbursement; You may submit Your itemized bill for services provided. The bill must show the following information:

- The patient's full name;
- The Employee's full name and Social Security Number, or the assigned privacy identification number;
- The provider's name, address and federal tax or Social Security Number;
- A description of each service or supply provided;
- The charge made for each Covered Expense or supply; and
- The date the service or supply was provided.

You must submit original bills. Photocopied bills will be accepted only when You have other coverage and this Plan is the secondary payer. Be sure to keep a copy for Your records.

**Any questions about a dental claim should be directed to Delta Dental at 800.335.8266 or 314.656.3001.**

All claims for dental benefits must be received by Delta Dental within one (1) year after the end of the year in which the expense is incurred. For example, all expenses incurred during 2018 must be received by Delta Dental by December 31, 2019. If a claim is denied due to a Delta Dental Participating Dentist's failure to make a timely submission, You will not be liable to such dentist for the amount which would have been payable by the Plan, provided You advised the dentist of Your eligibility for benefits at the time of treatment.

Delta Dental is primarily responsible for processing Your claims and for determining the benefits to be paid. If a claim for benefits under the Plan is denied, the reason for the denial will be stated in writing and delivered or mailed to the Member. The Plan will also provide a reasonable opportunity for a full and fair review of the decision denying the claim.

## Termination of Benefits

### Employees

Your coverage under this Plan will end on the earliest of the following dates:

1) End of the month of Your termination of employment;
2) For management Employees: End of the month of Your termination of employment due to Your retirement;
3) For all union represented Employees: End of the month prior to the date of Your retirement;
4) Date of Your death;
5) End of the month in which You no longer satisfy the eligibility requirements as specified in the ELIGIBILITY section of this booklet (for example, if Your status changes from full-time to part-time);
6) End of the month in which You last paid the required payroll deduction for coverage;
7) End of the month in which You commence an unpaid leave of absence (See CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT & RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)) for information on termination of coverage for Employees who are on an unpaid leave of absence due to military service, and CONTINUATION OF COVERAGE UNDER THE FAMILY AMD MEDICAL LEAVE ACT OF 1993 (FMLA));
8) Date of transfer to an Employee group not covered by the Plan;
9) The date the Plan terminates;
10) Date the Company amends the Plan to eliminate coverage for the class of eligible individuals to which You are a member;
11) Date You or a Covered Dependent participate in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent;
12) Date of Expiration of Labor Agreement providing for Your coverage under the Plan as stated in the ELIGIBILITY section of this document.

In addition, Your coverage under this Dental Plan will end on the date You cease to be eligible for such coverage option (for example, change in employment from contract to management status) or the date the dental plan option is discontinued.

### Dependents

Coverage for Your Covered Dependents will end on the earliest of the following dates:

1) The date Your coverage ends;
2) Except for divorce or legal separation, the end of the month in which Your Dependent(s) is no longer eligible (See ELIGIBILITY);
3) In the case of a Covered Spouse, the date of divorce;
4) In the case of a Covered Spouse, the date of legal separation;

5) End of the month in which You last paid the required payroll deduction for Dependent coverage;

6) Date of death of the Dependent;

7) The last day of the month that Your Dependent disabled child who is over the age of 26 is no longer disabled according to the Plan definition or You fail to provide proof of Your child's disability.

8) The date You fail to provide the required proof of Dependent status, in accordance with the procedures determined by the Plan Administrator;

9) The date the Plan terminates.

If a Member's coverage is terminated, all rights to receive benefits under this Plan will end as of the date of the Member's termination of coverage. However, the Member may be eligible for temporary healthcare continuation benefits as required by federal law. (See COBRA CONTINUATION BELOW).

## COBRA Continuation – Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985

This section contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Depending on the type of qualifying event, You, Your Covered Spouse and Covered Dependent Children may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

**Note**: Continuation coverage for participants who selected continuation coverage under a prior plan which was replaced by coverage under this Plan shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth below, whichever is earlier. A qualified beneficiary does not have to show that he/she is insurable to choose COBRA continuation coverage. COBRA continuation is provided, subject to the person's eligibility for coverage under the Plan.

Ameren has partnered with Conduent as the COBRA administrator. Members enrolled in COBRA benefits can obtain information regarding their COBRA benefits through "Healthcare and Life Benefits" at **www.myAmeren.com** or by accessing it directly at **www.benefitsweb.com/ameren.html**. COBRA participants can also check on the status of their account by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). **Ameren Benefits Center** customer service representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m. Central Standard Time (CST). The website also allows COBRA participants the ability to update addresses, print forms to add or drop Dependents due to a qualifying status change, or update Dependent information.

### Employees

A Covered Employee will become a qualified beneficiary if coverage is lost under the Plan because of one of the following qualifying events:

- Employee's termination of employment (except for gross misconduct).
- Employee's layoff or reduction in hours of employment, resulting in loss of coverage.

### Spouses

A Covered Spouse of a Covered Employee will become a qualified beneficiary if coverage is lost under the Plan because of any of the following qualifying events:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment, other than for gross misconduct; or reduction in the Covered Employee's hours of employment.
- Divorce or legal separation from the Covered Employee.

### Dependent Children

Your Covered Dependent Child will become a qualified beneficiary if he or she loses coverage under the Plan because of any of the following qualifying events:

- The death of the Covered Employee.
- Termination of the Covered Employee's employment, other than for gross misconduct; or reduction in the Covered Employee's hours of employment.
- Divorce or legal separation of the Covered Employee.
- The Dependent Child ceases to satisfy the Plan's eligibility rules for Dependent status.

### Newborn or Adopted Children

A child born to, adopted by or placed for adoption with a Covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the Covered Employee is a qualified beneficiary, the Covered Employee has elected continuation coverage for himself or herself. The child's COBRA continuation period begins when the child is enrolled in the Plan and it lasts until the continuation coverage for other family members ceases. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

If You want to add a new Dependent Child, You must complete the appropriate enrollment process within 31 days by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), or by completing and mailing the appropriate form(s) to the **Ameren Benefits Center** at the address listed on the form.

### Special Enrollment Rules for Qualified Beneficiaries

A qualified beneficiary receiving COBRA continuation coverage is also entitled to enroll eligible family members in the Plan under the special enrollment rules set forth in this document the same as if the qualified beneficiary was an Employee within the meaning of those rules.

If You want to add a new Dependent, You must complete the appropriate enrollment process by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), or by completing and mailing the appropriate form(s) to the **Ameren Benefits Center** at the address listed on the form.

### Alternate Recipients under Qualified Medical Child Support Orders

A child of a Covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order received by the Plan Administrator during the Covered Employee's

period of employment is entitled to the same rights under COBRA as a Covered Dependent Child of the Covered Employee, regardless of whether that child would otherwise be considered a Dependent.

## Length of Coverage

A Qualified Beneficiary's coverage may continue under COBRA as follows:

- Coverage for the Covered Employee and Dependent(s) may be continued for up to eighteen (18) months, if coverage is terminated due to the Covered Employee's:

  (1) termination of employment, other than for gross misconduct; or
  (2) reduced work hours.

  The eighteen (18) month period of continuation coverage may be extended for up to an additional eleven (11) months if a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage. If the disabled individual has non-disabled family members who are also receiving COBRA continuation coverage, the non-disabled qualified beneficiaries are also entitled to extend their COBRA continuation coverage from eighteen (18) to twenty-nine (29) months. The required contribution for the eleven (11) month extension may be increased, up to one hundred fifty percent (150%) of the cost of the Plan Sponsor's cost of providing coverage under the Plan for "similarly situated" covered individuals. However, if the disabled qualified beneficiary does not continue coverage, then any other qualified beneficiary continuing coverage due to the disability may be charged up to only 102% of the cost for the extended period of coverage.

  Each Covered Employee and each Covered Dependent has the responsibility to inform the Plan Sponsor of a Social Security Administration disability determination. Proof of disability must be provided within sixty (60) days from the date the Social Security Administration makes the determination and within the initial eighteen (18) month period of continuation coverage.

  If, during the initial eighteen (18) month period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines that the qualified beneficiary is no longer disabled after the initial eighteen (18) month period, the period of continuation coverage ends the first (1st) day of the month that begins more than thirty (30) days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed twenty-nine (29) months.

- Coverage for Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:

  (1) the Covered Employee's death;
  (2) the Covered Employee's divorce or legal separation; or
  (3) a Dependent Child's ceasing to satisfy rules for Dependent status.

- If the qualifying event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits

less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement.

- If another qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, a Covered Spouse and Dependent Children can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the Covered Spouse and any Dependent Children receiving continuation coverage if the Covered Employee or former Covered Employee dies or gets divorced or legally separated, or if the Covered Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

### Notification and Election Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the termination of employment or reduction of hours of employment, or death of the Employee, the Employer must notify the Plan Administrator of the qualifying event. When the qualifying event is a divorce, legal separation, or a child losing Dependent status under the Plan, each Member has a responsibility to notify the Plan Administrator within sixty (60) days of the qualifying event. Notice must be provided through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). Failure to provide notification of a qualifying event to the Plan Administrator within sixty (60) days will result in the loss of continuation coverage rights.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

## Continuation of Coverage under the Trade Act of 1974

Special COBRA rights apply to Employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Participants (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Health Care Reimbursement Plan coverage ended. If You qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974 or You will lose Your special COBRA rights.

### If You Have Questions

Questions concerning the Plan or Your COBRA continuation coverage rights should be addressed to the Plan Administrator or COBRA Administrator. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and

other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### Address Changes

In order to protect Your rights, You should keep the Plan Administrator informed of any address changes, either by going on-line through "Healthcare and Life Benefits" at **www.myameren.com**, or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). You should also keep a copy, for Your records, of any notices You send to the Plan Administrator. The address for the COBRA administrator is:

Ameren Benefits Center
PO Box 5204
Cherry Hill, NJ 08034-5204

## Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

In compliance with the provisions of the Family Medical Leave Act (FMLA), coverage under the Plan for a Covered Employee and his/her Covered Dependents may be continued during a period of leave under the FMLA just as if the Covered Employee were actively employed. In the case of a paid FMLA leave, any required contributions for coverage during the leave period will continue to be deducted from the Covered Employee's pay. If the FMLA leave is unpaid, the Plan Administrator will provide the Covered Employee with one or more of the following methods to pay any required contributions: (1) make regular periodic payments during the period of FMLA leave; or (2) upon return from the leave, pay the amounts advanced by the Company for the cost of any coverage maintained during the leave. The Plan Administrator will also make available any payment methods available to individuals on non-FMLA leaves of absence.

The Covered Employee's and his/her Dependents' coverage under the FMLA will cease due to the nonpayment of any required contributions or once the Plan or Plan Sponsor is notified or otherwise determines that the Covered Employee has terminated employment, exhausted FMLA leave entitlement, or does not intend to return from leave.

If the Covered Employee does not return to active employment with Ameren after his/her FMLA leave has expired or if the Plan Administrator is notified or otherwise determines that the Covered Employee is not returning to employment, coverage under the Plan may only be continued under COBRA (See COBRA CONTINUATION section of this booklet). The period of coverage during FMLA leave will not be counted toward the maximum number of months of coverage permitted under COBRA.

If the Covered Employee fails to return to active employment with Ameren following his/her FMLA leave, the Plan may recover any premiums it paid on behalf of the Covered Employee and his/her Dependents during the period of FMLA leave, unless the Covered Employee's failure to return was based upon the continuation, recurrence, or onset of a serious health condition of the Covered Employee or his or her family member, or a serious injury or illness of a family member in the military, which would otherwise qualify the Covered Employee for leave under the FMLA.

If coverage under the Plan was terminated during the Covered Employee's FMLA leave or the Covered Employee elected not to continue coverage, coverage under the Plan will be reinstated on the date the Covered Employee returns to active employment with Ameren, provided the Covered Employee (1) returns to active employment immediately upon expiration of his or her FMLA leave, (2) re-enrolls for coverage within 30 days of the Covered Employee's return to active employment, and (3) makes the required contribution.

## Continuation of Coverage Under the Uniformed Services Employment & Re-Employment Rights Act of 1994 (USERRA)

In the event a Covered Employee is absent from employment for military service, USERRA affords the Covered Employee the right to elect continuous health coverage for the Covered Employee and his/her Covered Dependents for up to twenty-four (24) months or the period of military service, whichever period is shorter. The period of military service begins on the date the Covered Employee's absence begins from employment due to military service, including Reserve and National Guard Duty, and ends upon the Employee's return to active employment with the Company or upon the Employee's failure to return for service or failure to apply for a position of reemployment as provided in the USERRA regulations.

A Covered Employee may be required to pay a portion of the cost of his/her benefits. If Your military service is less than thirty-one (31) consecutive days, Your healthcare coverage continues as if You remained employed, and You will be required to pay only Your normal share of the premium for this period of coverage. If Your military service is 31 days or more, Your healthcare coverage under the Plan will terminate on the last day of the month coincident with or next following 31 days of military service. However, You may elect to continue healthcare coverage for Yourself and Your Covered Dependents by paying the required premiums. You will be required to pay up to one hundred two percent (102%) of the full premium for Your own coverage. Dependents will be required to pay the normal Employee share of the premium for the first twelve (12) months of continuation. After the first twelve (12) months, Covered Dependents will also be required to pay up to one hundred two percent (102%) of the full premium for coverage.

If the Covered Employee elects to have coverage under the Plan reinstated upon reemployment, no exclusions or waiting periods will be applied. The only exception to USERRA's prohibition of exclusions is for an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of military service. If the Covered Employee returns to active employment during the same Plan Year in which he/she left, eligible charges the Covered Employee had accumulated towards satisfying Deductibles and Out-of-Pocket Expense maximums will be taken into account in determining benefits for that Plan Year.

A Covered Employee must notify the Plan Administrator that he/she will be absent from employment due to military service unless the Covered Employee cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. A Covered Employee must also notify the Plan Administrator that he/she wishes to elect continuation coverage for himself/herself and his/her Covered Dependents under the provisions of USERRA.

NOTE: The twenty-four (24) months of continuation coverage available under USERRA runs concurrently with COBRA continuation. In other words, an Employee who enters military service will be eligible only for a maximum of twenty-four (24) months of continuation coverage – not twenty-four (24) months followed by an additional eighteen (18) months under COBRA.

### If You Have Questions

Questions concerning the Plan or Your COBRA continuation coverage rights should be addressed to the **Ameren Benefits Center** by calling 877.7my.Ameren (**877.769.2637**).

Questions concerning Your or any of Your Dependents' coverage under COBRA should be addressed to the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). The **Ameren Benefits Center** customer service representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

## Privacy

In addition to this Summary Plan Description, there are also other formal documents that govern the Plan's operation. One of these documents is a document adopted by the Plan that describes how the Plan may use and disclose certain information that may be considered "protected health information" under the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law provides comprehensive requirements concerning Your protected health information.

Most of the comprehensive requirements are outlined in the "Notice of Privacy Practices" You have received from the Plan. This notice can also be found on **www.myAmeren.com** by selecting "Healthcare and Life Benefits", then "Healthcare and Life", then "Resource Materials", "Documents and Forms" and finally choosing "HIPAA Privacy Notice". In addition, You have the right to receive a paper copy of this notice by contacting the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

The Plan is permitted to use and disclose Your protected health information without Your consent or authorization, as necessary, to carry out Plan functions and duties. For example, the Plan may obtain health claims information and provide it to the Claims Administrator to perform claims adjudication and appeals. The Company and the Plan will comply with any law that requires a disclosure of Your protected health information, such as a court order.

Please review the Notice of Privacy Practices for a more complete discussion about how the Plan may use Your protected health information and disclose it to third parties.

## Claim and Appeal Procedures for Eligibility

If You file a claim regarding eligibility for Your or Your Dependent's coverage under this Plan, the following procedures apply. A casual inquiry (even if it is in writing) regarding eligibility requirements or a casual inquiry about benefits is not treated as a claim and is not subject to these claim and appeal procedures. You must send Your claims and appeals to the Plan Administrator. If You file a claim or appeal, You must do so in writing by U.S. mail or by email.

All claims related to eligibility must be submitted to:

The Ameren Benefits Center
P.O. Box 5204
Cherry Hill, NJ 08034-5204

All appeals related to eligibility must be submitted to:

Ameren Services
P.O. Box 66149 MC533
St. Louis, MO 63166-6149
Email: EBenefits@ameren.com

**Responding to Your Eligibility Claim**

Once You have filed a claim, the Plan Administrator will notify You of its decision within a reasonable period of time, but no later than ninety (90) days after receipt of Your eligibility claim. If You do not follow the required procedures for filing a claim, the Plan administrator will notify You and explain the proper procedures to follow in filing Your claim.

If the Plan Administrator, due to reasons beyond its control, determines that extra time is required to process Your claim, it will notify You in writing of the reasons for the extension and the new due date for its response to Your claim. The Plan Administrator will notify You in writing within the initial ninety (90)-day period after its initial receipt of Your claim that an extension of up to an additional ninety (90) days will be required. The notice will state the special circumstances involved and the date a decision is expected.

**If Your Eligibility Claim Is Denied**

If Your claim is denied, in whole or in part, the Plan Administrator will send You a written notice of its decision, which will include:

- The specific reason(s) for the denial of the claim;
- Reference to the specific Plan provision(s) on which the denial is based;
- A description of any additional information necessary for Your claim to be granted, as well as an explanation of why such information is necessary;
- A description of the Plan's appeal procedures and the time limits under those procedures; and
- A statement of Your right to bring a civil action under Section 502(a) of ERISA if the appeal of Your claim is denied.

**Appealing Your Eligibility Claim**

If Your claim for eligibility under the Plan is denied in whole or in part, and You do not agree with the decision of the Plan Administrator, You will have sixty (60) days following the receipt of the denial notice to file a written appeal with the Plan Administrator. The following procedures will apply in considering Your appeal.

- You may submit written comments, documents, records, and other information relevant to Your claim.
- Upon request, You will be provided (free of charge) copies of all the Plan Administrator's relevant documents.

The Plan Administrator will notify You, in writing, of its decision of Your appeal within a reasonable period of time, but no later than 60 days after its receipt of Your appeal request. If the Appeals Reviewer determines that an extension of time for processing the claim is needed,

it will notify You of the reasons for the extension and the extended due date before the end of the sixty (60)-day period.

### If Your Eligibility Appeal Is Denied

If Your appeal is denied, You will receive written notice of the decision, including the following information:

- The specific reason(s) for the denial of the claim; and
- Reference to the specific Plan provision on which the denial is based.

Upon request to the Plan Administrator, You will also be provided (free of charge) copies of all of the Plan Administrator's documents, records, and other information relevant to Your claim. You will have the right to bring a civil action under ERISA Section 502(a). You must appeal Your claim, and that appeal must be denied by the Plan Administrator, before You may bring a civil action under ERISA. You and Your Plan may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your state insurance regulatory agency.

### Deadline for Taking Legal Action

If Your appeal is denied and You want to bring legal action under Section 502(a) of ERISA, You must do so by no later than the earlier of:

- One year after the date the denial of Your appeal is issued; and
- The last day on which legal action could begin under the applicable statute of limitations under ERISA, including any state statute of limitations.

## Claims Procedure and Appeals For Dental Benefits

As a participant in the **Ameren Dental Plan**, You are entitled to certain rights and protections as stated in the regulations issued by the Department of Labor, effective January 1, 2002, for all health and welfare claims governed by the Employee Retirement Income Security Act of 1974 (ERISA). However, a participant may not bring a cause of action hereunder in a court, or other governmental tribunal, unless and until all administrative remedies set forth in this document have first been exhausted.

### Claim Determinations

Unless special circumstances require an extension of time for processing the claim, the time frame in which You will be provided with a written notice of the decision, will be determined by the type of claim as summarized below:

For claims for services rendered, You will be notified of an adverse benefit determination within 30 days. One 15-day extension is allowed for special circumstances if an extension is necessary due to matters beyond the control of the Plan. In this case, You will be notified prior to the end of the 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to make a decision. If the extension is necessary because You have failed to provide sufficient information to decide the claim, the notice of extension will specifically describe the required information to decide the claim, and You will be given at least 45 days from the receipt of the notice within which to provide the required information.

## Notification of Denial

If a claim is denied in whole or in part, You will be notified of the denial in writing. The notice of denial will contain the following information: the specific reason(s) for the denial; a reference to the specific provision(s) in the Plan on which the denial is based; a description of additional material or information necessary to perfect the claim; an explanation of why the material or information is needed; and an explanation of the procedure to appeal the denial. If an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, the notice will include the rule, guideline, protocol or other criterion or state that You will be provided with a copy free of charge upon request. Notice of a denial based on medical necessity, experimental treatment or a similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge. A Participant will also be informed of the Plan's appeal procedures and of Your right to bring a civil action under Section 502(a) of ERISA.

## Right to Appeal

If Your claim for benefits under the Plan has been denied, in whole or in part, You or any person You authorize to represent You, may appeal the denial of dental benefits by submitting a written appeal setting forth the basis for Your claim to the Plan Administrator. You should include with Your request for review any comments, documents, records or other information You would like to have considered. Appeals may be sent to the following address:

Delta Dental of Missouri
Appeals Committee
12399 Gravois Road
St. Louis, MO 63127-1702

1. Deadline for Filing Appeal

   Your appeal must be submitted to the Plan Administrator in writing within 180 days from the notice of denial. Failure to file an appeal within the 180-day period shall constitute a waiver of Your right to appeal the denial. During the 180-day period, You will have the opportunity to submit written comments, documents, records and other information relating to Your claim, whether or not this information was submitted or considered in the initial benefit determination. Additionally, You will be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to Your claim.

2. Decision on Appeal

   A decision on the appeal will be made by the Plan Administrator within 60 days after receipt of Your written appeal.

   Appeals will be conducted by an appropriate qualified individual who was not involved with the initial claim decision or a subordinate to that original decision maker. No deference to the initial claims denial will be given by the reviewer.

3. Notification of Determination on Appeal

   If a claim is partially or wholly denied on Appeal, You will be advised of the determination in writing. The notice will give the specific reason for the denial and reference Plan provisions

on which the denial is based. The notice will include statements as to the Participant's rights to obtain upon request, without charge, access to and copies of all documents, records and other information relevant to the claim, to bring a civil action under Section 502(a) of ERISA or to pursue other voluntary alternative dispute resolution options. The notice will also describe any voluntary appeal procedures under the Plan. If the Claims Administrator relied on a rule, guideline, protocol or similar criterion in denying the appeal, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. The decision of the Plan Administrator on appeal shall be final and binding.

If Your claim appeal is denied, in whole or in part, and You do not agree with the final determination, You have the right to bring civil action under section 502(a) of the Employee Retirement Income Security Act of 1974. For a description of additional rights and protections to which You may be entitled, see YOUR RIGHTS UNDER ERISA.

## Miscellaneous

### Plan Administration

The Administrative Committee has the authority to administer the Plan on a day-to-day basis. Except where the Administrative Committee has delegated the final discretionary authority for adjudicating claims to a Claims Administrator or other entity, the Administrative Committee has discretionary authority to construe and interpret the Plan, grant or deny benefits, construe any ambiguous provision of the Plan, correct any defect, supply any omission or reconcile any inconsistency in such manner and to such extent as the Administrative Committee in its sole and absolute discretion may determine, and to decide all questions of eligibility and to make all determinations as to the right of any person to a benefit.

To the extent the Administrative Committee has delegated such final and binding discretionary authority to a Claims Administrator, other person, entity, or group, the determination of such Claims Administrator, insurance company, or other person, entity or group, shall be final and binding unless otherwise required by law.

In a review of any decision of the Claims Administrator or other person, entity or group to which the Administrative Committee has delegated final and binding discretionary authority, such Claims Administrator, person, entity or group shall be deemed to have exercised its discretion properly unless it is proved duly that such action was arbitrary and capricious.

### No Contract of Employment

No provision in this document is intended to be, and may not be construed as constituting, a contract or other arrangement between You and the Plan Sponsor to the effect that You will be employed for any specific period of time.

### Plan Amendment or Termination

The Company hopes and expects to continue the **Ameren Dental Plan** in the years ahead but cannot guarantee to do so. Ameren Corporation, and any successor corporation which assumes the responsibilities of Ameren Corporation under the Plan, may amend or terminate the Plan or any benefit provided under the Plan from time to time or at any time, without advance notice thereof. Ameren Corporation, Ameren Services Company (as agent for Ameren Corporation), an officer of Ameren Corporation or Ameren Services Company, or such officer's delegate may

effect an amendment or termination of the Plan or a benefit provided under the Plan by written instruments describing the terms of such amendment or termination. Such amendment will be incorporated into this document.

The Administrative Committee may also amend the Plan through the issuance of revised Benefit Program booklets, enrollment materials, brochures, or Certificates.

### Verbal Statement May Not Alter Document

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefits. The terms of the Plan may not be amended by oral statements by Ameren representatives, the Plan Administrator or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan's terms will control. It is Your responsibility to confirm the accuracy of statements made by Ameren or its designees, including the Plan Administrator, in accordance with the terms of this SPD and other Plan documents.

### Applicability

Except as otherwise indicated, the provisions of this document shall apply equally to the Covered Employee and Dependents and all benefits and privileges made available to Covered Employee shall be available to Covered Employee's Dependents.

### Nontransferable Benefits

No person other than the Covered Employee and Covered Dependent is entitled to receive dental coverage or other benefits to be furnished by the Plan. Such right to dental care service coverage or other benefits is not transferable.

### Severability

In the event that any provision of this document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this document, which shall continue in full force and effect in accordance with its remaining terms.

### Waiver

The failure of Claims Administrator, the Plan Sponsor, or a participant to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

### Lost Distributees

If any person to whom a check is issued in payment of a benefit under this Plan cannot be located or does not present the check for payment, the amount of the check may be applied to other Plan purposes; provided, if any such person subsequently appears and makes demand for such payment, the Plan Administrator shall direct that such payment be made in full as soon as practical.

### Recovery of Excess Payments

In the event payments are made in excess of the amount necessary to satisfy the applicable provision of the Plan, the Plan shall have the right to recover excess payments from any individual,

insurance company or other organization to whom excess payments are made. The Plan shall also have the right to withhold payment of future benefits due until the overpayment is recovered.

### Collective Bargaining Agreement

With respect to eligible union represented Employees, the Plan is maintained pursuant to collective bargaining agreements with the local unions listed in the ELIGIBILITY section of this document. Copies of the respective collective bargaining agreements are available for inspection from the Plan Administrator upon request.

## Your Rights Under ERISA

As a participant in this Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and the updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for Yourself and any other Qualified Beneficiaries if there is a loss of coverage under the Plan as a result of a Qualifying Event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

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

If Your claim for a (welfare) benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such 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 You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in 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.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest Area 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, DC 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.

## General Information About the Plan

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| **Plan Name:** | Ameren Dental Plan, a component of the Ameren Employee Medical Plan |
| **Type of Plan:** | A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA), providing dental benefits. |
| **Plan Year:** | January 1 through December 31. Plan records are maintained on this basis. |
| **Plan Number:** | 510 |
| **Funding Medium and Type of Plan Administration:** | The Plan is generally funded from contributions made in part by the Plan Sponsor and in part by Plan participants. All contributions are paid directly to a trust established for the purpose of providing benefits under the Plan.<br><br>Plan Sponsor has a contract with Delta Dental of Missouri ("Claims Administrator") to process claims under the Plan including claims administration. Benefits under the Plan are not guaranteed under a contract or insurance policy. The Plan Sponsor is ultimately responsible for providing the Plan benefits, and not the Claims Administrator. |
| **Trustee:** | To the extent permitted under applicable law, dental benefits are paid out of trust funds held by The Bank of New York Mellon, located at 135 Santilli Highway, Everett, Massachusetts, 02149. If the trusts are terminated, the remaining assets will be distributed in accordance with the provisions of the trust agreements. |

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| **Plan Sponsor:** | Ameren Corporation<br>1901 Chouteau Avenue, Mail Code 533<br>Post Office Box 66149<br>St. Louis, MO 63166-6149<br>877.7my.Ameren (877.769.2637) |
| **Plan Sponsor's Employer Identification Number:** | 43-1723446 |
| **Plan Administrator:** | Administrative Committee<br>c/o Ameren Services Company<br>1901 Chouteau Avenue, Mail Code 533<br>Post Office Box 66149<br>St. Louis, MO 63166-6149<br>877.7my.Ameren<br>(877.769.2637) |
| **Claims Administrator:** | Delta Dental of Missouri<br>P. O. Box 8690<br>St. Louis, MO 63126-0690<br>800.335.8266 or 314.656.3001<br>www.deltadentalmo.com |
| **COBRA Administrator:** | Ameren Benefits Center<br>PO Box 5204<br>Cherry Hill, NJ 08034-5204<br>1.877.769.2637<br>www.myameren.com |
| **Named Fiduciary:** | Administrative Committee<br>c/o Ameren Services Company<br>1901 Chouteau Avenue, Mail Code 533<br>Post Office Box 66149<br>St. Louis, MO 63166-6149<br>877.7my.Ameren<br>(877.769.2637) |
| **Agent for Service of Legal Process:** | General Counsel<br>Ameren Services Company<br>1901 Chouteau Avenue, Mail Code 1300<br>Post Office Box 66149<br>St. Louis, MO 63166-6149<br>877.7my.Ameren<br>(877.769.2637)<br><br>Service of Legal Process also may be made upon the Trustee or the Plan Administrator. |

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| **Membership ID Card:** | Every Covered Employee receives membership ID card(s). Employees need to carry the Plan ID card(s) with them at all times, and present the ID card whenever the Employee or a Dependent receives dental services. If a dental Plan ID card is missing, lost, or stolen, contact Delta Dental at **800.335.8266** or **314.656.3001** to obtain a replacement. |