A Plan Designed to Provide
Security for Employees of

Ameren Vision 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:
Vision Service Plan Insurance Company

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 Vision Plan**, a component of the **Ameren Employee Medical Plan** (the "Plan") to provide vision benefits to its eligible Employees, their Spouses, and other eligible Dependents. All references herein to the "Ameren Vision Plan" and the "Plan" refer to the Vision 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 Vision Plan** has been established on a noninsured basis; all liability for payment of benefits is assumed by Ameren. While Vision Service Plan ("VSP") administers the payment of claims, VSP has no liability for the funding of the Plan.

While one of the functions of VSP 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 vision benefit claims and appeals to VSP.

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 Vision 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 a question 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 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 time benefits information will not be available.

In order to maintain confidentiality of Your benefits information, a password is required for Plan participants 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 Vision 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
Definitions 10
Schedule of Benefits 12
Covered Expenses 15
Expenses Not Covered 16
Coordination of Benefits 17
Subrogation 17
Payment of Benefits 17
How to File a Claim 18
Termination of Benefits 19
COBRA Continuation – Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 20
Continuation of Coverage under the Trade Act of 1974 24
Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA) 24
Continuation of Coverage Under the Uniformed Services Employment & Re-Employment Rights Act of 1994 (USERRA) 25
Privacy 26
Claim and Appeal Procedures for Eligibility 26
Claims Procedure and Appeals for Vision Benefits 28
Miscellaneous 30
Your Rights Under ERISA 32
General Information About the Plan 33

Ameren Vision Plan

Eligibility

Employees

You are eligible to participate in this Plan if You are classified by Ameren as either:

- 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
  - Ameren Illinois (formerly AmerenIP) and IBEW Local 51 (IP); or
  - Ameren Illinois (formerly AmerenIP) and IBEW Local 309 (IP); or
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  - 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[3] 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)

[3] AmerenEnergy Resources (AER) was divested to Illinois Power Holdings, LLC (commonly referred to as "Dynegy") effective December 2, 2013. The Grand Tower 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 Vision 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. Contact the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). 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 Vision 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. No person can be covered as a Dependent of more than one Employee.

A Dependent Child under the age of 26 who is also an Ameren Employee and eligible for coverage under an Ameren sponsored Vision 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 under more than one Ameren-sponsored vision plan at the same time.

Enrollment Provisions

Employees

In order to elect or waive coverage in the **Ameren Vision 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 vision or dental/vision 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 vision or dental/vision 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 immediately, You can add that Dependent only during Annual Enrollment, 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, marriage;
- You, Your Spouse or Dependent Child becomes employed or loses a job;
- Your Spouse 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 the vision 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.

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 vision plan (including COBRA continuation coverage) or had other vision 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 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 and 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 Dependents 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

Vision 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 or step-children 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 Vision 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**).

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.

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, vision 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 been enrolled hereunder and whose coverage under the Plan is in effect.

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.

Dependent means Your Spouse or Dependent Child, if that Spouse or 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.

Member means a Covered Employee or Covered Dependent.

Network Provider/In-Network Provider means a doctor (optometrist or ophthalmologist), or other provider who has agreed to participate in the VSP network.

Non-Network/Out-of-Network Provider means a doctor (optometrist or ophthalmologist) or other provider who does not participate in the VSP network.

Non-Specialty Contacts are soft, spherical single-vision lenses and do not include toric, multifocal, monovision, aphakic or other specialty lenses.

Plan means **Ameren Vision 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 spouses

(even if the state recognizes common-law marriages), ex-spouses, domestic partners, boyfriends, girlfriends or anyone else to whom the Employee is not currently married.

Visually Necessary or Appropriate means services and materials medically or Visually Necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

You/Your means an Employee who is eligible to participate in the vision 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 a Covered Member.

Schedule of Benefits

The **Ameren Vision Plan** allows You to go to any doctor. However, You get the best value from Your VSP benefits when You visit a VSP Network Provider. There are several advantages of using a VSP Network Provider:

- Lowers Your out-of pocket costs;
- You can change Your doctor at any time;
- You can go to a specialist of Your choice;
- You can select different doctors for each member of Your family;
- The networks are national;
- The doctor will file Your claim for You and/or Your Dependents.

The following chart shows how benefits are paid:

Plan Features	In-Network	Out-of-Network
Eye Exam (once every Plan Year)	**$10 co-pay**	**$10 co-pay, then You are reimbursed up to $50**
Pair of Eyeglasses (once every Plan Year)[1]		
– **Single Vision**	**$10 co-pay**	**$10 co-pay, then reimbursed up to $50**
– **Lined Bifocal**	**$10 co-pay**	**$10 co-pay, then reimbursed up to $75**
– **Lined Trifocal**	**$10 co-pay**	**$10 co-pay, then reimbursed up to $100**
– **Lenticular**	**$10 co-pay**	**$10 co-pay, then reimbursed up to $125**
Frames (once every Plan Year)[1,3]	**Frame of Your choice covered up to $200**	**Frame of Your choice covered up to $70.**
Elective Contacts (once every Plan Year)[2]	**Plan pays 100% up to $200**	**Plan pays 100% up to $150**
Laser Vision Correction	**Plan pays up to $500 per year**	**Plan pays up to $500 per year**

[1] If You select a new frame for Your existing lenses, a $10 co-pay will apply.

[2] You may receive benefits for eyeglasses or contact lenses, but not both in a calendar year.

[3] If You have had laser vision surgery (PRK, LASIK, or Custom LASIK) You can use Your frame allowance to buy non-prescription sunglasses.

Diabetic Eyecare Plus Program

The Diabetic Eyecare Plus Program provides services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Additionally, retinal screening is available for eligible members with diabetes. This program may allow Your VSP doctor to provide services not available under the regular Schedule of Benefits for this Plan. Your cost for this program is a $20 copay. Contact VSP at **800.877.7195** for more information.

Frames

Your VSP frame benefit offers You the freedom to choose a frame that complements Your lifestyle.

If You choose a frame that exceeds the $200 Plan allowance, You will be responsible for paying the difference at the time of Your doctor's visit.

Contact Lenses

When You choose contact lenses instead of glasses, Your $200 allowance applies to the cost of Your contacts.

Your cost for the contact lens evaluation and fitting is limited to $60, and is not applied to the cost of your contact lenses. This exam, which ensures proper fit of the contacts, is in addition to Your vision exam.

You receive a 15% discount on the cost of contact lens professional services from Your VSP network doctor.

Visually Necessary Contact Lenses

The Plan pays 100% of the professional fees and materials (after $10 co-pay) for Visually Necessary contact lenses obtained from a VSP network doctor, subject to prior authorization. When Visually Necessary contact lenses are obtained from a non-participating provider, the Plan covers up to $210 (after $10 co-pay).

Note: You can receive benefits for eye glasses or contact lenses, but not both.

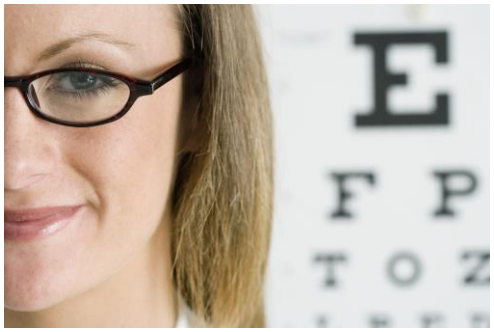
Why is the contact lens exam not covered as part of my routine eye exam?

The contact lens exam is a special exam which ensures the proper fit of Your contact lenses and evaluates Your vision with the contacts. Depending on Your needs, a doctor will provide training and education based on the type of services and eyewear provided. You should discuss the services that Your doctor provides to better understand the value of their contact lens exam, as well as the extent of the services necessary for Your individual eye health.

Extra Discounts Available From VSP Network Providers

When You purchase eyeglasses from a VSP Network Provider, You may be eligible to receive additional discounts off of lens extras, as well as other discounts from VSP. These discounts are subject to change from time to time at the discretion of the Claims Administrator. Visit **www.vsp.com** for additional information on these discounts. Examples of lens extras are:

- Scratch-resistant coating
- Anti-reflective coating
- Ultraviolet (UV) protection
- Progressive lenses
- Blended bifocal lenses
- Most tinted and photochromic lenses



When purchasing eyeglasses from a VSP Network Provider for Your Dependent Children, the Plan covers 100% of the cost of polycarbonate lenses.

Receive 30% off unlimited additional pairs of prescription glasses and sunglasses, including lens enhancements, if You purchase them from the same VSP provider who performs Your eye exam and on the same day Your eye exam is performed.

Receive 20% off additional prescription glasses and sunglasses if You purchase from any VSP provider within twelve (12) months of Your last eye exam.

Receive 15% off the cost of the contact lens exam (fitting and evaluation) if You purchase from the same VSP doctor who provided Your eye exam within the last 12 months.

Receive an additional $20 allowance for certain featured frame brands. You may also be eligible for an additional 20% discount on the amount over the Plan's frame allowance.

Up to a $39 copay on routine retinal screening as part of Your once a Plan Year eye exam.

Low Vision Benefit

If You or Your Covered Dependent has severe visual problems that are not correctable with regular lenses, subject to prior approval by VSP Consultants, the following additional benefits may be available:

- Supplementary Testing (complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated). These services are covered in full if provided by a VSP network doctor. If these services are provided by a non-participating doctor, they are covered up to $125.

- Supplemental low vision care aids, as Visually Necessary and Appropriate. The Plan will pay 75% of the cost and You pay 25% of the cost for such supplemental care aids if provided by a VSP network doctor. If supplemental low vision care aids are received from a non-participating doctor, the Plan will pay an amount not to exceed what VSP would pay a member doctor in similar circumstances.

Benefit Maximum

The maximum low vision benefit available is $1,000 per covered individual (excluding co-pay) every two years.

How to Receive Vision Benefits

Simply call the doctor's office and make an appointment. If You select a VSP network doctor, tell him or her that You are a VSP member. Your doctor and VSP will handle the rest.

How To Verify Participation in VSP Network

In order to verify if Your doctor is a participant in the VSP network, You can:

- Simply ask Your doctor if he/she is a VSP network doctor; or
- Visit VSP's website at **www.vsp.com** and search the directory for a VSP doctor; or
- Call VSP's customer service department at **800.877.7195**.

You do not need to notify VSP when You choose or change Your VSP network doctor. When You are ready, simply make an appointment with a VSP doctor.

VSP Savings Statement

Each time the Plan pays a claim for You, a VSP Savings Statement will be generated and will be available for You to access online at **www.vsp.com**. The Savings Statement will show You what the Plan paid on Your behalf and what the services would have cost You if there had been no Plan coverage.

Covered Expenses

The amount the Plan pays depends on the type of services provided (See SCHEDULE OF BENEFITS). The following are Covered Expenses under the Plan:

1. Annual eye examinations - complete vision analysis which includes an Appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Vision Care Materials, including single vision, bifocal, trifocal and lined lenticular lenses. These materials are available once per Plan Year, beginning on January 1.
3. Frames – once per Plan Year, beginning on January 1.
4. The following professional services as are necessary for lenses and frames:
    a. Prescribing and ordering proper lenses;
    b. Assisting in selection of frames;
    c. Verifying the accuracy of the finished lenses;
    d. Proper fitting and adjustment of frames;
    e. Subsequent adjustments to frames to maintain comfort and efficiency;
    f. Progress or follow-up work as necessary.
5. Contact lenses – Available once per Plan Year, beginning on January 1, in lieu of all other lens and frame benefits. Covered Person will be eligible for lenses and frames during the next Plan Year unless he or she opts again to receive contact lenses.
6. Low Vision Supplementary Testing and Supplemental Care Aids, subject to prior approval by VSP Consultants.

7. Additional diagnostic services for covered individuals who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, following routine eye examination by a VSP doctor.

Expenses Not Covered

The Plan is designed to cover visual needs, rather than cosmetic materials. If You or Your Covered Dependent selects any of the following options, the Plan pays the basic cost of the allowed lenses, and You or Your Covered Dependent pay the additional costs:

1. Optional cosmetic processes
2. Anti-reflective coating
3. Color coating
4. Mirror coating
5. Scratch coating
6. Blended lenses
7. Cosmetic lenses
8. Laminated lenses
9. Oversize lenses
10. Progressive multifocal lenses
11. Photochromic lenses; tinted lenses except Pink #1 and Pink #2
12. UV (ultraviolet) protected lenses
13. Certain limitations on low vision care
14. A frame that costs more than the Plan allowance
15. Contact lenses (except as noted under the SCHEDULE OF BENEFITS)

In addition, the Plan will not pay benefits for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.5 diopter power); or two pair of glasses in lieu of bifocals;
2. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
3. Medical or surgical treatment of the eyes;
4. Corrective vision treatment of an experimental nature;
5. Costs for services and/or materials above Plan benefit allowances;
6. Services and/or materials not indicated on this Schedule as covered Plan benefits.

Important Note: VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the covered person.

Coordination of Benefits

If a patient is covered by more than one vision plan (whether it is another carrier or another VSP plan), and therefore has duplicate coverage, he/she may:

- Receive two separate sets of service; OR
- Choose to have both plans pay for one set of services. In this case the patient is "coordinating benefits".

Determine Primary and Secondary Plan

When a patient has duplicate coverage and wants to coordinate benefits, VSP must determine the order of assignment. The plan that covers the patient as an employee is "primary". The plan that covers the patient as a dependent is "secondary".

If the patient is a dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Primary Plan

The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist.

Secondary Plan

If a VSP is the secondary plan, the patient will receive allowances (exam, lenses and frame) that will be used to pay up to, but not more than the billed amount. Only services used on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service or product of the primary plan. Well vision benefits may only be coordinated with services provided for Well vision care.

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 provider who participates in the VSP network, payment of benefits will be made directly to the provider. When services are received from an Out-Of-Network Provider, You will be required to pay the provider in full at the time of Your appointment and submit a claim to VSP for a partial reimbursement for Covered Expenses under the Plan. If You decide to see a provider not in the VSP network, we suggest You first

call VSP at **800.877.7195** to discuss the benefits of using In-Network Providers versus Out-Of-Network Providers.

If You, a provider or other person has been paid benefits under that 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 VSP 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 (3) administration of claims appeals. However, the Plan Sponsor is ultimately responsible for providing Plan benefits.

You do not need to file a claim if You use a VSP network doctor.

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

VSP
Attn: Out-of-Network Claims
P. O. Box 385018
Birmingham, AL 35238-5018
800.877.7195

Claims for vision 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 service 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 vision claim should be directed to VSP at 800.877.7195.

All claims for vision benefits must be received by VSP within 365 days from which date the Covered Expense is incurred.

VSP 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 AND 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 Vision 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 vision 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 handicapped child who is over the age of 26 is no longer handicapped according to the Plan definition or You fail to provide proof of Your child's handicap.
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, You and Your Covered Dependents may be eligible for temporary healthcare continuation benefits as required by federal law. (See COBRA CONTINUATION).

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 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 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 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.

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 5207
Cherry Hill, NJ 08034-5204

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.

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 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 Sponsor, 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 at **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 and the Company 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 Vision Benefits

As a participant in the **Ameren Vision 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 vision 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 addresses:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

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, insurance company, 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, insurance company or 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 Vision 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 vision coverage or other benefits to be furnished by the Plan. Such right to vision 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 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 healthcare 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

Plan Name:	Ameren Vision 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 vision benefits.
Plan Year:	January 1 through December 31
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. The Plan Sponsor has a contract with Vision Service Plan ("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, vision benefits are paid out of a 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.
Plan Sponsor:	Ameren Corporation 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Plan Sponsor's Employer Identification Number:	43-1723446
Plan Administrator:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Claims Administrator:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195 www.vsp.com
COBRA Administrator:	Ameren Benefits Center PO Box 5207 Cherry Hill, NJ 08034-5204 www.myameren.com
Named Fiduciary:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)

Agent for Service of Legal Process:	General Counsel Ameren Services Company 1901 Chouteau Avenue, Mail Code 1300 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637) Service of Legal Process also may be made upon the Trustee or the Plan Administrator.