A Plan Designed to Provide Security for Employees of

Ameren Employee Medical Plan Options Design

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

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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.

Adverse Benefit Determination means a denial of a request for service or failure to provide or make payment (in whole or in part) for a Covered Expense or any reduction or termination of a covered service. With respect to any non-grandfathered coverage option under the Plan, an Adverse Benefit Determination also includes a rescission of coverage (other than a retroactive termination of coverage due to the Member's failure to timely pay any required contributions).

Allowable Expenses means the portion of a Covered Expense which is payable under at least one of the plans covering the Member.

Ambulance Services or Ambulance means a state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Ambulatory Surgery Center means a facility designed to provide surgical care which does not require Hospital confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse ("R.N.") whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional Providers.

Ameren means Ameren Corporation and its affiliates that participate in the Plan.

Appropriate means that the type, level and length of service, and setting are needed to provide safe and adequate care and treatment.

Average Semi-Private Charge means:

- the Hospital's standard charge for semi-private room and board accommodations (if the Hospital has more than one charge, use the average of these charges); or
- 80% of the Hospital's lowest charge for single-bed room and board accommodations where the Hospital does not provide any semi-private accommodations.

Birthing Center means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a Specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing Services directed by a R.N. or certified nurse midwife; and

- has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and staff members being aware of such procedures.

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

Clinical Trial or Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other Life-Threatening Conditions.

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

Company means Ameren Corporation.

Concurrent Review means a Utilization Management Review conducted during a Member's Hospital stay or course of treatment.

Continued Stay Review means a review by the Claims Administrator of a Physician's report of the need for continued Hospital confinement to determine if the continued stay is for Medically Necessary Care.

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.

Copay means a specified dollar amount that must be paid by You or one of Your Covered Dependents each time certain or specified services are rendered.

Cosmetic Treatment or Service means a treatment or service to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body

which is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic treatment or service includes, but is not limited to, surgery, pharmacological regimens, and all related charges.

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 Allowed Amount. The treatment or service must be required for the treatment of a sickness, injury, or certain routine care and must be considered by the Claims Administrator to be Medically Necessary Care.

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.

Covered Transplant Procedure means any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care means assistance with meeting personal needs or the activities of daily living including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination, and taking medications.

Deductible; Deductible Amount for purposes of medical plan coverage means a specified dollar amount of medical Covered Expenses (and covered prescription drug expenses if enrolled in the Health Savings Plan or Health Savings Plan – Value) 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. For purposes of the Prescription Drug Program, Deductible means the dollar amount for each calendar year that a Member is responsible for paying under the Coinsurance option before any prescription drug benefits are payable.

Dental Services means any treatment or service, provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); and/or
- malocclusion (abnormal positioning and/or relationship of the teeth); and/or
- ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance.)

Dependent means Your Spouse, Domestic Partner or Dependent Child, if that Spouse, Domestic Partner or Dependent Child is not covered under this Plan as an Employee.

Dependent Child means: Your or Your Domestic Partner's natural child; Your stepchild; an adopted child; a child who has been placed with You for adoption; a child for whom You or Your Spouse/Domestic Partner have been appointed legal guardian or custodian by a court order; a child who is recognized under a QMSCO or National Medical Support Notice, as defined by ERISA § 609 (a), as having a right to enrollment under the Plan. When a court recognizes a child as a QMCSO-child, the child will be considered Your eligible Dependent.

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.

Developmental Delay means the statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age-appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an injury.

Domestic Partner An employee has a "Domestic Partner" if both individuals meet the following requirements:

- are at least 18 years of age and not related to each other by blood;
- are not married to another person under statutory or common law;
- are not in another domestic partnership;
- have been in an exclusive, committed relationship with each other for at least twelve (12) consecutive months and intend to remain so indefinitely;

- have shared the same principal residence for at least twelve (12) consecutive months;
- and are jointly responsible for financial obligations and for each other's common welfare.

Durable Medical Equipment means equipment that:

- can withstand repeated use; and
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person who is not sick or injured, or used by other family members; and
- is appropriate for home use; and
- improves bodily function caused by sickness or injury, or prevents further deterioration of the medical condition; and
- is not merely for comfort or convenience; and
- is ordered by a Physician, who certifies in writing the Medical Necessity for the equipment, and states the length of time the equipment will be required.

The Plan may require proof at any time of the continuing Medical Necessity of any item.

Emergency Medical Condition or Medical Emergency means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including pain). This condition may be as a result of an injury, sickness, or mental illness, which occurs suddenly and is such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or the health of another person (or with respect to a pregnant woman, the health of the woman or her unborn child); or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Employee generally means any person who is a regular employee of an Ameren Company and classified as an employee eligible to participate in the Plan. Employee does not include, however, any individual classified by the Company as an independent contractor, Temporary Referral Worker 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.

Employer or **Ameren Company** means each control group affiliate of the Company that has adopted the Plan with the Company's approval. For a current list of Employers participating in the Plan please contact the Plan Administrator.

Episode of Hospice Care means the period of time:

- beginning on the date a Hospice Care Program is established for a terminally ill individual; and

- ending on the earlier of the date six months after the date the Hospice Care Program is established, the date the attending Physician withdraws approval of the Hospice Care Program, the date the individual recovers or the date the individual dies.

Two or more Episodes of Hospice Care for the same individual will be considered one Episode of Hospice Care, unless separated by a period of at least three months during which no Hospice Care Program is in effect for the individual.

Experimental or Investigational Measures mean any treatment or service, regardless of any claimed therapeutic value, not Generally Accepted by Specialists in that particular field of medicine or dentistry, as determined by the Claims Administrator or its delegate.

Formulary means the list of Food and Drug Administration ("FDA")-approved prescription drugs and supplies developed by CVS Caremark's Pharmacy and Therapeutics Committee and/or customized by the Plan which represents the current clinical judgment of practicing healthcare practitioners based on a review of current data, medical journals, and research information. In Your pharmacy benefit Plan, the Formulary drug list is used as a guide for determining the amount that You pay as a Copay or Coinsurance for each prescription, with drugs listed on the Formulary typically available at a lower Copay or Coinsurance to You. The Formulary may change from time to time. To obtain information about prescription drugs on CVS Caremark's Formulary, You may call toll-free 877.817.0479 or visit CVS Caremark's website at www.caremark.com.

Generally Accepted means that the treatment or service for the particular sickness or injury which is the subject of claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical or dental community; and
- is not under scientific testing or research.

Generic Prescription Drug or Generic Drug means a drug that has the same active ingredients and is subject to the same rigorous FDA standards for quality, strength, and purity as its brand name equivalent. The brand name drug is the product name under which it is advertised and sold. Generic Drugs are usually sold under unfamiliar names although they have the same effectiveness, and are as medically equivalent, as the brand name drug.

Health Care Extender means an allied health practitioner who is delivering medical services under the direction and supervision of a Physician.

Direction and supervision means the Physician co-signs any progress notes written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

Health Professional or Health Care Professional means an individual who:

- has undergone formal training in a healthcare field;
- holds an associate or higher degree in a healthcare field, or holds a state license or state certificate in a healthcare field; and
- has professional experience in providing direct patient care.

Home Health Aide means a person, other than a R.N., who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

Home Health Care Agency means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

Home Health Care Plan or Home Health Care means a program of home care that:

- is required as the result of a sickness or injury; and
- prevents, delays, or shortens a Hospital confinement or Skilled Nursing Facility confinement; and
- is documented in a written plan of care; and
- is reviewed and certified by a Physician to be necessary.

Hospice means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and
- arranges, coordinates, and/or provides Hospice services for terminally ill individuals and their families; and
- maintains records of Hospice services provided and bills for such services on a consolidated basis.

Hospice Care Program means a program:

- managed by a Hospice and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician

to meet the special physical, psychological and spiritual needs of terminally ill individuals and their families.

Hospice Care Team means a group that provides coordinated Hospice services and normally includes:

- a Physician;
- a "Patient Care Coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- dietitian;
- physical therapist, occupational therapist, speech therapist, respiratory therapist;
- a mental health Specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

Hospital means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, Custodial Care facility, or training center. **Hospital** shall also include an inpatient alcohol or drug abuse treatment facility approved by the Claims Administrator.

Hospital Admission Review means a review by the Claims Administrator of a Physician's report of the need for Hospital confinement (scheduled or emergency) to determine if the confinement is for Medically Necessary Care.

Hospital Confinement Charges mean Covered Expenses billed by a Hospital for room, board, and other usual services while a Member is confined in a Hospital. The charges must be incurred while the Member is confined for a period of at least 23 consecutive hours (for any cause).

Hospital Room Daily Limit means the Covered Expenses by a Hospital for room and board while confined in a private room based on the average semi-private room charge. There is no limit for Covered Expenses incurred for a semi-private room, ward, or Intensive Care Accommodations.

Immediate Family means a Member's Spouse/Domestic Partner, 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.

Infertile or Infertility means the condition of a presumably healthy person who is unable to conceive or produce conception. This does not include conditions for men when the cause is a vasectomy or orchiectomy, or for women when the cause is tubal ligation or hysterectomy.

Initial Clinical Review means a clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

Inpatient means a person who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Accommodation means a Hospital facility exclusively reserved for critically and seriously ill or injured patients who require constant audio-visual monitoring as ordered by the attending Physician. Such accommodation provides room and board, specialized nursing care, and immediately available supplies and special equipment.

Intensive Outpatient Programs means short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Maternity Care means obstetrical care received both before and after the delivery of a child or children. It includes care for miscarriage and regular nursery care for a newborn infant as long as the mother's Hospital stay is a Covered Expense and the newborn infant is a Covered Dependent under the Plan.

Maximum Allowed Amount means the maximum amount of reimbursement the Plan will allow for Covered Expenses (See MAXIMUM ALLOWED AMOUNT section in this booklet).

Medically Necessary Care, or Medically Necessary or Medical Necessity means any treatment or service that is provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and determined by the Claims Administrator to be:

- medically Appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;
- obtained from a covered Network or Non-network Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;

- consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;
- cost-effective compared to alternative treatments or service, including no treatment or service. As to the diagnosis or treatment of the Member's illness, injury or disease, the service is: not more costly than an alternative service or sequence of services that is medically Appropriate; or performed in the least costly setting that is medically Appropriate;
- the most Appropriate level of services or supplies that can safely be provided and which cannot be omitted consistent with recognized professional standards of care;
- determined by the Plan Administrator or its delegate to be Generally Accepted;
- is not an Experimental or Investigational Measure;
- not otherwise subject to an expense not covered under this Plan.

Member means a Covered Employee or Covered Dependent.

Network Pharmacy means a Pharmacy that participates in the CVS Caremark network identified by the Claims Administrator for this Plan.

Network Provider/In-Network Provider means a Hospital, Physician, or other Provider who participates in Anthem's network programs identified by the Claims Administrator for this Plan.

Network Service Area means a geographic area within which Network Provider services are available to Members.

Noncertification means a decision by the Claims Administrator that an admission, continued stay, or other healthcare service has been reviewed and, based upon the information provided, does not meet the Claims Administrator's requirements for Medically Necessary Care, Appropriateness, healthcare setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

Non-Covered Expenses means charges for treatment and health care services that are not Covered Expenses because the treatment or services are not Medically Necessary Care, specifically excluded from coverage by the terms of this Plan, services received after benefits have been exhausted, or precertification was not obtained. Such charges are not eligible for payment by the Plan.

Non-Network/Out-Of-Network Provider means a Hospital, Physician, or other Provider who does not participate in the Anthem network identified by the Claims Administrators for this Plan.

Non-Preferred Brand Name or Non-Preferred Brand Name Prescription Drug means a brand-name drug that is not listed on Your Formulary. These drugs are typically more expensive alternatives to preferred drugs, providing the same treatment at a higher cost. Also known as "Non-Preferred Medication" or "Non-Formulary Brand."

Ordering Provider means the Physician or other Provider who specifically prescribes the healthcare treatment or service being reviewed.

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.

Out-Of-Pocket Maximum means the amount of Covered Expenses You and Your Covered Dependents must pay in a Plan Year before the Plan begins paying 100% of Covered Expenses for the remainder of the Plan Year.

Palliative Care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness.

Partial Hospitalization Program means structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than six (6) hours per day, five (5) day per week.

Peer Clinical Review(er) means a clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Pharmacy means an establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order.

Physical Therapy means the care of disease or injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician means doctor of medicine ("MD"); doctor of osteopathy ("DO"); audiologist; certified registered nurse anesthetist ; chiropractor; dentist; certified midwife; occupational therapist; optometrist; physician assistant; physical therapist; podiatrist ; psychologist; and speech pathologist.

Physician Visit means a face-to-face meeting between a Physician or Physician's staff and a Member for the purpose of medical treatment or service, except as otherwise covered under the LiveHealth Online ("LHO") telemedicine program.

Placement for Adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan means the **Ameren Employee Medical 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.

Post-Service Review means a review conducted after the Member is discharged from a Hospital or other healthcare facility received services or has completed a course of treatment.

Preferred Brand Name or Preferred Brand Name Prescription Drug means a brand-name drug that is listed on Your Formulary. (Also referred to as a "Formulary Brand Drug"). These drugs are brand name because they are patented and can only be made by one manufacturer or its licensees. "Preferred" means that CVS Caremark has approved them based on their safety, effectiveness and cost as compared to similar drugs.

Pre-Service Review means a review conducted prior to a Member's stay in a Hospital or other healthcare facility, receipt of services or course of treatment, including any required preauthorization or precertification.

Primary Care Physician means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist (for preventive care only), or pediatrician.

Provider means a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. To determine whether a specific Provider is covered, please call the number on the back of Your Identification Card.

Recovery means but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of whether You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Residential Treatment Center/Facility means a Provider licensed and operated as required by law, which includes:

- room, board and skilled nursing care (either a R.N. or licensed vocational nurse ("L.V.N.")/licensed practical nurse ("L.P.N.") on-site at least eight hours daily and with 24 hour availability; and
- Providers staffed with one or more Doctors available at all times; and
- Residential treatment that takes place in a structured Facility-based setting; and
- resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder; and
- facilities designated as residential, subacute, or intermediate care (which may occur in care systems that provide multiple levels of care); and.
- Providers fully accredited by The Joint Commission ("TJC"), the Commission on Accreditation of Rehabilitation Facilities ("CARF"), the National Integrated Accreditation for Healthcare Organizations, or the Council on Accreditation.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- nursing care; or
- rest care; or
- convalescent care; or
- care of the aged; or
- custodial Care; or
- educational care.

Retired Employee/Retiree means an Employee who is retired and meets the definition and eligibility for coverage under the **Ameren Retiree Medical Plan**.

Skilled Nursing Facility means an institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located and accredited by TJC or the CARF, as applicable, or meets specific rules set by the Claims Administrator, to provide skilled nursing care and that:

- is supervised on a full-time basis by a M.D., D.O. or a R.N.; and
- has transfer arrangements with one or more Hospitals, a Utilization Management Review Plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has a contract for the services of an M.D. or D.O., maintains daily records on each patient and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

A Skilled Nursing Facility does not include rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

Specialist/Specialty Provider means any Physician other than a Primary Care Physician who is classified as a Specialist by the American Boards of Medical Specialties and focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Medications/Specialty Drugs means high-cost drugs that are typically injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require pre-authorization to be considered Medically Necessary.

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 IRS 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.

Step Therapy means that before certain prescriptions can be approved and covered, You and Your Physician must first try other medications as specified by the Plan. If these specified medications do not work for You, then You and Your Physician can step up to other alternatives. Your pharmacist will inform You if Step Therapy applies to Your medication.

Transplant Network or Network Transplant Provider means a Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee by the Blue Cross Blue Shield Association ("Association"). Such Provider has entered into a transplant Provider agreement to render covered transplant procedures and certain administrative functions to You for the Transplant Network. A Provider may be a Network Transplant Provider with respect to certain covered transplant procedures or all covered transplant procedures. An "Out-of-Network Transplant Provider" means any Provider that has not been designated as a Center of Excellence for Transplants by the Claims Administrator nor has been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

Urgent Care means services received for a sudden, serious, or unexpected illness, injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Urgent Review means a review that must be completed sooner than a Pre-Service Review in order to prevent serious jeopardy to the Member's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without treatment.

Whether or not there is a need for an Urgent Review is based upon the Claims Administrator's decision using the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

Utilization Management Review or Utilization Review means a set of formal techniques performed by the Claims Administrator designed to monitor the use of or evaluate the clinical necessity, Appropriateness, efficacy or efficiency of medical or behavioral treatment, healthcare services, procedures, Providers, or facilities. This includes, but is not limited to, whether acute hospitalization, length of stay, outpatient care and/or diagnostic services are Appropriate.

Years of Service for purposes of determining eligibility for a surviving Covered Dependent of a Covered Employee means the length of time from date of hire to date of death of the Covered Employee.

You/Your means an Employee who is eligible to participate in the Plan 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.

Purpose

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

This booklet (including any subsequent supplements) constitutes the Summary Plan Description ("SPD") for the Plan and outlines the provisions and benefits afforded under the Plan as of January 1, 2023. It replaces and supersedes all prior summary plan descriptions for the Plan.

The Plan has been established on a noninsured basis; all liability for payment of benefits is assumed by Ameren. While Anthem BlueCross and BlueShield ("Anthem") and CVS Caremark ("CVS Caremark") administer the payment of claims, they have no liability for the funding of the Plan.

The Administrative Committee of the Company serves as the Plan Administrator. The Plan Administrator has complete and sole discretion to construe or interpret all 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. The Plan Administrator has also delegated discretionary authority for the administration of medical benefit claims and appeals to Anthem and prescription drug benefit claims and appeals to CVS Caremark.

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. The Plan Sponsor hopes and expects to continue the Plan in the years ahead but cannot guarantee to do so. The Plan Sponsor 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 YOUR 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.

Your Role in Controlling Healthcare Costs

Making choices about Your health can sometimes be difficult. When You seek healthcare, take the same approach You use for buying anything else. Ask questions. Make sure You get the most appropriate care for Your condition. Use the following guidelines to help You be a wise healthcare consumer:

Practice Good Health Habits. Staying healthy is the best way to control Your medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

See Your Physician Early. Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

Make Sure You Need Surgery. If You are unsure about the surgery You face, You may want to get a Second Opinion. If You need surgery, ask about same day surgery. Many procedures can be performed safely without an overnight Hospital stay. You may be able to have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

Use Outpatient Services for X-ray or Laboratory Tests. Outpatient preadmission and diagnostic tests can save costly room and board charges.

Compare Prescription Drug Prices. Discuss the use of Generic Prescription Drugs with Your Physician or pharmacist. Generic Prescription Drugs are often cheaper than brand name drugs for the same quality.

Use the Ameren Employee Assistance Program ("EAP"). The EAP is a proven resource that helps resolve stresses associated with emotional, relationship, parenting, financial and other personal problems.

Consider Hospital Stay Alternatives. Home Health Care Plan, Skilled Nursing Facilities, and Hospice Care Program services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

Review Medical Bills Carefully. Make sure You understand all charges and receive bills only for services You receive. Keep Your medical records up-to-date.

Talk to Your Physician. Discuss the need for treatment with Your Physician. It's Your body. To make wise healthcare decisions, You must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's healthcare costs, Your Physician will understand Your concern about Your medical expenses.

Be a wise healthcare consumer. Review Your benefits carefully so You can make informed healthcare decisions. You can help control healthcare costs while getting the most Your medical plan option has to offer.

In addition to the medical coverage provided under the Plan, Anthem also offers programs to help You stay healthy and/or manage disease. To learn more about these programs see ANTHEM HEALTH PROGRAMS or go to **www.anthem.com**. You may also call **844.344.7410** to speak to a Member services representative.

Five Tips for Improving Your Overall Health and Wellness

Want to become healthier, but don't know where to start? Check out these five tips for improving Your overall health and wellness.

1. **Eat right.** Better nutrition is about more than knowing which foods are good for You and which ones are bad. It's also about eating the right amounts of foods and the right mix of foods from all five food groups (grains, vegetables, fruits, milk, and meat and beans).
2. **Get moving.** Everyone knows that they should exercise, but actually fitting it into our daily lives is often another story. Nevertheless, exercise is an essential part of creating a healthy lifestyle. The American Academy of Physicians recommends that You exercise 4 – 6 times a week for 30 – 60 minutes.
3. **Maintain a healthy weight.** Determining if Your weight is normal has to do with more than just pounds – it also has to do with Your height. You can use a body mass index calculator to get a more complete idea of Your weight.
4. **Reduce stress.** Stress is a common part of everyday life and a certain amount of stress is actually good for You. Too much stress can negatively affect Your digestive, immune, nervous and cardiovascular systems. Look for Your stress triggers and work to change Your reaction to them.
5. **Know your health status and take steps to improve it.** By taking an active role in managing Your health, You can help prevent or delay the onset of chronic conditions. Go to the doctor each year for a physical and get all recommended preventive health screenings and tests. Ask Your doctor what You can do to improve Your cholesterol, blood pressure and other health numbers.

Medical Benefit Information

Anthem can answer questions about Your medical benefits and specific coverage. The Anthem staff can also provide information on topics such as outpatient surgery, healthcare alternatives, healthcare Providers, and treatment costs in Your area.

The Anthem staff does not prescribe medical treatment. That is up to Your Physician. But they can help You understand Your benefits and how to use them in the most cost-effective manner.

Call Anthem Member Services Number at **844.344.7410** if You wish to discuss Your medical benefits with the Anthem staff.

CVS Caremark can assist You with questions regarding Your prescription drug coverage. You can reach a CVS Caremark Customer Service representative at **877.817.0479**

Both Anthem and CVS Caremark phone numbers are also found on Your ID Cards.

Your Rights And Responsibilities As An Anthem Blue Cross Blue Shield Member

As an Anthem Blue Cross Blue Shield Member You have certain rights and responsibilities to help make sure that You get the most from Your Plan and access to the best care possible. That includes certain things about Your care, how Your personal information is shared and how You work with us and Your doctors. You also have a responsibility to take an active role in Your care. Anthem Blue Cross Blue Shield is committed to making sure Your rights are respected while providing Your health benefits, including giving You access to the Claims Administrator's Network Providers and the information You need to make the best decisions for Your health and welfare.

You have the right to:

- Speak freely and privately with Your doctors and other health professionals about all health care options and treatment needed for Your condition, no matter what the cost or whether it's covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Privacy, when it comes to Your personal health information, as long as it follows state and federal laws, and privacy rules.
- Get information about Anthem's network of doctors and other health care Providers.
- Make a complaint or file an appeal about:
    - Your health care Plan
    - Any care You get
    - Any Covered Expense or benefit ruling that Your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your doctor to tell You how that may affect Your health now and in the future.

You have the responsibility to:

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers and call their office if You have a delay or need to cancel.
- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- To the extent possible, understand Your health problems and work with Your doctors or other health care professionals to make a treatment plan that You all agree on.
- Follow the care plan that You have agreed on with Your doctors or health care professionals.
- Tell Your doctors or other health care professionals if You don't understand any care You're getting or what they want You to do as part of Your care plan.
- Follow all Plan rules and policies.
- Give Anthem, the Plan, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health care plans and insurance benefits You have in addition to Your coverage under the Plan.

How to Obtain Language Assistance

Anthem is committed to communicating with members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all Member Services Call Centers. Simply call the Member Services phone number on the back of Your ID Card (**844.344.7410**) and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services.

The Claims Administrator is committed to providing quality benefits and customer service to the Plan's Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Rights and Responsibilities statement.

Identity Protection Services

If You are enrolled in an Anthem medical plan You automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to You.

Anthem Non-Discrimination Notice

It's important we treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID Card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-

800-368-1019 (TDD:1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get Help in Your Language

You have the right to get this information and help in your language for free. Call the Member Services number on your ID Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID Card.

myAmeren Benefits

myAmeren Benefits is Ameren's employee benefits customer call center. When You have questions about Your eligibility or any other benefits, call **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). **myAmeren Benefits** is available Monday through Friday from 7:00 a.m. to 7:00 p.m., Central Standard Time (CST).

myAmeren.com

The Company maintains **www.myAmeren.com** where Plan participants can enroll, view, or make changes to elected benefit coverage. 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.

Questions about Your benefits should be directed to **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**).

Eligibility

Employees

You are eligible to participate in this Plan as an Employee if You are classified by an Ameren Company as:

- a full-time non-union represented (sometimes referred to as "management") Employee of an Ameren Company; or
- a regular full-time Employee represented by a collective bargaining agreement between:
    - Ameren Missouri and UGSOA Local Union 11; or
    - Ameren Illinois (CIPS) and IBEW Local Union 309; or
    - Ameren Illinois (CIPS) and IBEW Local Union 649; or
    - Ameren Illinois (CIPS) and IBEW Local Union 702[1]; or
    - Ameren Illinois (CILCO) and IBEW Local Union 51; or
    - Ameren Illinois (IP) and IBEW Local 51; or
    - Ameren Illinois (IP) and IBEW Local 309; or
    - Ameren Illinois (IP) and IBEW Local 702; or
    - Ameren Illinois (IP) and Laborers Local12 Counties; or
    - Ameren Illinois (IP) and Pipefitters Local 101; or
    - Ameren Illinois (IP) and Pipefitters Local 360; or
    - Ameren Illinois (IP) and Laborers Local 459; or
    - Ameren Illinois (IP) and IBEW 51 MDF; or
    - Ameren Illinois (IP) and Laborers Local 100; or
- a regular full-time Employee (1) whose employment was covered by one of the following collectively bargained agreements on the date the applicable business was divested or acquired[2] and (2) is receiving benefits under the Ameren Long Term Disability Plan or (3) Surviving Dependents of AER divestiture employees from one of the following collectively bargained agreements:
    - 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)

    Employees who meet this criteria are considered "AER Divestiture Employees" for purposes of this SPD; or
- ➢ a participant in the Temporary Voluntary Reduced Hours Program.

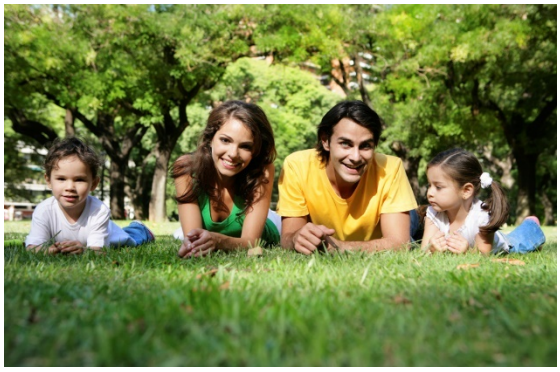
[1] Ameren Illinois (CIPS) and IBEW Local Union 702E – Illini, 702S – Shawnee, 702W – Great Rivers

[2] 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.

Dependents

If You enroll in the Plan, Your Dependents are also eligible for coverage, provided that they are not serving in active duty in the Armed Forces of any country and You enroll them according to the appropriate procedures. Eligible Dependents are limited to Your:

- Spouse;
- Domestic Partner who meets (and continues to meet) all the requirements on the Ameren Affidavit of Domestic Partnership form. You and Your Domestic Partner must sign and submit an accurate and complete Affidavit of Domestic Partnership form on-line at www.myAmeren.com. A form can also be obtained by calling **myAmeren Benefits** at 877.my.Ameren (877.769.2637); [1]
- Dependent Children who have not reached age 26. A child and/or spouse/domestic partner of any Dependent Children are not eligible for coverage under the Plan;



- 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 Anthem 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; or

  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 date You fail to provide the required proof of Dependent status.

Important Note: Except as noted, a Spouse/Domestic Partner who is eligible for coverage under the Plan as an Employee, or under the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan** as a retiree, cannot be covered as Your Dependent under this Plan, whether or not they chose to enroll in the Plan for which they are eligible.

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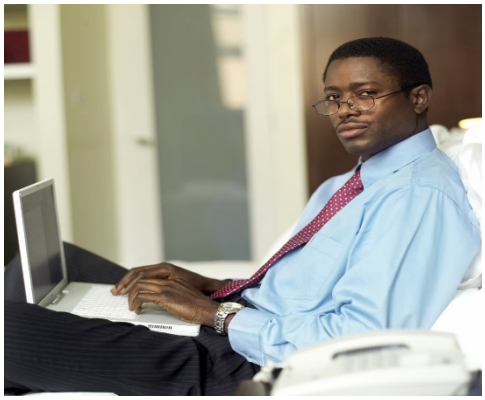
[1] The employee contributions for benefits associated with Your Domestic Partner and any of his or her children will be processed as a post-tax deduction for federal taxes for payroll purposes. The value of the employer's portion of the coverage will be included in Your (the employee's) income for tax purposes.

A Dependent Child under the age of 26 who is also an Employee and is eligible for coverage under the **Ameren Employee Medical Plan** as an Employee, can be covered as an Employee, or can be covered as the Dependent Child of another 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/Retiree.** No person can be covered under more than one medical plan option in the Plan. No person can be covered under the Plan**,** the **Ameren Retiree Medical Plan** and/or the **Ameren Retiree Health Reimbursement Account Plan**, at the same time.

Enrollment Provisions

Employees



In order to elect or waive coverage in the Plan, You must complete the appropriate enrollment or waive process, either on-line at **www.myAmeren.com** or by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). To obtain medical coverage, You are required to provide a valid Social Security number for Yourself and each Dependent You wish to cover. A Social Security number is required for a child who is six (6) months and older.

You must choose a coverage category. The coverage categories are:

- Waive coverage
- You Only
- You + Spouse/Domestic Partner
- You + Child(ren)
- You + Family

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 or from part-time to full-time), You must elect a coverage category (including waive coverage) within 31 days of when You become eligible for this Plan. 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 under the lowest priced medical option available to You, and the applicable payroll deduction will be taken. The default coverage is the Health Savings – Value Plan without a Health Savings Account ("HSA").

Important Note: If You become eligible to participate in a new medical plan option in this Plan due to a qualified status change, and were covered under another option in the Plan immediately prior to Your change in employment status, Your Covered Dependents will also become covered under this new option if they were previously covered under the other option.

Dependents

Coverage for Your eligible Dependents generally will begin on the same date Your coverage begins if You enroll them at the time You enroll Yourself in the Plan. If You choose not to cover Your Spouse and/or other eligible Dependent(s) immediately, You can add such Dependent(s) only during the Annual Enrollment Period, unless You qualify for a special enrollment right (see below) or You experience a change in status (see below).

HIPAA Special Enrollment Rights

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 qualify for a special enrollment period due to a loss of coverage, the acquisition of a new Dependent or eligibility for premium assistance.

A request for special enrollment must be made either on-line at **www.myAmeren.com** or by calling **myAmeren Benefits** at 877.7my.Ameren (877.769.2637).

If You do not enroll Yourself or Your eligible Dependents during the 31-day or 60-day special enrollment periods described above, enrollment is not permitted until the next Annual Enrollment Period.

In accordance with federal law, your deadlines for requesting a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") special enrollment event may be temporarily suspended due to the COVID-19 pandemic. Contact **myAmeren Benefits** at 877.7my.Ameren (877.769.2637) for complete information about how this relief impacts you.

Loss of Other Coverage

If You waive coverage for Yourself and/or Your eligible Dependent(s) under the Plan due to the existence of other group health plan coverage (including Consolidated Omnibus Budget Reconciliation Act ("COBRA") continuation coverage) or health insurance coverage at the time enrollment was waived, and such coverage ends or will end as a result of:

a) loss of eligibility (due to such reasons as death of a Spouse/Domestic Partner, divorce, legal separation, termination of employment, reduction in the number of hours of employment, or reaching the lifetime maximum for all benefits), or

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

c) exhaustion of COBRA continuation coverage.

You may be able to enroll Yourself (if not already covered) and Your eligible Dependent(s) in the Plan by requesting enrollment within 31 days after the loss of the other coverage (including cessation of the employer's contribution) or in the case of reaching the lifetime maximum, within 31 days after the claim for benefits was denied. Coverage will be effective as of the date coverage was lost.

If You waive coverage for Yourself and/or Your Eligible Dependent(s) under the Plan because of existing health coverage under Medicaid or a state Children's Health Insurance Program ("CHIP"), You may be able to enroll Yourself and Your eligible Dependent(s) in this Plan if You or an Eligible Dependent lose eligibility for such coverage. You must request enrollment in the Plan within 60 days after the Medicaid or CHIP coverage ends. Coverage under the Plan will be effective as of the date the Medicaid or CHIP coverage was lost.

Acquisition of New Dependent

If You acquire an eligible Dependent through marriage, establishment of a domestic partnership, birth, adoption, or Placement for Adoption while You are eligible for the Plan, You (if not already covered) 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 an eligible Dependent Child, Your Spouse or Domestic Partner may also be enrolled as Your eligible Dependent if otherwise eligible for coverage. Coverage will be effective as of the date of marriage, establishment of a domestic partnership, birth, adoption, or Placement for Adoption.

Eligibility for Premium Assistance

If You or an eligible Dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, You may be able to enroll Yourself and Your eligible Dependent(s) in this Plan by requesting enrollment within 60 days after Your or Your Dependent's determination of eligibility for such assistance. Coverage under the Plan will be effective no later than the first day of the first calendar month beginning after the date the Plan receives Your request for special enrollment.

Making Changes to Your Coverage During the Year

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 the following events:

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

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.

Annual Enrollment Period

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

Cost of Coverage

For full-time Employees, the Company currently pays a portion of the cost of this coverage for You and Your eligible Covered Dependents. You pay the remainder of the cost for Your coverage and Your 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 the Plan.

Coverage of Certain Dependents May be Taxable

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

Domestic Partner and Children of Your Domestic Partner

The employee contributions for benefits associated with Your Domestic Partner and any of his or her children will be processed as a post-tax deduction for federal taxes for payroll purposes. The value of the employer's portion of the coverage will be included in Your (the employee's) income for tax purposes.

Children

Your children, and stepchildren may receive Ameren healthcare coverage on a tax-free basis for federal tax purposes until the end of the month in which 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 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 **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**).

Working Spouse Contribution

Employees who are eligible for this Plan, and who enroll a Spouse/Domestic Partner in coverage under the Plan, will be subject to an additional contribution toward the cost of that coverage if the Spouse/Domestic Partner is employed and is eligible for coverage under his/her employer's group health plan, regardless of the cost of that coverage or the benefits of that plan (the "Working Spouse Contribution"). The Working Spouse Contribution is a pre-tax contribution subject to Section 125 rules for pre-tax deductions (or an after-tax contribution for a Domestic

Partner). The Working Spouse Contribution does not apply to surviving spouses of deceased active Employees who are eligible to continue coverage under the Plan. (See CONTINUATION OF BENEFITS FOR SURVIVING DEPENDENT OF DECEASED EMPLOYEES in this booklet).

The amount and tax status of the Working Spouse Contribution is subject to change.

Coverage Identification Card

Once You are enrolled in the Plan, You will be issued "Identification Cards" or "ID Card" which provide information about Your medical and prescription drug coverage. You should carry the ID Cards with You at all times, and show them to Your Providers when You go to the Physician, Hospital, or Pharmacy. If You lose Your medical plan ID Card, You may obtain a replacement by calling Anthem at **844.344.7410**, or by visiting **www.anthem.com**. If You lose Your prescription drug plan Identification Card, You may obtain a replacement by calling CVS Caremark at 877.817.0479, or by visiting **www.caremark.com**. To obtain an ID Card through Anthem's or CVS Caremark secure website, You must first register with a unique login and password.

Other Events that Allow You to Make Changes to Your Coverage

Entitlement to Government Benefits

If You or Your Spouse or Dependent becomes entitled to or loses entitlement to Medicare or Medicaid, or loses entitlement to certain other governmental group medical programs, You may make a corresponding change to Your coverage.

QMCSOs

You may also be entitled to make the appropriate coverage change if there is a change required pursuant to a QMCSO.

When You Retire

When You retire, You are no longer eligible to participate in this Plan for active Employees. Covered Employees who lose coverage under the Plan due to their retirement have the right to temporarily continue their coverage in the Plan for up to eighteen (18) months at their own expense pursuant to COBRA.

However, You may be eligible to enroll for coverage under the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan.** Details addressing the eligibility requirements, effective date of coverage, Dependent eligibility and cost of coverage may be found in the **Ameren Retiree Medical Plan** and the **Ameren Retiree Health Reimbursement Account Plan** summary plan descriptions. To access the summary plan descriptions on-line, log on to **myAmeren.com**. You may also request a copy of a summary plan description by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637).**

Note: If You elect to continue Your coverage in the Plan through COBRA, and You are eligible for coverage in the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan,** You will not be allowed to enroll in the **Ameren Retiree Medical Plan** at the end of the temporary 18-month continuation period.

Procedure for Making Changes

If You have a status change and want to enroll Yourself, add a new Dependent or elect a new medical plan option, You must complete the appropriate enrollment process either on-line at **www.myAmeren.com** or by calling **myAmeren Benefits** at 877.7my.Ameren (877.769.2637) within 31 days of the event in order for the 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 **myAmeren Benefits** within 31 days of the change in 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.

Anthem Network Programs

The Anthem medical plan options are designed to help You reduce healthcare expenses whenever You use a Physician or Hospital that is a Network Provider. Anthem is able to reduce healthcare costs because, due to the number of people in the program, it can negotiate discounts with Physicians and Hospitals and then pass these discounts on to the Members.

Your Network Provider should bill the program directly for any treatment or services rendered. This practice is necessary because all payments for Anthem claims must be paid directly to the healthcare Provider rather than to the Member. It is then the Provider's responsibility to contact You if there are any remaining charges for the treatment or services or if You are due a refund.

Anthem does not guarantee the quality of care or the status of the Providers in their Network.

An Anthem National Network Provider directory is available by accessing Anthem's website at **www.anthem.com** or by calling **844.344.7410**.

To locate an Anthem National Network Physician via the Anthem website, follow the steps below:

- Log on to **www.myAmeren.com** and then click on "Anthem.com"; or
- Visit the Anthem website at **www.anthem.com**
- Login to find In-Network Providers
- Select "Find a Doctor"
- Follow the on-screen instructions to view Your Network Providers. You can search by location, name, specialty and more to fit Your needs.

You can search for Providers without logging into the Anthem website, however, search results will not be limited to In-Network Providers for Your specific plan.

We recommend that You always verify Your Provider's participation in the Network when You make Your appointment. Also, be sure to show Your medical ID Card when visiting the Physician or Hospital.

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Network Provider charges, unless such charges relate to treatment that qualifies as an Emergency Medical Condition or Medical Emergency (as explained later in this SPD). This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket Expenses to You. Contact the Claims Administrator at **844.344.7410** for help in finding a Network Provider or visit Anthem's website and follow the directions stated above. Additionally, in some cases, some Network Providers may also bill for services or equipment that is above the standard as stated in their Provider contract with Anthem, such as hearing aids that are above the base model. You

are responsible for paying the difference between the standard base model and the premium model. We recommend that You always verify with Your Provider any amount that You may be responsible for in addition to any Copays or Coinsurance amounts.

If You or a Covered Dependent are receiving Covered Services for (i) a serious and complex condition, (ii) a course of institutional or inpatient care, (iii) a nonelective surgery, (iv) pregnancy, or (v) a terminal illness from a Network Provider or at a Network facility and such Provider or facility leaves the Network or another change in the relationship between the Plan and such Provider or facility changes and such change causes you to lose benefits for the foregoing Covered Services, the Plan will provide You notice that you are a "Continuing Care Patient". You may have the right to continue to receive Covered Services from the Provider or facility at the Network level of benefits until the earlier of when You are no longer a Continuing Care Patient or 90 days.

Inter-Plan Arrangements

Out-of-Area Services

Anthem has relationships with other Blue Cross and/or Blue Shield licensees. Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Association. Whenever You access healthcare services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem service area, You will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are claims for prescription drugs that You obtain from a Pharmacy, as well as most dental or vision benefits.

BlueCard® Program

Under the BlueCard® Program, when You receive Covered Expenses within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Expenses outside the Anthem service area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Expenses; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects the actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider, or an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing

arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

Negotiated (non–BlueCard® Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard® Program, Anthem may process Your claims for Covered Expenses through negotiated arrangements for National Accounts.

The amount You pay for Covered Expenses under this arrangement will be calculated based on the lower of either billed charges for Covered Expense or the negotiated price made available to Anthem by the Host Blue.

Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Expenses under a value-based program inside a Host Blue's service area ("Value-Based Program"), You will not be responsible for paying any of the Provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard® Program) Arrangements

If Anthem has entered into a negotiated arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard® Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

Nonparticipating Providers Outside the Claims Administrator's Service Area

The pricing method used for Nonparticipating Provider claims incurred outside the Anthem Service Area is described Claims Payment.

Care Outside the United States – Anthem Blue Cross Blue Shield Global Core

Anthem's Blue Cross Blue Shield Global Core program provides coverage through an international network of Hospitals, Physicians and other healthcare Providers. The program also assures that at least one staff member at the Hospital will speak English, or the program will provide translation assistance. To find participating Providers, visit **www.bcbsglobalcore.com**. To access the international directory of Providers, You will need to enter Your identification number which is located on the front of Your Identification Card.

Prior to travel outside the United States, call Anthem's Member Services at the number on Your Identification Card. Your coverage outside the United States may be different and we recommend:

- Before You leave home, call the Member Services number on Your Identification Card for coverage details. Please note that You only have coverage for Medical Emergency services when travelling outside the United States.
- Always carry Your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The Blue Cross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll-free at 800.810-BLUE (2583) or by calling collect at 804.673.1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Member Services Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need Inpatient care. After calling the Member Services Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on Your Identification Card. **Note**: this number is different than the phone numbers listed above for Blue Cross Blue Shield Global Core.

Payment Information

- **Participating Blue Cross Blue Shield Global Core Hospitals**. In most cases, when You make arrangements for hospitalization through Blue Cross Blue Shield Global Core, You should not need to pay upfront for Inpatient care at participating Blue Cross Blue Shield Global Core hospitals except for the Out-of-Pocket costs (non-covered services, Deductible, Copays and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- **Doctors and/or non-participating Hospitals**. You will need to pay upfront for outpatient services, care received from a Physician, and Inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center. Then You can complete a Blue Cross Blue Shield Global Core claim form and send it with the original bill(s) to Blue Cross Blue Shield Global Core Service Center (the address is on the form).

Claim Filing

- The Hospital will file Your claim if the Blue Cross Blue Shield Global Core Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.
- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the Blue Cross Blue Shield Global Core Service Center, or online at **www.bcbsglobalcore.com**. The address for submitting claims is:

Service Center
P.O. Box 2048
Southeastern, PA 19399
Email Address: claims@bcbsglobalcore.com

Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs ("PIPs") – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These PIPs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the PIP as a consequence of failing to meet these pre-defined standards.

The PIPs are not intended to affect Your access to health care. The PIP payments are not made as payment for specific Covered Expenses provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Claims Administrator under the PIP(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the PIP(s).

Anthem Programs

Total Health Total You

With Your unique health plan Total Health, Total You, helpful benefits and health information are always at Your fingertips. Through an app called "Engage", You can chat with a member services Health Guide about claims or health questions, keep track of health care spending, find Network doctors and urgent care centers, or use online wellness tools. Total Health, Total You can also help You:

- Manage pain or chronic conditions, like asthma or diabetes
- Understand Your medications and prescriptions
- Navigate hospital stays or major medical decisions
- Work through a difficult life situation—such as depression or a death in the family
- Stay healthy through wellness resources

Anthem has a team ready to help—from nurses to social workers, dietitians, respiratory therapists, pharmacists, exercise physiologists, and more.

It's all included in Your plan, at no cost to You. Reach out to a supportive member services Health Guide and download the Engage app by searching "Engage Wellbeing" in the App store.

Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each covered service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

Anthem Health Guide

Anthem Health Guide is an enhanced customer service model designed to help answer Your questions, locate high-quality Providers and help you navigate the healthcare system. Anthem's Health Guides work closely with healthcare professionals, such as nurses, health coaches, social workers and educators, using smart engagement technology to provide personalized guidance for You. It provides comprehensive support to help You connect with programs offered by Ameren, stay on top of exams, tests or preventive screenings with reminders, and help You compare costs on healthcare services. Using In-Network physicians, especially those with a Blue Distinction designation, can help You find the care that's right for You. You will be able to reach a Health Guide by phone, online or by email.

- Phone: 844.344.7410 (located on the back of Your ID Card)
- Website: Register and log in at www.anthem.com, choose "Customer Support" then select "Contact Us" to chart with a representative or send an email.
- Mobile App: Download the free Anthem Blue Cross and Blue Shield app.

Anthem 360° Health Programs

Anthem has health-based resources to help You become more engaged in Your health and empower You to make the health care decisions that are right for You. The programs are described below. For more information contact Anthem at **844.344.7410** if there is not a phone number listed below the program description.

24/7 NurseLine

Round-the-clock access to health information can be vital to Your peace of mind and Your physical well-being. Nurse coaches are available to speak with You about Your general health issues any time of the day or night through a convenient toll-free number. To reach the 24/7 NurseLine, call **800.700.9184**.

Future Moms

Future Moms is a free, voluntary program to help You take care of Your baby before You deliver. If You register for Future Moms, You get:

- 24/7 toll-free access to a registered nurse who'll answer Your questions and discuss any pregnancy-related issues with You.
- A helpful book: Your Pregnancy Week by Week
- Educational materials to help You handle any unexpected events
- A questionnaire to evaluate Your risk for preterm delivery
- Useful tools to help You, Your Physician and Your Future Moms nurse track Your pregnancy and spot possible risks

Register for the Future Moms program by calling **800.828.5891**.

ConditionCare Core Programs

Anthem ConditionCare nurses can help You manage the symptoms of asthma, diabetes, chronic obstructive pulmonary disease, heart failure and coronary artery disease. The ConditionCare nurses gather information from You and Your Physician, and then they create a personalized plan for You. Information and encouragement are as close as Your phone. Call **866.842.3358** and ask to speak to a ConditionCare nurse.

MyHealth Advantage

Anthem's MyHealth Advantage is a free service designed to keep You and Your bank account healthier. Here's how it works: MyHealth Advantage reviews Your health status daily and checks to see what medications You are taking and quickly alerts Your Physician if a potential drug interaction is spotted. MyHealth Advantage also keeps track of Your need for routine tests and checkups and reminds You to make these appointments by mailing a MyHealth Note to Your home. MyHealth Note includes a convenient summary of all Your recent claims. And from time to time, MyHealth Advantage offers tips to save You money on prescription drugs and other health care supplies.

ComplexCare

ComplexCare is for those Members with multiple health issues or a condition that puts them at risk for frequent or high levels of medical care. It can team participants, their families and their health care Providers with a ComplexCare nurse and other clinicians to help them achieve tailored health goals and avoid costly hospital readmissions. Participants have 24-hour toll-free access to ComplexCare nurses for individualized education as well as preventive care and self-management tips. The nurses provide personalized attention and lifestyle coaching, help participants make better decisions about care options and care transitioning and coordinate care between Providers and other necessary services. A nurse will contact those Members who are eligible to receive program benefits.

Behavioral Health

Coping with complex behavioral health and medical conditions can be confusing and frustrating. Fortunately, You don't have to face these issues alone. Anthem's Behavioral Health and ConditionCare Depression and Bipolar programs can help guide You through Your difficult mental and physical health care challenges. Care managers for the program are licensed mental health professionals who'll work closely with You to develop a plan for achieving Your behavioral health goals and overcoming the barriers to reaching them. The care managers will also coordinate the services You receive from health Providers, community and online resources, and help ensure

that You get the most value from Your health plan's available benefits. Examples of behavioral health Providers from whom You can receive Covered Expenses include:

- Psychiatrist
- Psychologist
- Licensed clinical social worker ("L.C.S.W.")
- Mental health clinical nurse specialist
- Licensed marriage and family therapist ("L.M.F.T.")
- Licensed professional counselor ("L.P.C.")
- Any agency licensed by the state to provide these services when they have to be covered by law.

Autism Spectrum Disorders Program

The Autism Spectrum Disorders ("ASD") Program (the "ASD Program") offers families touched by Autism resources and support in identifying and navigating appropriate treatment and resources. The program focuses on the individual touched by Autism and the family. The ASD team facilitates a connection to the knowledge and community resources that will assist the family with a foundation of care and support. Referrals and education are tailored to meet the family's needs and concerns. Ongoing support is provided to help overcome obstacles and integrate new services and support for the individual and the family.

ASD Program case managers assist with coordination of navigating the complex health care system and addressing the unique challenges of autism. A customized care plan helps to identify available services, secure access to care, and facilitates collaboration between treatment Providers.

LiveHealth Online

Anthem's LHO telemedicine program allows You to have a virtual office visit with an In-Network Physician 24 hours a day, seven day a week, through Your smart phone or any computer with internet access and a camera. The Physician is able to answer questions, make a diagnosis, and prescribe basic medication when needed. The cost of the visit will be based on the Plan option in which You are enrolled. You should enroll at **www.livehealthonline.com** when You need to use the service. Online visits are not covered from Providers other than those contracted with LHO.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Expenses. Reimbursement for services rendered by Network and Non-Network Providers is based on the Plan's Maximum Allowed Amount for the Covered Expense that You receive.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Plan will allow for services and supplies:

- that meet the Plan's definition of Covered Expenses, to the extent such services and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and

- that are provided in accordance with all applicable preauthorization, Utilization Management or other requirements set forth in this summary plan description.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copay or Coinsurance. In addition, when You receive Covered Expenses from a Non-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Expenses from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Expenses. These rules evaluate the claim information and, among other things, determine the accuracy and Appropriateness of the procedure and diagnosis codes included in the claim.

Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Expenses You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professionals, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Expenses performed by a Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Expenses.

Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Expenses, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copay or Coinsurance. An Anthem National Network Provider directory is available by accessing Anthem's website at **www.anthem.com** or by calling **844.344.7410**.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Non-Network Providers, subject to Association rules governing claims filed by certain ancillary Providers.

For Covered Expenses You receive from a Non-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Non-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Non-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Non-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Expenses rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated price.

Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket Expenses to You. For help in finding a Network Provider, visit Anthem's website at **www.anthem.com**, or call Anthem at **844.344.7410**.

Member Services is also available to assist You in determining the Plan's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to

know the Provider's charges to calculate Your Out-of-Pocket Expenses. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

For certain Covered Expenses and depending on the Plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Expense limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this Summary Plan Description for Your cost share responsibilities and limitations or call Anthem at **877.403,0610** to learn how the Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Expenses. You may be responsible for the total amount billed by Your Provider for Non-Covered Expenses, regardless of whether such services are performed by a Network or Non-Network Provider. Non-Covered Expenses include services specifically excluded from coverage by the terms of this Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Expenses from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Expenses. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Expense, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Expenses You receive from a Non-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Expense. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Expenses if You receive services for a Medical Emergency from a Non-Network Provider and are not able to contact the Claims Administrator until after the Covered Expense is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Expense received from an Non-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Anthem at **844.344.7410** for Authorized Services information or to request authorization.

Utilization Management Review

Your employer has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include precertification and Utilization Management Review requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

The Plan uses Utilization Review in order to determine when services are Medically Necessary or Experimental or Investigative Measures. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service. A service must be Medically Necessary to be a Covered Expense. When level of care, setting or place of service is part of the review, a service that can be safely administered to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if the service is administered in a higher level of care, or higher cost setting/place of care.

Certain treatments and services must be reviewed to determine Medical Necessity in order for You to receive benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. It may be decided that a service that was asked for is not Medically Necessary if You have not tried other treatments that are more cost effective.

Utilization Management Review includes the processes of precertification, predetermination and post service clinical claims review. The purpose of Utilization Review is to promote the delivery of cost-effective medical care by reviewing the use of Appropriate procedures, setting (place of treatment or service), and resources and by optimizing the health of the Members the Claims Administrator serves. These processes are described in the following section.

Network Providers are required to obtain prior authorization in order for You to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy and clinical guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

The Plan Administrator or its delegate will make available the criteria for determining whether a service is Medically Necessary with respect to mental health/substance abuse benefits upon request.

Exceptions to the Utilization Review Program

From time to time, the Claims Administrator may waive, enhance, modify or discontinue certain medical management processes. In addition, the Claims Administrator may select certain qualifying health care Providers to participate in a program or a Provider arrangement that exempts them from certain procedural or medical management processes (including Utilization Management Review, case management, and disease management) if, in their discretion such a change furthers the provision of cost effective, value based and quality services. In addition, the Claims Administrator may select certain qualifying health care Providers to participate in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt claims from medical review if certain conditions apply.

If You have any questions regarding the information contained in this section, You may call the Member Services telephone number on Your ID Card or visit **www.anthem.com**.

Types of Review

Pre-Service Review – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

Precertification – A required Pre-Service Review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for You to get benefits.

The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is an Experimental or Investigational Measure. Notwithstanding anything else contained in this SPD, precertification will not be required for treatment related to an Emergency Medical Condition or Medical Emergency (including post-emergency stabilization care).

For admissions following a Medical Emergency, You, Your authorized representative or Physician must tell the Claims Administrator within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first forty-eight (48) hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48 or 96 hours require precertification.

Continued Stay/Concurrent Review - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment ("Continued Stay/Concurrent Review").

Both Pre-Service Reviews and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

Post-Service Review – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-Service Reviews are performed when a service, treatment or admission does not require precertification, or when precertification was required but not obtained. Post-Service Reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Treatment and Services Requiring Precertification

The following list of services are *examples* of some of the most common treatments and services that require precertification, and must be determined by the Claims Administrator to be Medically Necessary to be a Covered Expense under the Plan. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and Appropriate. The list is not inclusive of all treatments and services that require precertification, and is subject to change from time to time. Please call the Member Services telephone number on Your medical ID Card to confirm the most current list, and whether Your service or procedure is considered a Covered Expense.

If You or Your Non-Network Provider do not obtain the required precertification for Inpatient Covered Expenses, a $200 penalty will apply and Your Out-of-Pockets costs will increase. This does not apply to Medically Necessary services from an In-Network Provider.

Inpatient Admission:

- Acute Inpatient
- Bariatric procedures
- Elective admissions
- Emergency admissions (Claims Administrator requires Plan notification no later than two (2) business days after admission)

- OB related admissions (complications; excludes childbirth except in cases where inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery)
- Newborn stays beyond mother (does not include routine maternity stay)
- Inpatient Skilled Nursing Facility
- Long-term acute rehab facility
- Rehabilitation facility admissions

Outpatient Services:

- Ambulance services: air and water (excludes 911 initiated emergency transport)
- Bariatric surgery and other treatments for clinically severe obesity
- Lumbar spinal fusion and lumbar total disc arthroplasty)
- UPPP surgery (uvulopalatopharyngoplasty, uvulopharyngoplasty)
- Plastic/reconstructive surgeries including but not limited to:
    - Blepharoplasty
    - Rhinoplasty
    - Panniculectomy and lipectomy/diatasis recti repair
    - Insertion/injection of prosthetic material collagen implants
    - Chin implant, mentoplasty/osteoplasty mandible
- Durable Medical Equipment/prosthetics
    - Wheeled mobility devices: special size, motorized or powered,ultra lightweight, and accessories
    - Hospital beds, rocking beds, and air beds
    - Prosthetics: Electronic or externally powered and select other prosthetics
- Private duty nursing
- Dental anesthesia (applies only to the Standard Plan, Health Savings Plan and Health Savings Plan - Value).

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for ALL solid organ and bone marrow/stem cell transplants (including kidney only transplants)
- All outpatient services for the following:
    - Stem cell/bone marrow transplant (with or without myeloablative therapy)
    - Donor leukocyte infusion

Mental Health/Substance Abuse (MHSA):

- Acute Inpatient admissions
- Transcranial magnetic stimulation
- Intensive Outpatient therapy
- Partial Hospitalization Program
- Residential care
- Behavioral health in-home programs

AIM Specialty Health Services

- Radiologic Imaging procedures such as:
    - Computerized tomography ("CT") scan
    - Positron emission tomography ("PET") scan
    - Magnetic resonance imaging ("MRI")
    - Magnetic resonance angiogram ("MRA")
    - Computed tomography angiography ("CTA")

    - Nuclear cardiology scans
- Sleep study services

(See MEDICAL COVERED EXPENSE section for more information on the AIM Imaging Cost and Quality Program)

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Women's Health and Cancer Rights Act of 1998

If You (or a Covered Dependent) are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

Who is responsible for Precertification?
You are responsible for precertification regardless if services are provided by a Network Provider or Out-of-Network/Non-Participating Provider.

Typically, Network Providers know which services need precertification and will obtain precertification when needed. Your Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the Ordering Provider, facility or attending Physician ("Requesting Provider") will get in touch with the Claims Administrator to request a precertification. However, You may request a precertification or You may choose an authorized representative to act on Your behalf with regard to a specific request. The authorized representative can be anyone who is 18 years of age or older.

Subject to the terms of the Plan, the Claims Administrator will utilize its clinical coverage guidelines, such as medical policies, clinical guidelines, preventive care clinical coverage guidelines, and other applicable policies and procedures, to assist in making Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request for precertification. To request this information, contact the Member Services telephone number on Your medical ID Card.

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the "Appeal Rights" section to see what rights may be available to You.

Request Categories:

- **Urgent** – A request for precertification or predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.
- **Pre-Service** – A request for precertification or predetermination that is conducted prior to the service, treatment or admission.
- **Continued Stay Review/Concurrent** - A request for precertification or predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission.
- **Post-Service Review** - A request for precertification that is conducted after the service, treatment or admission has occurred. A Post-Service Review for clinical claims is also retrospective. Post-Service Review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal laws. For more details contact Member Services at the phone number on the back of Your Identification Card.

Request Category	Timeframe Requirement for Decision and Notification
Urgent Pre-Service Review	72 hours from the receipt of request
Non-Urgent Pre-Service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay/Concurrent Review when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the Requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

For more information, see the CLAIMS FILING PROCEDURES in this booklet. You may also call the telephone number on Your ID Card.

Precertification does not guarantee coverage for or payment of the treatment, service or procedure reviewed. For benefits to be paid, on the date You receive treatment or service, the following must be met:

1. You are a Member; and
2. the treatment, service or surgery is a Covered Expense under Your Plan option; and
3. the treatment or service is not subject to an exclusion under Your Plan option; and
4. You have not exceeded any applicable limits under Your Plan option.

Important Information

From time-to-time certain medical management processes (including Utilization Management Review, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or claim is currently exempted from the standards which otherwise would apply, does not mean the exemption will apply in the future. The Plan may stop or change any such exemption with or without advance notice at any time.

You may find out whether a Provider is taking part in certain programs by contacting the Member Services number on the back of your ID Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical Utilization Management Review guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Termination of Benefits

Employees

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

- End of the month of Your termination of employment;
- For management Employees, end of the month of Your termination of employment due to Your retirement (See RETIREES section in this booklet);
- For all union represented Employees, end of the month prior to the date of Your retirement;
- Date of Your death;
- 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 and You are not eligible for benefits as a part-time Employee as stated in the ELIGIBILITY section of this booklet.);
- End of the month that You last paid the required payroll deduction for coverage;
- End of the month in which You commence an unpaid leave of absence (See also 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));
- Date of transfer to an Employee group not covered by the Plan;
- The date the Plan terminates;
- Date the Company amends the Plan to eliminate coverage for the class of eligible individuals to which You are a member;
- 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;
- Date of expiration of the collective bargaining agreement providing for Your coverage under the Plan as stated in the ELIGIBILITY section of this document.

In addition, Your coverage under Your medical plan option 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 medical plan option is discontinued.

Dependents

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

- The date Your coverage ends except by reason of Your death (See CONTINUATION OF BENEFITS FOR SURVIVING DEPENDENTS OF DECEASED EMPLOYEES);
- Except for divorce or legal separation, the end of the month in which Your Dependent(s) is no longer eligible (See ELIGIBILITY);
- In the case of a Covered Spouse, the date of divorce;
- In the case of a Covered Spouse, the date of legal separation;

- In the case of a Domestic Partner, the date of no longer meeting the Affidavit of Domestic Partnership requirements;
- End of the month in which You last paid the required payroll deduction for Your Dependent's coverage;
- End of the month that a child no longer meets the definition of "Dependent Child"
- Date of death of the Dependent;
- 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 Dependent Child's handicap;
- The date You fail to provide the required proof of Dependent status, in accordance with the procedures determined by the Plan Administrator; or
- 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 in this booklet).

Continuation of Benefits for Surviving Dependents of Deceased Employees

Federal law (COBRA) requires the Company to offer a temporary extension of healthcare benefits to Your Covered Dependents who lose coverage under the Plan due to Your death. (See COBRA CONTINUATION in the next section.)

However, Your Covered Dependents may also be eligible for continuation of coverage under the Plan as a surviving Dependent of an active Employee included in the list below of "Covered Employees." In this case, Your Covered Dependents have the right to elect a temporary extension of benefits under COBRA, or continuation of coverage under the Plan as a surviving dependent. If Your Covered Dependents elect a temporary extension of their coverage in the Plan under COBRA, they will not be allowed to enroll in the Plan at any time in the future.

This section discusses continuation benefits currently offered by the Plan to Your Covered Dependents upon Your death. These benefits may be amended or terminated by the Company at any time with respect to both current surviving Dependents and/or future surviving Dependents. Additionally, contribution rates may be adjusted from time to time by the Company for each of the groups stated below.

For the following groups of Employees:

- **Full-time management Employees; and**

Full-time Employees represented by a collective bargaining agreement between:

- **Ameren Missouri and UGSOA Local Union 11; or**
- **Ameren Illinois (CIPS) and IBEW Local Union 309; or**
- **Ameren Illinois (CIPS) and IBEW Local Union 649; or**
- **Ameren Illinois (CIPS) and IBEW Local Union 702; or**
- **Ameren Illinois (CILCO) and IBEW Local Union 51; or**
- **Ameren Illinois (IP) and IBEW Local 51; or**
- **Ameren Illinois (IP) and IBEW Local 309; or**

- **Ameren Illinois (IP) and IBEW Local 702; or**
- **Ameren Illinois (IP) and Laborers Local12 Counties; or**
- **Ameren Illinois (IP) and Pipefitters Local 101; or**
- **Ameren Illinois (IP) and Pipefitter Local 360; or**
- **Ameren Illinois (IP) and Laborers Local 459; or**
- **Ameren Illinois (IP) and IBEW 51 MDF; or**
- **Ameren Illinois (IP) and Laborers Local 100**

Full-time AER Divestiture Employees:

- Eligible surviving Dependents of a regular full-time Employee who died prior to December 2, 2013 and was represented by a collective bargaining agreement between:
    - 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, and Hutsonville); 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,); or
- Eligible surviving Dependents of a regular full-time Employee who died prior to February 1, 2014 and was represented by a collective bargaining agreement between:
    - AmerenEnergy Generating Company and IUOE Local Union 148 (Grand Tower).

Surviving Dependents who meet this criteria are considered "Surviving Dependents of AER Divestiture Employees" for purposes of the SPD.

or

Participants in the "Temporary Voluntary Reduced Hours Program".

If You die while an active Employee and had completed at least two Years of Service at the time of Your death, the Company, at its own cost, continues coverage for Your Covered Dependents under the Plan until the end of the month in which Your death occurred. Thereafter, Your surviving Covered Dependents may continue their coverage under the Plan by paying the applicable premium each month. Currently the required contributions for surviving Dependents is the same rate as Dependents of active Employees; however, surviving Dependents of deceased active management Employees who died prior to January 1, 2005, are currently not required to pay any premiums.

The coverage of any surviving Covered Dependents will end if they terminate coverage (either by election or failure to pay the required contribution) or become covered under any other group or franchise medical care insurance or benefit plan. In the case of a surviving Covered Spouse/Domestic Partner, coverage will end on the last day of the month in which she/he remarries. The coverage of any surviving Covered Dependent Children will end on the last day of the month in which they no longer meet the eligibility requirements for Dependent Children (See the section called ELIGIBILITY).

When a surviving Covered Spouse/Domestic Partner or Dependent Child becomes eligible for Medicare due to reaching age 65 or due to a disability, the Company will no longer provide medical

coverage for the Spouse/Domestic Partner or Dependent Child under the Plan. However, except as provided below, if You had ten (10) Years of Service prior to Your death, Your surviving Covered Dependents who lose coverage under this Plan due to Medicare eligibility may be given the opportunity to elect coverage under the **Ameren Retiree Medical Plan** if eligible. (See Eligibility Section of Retiree Medical Ameren Post 92 Plan.) Surviving Covered Dependents of active Ameren Missouri Employees who died prior to 1992 currently pay no premiums for their coverage under the **Ameren Retiree Medical Plan**.

All other surviving Covered Dependents are required to pay a portion of his/her cost of coverage.

If You die **before** completing two Years of Service, Your Covered Dependents cannot continue in the Plan except as available under COBRA. (See COBRA CONTINUATION in the next section.)

The following surviving Covered Dependents are no longer eligible for this Plan nor coverage under the Ameren Retiree Medical Plan at the time they become eligible for Medicare:

- Surviving Covered Dependents of Employees who had less than 10 Years of Service at the time of death;
- Surviving Covered Dependents of AmerenCILCO management Employees who died prior to January 1, 2004;
- Surviving Covered Dependents of Employees who were represented by a collective bargaining agreement with AmerenCILCO IBEW Local 51 and who died prior to January 1, 2005;
- Surviving Covered Dependents of Employees who were represented by a collective bargaining agreement with AmerenEnergy Resources Generating Company NCF&O Local 8 and who died prior to January 1, 2007.

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/Domestic Partner and Covered Dependent Children may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under a QMCSO may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

As a result of the COVID-19 crisis, the Department of Labor and the IRS (the "Agencies") issued guidance on May 4, 2020 suspending certain benefit plan deadlines that occur during the COVID-19 "Outbreak Period". The new guidance defines "Outbreak Period" as the period beginning on March 1, 2020 and ending sixty (60) days after the announced end of the COVID-19 national emergency, or such other date announced by the Agencies in a future notification. (The "national emergency" is defined as the period established by the President's Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease Outbreak and by separate letter issued under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121, et. seq.

As of the publication of this SPD, the Outbreak Period has not yet ended. Note that the deadlines that are suspended during the Outbreak Period will begin running again as soon as the Outbreak Period ends.

The deadlines for the following events are suspended for the Outbreak Period:

- Electing COBRA continuation coverage;
- Paying your initial COBRA premium;
- Paying your monthly COBRA premium for ongoing coverage; and
- Reporting certain qualifying events (e.g. divorce or legal separation) or an SSDI disability determination)"

Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

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 Businessolver as the COBRA administrator. Members enrolled in COBRA benefits can obtain information regarding their COBRA benefits at **www.myAmeren.com**. COBRA participants can also check on the status of their account by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). **myAmeren Benefits**

Benefit Advocates are available Monday through Friday, from 7:00 a.m. to 7:00 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. The address for the COBRA administrator is:

myAmeren Benefits
PO Box 850512
Minneapolis, MN 55485-0512

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/Domestic Partner

A Covered Spouse or Domestic Partner 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.
- The Affidavit of Domestic Partnership requirements are no longer met.
- The Covered Employee becomes entitled to Medicare (Part A, Part B or both).

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 Covered Employee becomes entitled to Medicare (Part A, Part B or both).
- 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 **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**), or by completing and mailing the appropriate form(s) to **myAmeren Benefits** 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 within 31 days by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**), or by completing and mailing the appropriate form(s) to **myAmeren Benefits** 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 QMCSO 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 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 Covered 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, Domestic Partner and Dependent Children can get up to 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, Domestic Partner and any Dependent Children receiving continuation coverage if the Covered Employee or former Covered Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), 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, Domestic Partner 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, death of the Employee, or the Employee becoming entitled to Medicare benefits (Part A, Part B or both), 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 at **www.myAmeren.com** or by calling **myAmeren Benefits** 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/Domestic Partner, 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 **myAmeren Benefits** by calling 877.7my.Ameren (**877.769.2637**). **myAmeren Benefits** customer service representatives are available Monday through Friday, from 7:00 a.m. to 7:00 p.m., Central Standard Time (CST).

Questions concerning Your or any of Your dependents' coverage under COBRA should be addressed to **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**).

For more information about Your rights under ERISA, including COBRA, 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, by updating Your home contact information in Workday through the Ameren co-worker intranet, Co-worker Connect. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

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 and 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. A full description of the requirements and benefit protections available under the FMLA can be found in the Company's FMLA policy, which is available upon request from the Plan Administrator.

Other Leaves of Absence

Depending on the circumstances, Your medical coverage may be continued even though You are not actively at work.

- Sickness or accidental injury. If You stop active work because of sickness or accidental injury but are not totally disabled, the Plan may continue coverage as long as all required contributions are paid.

- Long-term disability. If You are receiving monthly long-term disability benefits from the Company, coverage may continue up to the maximum period of payment defined under the Ameren Long Term Disability Plan. Contributions for Your coverage will be deducted on a pre-tax basis from Your disability payment. In the event that Your disability payment is insufficient to cover the premiums, or Your disability payments do not come from the Company, You must contact **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**) to make arrangements for payment of Your premiums.

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, the Uniformed Services Employment and Reemployment Rights Act ("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. A full description of the requirements and benefits available under USERRA can be found in the Company's USERRA policy, which is available upon request from the Plan Administrator.

Note: The 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 24 months of continuation coverage – not 24 months followed by an additional 18 months under COBRA.

Privacy Practices

In addition to this SPD, 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 ("PHI") under HIPAA. HIPAA 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**. In

addition, You have the right to receive a paper copy of this notice by contacting **myAmeren Benefits** 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 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.

ANTHEM CALLER VERIFICATION POLICY

Anthem has a caller verification policy that is set up to ensure that Your PHI is only shared with You or someone You have authorized.

The policy requires that the person requesting information must provide Anthem with their name and their relationship to the Member. Then, the caller must provide the Member's name, ID number, and date of birth to Anthem. One of the following items may be substituted for a piece of the required information:

- Member's address
- Member's phone number
- Social Security Number

If You are calling regarding a specific claim, additional information regarding the claim will be requested. For example, the date of service, claim number, charged amount and Provider name will be necessary.

Note: Covered Dependents who are age eighteen (18) and older are required to provide authorization to Anthem in order for Anthem to share PHI with the Employee and/or spouse of the Employee who is/are the parent(s) of the Dependent.

Coordination With Other Benefits

Introduction

The Plan provides for Coordination of Benefits with other group health plans which cover You and Your Covered Dependents. For the Standard Plan, Health Savings Plan, and Health Savings Plan – Value , medical expenses are subject to Coordination of Benefits. In simple terms, Coordination of Benefits means that if this Plan is secondary, the amount paid by the primary group health plan will be deducted from the total Allowable Expenses, and the balance of the Allowable Expenses will be paid by this Plan, subject to the following limits:

- The Plan will not pay more under Coordination of Benefits than it would have paid if there were no other coverage under another group health plan;

- The total of benefits paid by both this Plan and any other group health plan will not exceed 100% of Allowable Expenses for that bill.

The order of benefit determination rules below determine which health plan will pay as the primary health plan. The primary health plan pays first without regard to the possibility that another health plan may cover some expenses. The secondary health plan pays after the primary health plan and may reduce the benefits it pays according to the terms of the secondary health plan.

Definitions

The term "health plan" shall have the meaning set forth below whenever used in this section of this document.

- **"Health plan"** shall mean any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated payment for covered individuals of a group, the separate contracts are considered parts of the same health plan and there is no integration or Coordination of Benefits among those separate contracts, unless specifically indicated.

- **"Health plan"** includes: group insurance, closed panel or other forms of group or group-type payment (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare, Medicaid or other governmental benefits as permitted by law.

- **"Health plan"** does not include: amounts of hospital indemnity insurance of $200 or less per day; school accident type payment, benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and payment under other governmental plans, unless permitted by law. For purposes of this section, "health plan" also does not include pharmacy benefits.

Each contract for payment under this section is a separate health plan. Also, if a contract has two parts and integration of benefits or coordination of benefit rules apply only to one of the two, each of the parts is a separate health plan.

Coordination of Benefits for Participants in the Standard Plan, Health Savings Plan and Health Savings Plan - Value (Soft Non-Duplication of Benefits)

When this Plan is secondary, this Plan will look at the total Covered Expenses, subtract the amount that the primary health plan has already paid, and then pay the remaining or left over amount at this Plan's normal Coinsurance rate. This Plan will not pay more under Coordination of Benefits than it would have paid if there were no other coverage under another health plan.

With respect to all medical plan options, the Plan reserves the right to:

- Obtain reimbursement from any other health plan(s) for the cost of the covered services provided, which are payable under the other health plan(s) but not in excess of 100% of the Covered Expenses under this Plan in the aggregate;
- Deny payment for such coverage and require the Member to seek payment from the other health plan; and
- Pay to other health plan(s) any amount that the Plan determines will satisfy the intent of these Coordination with other Coverage provisions, in which case the amount paid will be considered payment for the applicable Coverage and the Plan will have no further liability.

Further, the Plan retains all rights of Recovery, including, but not limited to, such rights against the Workers' Compensation insurer or other entity where applicable and permitted by law.

Duty to Notify the Plan of Other Payment

Members must notify the Plan Administrator of the existence of any and all other payment under other health plans, as well as the benefits payable under such health plans. The Member agrees to assist the Plan in the implementation of its right to integrate or coordinate with other coverage, including the execution of any assignment or other documents necessary to authorize or facilitate such payment to Claims Administrator or to any of its contracting participating Providers. The Plan shall have the right to release to, or receive from any Physician, other medical professional, insurance company, or any other person or organization, any claim information, including copies of records relating thereto, necessary for the administration of the Coordination of Benefits with other health plan(s) and benefits provided by such health plan(s).

Order of Benefit Determination

When a Member is eligible for coverage under more than one health plan, this Plan shall be the secondary health plan, unless the other health plan has rules for the Coordination of Benefits with the coverage of this Plan and both the other health plan's rules and the rules of this Plan, inclusive below, require that benefits be covered under this Plan before the benefits of the other health plan. A health plan that does not contain an integration of benefits or Coordination of Benefits provision is always primary. This Plan determines coverage by using the first of the following rules that apply.

1. The health plan that covers the person as an employee is the primary health plan. The health plan that covers the person as a dependent is the secondary health plan.
2. The health plan that covers a person as an employee who is neither laid-off nor a retired employee (nor that employee's dependent) is the primary health plan. The health plan that covers a person as a laid-off or retired employee or that employee's dependent is the

secondary health plan. If the other health plan does not have this rule, and if as a result, the health plans do not agree on the order of benefits, this rule is ignored.

3. The health plan that covers a person as an employee, participant, subscriber, or retiree (or as the person's dependent) is the primary health plan. The health plan that covers a person due to a right of continuation provided by federal or state law is the secondary health plan. If the other health plan does not have this rule, and if as a result, the health plans do not agree on the order of benefits, this rule is ignored.
4. When this Plan and another health plan cover the same child as a dependent of different persons, called "parents":
   a. The primary health plan is the plan of the parent whose birthday is earlier in the year if:
      (1) the parents are married;
      (2) the parents are not separated (whether or not they ever have been married); or
      (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care payment.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare payment and the health plan of that parent has actual knowledge of those terms, that health plan is primary. This rule applies to claim determinations periods or calendar years commencing after the health plan is given notice of the court decree.
   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      (1) the plan of the custodial parent;
      (2) the plan of the spouse or domestic partner of the custodial parent;
      (3) the plan of the non-custodial parent; and then
      (4) the plan of the spouse or domestic partner of the non-custodial parent.
5. When a Dependent Child has coverage under either or both parents' plans, and also has coverage as a dependent under his/her spouse's or domestic partner's plan, the plan that covered the Dependent Child the longest is the primary plan, and the plan that covered the Dependent Child the shorter period of time is the secondary plan. In the event the Dependent Child's coverage under the spouse's or domestic partner's plan began on the same date as the coverage under either or both parents' plan, the order of benefits will be determined by applying the birthday rule in item 4 above.

   If none of the above rules determine the order of benefits, the health plan that covered the individual for the longer period of time is the primary health plan.

Here is an **example** of how this might work in a hypothetical situation:

John is an Ameren Employee with family coverage under the Standard Plan, with benefits for Hospital emergency room services payable at 100% after a $125 Copay. Mary, his wife, works for ABC Corp., and is covered under another plan with Hospital benefits payable at 80% after a $250 Deductible.

$1000	Covered Expenses for Hospital services for Mary
- 250	Minus Mary's Deductible
750	Covered Amount subject to 80% Coinsurance
x 80%	
$ 600	Paid by Mary's Plan with ABC Corp.

$1000	Covered Expenses Under **Ameren Employee Medical Plan**
- 600	Paid by Mary's Plan
$ 400	Amount payable by Ameren Plan

Through the Coordination of Benefits provision, Mary's Hospital bill would be paid in full ($600 paid by Mary's employer's medical plan and the balance of the Covered Expenses paid by Ameren's Plan).

Medicare Coverage For Members in the Standard Plan, Health Savings Plan, and Health Savings Plan - Value

An active Covered Employee age 65 or older or an active Covered Employee's Spouse/Domestic Partner who is age 65 or older is eligible for the same medical benefits as an individual under age 65. Claims should be sent to the Claims Administrator for payment by the Plan first. After the claim is processed under the Plan, the claim should be submitted to Medicare.

If a Covered Employee age 65 or older elects to have Medicare as his or her primary medical coverage, his or her medical coverage and the coverage of his or her Dependents under the Plan will end on the date the Employee is enrolled in Medicare.

Note: If You are enrolled in the Health Savings Plan or Health Savings Plan – Value and are contributing to an HSA, IRS rules prohibit the contribution to an HSA by You or the Company if You are enrolled in Medicare Part A and/or Part B. If You have enrolled in Medicare due to a disability, or because You are age 65 or older (even though You are still working as an active Employee), You are not eligible to contribute to an HSA. This also includes the Ameren contribution. If You continue to make HSA contributions (including the Ameren contribution) after enrolling in Medicare, You may be subject to penalties for excess or ineligible contributions.

If an Employee becomes eligible for benefits under the Ameren Long Term Disability Plan and becomes eligible for Medicare due to disability, Medicare will become the primary payer of medical benefits for the Employee and the Plan will be the secondary payer. Claims for benefits should be filed with Medicare first and then submitted under the Plan. If You do not elect Medicare Part A and Part B, the Plan will estimate the benefit that would have been payable by Medicare and will consider payment based on the remaining charges.

If Your Covered Dependent becomes entitled to benefits under Medicare due to a disability (excluding kidney dialysis), the Plan will be primary. Medicare will pay benefits on a secondary basis, unless Your Covered Dependent elects to have Medicare as the primary payer.

Federal law generally requires that the Plan pay benefits before Medicare for Employees who are active (rather than retired). The Plan will pay secondary to Medicare, however, whenever permissible by federal law.

When Medicare is the primary payer for a Covered Employee or a Covered Dependent, he or she will no longer need to contact the Claims Administrator for precertification. However, the Employee's Dependents who are not eligible for Medicare, if any, will still need to contact the Claims Administrator for precertification.

TRICARE

TRICARE is government sponsored health care coverage for military personnel on active duty. The coordination of Your benefits under TRICARE works differently from the Medicare and National Association of Insurance Commissioners rules. If You or Your Covered Dependents are receiving benefits under TRICARE, but are not on active duty, generally TRICARE will be the secondary payer with respect to any benefit offered under the Plan. For more information on how TRICARE coordinates with employer provided group health plan coverage, please contact the Plan Administrator.

Claim and Appeal Procedures for Eligibility

If You file a claim regarding eligibility for Your or Your Dependent's coverage under this Plan ("Eligibility Claim"), or Your Eligibility Claim is denied and You desire to file an appeal ("Eligibility Appeal"), 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 an Eligibility Claim and is not subject to these claim and appeal procedures. You must send Your Eligibility Claims and Eligibility Appeals to the Plan Administrator. If You file an Eligibility Claim or Eligibility Appeal, You must do so in writing by U.S. mail or by email.

All Eligibility Claims must be submitted to:

myAmeren Benefits
P.O. Box 85012
Minneapolis, MN 55485-0512

All Eligibility Appeals for denied Eligibility Claims must be submitted to:

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

Due to the COVID-19 pandemic, the Department of Labor has issued guidance that temporarily suspends important deadlines related to your claims and appeals. If you have questions about how this guidance impacts your right to file a claim or appeal, please contact **myAmeren Benefits** at 1-877-769-2637

Responding to Your Eligibility Claim

Once You have filed an Eligibility 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 an Eligibility Claim, the Plan administrator will notify You and explain the proper procedures to follow in filing Your Eligibility Claim.

If the Plan Administrator, due to reasons beyond its control, determines that extra time is required to process Your Eligibility Claim, it will notify You in writing of the reasons for the extension and the new due date for its response to Your Eligibility Claim. The Plan Administrator will notify You in writing within the initial ninety (90)-day period after its initial receipt of Your Eligibility 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 Eligibility 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 Eligibility Claim;
- Reference to the specific Plan provision(s) on which the denial is based;
- A description of any additional information necessary for Your Eligibility 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 Eligibility Appeal of Your Eligibility Claim is denied.

Appealing Your Eligibility Claim

If Your Eligibility Claim 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 Eligibility Appeal.

- You may submit written comments, documents, records, and other information relevant to Your Eligibility 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 Eligibility Appeal within a reasonable period of time, but no later than 60 days after its receipt of Your Eligibility 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 Eligibility Appeal is denied, You will receive written notice of the decision, including the following information:

- The specific reason(s) for the denial of the Eligibility 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 Eligibility Claim. You will have the right to bring a civil action under ERISA Section 502(a). You must appeal Your Eligibility Claim, and that Eligibility 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 Eligibility 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 Eligibility 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.

Claim Filing Procedures for Medical and Prescription Drug Benefits

Except in the case of medical care received from Network Providers or prescriptions obtained at a retail Network Pharmacy or through the CVS Caremark Mail Service Pharmacy, claim forms and other information needed to prove loss must be filed with the Claims Administrator within the time periods specified in the "Medical Claim Filing Procedures" and "Prescription Drug Claim Filing Procedures" sections below in order to obtain payment of plan benefits. The Claims Administrator will provide forms and other filing assistance. If forms are not provided within 15 calendar days after the Claims Administrator receives notice of Your claim, You will be considered to have complied with the requirements regarding proof of loss by submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character, and extent of the loss.

Medical Claim Filing Procedures

Participating Anthem Network Providers will file Your claims for You. Those Participating Providers will send Your claim to Anthem. If they incorrectly file Your claim with Anthem, Anthem will notify the Provider that the claim must be resubmitted to Anthem.

You are responsible for filing a completed claim form for all other medical claims (for example, claims for services You receive from Non-Network Providers) with the Claims Administrator at the address below in order to obtain payment of Plan benefits. You can also obtain claim forms or submit a claim by going to www.Anthem.com and registering on the website.

Anthem Blue Cross Blue Shield
P. O. Box 105187
Atlanta, GA 30348

All medical claims must be received by the Claims Administrator within one year after the end of the year in which the expense is incurred. For example, all expenses incurred during 2023 must be received by the Claims Administrator by December 31, 2024. No benefits are payable for claims filed after the deadline.

When filing a medical claim for Yourself, please be sure Your claim includes the patient's name, Your name (if different from patient's name), Provider of services, dates of service, diagnosis, description of treatment or service provided and cost of the treatment or service. The Claims Administrator may request additional information to substantiate Your claim or require a signed unaltered authorization to obtain that information from the Provider. Your failure to comply with such request could result in declination of the claim.

Prescription Drug Claim Filing Procedures

CVS Caremark's Network Pharmacies will file Your prescription drug claims for You. If You purchase prescription drugs at a non-participating retail Pharmacy, You must pay the full cost of the prescription at the time of purchase and submit a completed claim form for reimbursement to the Claims Administrator at the address below.

CVS/Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Attn: Claims Department

Claim forms may be obtained either by calling CVS/Caremark at **877.817.0479** or by visiting their website: **www.caremark.com**.

All Pharmacy claims must be received by CVS Caremark within one year of the date of prescription purchase.

Post-Service Claims

The Claims Administrator will make a benefit determination and notify You or Your authorized representative in writing within 30 calendar days from receipt of a post-service claim. The initial 30-day determination period may be extended up to 15 additional days due to reasons beyond the Claims Administrator's control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing within the initial 30-day period of the reason necessitating the extension and the date by which a decision is expected to be made. If a claim cannot be processed due to incomplete information, the Claims Administrator will send written notification prior to the expiration of the 30 calendar days explaining the specific information needed. You will have at least 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Plan may be processed and paid within a few days after the Claims Administrator receives the completed claim. If a claim cannot be paid, the Claims Administrator will promptly explain why.

Pre-Service Claims

The Claims Administrator will make a benefit determination and notify You or Your authorized representative of its determination (whether adverse or not) within 15 calendar days after receipt of the claim. The 15-day period may be extended up to 15 additional days if the Claims Administrator determines that an extension is necessary due to matters beyond its control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing, prior to the expiration of the initial 15-day period, of the reason

necessitating the extension and the date by which a decision is expected to be made. If the extension is needed because You have not submitted all the necessary information, the notice of extension will specifically describe the additional information that is needed. You will be afforded at least 45 days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received. If You did not follow the claims procedures, the Claims Administrator will notify You (or Your authorized representative) of the failure and the proper procedures as soon as possible but not later than 5 days after the claim was received.

Urgent Care Claims

The Claims Administrator will make a benefit determination and notify You (or Your authorized representative) of its determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The Claims Administrator may notify You (or Your authorized representative) orally and then furnish a written notification no more than three calendar days later. If You did not follow the claims procedures or did not provide all of the necessary information, the Claims Administrator will notify You (or Your authorized representative) of the failure and the proper procedures or the specific additional information needed as soon as possible but not later than 24 hours after the claim was received. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide all additional information requested. The Claims Administrator will notify You (or Your authorized representative) of its determination regarding as soon as possible, but not later than 48 hours after the earlier of the time the required information is received by the Claims Administrator or the expiration of the specified period for providing the additional information.

Concurrent Care Claims

If an on-going course of treatment involving Urgent Care was previously approved for a specific period of time or number of treatments, and You (or Your authorized representative) request that the course of treatment be extended beyond the previously approved period of time or number of treatments, the Claims Administrator will notify You (or Your authorized representative) of its determination (whether adverse or not) as soon as possible taking into account the medical exigencies but not later than 24 hours after receipt of the request. Your request must be made at least 24 hours prior to the expiration of the approved course of treatment.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, any reduction or termination of the course of treatment (other than by plan amendment or termination) before the end of the previously approved period of time or number of treatments, will be considered a claim denial. The Claims Administrator will notify You at a time sufficiently in advance of the reduction or termination to allow the You to appeal and obtain a determination on review before the benefit is reduced or terminated.

Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator will provide You (or Your authorized representative) with written or electronic notice of the Adverse Benefit Determination. To the extent required by law, the notice will include:

- sufficient information to identify the claim involved, including the date of service, the health care Provider, the claim amount (if applicable) and the diagnosis and treatment codes (along with the corresponding meaning of such codes);

- the specific reason(s) for the denial (including the denial code and its corresponding meaning);
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one (1) year of the grievance or appeal decision if You appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge; and
- if the denial is based on a Medical Necessity or an Experimental or Investigational Measure or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- if the denial relates to a claim involving Urgent Care, a description of the expedited review process applicable to such claims;
- a description of the Plan's standard, if any, used in denying the claim;
- a description of available external review procedures; and
- disclosure of the availability of and contact information for any applicable ombudsman established under law to assist individuals with the internal claims and appeals and external review procedures.

Informal Inquiries Regarding Claims

For Medical Claims:

Participants may direct informal inquiries regarding a question about the Plan or a service You have received, or denials of medical claims to Anthem by calling **844.344.7410**.

A Member services representative will review and research the inquiry. You will be informed of the resolution and if the decision is adverse to You, You will be advised of Your rights to request a formal appeal. You also have the right to bypass this informal inquiry process and immediately file a formal appeal as described in the APPEAL RIGHTS section below.

For Prescription Drug Claims:

You may direct informal inquiries regarding denial of prescription drug claims to CVS Caremark Member Services Department. They are available 24 hours a day, 7 days a week by calling **877.817.0479**.

A Customer Service Representative will review and research the inquiry. You will be informed of the resolution and if the decision is adverse to the You, You will be advised of Your rights to request a formal appeal. You also have the right to bypass this informal inquiry process and immediately file a formal appeal as described in the APPEAL RIGHTS section below.

Appeals of Adverse Benefit Determinations

If a medical or prescription drug claim results in an Adverse Benefit Determination, You or Your authorized representative may appeal the decision as described below. If You or Your authorized representative does not file an appeal within the specified period, You will be barred from challenging the Adverse Benefit Determination in the future.

Internal Appeal Process For Medical Claims

You have the right to appeal an Adverse Benefit Determination. You (or Your authorized representative) must file Your appeal within 180 calendar days after You are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination. If You (or Your authorized representative) do not file an appeal within the 180-day period, You are barred from challenging the Adverse Benefit Determination in the future.

The time frame allowed for the Claims Administrator to complete its review depends upon the type of claim involved (e.g. Pre-Service, Concurrent, Post-Service, Urgent, etc.).

For Pre-Service claims involving Urgent Care or concurrent care, You may obtain an expedited review. You (or Your authorized representative) may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving Urgent Care or concurrent care, You (or Your authorized representative) must contact the Claims Administrator at **844.344.7410** and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by You (or Your authorized representative), except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. Urgent Care). You (or Your authorized representative) must submit a request for review to:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348

You must include Your Member identification number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

To the extent required by law, the following rules will also apply to Your appeal:

- You (or Your authorized representative) will be permitted to review the claim file and to present evidence and testimony.
- You (or Your authorized representative) will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance so that You (or Your authorized representative) will have a reasonable opportunity to respond prior to the due date for notice of the final decision on appeal.
- Prior to issuing an Adverse Benefit Determination on a medical claim based on a new or additional rationale, the Claims Administrator shall provide You or Your authorized representative), free of charge, with the rationale. Such rationale will be provided as soon as possible and sufficiently in advance to provide You (or Your authorized representative) a reasonable opportunity to respond prior to the due date for notice of the final decision on appeal.
- Additionally, no decisions involving hiring, compensation, termination, promotion, or related matters regarding any individual (e.g., a claims adjudicator or medical expert) may be based on the likelihood that the individual will support the benefits denial.

How Your Appeal will be Decided

In considering Your appeal, the Claims Administrator will not defer to the initial benefit determination or, for second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is an Experimental or Investigational Measure, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. The health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. By appealing the initial denial, You consent to the review of medical information pertinent to the claim by the above-referenced health care professional consulted in connection with the appeal. The identification of any medical experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be provided upon request, without regard to whether the expert's advice was relied upon in making the benefit determination.

Notification of the Outcome of the Appeal

If You appeal a claim involving Urgent Care or concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal. If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal. If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

If a claim is partially or wholly denied on appeal, 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 Your right 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. Notice of a denial based on Medical Necessity or Experimental or Investigational Measure 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.

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the appeal procedures outlined under this section, the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

Voluntary Second Level Appeals

If You are dissatisfied with the Claim Administrator's appeal decision, a voluntary second level appeal may be available. This voluntary level of appeal will be a panel review, independent review, or other process consistent with the entity reviewing the appeal. If You would like to initiate a second level appeal, You must contact the Claim Administrator in writing and request a second level appeal within 60 calendar days of Your receipt of the denial of the first level appeal. No fees or costs are imposed for this voluntary level of appeal and any statute of limitations or other defense based on timeliness will be tolled during the time that this second appeal is pending. The decision as to whether or not to submit Your benefit dispute to this voluntary level of appeal will have no effect on Your rights to any other benefits under the Plan. The Plan will not assert that You have failed to exhaust Your administrative remedies if You elect not to participate in this voluntary second appeal. For additional information regarding the availability of a voluntary second level of appeal, please contact the Claims Administrator.

Internal Appeal Process for Prescription Drug Claims

If You disagree with a prescription drug claim denial at a retail Pharmacy or through the CVS Caremark Mail Service Pharmacy, You should contact CVS Caremark at **877.817.0479**. CVS Caremark will research the inquiry and will respond providing the rationale behind the denial. It

may be necessary for You or Your Physician to provide additional information that will allow reconsideration of the claim.

If it is determined that based upon CVS Caremark's analysis, the claim was properly denied, You (or Your authorized representative) may contact the Claims Administrator for further consideration. A written appeal should be submitted to:

CVS Caremark
Appeals Department MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax 1-866-689-3092

Your written appeal should include the Member's (and Covered Employee's, if applicable) name, the date You attempted to fill the prescription, the prescribing Physician's name, the drug name and quantity, the cost for the prescription (if applicable), the reason You believes the claim should be paid, and any other written documentation to support the request for review.

The appeal must be submitted to the Claims Administrator within 180 calendar days after receipt of the initial claim denial from CVS Caremark. If the claim appeal is not filed during this 180-day period, You will be barred from challenging the decision by CVS Caremark. to deny the claim. The Claims Administrator will take into account all information submitted relative to the claim.

You have the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

Appeals will be conducted by an appropriate qualified individual who was not involved with the initial claim decision nor a subordinate to that original decision maker. No deference to the initial claims denial will be given by the reviewer. If the claim was denied based on a medical judgment (including whether a treatment, drug, or other item is an Experimental or Investigational Measure, or not Medically Necessary or Appropriate), the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in that judgment and who was not consulted on the initial decision. By appealing the initial denial, You consent to review of medical information pertinent to the claim by the above referenced health care professional consulted in connection with the review of the appeal. Upon request, You will be provided with the identification of medical experts whose advice was obtained in connection with the appeal whether or not the Claims Administrator relied on their advice.

The Claims Administrator will advise You of the decision on the appeal in writing within 60 days of receipt of the appeal. All claims decisions made by the Claims Administrator will be final, binding, and conclusive.

External Review Procedures

You may also have the right to request an external review of a claim following an Adverse Benefit Determination if it was based on medical judgement, or pertained to a rescission of coverage. External review is not available with respect to any denial, reduction, termination, or failure to provide payment for a benefit relating to an individual's failure to meet the Plan's eligibility requirements or based on an interpretation of the Plan's terms.

You must submit Your request for external review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an external review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving Urgent Care or concurrent care, You may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited external review, You or Your authorized representative must contact the Claims Administrator and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348

CVS Caremark
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

You must include Your Member identification number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek external review will not affect Your rights to any other benefits under the Plan. There is no charge for You to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Legal Action

When claiming a benefit under the Plan, You must follow the procedures described in this section of this SPD. If Your claim is not paid to Your satisfaction, You have the right to file an appeal, the procedures for which are also described in this section. If Your appeal is denied, You have the right to bring legal action against the Plan. Such legal action can be brought no earlier than 90 calendar days after You filed Your claim for benefits. However, You must exhaust the Plan's internal appeals process, not including any voluntary level of appeal, before You can file a lawsuit or take other legal action of any kind against the Plan. Further, You may not bring a lawsuit or take other legal action against the Plan after one (1) year has elapsed following the date of the Plan's final decision on the claim or other request for benefits.

If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

Facility of Payment

The Plan allows You to assign Your benefits to a Hospital or other service Provider. This means that benefits payable by the Plan will be paid directly to the service Provider and You will be billed for any remaining balance.

Payment of benefits for Non-Network Providers will be made to You, unless there is an assignment of benefits to be paid directly to that Provider providing the service. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Plan to the full extent of those payments.

- If payment amounts remain due upon Your death, those amounts may, at the Plan's option, be paid to Your estate, spouse, child, parent, or Provider of services.
- If the Plan Administrator believes You are not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Plan may pay whoever has assumed responsibility for Your care and support.
- Benefits payable to a Network Provider will be paid directly to the Network Provider on Your behalf.
- Benefits payable to a Network Transplant Provider will be paid directly to the Network Transplant Provider.

Subrogation and Reimbursement

Applicability

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You or one of Your Covered Dependents sustained and You have a right to a Recovery or have received a Recovery from any person or entity who is or may be liable for Your or Your Covered Dependents' injury, illness, disability or death, including without limitation: an insurance company, worker's compensation, homeowner's insurance, all coverages under an automobile policy (including "no fault" coverage, medical coverage, and uninsured or underinsured motorist coverage), and other similar coverages.

By participating in the Plan or receiving benefits under the Plan, You and Your Covered Dependents consent and agree that the Plan will have the right of subrogation and reimbursement with respect to the full amount of benefits paid to or on behalf of You or a Covered Dependent

as a result of an injury, illness, disability or death that is or may be the responsibility of any party. The Plan will also have a lien upon any Recovery to the full amount of benefits and expenses paid by the Plan.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan’s equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your Recovery to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.
- Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

Member and Dependent Obligations

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Administrator has sole discretion to interpret the terms of the subrogation and reimbursement provision of the Plan in its entirety and the Plan Sponsor reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. If the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

Miscellaneous Provisions

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 or other person, entity, or group, the determination of such Claims Administrator or other person, entity or group, shall be final and binding, unless otherwise required by law.

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 Plan Sponsor hopes and expects to continue the Plan in the years ahead but cannot guarantee to do so. The Company, and any successor corporation which assumes the responsibilities of the Company 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. The Company, or its 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, summary plan descriptions, 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 SPD shall apply equally to the Covered Employee and Dependents and all benefits and privileges made available to Covered Employee shall be available to the Covered Employee's Dependents.

Nontransferable Benefits

No person other than the Member is entitled to receive healthcare coverage or other benefits to be furnished by the Plan. Such right to healthcare 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 the Claims Administrator, the Plan Sponsor, or a Member 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.

Receiving Advice Disclaimer

The Company cannot advise You regarding tax, investment, or legal considerations relating to the Plan. Therefore, if You have questions regarding benefit planning, You should seek advice from a personal advisor (e.g. legal counsel, tax advisor, investment advisor)

Prohibition on Rescissions

In general, the Plan is not allowed to rescind (i.e., retroactively cancel or terminate) Your (or Your Dependents) medical plan coverage once You (or Your Dependents) become covered under the medical plan. However, Your (and/or Your Dependents) coverage under the medical plan may be rescinded (i.e. cancelled or discontinued with a retroactive effective date) if You (and/or Your

Dependents) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of the Plan. If the Plan Administrator seeks to rescind medical coverage for fraud or an intentional misrepresentation of a material fact, Plan Administrator will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded.

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

Coverage for certain Employees under the Plan is made available 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 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 updated SPD. 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 SPD 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 the people 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 benefit or exercising Your rights under ERISA.

If Your claim for a 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 a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If 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, but only after you have exhausted the Plan's claims and appeals procedures. 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 EBSA, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of EBSA.

General Information About the Plan

Plan Name:	Medical Program, a component of the Ameren Employee Medical Plan
Type of Plan:	An employee welfare benefit plan providing medical benefits.
Plan Year:	January 1 through December 31
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. Plan Sponsor has a contract with Anthem (Claims Administrator) and CVS Caremark (Claims Administrator) to provide certain services to 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, medical and prescription drug 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.
Plan Sponsor:	Ameren Corporation 1901 Chouteau Avenue Post Office Box 66149, Mail Code 533 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Plan Sponsor's Employer Identification Number:	43-1723446
Plan Number:	510
Plan Administrator:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149, Mail Code 533 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Claims Administrator for Medical Benefits:	Anthem BlueCross BlueShield P.O. Box 105557 Atlanta, GA 30348
Claims Administrator for Prescription Drug Benefits:	CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136
COBRA Administrator:	**myAmeren Benefits** PO Box 850512 Minneapolis, MN 55485-0512 1.877.769.2637 www.myameren.com
Named Fiduciary for Plan:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149, Mail Code 533 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)

Named Fiduciary for Medical Claims and Appeals	Anthem BlueCross BlueShield P.O. Box 105557 Atlanta, GA 30348
Named Fiduciary for Prescription Drug Appeals	CVS Caremark Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084
Agent for Service of Legal Process:	General Counsel Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149, Mail Code 1300 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.

Schedule of Benefits – Options Program

How the Coverage Options Work

This **Options Program** has three different benefit schedules:

- Standard Plan,
- Health Savings Plan, and
- Health Savings Plan - Value

Anthem Network Programs

The medical plan options are designed to help You reduce healthcare expenses whenever You use a Provider that is participating in the Anthem Network of Providers. Depending on the Plan option You are enrolled in, You will either pay a Copay at the time of service, or a Coinsurance payment that is determined after Your claim has been processed. You can use Non-Network Providers, however Anthem is able to negotiate discounts with Physicians and Hospitals and then pass these discounts on to You. This can mean significant savings for You and the Plan when You use a Network Provider.

Your Network Provider should bill the Plan directly for any treatment or services rendered. This practice is necessary because all payments for medical claims must be paid directly to the Provider rather than to the Member. It is then the Provider's responsibility to contact You if there are any remaining charges for the treatment or services, such as Coinsurance, or if You are due a refund.

Summary of Benefits – Standard Plan

The following Summary of Benefits charts compare how benefits are paid for various types of care for the Standard Plan. Only commonly used services are listed to help You understand how the Plan pays benefits.

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Standard Plan		
Plan Feature	**In-Network**	**Out-of-Network**
Deductible • Per Person • Per Family	 $600 $1,200	 $900 $1,800
Network and Non-Network Deductibles reduce each other		
Out-of-Pocket Maximum (includes the Deductible) • Per Person • Per Family	 $3,500 $7,000	 $ 7,000 $14,000
Network and Non-Network Out-of-Pocket Expenses reduce each other. Non-covered services, precertification penalties, drug Copays and Coinsurance, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum.		
Inpatient Hospital (precertification required; Refer to UTILIZATION MANAGEMENT REVIEW)	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Outpatient Facility	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Emergency Room Services	If a true Medical Emergency, You pay the In-Network deductible, then the plan pays 90%, both In-Network and Out-of-Network. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible and Coinsurance.	
Ambulance	If a true Medical Emergency, the Plan pays 100%, both In-Network and Out-of-Network. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible and Coinsurance.	
Urgent Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 90%
LiveHealth Online	You pay Deductible, then the Plan pays 90% per online visit to a Network Physician	Not Covered
Office Visits (Including covered diagnostic services performed in the Physician's office)	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Standard Plan (continued)		
Plan Feature	**In-Network**	**Out-of-Network**
Maternity Care Office Visits (Prenatal & Postnatal), In-Hospital delivery, and newborn nursery services	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Infertility Services Covered Services include infertility diagnostic and treatment services. Covered Services include, but are not limited to, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer), artificial insemination. Lifetime maximum benefit of $25,000 medical and prescription drug combined.	You pay Deductible, then the Plan pays 90% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined	You pay Deductible, then the Plan pays 70% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined
Mental Health/Substance Abuse Inpatient hospital, outpatient facility, physician office visits	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Allergy Injections and Serum	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Chiropractic Services – Limited to 25 visits per year	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Physical Therapy - Limited to 25 visits per year	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Speech/Occupational Therapy - Limited to a combination of 20 visits per year for covered diagnoses.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Wellness and Preventive Care Services according to the U.S. Preventive Services Task Force guidelines (including routine colonoscopies)	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply
Women's Wellness and Preventive Care Services	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply
Colonoscopies Non-routine	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Standard Plan (continued)		
Plan Feature	**In-Network**	**Out-of-Network**
Home Health Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Hospice Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
X-Ray and Laboratory Services - Performed in a Hospital or other independent outpatient facility	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Durable Medical Equipment Precertification may be required.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Prescription Drugs	See PRESCRIPTION DRUG PROGRAM FOR STANDARD PLAN	
All Other Covered Expenses	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

Summary of Benefits – Health Savings Plan

The following Summary of Benefits charts compare how benefits are paid for various types of care for the Health Savings Plan. Only commonly used services are listed to help You understand how the Plan pays benefits.

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan		
Plan Feature	**In-Network**	**Out-of-Network**
Deductible • Employee Only Coverage • Employee & Spouse/Domestic Partner (contributions may not be made to a HSA on behalf of a Domestic Partner), Employee & Child, or Employee & Family Coverage	$1,550 $3,100 IMPORTANT NOTE: The $1,550 Deductible applies ONLY if You have elected Employee Only coverage. If You have elected to cover any family members under the Health Savings, the Plan will not pay benefits until Your annual Deductible of $3,100 has been met, whether by one or more Members. Covered Expenses for both medical and prescription drugs apply toward the Deductible.	
Out-of-Pocket Maximum (includes the Deductible) • Per Person • Per Family	$4,000 per person $8,000 per family	$ 6,700 per person $13,400 per family
Network and Non-Network Out-of-Pocket Expenses reduce each other. Non-covered services, precertification penalties, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum. Covered Expenses for both medical and prescription drugs apply toward the Out-of-Pocket Maximum.		
Inpatient Hospital (precertification required)	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Outpatient Facility	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Emergency Room Services	If a true Medical Emergency, You pay the In-Network Deductible, then the Plan pays 100%. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible and Coinsurance.	
Ambulance	If a true Medical Emergency, You pay the Deductible, then the Plan pays 100%. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible and Coinsurance.	
Urgent Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 80%

Note: This chart is only a summary of plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan (continued)		
SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
LiveHealth Online	You pay Deductible, then the Plan pays 80% per online visit to a Network Physician	Not Covered
Office Visits (Including covered diagnostic services performed in the Physician's office)	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Maternity Care Office Visits (Prenatal & Postnatal), In-Hospital delivery, and newborn nursery services	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Infertility Services Covered Services include infertility diagnostic and treatment services. Covered Services include, but are not limited to, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer), artificial insemination. Lifetime maximum benefit of $25,000 medical and prescription drug combined.	You pay Deductible, then the Plan pays 80% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined	You pay Deductible, then the Plan pays 60% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined
Mental Health/Substance Abuse Inpatient hospital, outpatient facility, physician office visits	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Allergy Injections and Serum	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Chiropractic Services Limited to 25 visits per year	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Physical Therapy Limited to 25 visits per year	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Speech/Occupational Therapy Limited to a combination of 20 visits per year for covered diagnoses	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Wellness and Preventive Care Services according to the U.S. Preventive Services Task Force guidelines (including routine colonoscopies)	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply
Women's Wellness and Preventive Care Services	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply

Note: This chart is only a summary of plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan (continued)		
SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Colonoscopies Non-routine	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Home Health Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Hospice Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
X-Ray and Laboratory Services - Performed in a Hospital or other independent outpatient facility	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Durable Medical Equipment Precertification may be required	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Prescription Drugs (see PRESCRIPTION DRUG PROGRAM FOR HEALTH SAVINGS PLAN**)**	You pay Deductible, then the Plan pays 80% You may obtain up to a maximum supply of 34 days for each prescription for retail drugs and up to 90 days for each prescription for home delivery drugs	
All other Covered Expenses	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%

Health Savings Account

The Health Savings Plan is a qualified high deductible health plan option. Accordingly, if You enroll for coverage under the Health Savings Plan, You may be eligible to participate in the Ameren HSA Program. Employees and/or surviving Dependents participating in the Ameren HSA Program can receive Company contributions to their HSA. For 2023, the Company contribution for an Employee and/or surviving Dependent enrolling for Employee Only coverage is $650 annually ($27.08 per pay period benefit deductions are taken). The annual contribution for an Employee and/or surviving Dependent enrolling for family coverage is $1,300 ($54.16 per pay period benefits deductions are taken). Participants in the Ameren HSA Program may also make their own contributions to the HSA. For details regarding the Ameren HSA Program, please refer to the "Ameren Health Savings Account Program" summary document.

Note:

- IRS rules prohibit the contribution to an HSA by You or the Company if You are enrolled in Medicare Part A and/or Part B. If You have enrolled in Medicare due to a disability, or because You are age 65 or older (even though You are still working as an active Employee), You are not eligible to contribute to an HSA. This includes the Ameren contribution. If You continue to make HSA contributions (including the Ameren contribution) after enrolling in Medicare, You may be subject to penalties for excess or ineligible contributions.

Summary of Benefits – Health Savings Plan – Value

The following Summary of Benefits charts compare how benefits are paid for various types of care for the Health Savings Plan - Value. Only commonly used services are listed to help You understand how the Plan pays benefits.

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan - Value		
Plan Feature	**In-Network**	**Out-of-Network**
Deductible • Employee Only Coverage	$2,500	
• Employee & Spouse/Domestic Partner (contributions may not be made to an HSA on behalf of a Domestic Partner), Employee & Child, or Employee & Family Coverage	$5,000 IMPORTANT NOTE: The $2,500 Deductible applies ONLY if You have elected Employee Only coverage. If You have elected to cover any family members under the Health Savings Plan - Value, the Plan will not pay benefits until Your annual Deductible of $5,000 has been met, whether by one or more Members. Covered Expenses for both medical and prescription drugs apply toward the Deductible.	
Out-of-Pocket Maximum (includes the Deductible) • Per Person • Per Family	$5,000 per person $10,000 per family	$7,000 per person $15,000 per family
Network and Non-Network Out-of-Pocket Expenses reduce each other. Non-covered services, precertification penalties, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum. Covered Expenses for both medical and prescription drugs apply toward the Out-of-Pocket Maximum.		
Inpatient Hospital (precertification required)	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Outpatient Facility	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Emergency Room Services	If a true Medical Emergency, You pay the In-Network Deductible, then the Plan pays 100%. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible Coinsurance.	
Ambulance	If a true Medical Emergency, You pay the Deductible, then the Plan pays 100%. If not a true Medical Emergency, as defined by the Plan, You pay the applicable Deductible and applicable Coinsurance.	
Urgent Care	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 70%

Note: This chart is only a summary of plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan - Value (continued)		
SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
LiveHealth Online	You pay Deductible, then the Plan pays 70% per online visit to a Network Physician	Not Covered
Office Visits (Including covered diagnostic services performed in the Physician's office)	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Maternity Care Office Visits (Prenatal & Postnatal), In-Hospital delivery, and newborn nursery services	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Infertility Services Covered Services include infertility diagnostic and treatment services. Covered Services include, but are not limited to, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer), artificial insemination. Lifetime maximum benefit of $25,000 medical and prescription drug combined.	You pay Deductible, then the Plan pays 70% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined	You pay Deductible, then the Plan pays 50% Lifetime maximum benefit of $25,000 In-Network and Out-of-Network medical and prescription drug combined
Mental Health/Substance Abuse Inpatient hospital, outpatient facility, physician office visits	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Allergy Injections and Serum	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Chiropractic Services Limited to 25 visits per year	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Physical Therapy Limited to 25 visits per year	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Speech/Occupational Therapy Limited to a combination of 20 visits per year for covered diagnoses	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Wellness and Preventive Care Services according to the U.S. Preventive Services Task Force guidelines (including routine colonoscopies)	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply

Note: This chart is only a summary of plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
Health Savings Plan - Value (continued)		
SERVICE	**IN-NETWORK**	**OUT-OF-NETWORK**
Women's Wellness and Preventive Care Services	The Plan pays 100%; Deductible does not apply	The Plan pays 70%; Deductible does not apply
Colonoscopies Non-routine	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Home Health Care	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Hospice Care	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
X-Ray and Laboratory Services - Performed in a Hospital or other independent outpatient facility	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Durable Medical Equipment Precertification may be required	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
Prescription Drugs (see PRESCRIPTION DRUG PROGRAM FOR HEALTH SAVINGS PPO**)**	You pay Deductible, then the Plan pays 70% You may obtain up to a maximum supply of 34 days for each prescription for Retail Drugs and up to 90 days for each prescription for Home Delivery Drugs	
All other Covered Expenses	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%

Health Savings Account

The Health Savings Plan - Value is a qualified high deductible health plan option. Accordingly, if You enroll for coverage under the Health Savings Plan - Value, You may be eligible to participate in the Ameren HSA Program. Employees and/or surviving Dependents participating in the Ameren HSA Program can receive Company contributions to their HSA. For 2023, the Company contribution for an Employee and/or surviving Dependent enrolling for Employee Only coverage is $650 annually ($27.08 per pay period benefit deductions are taken). The annual contribution for an Employee and/or surviving Dependent enrolling for family coverage is $1,300 ($54.16 per pay period benefit deductions are taken). Participants in the Ameren HSA Program may also make their own contributions to the HSA. For details regarding the Ameren HSA Program, please refer to the "Ameren Health Savings Account Program" summary document.

Note:

- IRS rules prohibit the contribution to an HSA by You or the Company if You are enrolled in Medicare Part A and/or Part B. If You have enrolled in Medicare due to a disability, or because You are age 65 or older (even though You are still working as an active Employee), You are not eligible to contribute to an HSA. This also includes the Ameren contribution. If You continue to make HSA contributions (including the Ameren contribution) after enrolling in Medicare, You may be subject to penalties for excess or ineligible contributions.

Important Provisions in the Plans

Unless otherwise specified, the provisions described in this section apply to all of the medical plan options: the Standard Plan, the Health Savings Plan, and the Health Savings Plan - Value.

Incidental Providers

For radiologists, anesthesiologists, pathologists, emergency room Physicians, and any other Out-of-Network Providers who treat You or Your Covered Dependents, You and Your Covered Dependents will receive the Network level of benefits (up to the Maximum Allowed Amount) when such services are provided at a Network Hospital (inpatient, outpatient, and Hospital emergency room), or Network licensed free-standing surgical center.

For example, if You receive treatment at a participating Anthem Hospital, and the radiologist who performs a service for this visit is an Out-of-Network Provider, the radiologist's bill for service will be paid at the Network level of benefits. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges (including any Coinsurance, Copay or Deductible) if you receive disclosures from the Out-of-Network Provider regarding the additional charges that will be incurred from receiving the care by an Out-of-Network Provider and you consent to such charges.

Precertification Requirements

Hospital Confinement Charges will be subject to a $200 penalty unless the precertification requirements described in the UTILIZATION MANAGEMENT REVIEW section of this booklet are satisfied. If You or Your Provider do not obtain the required precertification for Inpatient Covered Expenses from a Non-Network Provider, a $200 penalty will apply and Your Out-of-Pocket costs will increase.

Deductible Amounts

The Deductible Amount is measured by calendar year (January through December). The Deductible for each calendar year depends on the applicable benefit schedule (Standard Plan, Health Savings Plan or Health Savings Plan - Value) and whether a Provider is In-Network or Out-of-Network. If a Deductible applies, the Plan will subtract the Deductible Amount from Covered Expenses and will then pay the remaining portion of Covered Expenses as stated in the Schedule of Benefits for Your respective benefit schedule.

For the Standard Plan: You pay one individual Deductible each calendar year. Only amounts up to the individual Deductible Amount for each Member will apply toward satisfaction of the family Deductible Amount. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount. The Copay amounts paid under the Prescription Drug Program cannot be used to help satisfy this Deductible Amount. Also, any penalties incurred as a result of failure to comply with Utilization Management requirements may not be used to help satisfy Your Deductible.

For the Health Savings Plan and Health Savings Plan - Value: The individual Deductible Amount applies only if You are enrolled in Employee Only coverage. The family Deductible Amount applies if You and any family members are enrolled, and the family Deductible amount can be satisfied by one individual. Prescription drug purchases can help satisfy the deductible, but any

penalties incurred as a result of failure to comply with Utilization Management Review requirements may not be used to help satisfy Your Deductible.

Out-of-Pocket Maximums

For the Standard Plan: The Out-Of-Pocket Maximum is the amount of Covered Expenses a Member would pay in a Plan Year before the Plan begins to pay 100% of Covered Expenses.

The Out-of-Pocket Maximum consists of any Deductible payments and the Covered Employee or Covered Dependent's portion of Covered Expenses. Once a Covered Employee or Dependent has incurred the total Out-Of-Pocket Maximum, the Plan pays 100% of all Covered Expenses for the remainder of the Plan Year.

Only amounts up to the individual Out-of-Pocket Maximum for each Member will apply toward satisfaction of the family Out-of-Pocket Maximum amount. The family Out-of-Pocket Maximum is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount.

The Out-of-Pocket Maximum does not include the following:

- the amount You pay because of penalty charges for failure to comply with the Utilization Management Review requirements;
- expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount;
- prescription drug Copays;
- prescription drug Coinsurance amounts or deductibles.

For the Health Savings Plan and Health Savings Plan - Value:
The Out-Of-Pocket Maximum is the amount of Covered Expenses a Member would pay in a Plan Year before the Plan begins to pay 100% of Covered Expenses.

The Out-of-Pocket Maximum consists of any Deductible payments and the Covered Employee or Covered Dependent's portion of Covered Expenses, including prescription drugs. Once a Covered Employee or Dependent has incurred the total Out-Of-Pocket Maximum, the Plan pays 100% of all Covered Expenses, including covered prescription drugs, for the remainder of the Plan Year.

The individual Out-of-Pocket Maximum applies to each covered family member up to the combined family Out-of-Pocket Maximum. Only amounts up to the individual Out-of-Pocket Maximum for each Member will apply toward satisfaction of the family Out-of-Pocket Maximum amount. The family Out-of-Pocket Maximum is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount.

The Out-of-Pocket Maximum does not include the following:

- the amount You pay because of penalty charges for failure to comply with the Utilization Management Review requirements; or
- expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount.

Important Notice for Mastectomy Patients-Women's Cancer Right Act of 1998

If a Covered Employee or a Covered Dependent elects breast reconstruction in connection with a mastectomy, such individual is entitled to coverage under this Plan for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Such services will be performed in a manner determined in consultation with the attending Physician and the patient. This coverage is also addressed within the Medical Expense Coverage, Covered Expenses section of this SPD.

Medical Covered Expenses

Unless otherwise specified, the provisions described in this section apply to all of the medical plan options: the Standard Plan, the Health Savings Plan and the Health Savings Plan - Value. No benefits are available for services that are not specifically described as Covered Expenses in this document. This exclusion applies even if Your Physician orders the service.

Covered Expenses will be the actual cost charged to You or one of Your Covered Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed the Maximum Allowed Amount. Except for the wellness benefits outlined under Covered Expenses, the expenses must be ordered by a Physician for therapeutic treatment of an injury or sickness and must not be listed as an exclusion under EXPENSES NOT COVERED in this booklet. If a service is Medically Necessary but not specifically listed and not otherwise excluded, the service is not a Covered Expense.

Covered Expenses include the Maximum Allowed Amount for:

1. Hospital for room and board, Intensive Care Accommodations and necessary services and supplies furnished by the Hospital. The Maximum Allowed Amount does not include charges for private Hospital room and board and general nursing care that exceed the Hospital Room Daily Limit. Pre-certification is required for all inpatient confinements;
2. Birthing Center services;
3. Ambulatory Surgery Center services;
4. the professional services of a Physician or surgeon;
5. the services of a Health Care Extender;
6. the services of a L.P.N. or a licensed registered nurse R.N.;
7. Physical Therapy services up to 25 outpatient visits per calendar year;
8. the services of occupational therapist, licensed speech pathologist, audiologist, and speech language pathologists, up to a combination of 20 visits per calendar year. Speech therapy services will only be covered to restore speech lost or impaired due to:
    - a stroke,
    - an accidental injury, or
    - surgery, radiation therapy or other treatment which affects the vocal chords.

9. habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living for a diagnosis that is considered a Covered Expense under this Plan. These services may include physical and occupational therapy, speech-language pathology and other services in a variety of Inpatient and/or outpatient settings.
10. chiropractic services up to a 25 visits per calendar year;
11. nutritional counseling for: diabetic education; when related to pre- and post- surgery for approved medically necessary bariatric surgery; eating disorders; and, when considered a preventive care benefit under healthcare reform.
12. treatment for gender identity disorder, including transgender surgery.
13. drugs and medicines requiring a Physician's prescription and approved by the FDA for general marketing (excluding those charges paid under the CVS Caremark Prescription Drug Program, if applicable);
14. surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
15. Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, and certain replacement parts such as batteries, cases and tubing, unless damage results from Your or Your Covered Dependent's negligence or abuse of such equipment. Covered Expenses will not include charges which are in excess of the purchase price of the equipment.

    Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Expense, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Expense is Your responsibility;
16. anesthesia;
17. oxygen, nebulizers and related charges;
18. blood transfusions (including the cost of blood and blood plasma);
19. x-ray and laboratory examinations made for diagnostic purposes in connection with the therapeutic treatment (This includes a professional component that is billed by a pathologist in connection with the laboratory testing or a radiologist in connection with x-rays);
20. colonoscopies (for both preventive and Medically Necessary reasons);
21. x-ray, radium, and radioactive isotope therapy;
22. professional Ambulance Service is subject to Medical Necessity and is a Covered Expense when You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by emergency medical technicians, paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. One or more of the following criteria are met.
    - For ground Ambulance, You are taken:
        - From Your home, the scene of an accident or medical Emergency to a Hospital;
        - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
        - Between a Hospital and a Skilled Nursing Facility or other approved facility.

Emergency ground Ambulance Services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider. Non-emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Provider are not a Covered Service. Other non-covered Ambulance Services include, but are not limited to trips to:

  - A Provider's office or clinic;
  - A morgue or funeral home.

- For air or water Ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and an approved facility.

When using an air Ambulance, if You use an Out-of-Network Provider, that Provider may not bill You for any charges that exceed the Plan's Maximum Allowed Amount. The amount of any Coinsurance or Copay you are responsible for will be counted toward your Deductible and Out-of-Pocket Maximum. You must be taken to the nearest facility that can give care for Your condition. In certain cases the Claims Administrator may approve benefits for transportation to a facility that is not the nearest facility. Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an Ambulance Service, even if You are not taken to a facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air Ambulance when it is not Appropriate to use a ground or water Ambulance. For example, if using a ground Ambulance would endanger Your health and Your medical condition requires a more rapid transport to a facility than the ground Ambulance can provide, the Plan will cover the air Ambulance. Air Ambulance will also be covered if You are in an area that a ground or water Ambulance cannot reach. Air Ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital, such as a Skilled Nursing Facility, or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air Ambulance will only be covered if using a ground Ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You.

Non-Emergency Air Ambulance

When using an air Ambulance, for non-emergency transportation, the Claims Administrator reserves the right to select the air Ambulance provider. If You do not use

the air Ambulance provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's, Maximum Allowed Amount.

23. transportation within the continental United States and Canada by railroad or regularly scheduled flight of a commercial airline from the location where the Member becomes disabled due to any covered injury or disease to (but not returning from) a legally constituted Hospital equipped to furnish special treatment for such disability;
24. eye exams or glasses that are necessary to repair damage that was caused solely by an accidental injury that occurred while You or Your Dependent were covered under the Plan and provided such charges are incurred within six months of the date of the accident;
25. Cosmetic Treatment or Services (or complications arising therefrom) that result from a sickness or an accidental injury, provided the procedure or service is completed within 24 months after the onset date of that sickness or injury;
26. Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident, but did not result from chewing (except where the chewing or biting results from an act of domestic violence or directly from a medical condition). Covered Expenses are limited to the least expensive procedure that would provide professionally acceptable results;
27. dental care provided in a Hospital (including the charges provided by the Hospital, Physician, or nurse) as described in the "General Anesthesia–Charges for Dental" section of this SPD and subject to Utilization Review by the Claims Administrator;
28. treatment or service due to any form of temporomandibular joint disorder; malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type;
29. hearing aids as follows:
    - otologic examination of each ear by a Physician;
    - audiologic examination and hearing evaluations of each ear by a certified or licensed audiologist;
    - **Standard Plan, Health Savings Plan and Health Savings Plan-Value** : one personal hearing aid for each ear every five years. Covered Expenses will include: ear molds, the hearing aid, the initial batteries, cords and other necessary equipment, a warranty, and follow up consultation within 30 days after delivery of the hearing aid;

      If You and the hearing aid Provider agree on a device with additional features prior to the hearing aid being provided, You may be responsible for the amount over the Allowed Amount.
30. wellness and preventive care services according to the U.S. Preventive Services Task Force guidelines. Deductibles, Copays and Coinsurance will be waived when You use a Network Provider. Some examples of wellness and preventive care services include, but are not limited to the following:
    - annual physical examination performed in a Physician's office;
    - well-woman care (including pap smears and gynecological exams);
    - mammograms;
    - prostate specific antigen;

- well child care - including immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diptheria/tetanus; mumps, measles, rubella and certain others vaccines, at the Network coverage level, whether obtained by a Network or Non-Network Provider);
- adult immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diphtheria/tetanus; shingles; and certain others vaccines, at the Network coverage level, whether obtained by a Network or Non-Network Provider);
- diagnostic screening tests and x-rays provided during the exams;

31. women's wellness and preventive care services as provided under The Patient Protection and Affordable Care Act of 2010. Deductibles, Copays and Coinsurance will be waived when You use a Network Provider. Women's wellness and preventive care services include:
    - well-women visits;
    - screening for gestational diabetes;
    - human papillomavirus testing;
    - counseling for sexually transmitted infections;
    - counseling and screening for human immune-deficiency virus;
    - contraceptive methods and counseling;
    - breastfeeding support, supplies, and counseling (breast pumps are limited to one per pregnancy); and
    - screening and counseling for interpersonal and domestic violence;
32. treatment or service for smoking cessation or nicotine addiction;
33. Clinical Trials as described in this SPD;
34. Home Health Care Plan as described in this SPD;
35. Hospice Care Programs as described in this SPD;
36. Skilled Nursing Facility as described in this SPD;
37. treatment or service related to mental health and alcohol or other substance abuse, including methadone clinics, and includes:
    - Inpatient services in a Hospital or any facility that must be covered by law, including psychotherapy, psychological testing, electroconvulsive therapy, and detoxification;
    - outpatient services including office visits, therapy and treatment in an outpatient department of a hospital or outpatient facility, such as Partial Hospitalization Program/Day Treatment Programs, Intensive Outpatient Programs, and in-Network intensive in-home behavioral health program – when available in Your area;
    - residential treatment which is specialized 24-hour treatment in a licensed residential treatment center which offers individualized and intensive treatment and includes: observation and assessment by a psychiatrist weekly or more often; and, rehabilitation, therapy, and education;
    - LiveHealth Online visits;
    - Covered Expenses include services from the following Providers: psychiatrist, psychologist, L.C.S.W., mental health clinical nurse specialist, L.M.F.T., and L.P.C., or any

agency licensed by the state to provide these services when required to cover them by law;

38. human to human transplants as described under Transplant Services in this booklet;
39. treatment or service related to the pregnancy of a Covered Employee, the Covered Spouse/Domestic Partner, or a Covered Dependent Child of an Employee;
40. treatment or service provided in a Veterans Administration Hospital for non-service connected illness;
41. treatment or service provided while confined in a military medical facility incurred by a U.S. military retiree (and any Covered Dependents);
42. reconstructive breast surgery in connection with a mastectomy for:
    - reconstruction of the breast on which a mastectomy has been performed; and
    - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - prosthetic devices and physical complications of the mastectomy, including lymphedemas;
43. reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment is a Covered Expense under this Plan;
44. one wig per person per Plan year following cancer treatment for malignancy.
45. Gene Therapy services when services are approved in advance through precertification and deemed medically necessary
46. ABA Therapy. Medically necessary applied behavioral analysis services are covered up to age 26; annual maximum benefit of $45,000 per year.
47. Infertility Services. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from Infertility. This includes surgical procedures to correct a diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. Covered fertilization services include artificial insemination, in-vitro fertilization, GIFT (gamete intra-fallopian transfer), or ZIFT (zygote intra-fallopian transfer) procedures. See the Schedule of Benefits for benefit limitations, Coinsurance and Copayment amounts. A diagnosis of Infertility is not required for treatment of Infertility to be covered.

An expense is considered "incurred" on the date the services or supplies related to the charge are provided or received.

LiveHealth Online

Anthem's LHO telemedicine program allows You to have a virtual office visit with an In-Network Physician 24 hours a day, seven day a week, through Your smart phone or any computer with internet access and a camera. Using LHO provides You with:

- Immediate Physician Visits through live video;
- Your choice of U.S. board-certified LHO Physicians;

- Private, secure and convenient online visits.

The Physician is able to answer questions, make a diagnosis, and prescribe basic medication when needed. The qualifications of the LHO Physicians include:

- U.S. board-certified
- Average of fifteen (15) years of practicing medicine
- Mostly Primary Care Physicians
- Specially trained for online visits

The cost of the visit is considered to be a visit to a primary care physician and will be based on the Plan option in which You are enrolled. You should enroll at **www.livehealthonline.com** when You need to use the service. Examples of when LHO may work for You include:

- Cold and flu symptoms such as a cough, fever and headaches;
- Allergies
- Sinus infections
- Family health questions.

Non-Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation

Note: LHO is not intended for use for a work-related illness or injury. Employees should contact their supervisor if injured at work. Additionally, for Employees who are required to submit Form 4801 for missed work days, LHO is not appropriate since LHO is unable to provide either the Form 4801 or the information required on the Form 4801.

AIM Imaging Cost and Quality Program

"AIM Specialty Health Program" is a program that provides You with access to important information about imaging procedures You might need such as CT, PET, MRI, MRA, CTA or nuclear cardiology scans, sleep study services.

The AIM Specialty Health Program may apply if Your Physician prescribes an imaging procedure or sleep study. This program offers pre-authorization for the services and is designed to help You make an informed choice when selecting a specialty Provider. If the Provider You select is not the most cost effective, quality choice available in Your area, AIM may contact You with more affordable quality options and if You choose, help reschedule Your appointment, which will save money for both You and the Plan. Here's how the AIM Specialty Health Program works:

- Your Physician refers You to a radiology Provider for an MRI, CT, or other scan;
- AIM works with Your Physician to help make sure that You are receiving the right test – using evidence-based guidelines;

- AIM reviews the referral to see if there are other Providers in Your area that are high quality but at a lower cost than the Provider You may have been referred to;
- If AIM finds another Provider that meets the quality and cost criteria, AIM will contact You with that information;
- You have the choice – You can use the Provider Your Physician suggested, or You can choose to see a Provider that AIM identifies.

The AIM Specialty Health Program gives You the opportunity to reduce Your health care expenses (and those of the Plan) by selecting high quality, lower cost Providers or locations. No matter which Provider You choose, Your health care benefits under the Plan remain the same.

Sleep Study Program

The AIM Specialty Health Program also includes benefits for the "Sleep Management Program", which helps Your Physician make informed decisions about Your treatment. The Sleep Management Program includes outpatient and home sleep testing and therapy. If You require sleep testing, You may be asked to complete the sleep study testing in Your home depending on Your medical condition. Home sleep studies reflect Your normal sleep pattern versus going to an out-patient facility for the test.

Under this program, precertification is required for:

- Home sleep tests
- In-lab sleep studies (polysomnography, a recording of behavior during sleep)
- Titration studies (to determine the exact pressure needed for treatment)
- Treatment orders for equipment, including positive airway pressure devices (APAP, PAP, BPAP, ASV), oral devices and related supplies.

AIM will review Your care quarterly to assure that ongoing treatment is Medically Necessary. This review includes periodic updates from Your Physician and/or medical equipment supplier, along with Your compliance with the treatment Your Physician has ordered.

Talk to Your Physician about getting approval for any sleep testing and therapy equipment and supplies.

Autism Spectrum Disorders Program ("ASD")

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. Anthem provides specialized case management services for members with autism spectrum disorders and their families.

For families touched by ASD, Anthem's ASD Program provides support for the entire family, giving assistance wherever possible and making it easier for them to understand and utilize care – resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education

- Educates and engages the family on available community resources, helping to create a system of care around the member.
- Increase knowledge of disorder, resources, and appropriate usage of benefits.

Guidance

- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
- Assure that parents and siblings have the best support to manage their own needs.

Coordination

- Enhanced member experience and coordination of care.
- Assistance in exploration of medical services that may help the member, including referrals to medical case management.

ASD Program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

Case Management

Covered Expenses will also include case management services provided pursuant to the Plan, to utilize a more cost effective Generally Accepted form of Medically Necessary Care, when compared to use of Covered Expenses contained in this Plan.

Case management is a process which coordinates healthcare services for a Member to promote quality, Appropriate, cost-effective outcomes. The process involves early intervention and proactively working with the Member, family, treatment team, insurance company or employer, and community or government resources to address problems, barriers, fragmentation of care, and solutions.

Multiple Surgical Procedures

If a Member undergoes two or more procedures during the same anesthesia period, Covered Expenses for the services of the Physician, facility, or other covered Provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of the Maximum Allowed Amount for the first or primary procedure; and
- 50% of the Maximum Allowed Amount for any additional procedures.

Covered Expenses For An Assistant During Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of an M.D. or D.O. would be required to assist the primary surgeon.

Note: The percentiles described in the MULTIPLE SURGICAL PROCEDURES section above will be applied to Covered Expenses.

General Anesthesia–Charges for Dental

Covered Expenses will include charges incurred for the administration of general anesthesia in a Hospital, surgical center, or office for the covered dental care. Covered Expenses will also include Hospital and facility charges related to the covered dental care received while under anesthesia.

Benefits are payable when incurred by You or Your Covered Dependent who:

- is less than five years of age; or
- is severely disabled; or

- who has a medical or behavioral condition which requires hospitalization or general anesthesia when covered dental care is provided.

Benefits will be payable the same as for any other covered treatment or service.

Out-of-Network for an Emergency Medical Condition

Covered Expenses for care received from an Out-of-Network Provider for an Emergency Medical Condition or Medical Emergency will be provided at the Network Provider level of benefits. If You receive care from an Out-of-Network Provider for an Emergency Medical Condition or Medical Emergency, you will be responsible for paying the Coinsurance, Copay or Deductible that would apply had the care been provided by a Network Provider. Any payments You make for care for an Emergency Medical Condition or Medical Condition will count toward any applicable Deductible and You will not be required to pay more than the Out-of-Pocket Maximum.

Continuation of care, including post-emergency stabilization and non-emergency follow-up care once discharged, from a Non-Network Provider beyond that needed to evaluate or stabilize Your condition in an Emergency will be covered as if provided by a Network Provider unless the Provider determines you are fit to travel using nonmedical transportation to a Participating Provider within in a reasonable distance and You are provided disclosures by the Out-of-Network Provider and You consent to receive the care from the Out-of-Network Provider. If You do consent to receive the care from the Out-of-Network Provider, You may be responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges, in addition to any applicable Coinsurance, Copay or Deductible.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved Clinical Trial if the services are a Covered Expense under this Plan. An "approved Clinical Trial" mean a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - CMS.
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - Any of the following if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines: 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and, 2) assures unbiased

review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The Department of Veterans Affairs.
- The Department of Defense.
- The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the FDA;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits. Routine patient care costs include items, services, and drugs provided to You in connection with an approved Clinical Trial that would otherwise be covered by this Plan. When a requested service is part of an approved Clinical Trial, it is a Covered Expense even though it might otherwise be Investigational as defined by this Plan. All other requests for Clinical Trials services, including requests that are not part of Approved Clinical Trials, will be reviewed according to clinical coverage guidelines, related policies and procedures.

Treatments or services that are provided during the Clinical Trial and are considered Covered Expenses under the Plan will be covered.

The Plan does not provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

- The Experimental or Investigative Measures; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the Clinical Trial.

Home Health Care

Covered Expenses will include charges by a Home Health Care Agency for:

- part-time or intermittent home nursing care by or under the supervision of a R.N.; and
- part-time or intermittent home care by a Home Health Aide; and
- physical, occupational, speech, or respiratory therapy; and
- intermittent services of a registered dietician or social worker; and
- drugs and medicines which require a Physician's prescription, as well as other supplies prescribed by the attending Physician; and
- laboratory services.

The Home Health Care services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- established prior to the initiation of the Home Health Care Plan services; and
- prescribed by the attending Physician.

The general exclusions listed in this section under EXPENSES NOT COVERED will apply to Home Health Care Plan. In addition, Covered Expenses will not include charges for:

- services or supplies not included in the Home Health Care Plan; or
- the services of any person in Your or Your Covered Dependent's Immediate Family, or any person who normally lives in Your or Your Covered Dependent's home; or
- Custodial Care; or
- transportation services.

Hospice Care

Covered Expenses will include charges for Hospice services provided by a Hospice, Hospice Care Team, Hospital, Home Health Care Agency, or Skilled Nursing Facility for the Palliative Care of pain and other symptoms that are part of a terminal disease for:

- any terminally ill Member who chooses to participate in a Hospice Care Program rather than receive aggressive medical treatment to promote cure, and who, in the opinion of the attending Physician, is not expected to live longer than twelve months; and
- the family (You and Your Covered Dependents) of any such Member;

but only to the extent that such Hospice services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages that program.

Hospice services consist of:

- Care from an interdisciplinary Hospice Care team with the development and maintenance of an Appropriate plan of care; and
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care; and
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a R.N.; and
- Social services and counseling services from a licensed social worker; and
- Nutritional support such as intravenous feeding and feeding tubes; and
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist; and
- Pharmaceuticals (requiring a Physician's prescription), medical equipment, and other supplies prescribed for the terminally ill Member by a Physician as needed for the Palliative Care of the condition, including oxygen and related respiratory therapy supplies; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one (1) year after the Member's death. Immediate family means Your spouse/Domestic Partner, children, stepchildren, parents, brothers and sisters.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than twelve (12) months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the Hospice Care Plan.

Benefits for Covered Expenses beyond those listed above, such as chemotherapy and radiation therapy given as Palliative Care, are available to a Member in Hospice. These additional Covered Expenses will be covered under the other sections in this SPD.

The general exclusions listed in this section under EXPENSES NOT COVERED will apply to Hospice care. In addition, Covered Expenses will not include Hospice charges that:

- are for Hospice services not approved by the attending Physician and the Claims Administrator; or
- are for transportation services; or
- are for Custodial Care; or
- are for Hospice services provided at a time other than during an Episode of Hospice Care.

Skilled Nursing Facility Confinement

Covered Expenses will include charges by a Skilled Nursing Facility for room, board and other services required for treatment, provided the confinement:

- is certified by a Physician as necessary for recovery from a sickness or injury; and
- requires skilled nursing services.

Covered room and board charges for each day will be not more than:

- the actual room charge (if Hospital confinement was in a semi-private room); or
- the Hospital Room Daily Limit (if the Hospital confinement was in a private room)

of the Hospital in which You or Your Covered Dependent was confined before the Skilled Nursing Facility confinement. If You or Your Covered Dependent were not confined immediately prior to admission to the Skilled Nursing Facility, this will be calculated based on the room rate of the most recent Hospital confinement within the past 90 days. If You or Your Covered Dependent have not been Hospital confined during this period, the room rate will be based on the room rate at the Hospital Your Physician would have admitted You to for this sickness or injury if hospitalization had been required.

Covered Expenses will not include charges incurred for a Skilled Nursing Facility confinement:

- after the date the attending Physician stops treatment or withdraws certification;
- You reach the maximum level of recovery possible and no longer require other than routine care;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than skilled convalescent care.

Work-Life Employee Assistance Program for Behavioral Health

Benefits are payable for Covered Expenses for mental health and chemical dependency treatment provided to a person while covered under the Plan. You also may use the EAP instead of, or in addition to, the services covered by the Plan.

Ameren's EAP program provides up to six free sessions with a professional counselor. If ongoing care is appropriate after the six free sessions, You may be able to continue working with the same

counselor or the counselor can refer You to another Provider that specializes in the clinical area recommended.

If You or a Covered Dependent need treatment for mental health, alcohol or other substance abuse problems, You or Your Covered Dependent should contact the Employee Assistance Program at 877.769.2637. An appointment will be scheduled with You or Your Covered Dependent to see a counselor. The counselor will assess the problem, determine the Appropriate treatment, and refer You or Your Dependent to the appropriate Provider.

In the case of emergency treatment that results in a hospitalization, Anthem must be notified within 24 hours of admission to a facility. All other hospitalizations require precertification by Anthem (See UTILIZATION MANAGEMENT REVIEW).

Transplant Services

"Transplant Services" means Covered Expenses incurred in connection with transplants listed below, which are Medically Necessary and not considered to be an Experimental or Investigational Measure. These benefits will be payable instead of any other benefits described in this booklet, unless otherwise indicated below.

The following human-to-human organ or bone marrow transplant procedures will be considered Covered Expenses for Member, subject to all limitations and maximums described in this section:

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Pancreas;
- Kidney-Pancreas;
- Small bowel;
- Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period, unless a tandem transplant or infusion meets the Plan's definition of Medically Necessary Care and is not an Experimental or Investigational Measure.

Cornea and skin transplants are not covered for the purpose of this Transplant Services section. Instead, cornea and skin transplants are treated the same as general medical expenses and are not subject to any conditions set forth in this Transplant Services section.

Covered Expenses for Transplant Services include all services listed in the general medical Covered Expenses section, including, but not limited to, services by a Home Health Care Agency, Skilled Nursing Facility, or Hospice.

Covered Expenses include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which

has been determined by the Claims Administrator to be Medically Necessary Care, not to exceed $10,000 per approved transplant.

Covered Expenses also include charges incurred by the organ donor for a covered transplant (including charges for organ or tissue procurement), if the charges are not covered by any other medical expense coverage.

If transplant related services are provided by a Provider in the Transplant Network, travel and lodging expenses for the Member transplant recipient and a travel companion will be covered if the treating facility is greater than 100 miles one way from the Member's home (excluding travel or lodging provided by a family member or friend). This would include Ambulance expenses that would otherwise be excluded under the medical Ambulance benefit, if such expenses are incurred solely to meet timing requirements imposed by the transplant. Benefits payable cannot be used to satisfy any Deductible or Copay amount under the Ambulance benefit in the general medical section.

For the Standard Plan Health Savings Plan and Health Savings Plan-Value, travel and lodging benefits will be payable at 100% after the Deductible Amount, up to a maximum benefit of $10,000 for each approved transplant.

For Transplant Services provided by any covered Provider other than a Provider in the Transplant Network, benefits are payable the same as any other covered treatment or service, subject to the same Deductibles and Coinsurance amounts for each Member.

No benefits are payable for travel and lodging expenses if services are provided outside the Transplant Network.

The general medical limitations listed in the EXPENSES NOT COVERED section of this booklet also apply to Transplant Services. In addition, limitations specific to Home Health Care, Skilled Nursing Facility confinement, and Hospice Care provisions will apply to Transplant Services if those benefits are used in connection with a covered transplant.

For each transplant episode, the Covered Expenses will be limited to:

- transplant evaluations from no more than two transplant Providers; and
- no more than one listing with the United Network of Organ Sharing.

If the transplant is not covered under the Plan, all charges related to the transplant and all related complications will be excluded from payment under the Plan, including, but not limited to, dose-intensive chemotherapy.

Prior Approval and Precertification

In order to maximize Your benefits, it is strongly recommended that You contact the Claim Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is a Covered Expense and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Claims Administration at **844.344.7410** and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the covered transplant procedure, You or Your

Provider must contact the Claims Administrator's transplant department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen ("HLA") testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage in not an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Expenses Not Covered

Unless otherwise specified, the provisions described in this section apply to all of the medical plan options: the Standard Plan, the Health Savings Plan, and the Health Savings Plan - Value. No benefits are available for services that are not specifically described as Covered Services in this booklet. This exclusion applies even if Your Physician orders the service.

Expenses for which no benefits will be paid include but are not limited to (this is not an exhaustive list):

1. Except as defined under "Wellness and Preventive Care Services and Women's Wellness and Preventive Care Services" section of this SPD (see MEDICAL COVERED EXPENSE) treatment or service that is not for Medically Necessary Care;
2. treatment or service that is an Experimental or Investigational Measure (except as described under CLINICAL TRIALS);
3. any part of a charge for treatment or service that exceeds the Maximum Allowed Amount;
4. additional charges incurred because care was provided after hours, on a Sunday, holidays, or weekend;
5. the services of any person in Your Immediate Family or any person in Your Covered Dependent's Immediate Family;
6. treatment or service that results from participation in criminal activities, as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. However, this exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence;
7. acupuncture or acupressure treatment;
8. molecular genetic testing (specific gene identification) for purposes of health screening or if not part of a treatment regimen for a specific sickness, unless certain criteria (as determined by the Claims Administrator) have been met and the testing is accompanied by genetic counseling;
9. treatment or services by a Christian Science practitioner;
10. Dental Services and materials, including dental implants (except as described under COVERED EXPENSES);
11. hearing aids or other implantable devices (except as described under COVERED EXPENSES);

12. eye examinations for the correction of vision or the fitting of glasses or frames or lenses, (except as described under COVERED EXPENSES);
13. eyeglasses or contact lenses (except as described under COVERED EXPENSES), including corrective lenses implanted during cataract surgery;
14. treatment or service for unattended home sleep studies;
15. drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing;
16. vitamins, minerals, nutritional supplements (even if the only source of nutrition) or special diets (whether they require a Physician's prescription or not);
17. wigs or hair prostheses (except as described under COVERED EXPENSES);
18. treatment or services for Custodial Care;
19. comfort or convenience services and supplies such as personal hygiene items, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, Hoyer lift, gait belt, bedpans, physical fitness equipment, stair glides, elevators or lifts, motorized carts, motorized wheelchairs (unless medically necessary), scooters, strollers, amigo carts, standing frames, feeding chairs, feeding equipment, whether or not recommended by a Physician;
20. charges for heating pads, heating and cooling units, ice bags or cold therapy units;
21. Cosmetic Treatment or Service or any complications arising there from (except as described under COVERED EXPENSES);
22. treatment or service for educational or training problems, learning disorders, marital counseling, or social counseling (except as provided under HOME HEALTH CARE or HOSPICE);
23. educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood, hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered;
24. treatment or service for Developmental Delay;
25. treatment or service for which You or Your Covered Dependent have no financial liability or that would be provided at no charge in the absence of coverage;
26. treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or federal law);
27. treatment or service that results from war or act of war, whether declared or undeclared;
28. treatment or service to improve vision by changing the refraction such as, but not limited to: kerato-refractive eye surgery or LASIK (laser assisted in-situ keratomileusis) for myopia (nearsightedness), hyperopia (farsightedness), or astigmatism, including any complications therefrom;
29. charges for telephone calls and/or telephone consultations;
30. charges for e-mail communication or e-mail consultations;

31. charges for Physician overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment);
32. treatment or service for a Provider's standby services ("waiting time" by the Provider);
33. treatment or service that results from a sickness or injury that is covered by a Workers' Compensation Act, or other similar laws;
34. the reversal of elective sterilization;
35. Any infertility services or supplies beyond the benefit maximum. Benefits for infertility services are limited to $25,000 (medical and prescription drug combined) per Covered Person during the entire time You are covered under the Plan.
36. barrier-free home modifications including, but not limited to, ramps, grab bars, or railing, whether or not recommended by a Physician;
37. treatment or service for, gambling addiction or stress management (except as covered under prescription drug benefits);
38. treatment or service for insertion, removal, or revision of breast implants, unless provided post-mastectomy;
39. missed appointments;
40. treatment or service for any sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the sickness or condition occurs post-mastectomy;
41. non-implantable communicator-assist devices, including but not limited to, communication boards, and computers;
42. treatment or service for work-hardening services or vocational rehabilitation programs;
43. treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained;
44. treatment or services for obesity, (except Medically Necessary Care for morbid obesity, including surgery will be covered. Precertification is required.);
45. cryopreservation or storage (except as described under TRANSPLANT SERVICES);
46. treatment or service for and complications related to:
    - human-to-human organ or bone marrow transplants, except as described under Transplant Services; or
    - animal-to-human organ or tissue transplants; or
    - implantation within the human body of artificial or mechanical devices designed to replace human organs;
47. treatment or service that results from the abortion of a pregnancy, except that benefits will be payable for the abortion only if continuation of the pregnancy would endanger the life of the mother. However, if medical treatment is required because of complications resulting from an abortion, benefits will be payable for such medical treatment;
48. Residential accommodation to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center;
49. treatment or service for foot care with respect to: corns, calluses, flat feet, fallen arches, trimming of toe nails, chronic foot strain, or symptomatic complaints of the feet, casting for

orthotics, or any appliance (including orthotics). This limitation does not apply for Medically Necessary foot care (including treatment for diabetes, bunions, custom molded orthotics and/or shoes);

50. Charges for travel and lodging except as described under TRANSPLANT SERVICES;
51. treatment or service provided outside the United States, when travel is primarily for the purpose of receiving medical diagnosis and treatment;
52. waiving of Copays, Coinsurance or Deductibles for which You are otherwise responsible for under the terms of this Plan by Out-of-Network Providers for the purpose of promoting their own business.

Prescription Drugs Administered by a Medical Provider

While Your Prescription Drug program is administered by CVS Caremark, the information in this section applies only to those prescription drugs that are administered to You under the medical benefits of this Plan.

This Plan covers prescription drugs including Specialty Drugs, that must be administered to You as part of a Physician's visit, home care visit, or at an outpatient facility when they are Covered Expenses. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to You in a medical setting. Benefits for drugs that You inject or get through Your pharmacy benefits (i.e., self-administered drugs) are not covered under this section. Benefits for those drugs are described in the PRESCRIPTION DRUG PROGRAM section.

Important Details About Prescription Drug Coverage As A Medical Benefit

In order to determine if the prescription drug is eligible for coverage under the Plan as a medical benefit, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, risk, evaluation and mitigation strategies certification,
- Step Therapy requiring one drug, drug regimen, or another treatment to be used prior to the use of another drug, drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an "Anthem Prescription Drug List", which is a formulary developed by the Claims Administrator which is a list of FDA-approved drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Your prescribing Physician may be asked to provide more details before the Plan decides if the drug is eligible for coverage.

Precertification

Precertification may be required for certain prescription drugs to help ensure proper use and guidelines for prescription drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of prescription drugs that need precertification, please call the phone number on the back of Your medical ID Card. The list will be reviewed and updated from time to time. Including a prescription drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify prescription drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

If precertification is denied You have the right to file an appeal as outlined in the "Your Right To Appeal" section of this SPD.

Designated Pharmacy Provider

The Plan in its sole discretion, may establish one or more "Designated Pharmacy Providers" which provide specific pharmacy services (including shipment of prescription drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For prescription drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care Coordinator will work with You and Your Provider to obtain precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain prescription drugs for treatment of certain clinical conditions such as hemophilia. The Plan reserves the right to modify the list of prescription drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may change, from time to time, and with or without advance notice, the Designated Pharmacy Provider for a drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your prescription drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network Provider level.

You can get the list of the prescription drugs covered under this section free of charge by calling Member Services at the phone number on the back of Your medical ID or check the Claims Administrator's website at **www.anthem.com**.

The Claims Administrator and/or it designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain prescription drugs that are administered to You under the medical benefits of this Plan, and which positively impact the cost effectiveness of Covered Expenses. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copay or Coinsurance.

Prescription Drug Program Administered by CVS Caremark

The "Prescription Drug Program", administered by CVS Caremark is designed to provide You with several convenient options for obtaining prescription drugs. Whenever You have a prescription to

be filled, You will use the Prescription Drug Program. If the prescription is needed immediately, You should use the participating retail Pharmacy of Your choice. For ongoing prescriptions taken over longer periods of time (sometimes referred to as maintenance medications), You should consider using the CVS Caremark Mail Service Pharmacy. For Specialty Medications, You will need to use the CVS Specialty Pharmacy to fill Your prescription.

In Your pharmacy benefit Plan, the Formulary drug list is used as a guide for determining the amount that You pay as a Copay or Coinsurance for each prescription, with drugs listed on the Formulary typically available at a lower Copay or Coinsurance to You. The Formulary is a list of FDA-approved prescription drugs and supplies developed by CVS Caremark's Pharmacy and Therapeutics Committee and/or customized by the Plan which represents the current clinical judgment of practicing healthcare practitioners based on a review of current data, medical journals, and research information. The Formulary may change from time to time. To obtain information about prescription drugs on CVS Caremark's Formulary, You may call toll-free 877.817.0479 or visit CVS Caremark's website at **www.caremark.com**.

The following chart is a quick reference for You to use if You have questions about Your prescription drug benefits.

Information Needed	Who to Call	Website Address
If You have questions about: • Retail network Pharmacies • Status of Your claim or Home Delivery prescription • Claim history • How to request a drug through the Home Delivery Program • Your cost or coverage for a drug	CVS Caremark Customer Service **877.817.0479** Be sure to identify Yourself as a Member in the **Plan** and have available the Employee's social security number, or the CVS Caremark assigned alternative identification number.	**www.caremark.com** You can create Your own personal profile so Your information will be available only to You.
Specialty Pharmacy	CVS Specialty Pharmacy **1.800.238.7828**	

Schedule of Prescription Drug Benefits for Standard Plan

Standard Plan Prescription Drug Program Administered by CVS Caremark	
	Prescription Drug Program
Deductible	$0
Out-of-Pocket Maximum (includes Deductibles)	$4,000 per individual $8,000 per family
Retail Drugs (34-day supply and when obtained at a participating retail pharmacy) *	$10 for Generic Drugs $40 for Preferred Brand Name Prescription Drugs $60 for Non-Preferred Brand Name Prescription Drugs $125 for Specialty Drugs $0 for certain generic Affordable Care Act ("ACA") contraceptive drugs purchased at an in-network pharmacy $30 for generic non-ACA extended cycle contraceptive drugs $120 for Preferred Brand Name non-ACA extended cycle contraceptive drugs $180 for Non-Preferred Brand Name non-ACA extended cycle contraceptive drugs
Mail Service Pharmacy Drugs (90-day supply)	$20 for Generic Drugs $80 for Preferred Brand Name Prescription Drugs $120 for Non-Preferred Brand Name Prescription Drugs $0 for certain generic Affordable Care Act (ACA) contraceptive drugs purchased at an in-network pharmacy

* Certain medications that are subject to the "Drug Quantity Management Program" are subject to a lower maximum day supply at the retail Pharmacy. (See Drug Quantity Management within this Prescription Drug Program section).

Currently, the Plan pays the full cost of a covered drug, which is prescribed for You or a Covered Dependent, after the Copay (after applicable Deductible) is paid. The drug Copay amount is not reimbursable under any other medical Plan provision and cannot be applied to the annual medical Deductible or medical Out-of-Pocket Maximum.

Once a Covered Employee or Dependent has incurred the pharmacy Out-Of-Pocket Maximum, the Plan will pay 100% of all covered prescription drug expenses for the remainder of the Plan Year for that Member. The Out-of-Pocket Maximum does not include prescription drug expenses which are not covered by the Plan.

Note: Prescription drugs used in the treatment of infertility have a combined medical and prescription drug lifetime maximum benefit of $25,000.

Schedule of Prescription Drug Benefits for Health Savings Plan

If You and Your Covered Dependents are participating in the Health Savings Plan, Your prescription drug program is administered by CVS Caremark. The Health Savings PPO medical Plan deductible of $1,550 for individual coverage, or $3,100 if You cover family members, must be met before payments begin. This means that You must pay the full cost of the discounted prescription at the time of purchase and the cost is applied to Your Deductible. Once Your Deductible has been met, You pay 20% of the CVS Caremark discounted price for the medication, no matter which category the drug falls into. The prescription drug benefit is electronically integrated with the medical benefit, so most Pharmacies will know if You have met Your Deductible.

For the Health Savings Plan, the Out-of-Pocket Maximum includes covered medical and drug expenses. Once You have met the Out-of-Pocket Maximum, Your covered prescription drugs would be paid by the Plan at 100%. The Out-of-Pocket Maximum does not include prescription drug expenses which are not covered by the Plan.

Health Savings Plan Prescription Drug Program Administered by CVS Caremark	
	Prescription Drug Program
Deductible	$1,550 per individual $3,100 per family
Out-of-Pocket Maximum (includes Deductibles)	$4,000 per individual $8,000 per family
Retail Drugs (34-day supply and when obtained at a participating retail pharmacy) *	You pay the deductible, then the plan pays 80% (You pay 20%) for each covered Generic Drug, Preferred Brand Name Prescription Drug, Non-Preferred Brand Name Prescription Drug or Specialty Drug or refill up to the Out-of-Pocket Maximum shown above.
Mail Service Pharmacy Drugs (90-day supply)	You pay the deductible, then the plan pays 80% (You pay 20%) for each covered Generic Drug, Preferred Brand Name Prescription Drug, Non-Preferred Brand Name Prescription Drug or Specialty Drug or refill up to the Out-of-Pocket Maximum shown above.

* Certain medications that are subject to the "Drug Quantity Management Program" are subject to a lower maximum day supply at the retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section).

Note: Prescription drugs used in the treatment of infertility have a combined medical and prescription drug lifetime maximum benefit of $25,000.

Schedule of Prescription Drug Benefits for Health Savings Plan – Value

If You and Your Covered Dependents are participating in the Health Savings Plan - Value, Your prescription drug program is administered by CVS Caremark. The Health Savings Plan - Value medical Plan deductible of $2,500 for individual coverage, or $5,000 if You cover family members, must be met before payments begin. This means that You must pay the full cost of the discounted prescription at the time of purchase and the cost is applied to Your Deductible. Once Your Deductible has been met, You pay 30% of the CVS Caremark discounted price for the medication, no matter which category the drug falls into. The prescription drug benefit is electronically integrated with the medical benefit, so most Pharmacies will know if You have met Your Deductible.

For the Health Savings Plan – Value, the Out-of-Pocket Maximum includes covered medical and drug expenses. Once You have met the Out-of-Pocket Maximum, Your covered prescription drugs would be paid by the Plan at 100%. The Out-of-Pocket Maximum does not include prescription drug expenses which are not covered by the Plan.

Health Savings Plan – Value Prescription Drug Program Administered by CVS Caremark	
	Prescription Drug Program
Deductible	$2,500 per individual $5,000 per family
Out-of-Pocket Maximum (includes Deductibles)	$5,000 per individual $10,000 per family
Retail Drugs (34-day supply and when obtained at a participating retail pharmacy) *	You pay deductible, then the plan pays 70% (You pay 30%) for each covered Generic, Preferred Brand, Non-Preferred Brand or Specialty prescription drug or refill up to the Out-of-Pocket Maximum shown above.
Mail Service Pharmacy Drugs (90-day supply)	You pay deductible, then the plan pays 70% (You pay 30%) for each covered Generic, Preferred Brand, Non-Preferred Brand or Specialty prescription drug or refill up to the Out-of-Pocket Maximum shown above.

* Certain medications that are subject to the "Drug Quantity Management Program" are subject to a lower maximum day supply at the retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section).

Note: Prescription drugs used in the treatment of infertility have a combined medical and prescription drug lifetime maximum benefit of $25,000.

Preventive Prescription Drugs

You pay the generic, Preferred Brand Name or Non-Preferred Brand Name copay for preventive medications under the Standard Plan.

For preventive medications under the Health Savings Plan or the Health Savings Plan – Value, Your deductible is waived. You pay 20% coinsurance for the Health Savings Plan or 30% coinsurance for the Health Savings Plan – Value whether or not You have met Your medical deductible under the Plan. The coinsurance You pay for preventive medications will apply toward Your annual out-of-pocket maximum.

Generic preventive statin prescription drugs (for high cholesterol) can be refilled at no cost to You under all the Plans.

To determine if Your prescription drug is considered a preventive medication, contact CVS Caremark at **877.817.0479**.

Obtaining Prescription Drugs

Prescription Drugs Obtained at a Participating Retail Pharmacy

You may obtain up to a 34-day supply of a covered prescription drug at the retail Pharmacy. Your prescription drug program ID Card must be presented to the pharmacist when You have the prescription filled. Certain medications subject to the Drug Quantity Limits Program are subject to a lower maximum day supply at the retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section).

There are no claim forms to complete if the prescription is purchased from a participating Pharmacy that honors this Prescription Drug Program. Except for participants in the Health Savings PPO Plan, any Coinsurance amounts You pay for a prescription drug under this Program cannot be used to satisfy any applicable annual Deductible or annual Out-of-Pocket Expense Maximum applicable to medical benefits under the **Ameren Employee Medical Plan**. Under this Program, the prescription quantity dispensed by the pharmacist will be limited to the lesser of the amount normally prescribed by a Physician, or for certain drugs the amount indicated through clinical programs (see CLINICAL PROGRAMS within this PRESCRIPTION DRUG PROGRAM section). Under no circumstance may a retail prescription exceed a 34-day supply.

Since the CVS Caremark organization is recognized nationwide, the Prescription Drug Program will be easy to use wherever You or Your Covered Dependents are. Most Pharmacies in the United States participate in the CVS Caremark Pharmacy network, but You should contact Your Pharmacy to verify its participation. You may also call CVS Caremark at **877.817.0479** or access their website at www.caremark.com to find participating Pharmacies.

If You are told at a retail Pharmacy that the **Ameren Employee Medical Plan** does not cover Your prescription, please contact CVS Caremark at **877.817.0479** to determine the reason.

Prescription Drugs Obtained at a Non-Participating Retail Pharmacy

If You have a prescription filled at a non-participating Pharmacy, (for example, You visit a non-participating Pharmacy while on vacation), the full cost of the prescription must be paid at the time of purchase and a completed claim form must be submitted to CVS Caremark for reimbursement within 365 days of the purchase. Claim forms may be obtained either by calling CVS Caremark at **877.817.0479** or by visiting their website: **www.caremark.com**.

Prescription Drugs Obtained Through the CVS Caremark Mail Service Pharmacy

All Members may purchase prescription drugs through the CVS Caremark Mail Service Pharmacy instead of obtaining them at a retail pharmacy. This program works very well for people who are taking maintenance drugs to treat chronic or long-term health conditions such as arthritis, diabetes, asthma, heart conditions, and high blood pressure. By using the Mail Service Pharmacy option, Members can obtain up to a 90-day supply of a drug and pay the equivalent of two retail Copays if they are participating in the Standard Plan. Participants in the Health Savings Plan and Health Savings Plan – Value may also realize savings by using the Mail Service Pharmacy.

Therefore, it is most economical if a Physician prescribes a 90-day supply whenever appropriate. A maximum of a 90-day supply of a drug may be ordered at one time. Refills will not be dispensed until 60 days of a 90-day supply have been used. If You or a Covered Dependent needs medication immediately, ask the Physician to write two prescriptions, one for a 30-day supply and the other for a 90-day supply. Fill the 30-day prescription at a local participating retail Pharmacy for medication to take until the first Mail Service Pharmacy prescription arrives.

To enroll in the CVS Caremark Mail Service Pharmacy, complete a CVS Caremark patient profile/order form and send it with the prescription and applicable Copay to the address printed on the form. The form may be obtained either by calling CVS Caremark at **877.817.0479** or by visiting the website at **www.caremark.com**. Alternatively, ask Your Physician to ePrescribe Your prescription for a 90-day supply to the CVS Caremark Mail Service Pharmacy. The Copay may be paid either by check or by credit card. The form explains how to pay by credit card. The prescription may also be refilled online by visiting **www.caremark.com**.

All prescriptions are reviewed by a pharmacist, checked for adverse drug interactions, and verified by quality control before they are dispensed and mailed. Generic medication will be dispensed when available and allowed by law, unless a Physician has indicated on the prescription that a Brand Name Drug must be provided. It will usually take ten (10) to fourteen (14) working days to receive an order. Some drugs cannot be sent through the mail.

You may call CVS Caremark at 877.817.0479 if You have questions or need to check the status of an order. Members must identify themselves as participants in the Plan and must be prepared to provide the Employee's Social Security number or the CVS Caremark assigned alternate identification number.

Prescription Drugs Obtained Through the Maintenance Choice Program

The Maintenance Choice Program allows You the choice to obtain a 90-day supply of designated maintenance medications through the CVS Mail Order Pharmacy, or at retail CVS Pharmacy locations for the same Copay or Coinsurance.

If You are enrolled in the Standard Plan Prescription Drug Program, You will pay the same Copay whether You obtain Your maintenance medication through the Mail Service Pharmacy or at a participating CVS retail pharmacy (two Copays for three months of the maintenance medication.)

If You are enrolled in the Health Savings or Health Savings – Value medical plan options, You may have slightly lower costs if You obtain Your maintenance medication through the Mail Service Pharmacy, rather than obtaining Your maintenance medication at a participating CVS retail pharmacy.

If You continue to fill a one-month supply of Your maintenance medication instead of a three-month supply, or if You do not use a CVS pharmacy or the Mail Service Pharmacy to fill a designated maintenance medication, You will be responsible for paying the full cost of Your maintenance prescription medication. Full cost is the actual cost of Your prescription medication. For example, if the actual cost of the prescription is $75.00, but Your Copay or Coinsurance is only $20.00, Your cost for the maintenance prescription medication for not using the Maintenance Choice Program would be the actual cost of $75.00.

You can find out if Your prescription medication is a maintenance medication under the Maintenance Choice Program by contacting CVS at **877.817.0479**, or at **www.caremark.com**.

Specialty Pharmacy Program

Your prescription drug benefits include a specialty Pharmacy service from CVS Caremark Specialty Pharmacy.

If you use a Specialty Medication, you will be required to use the CVS Caremark Specialty Pharmacy. Specialty Medications typically have one or more of the following characteristics:

- Target chronic, complex and/or rare disease states;
- Require special handling, storage, inventory, distribution and/or administration; administration may be oral, inhaled, infused or injected; or
- Require customized management for successful usage, including medication utilization review, frequent patient monitoring and training, coordination of care and adherence management.
- All Specialty Medications must be approved through the CVS Caremark Specialty Pharmacy Program. The CVS Caremark Specialty Pharmacy Program will work with your physician to review your medication and treatment plan, and will provide you with the following services:
- Personally arranged, timely delivery of specialty medications,
- Assistance filing claims,
- Access to education, tools and support from a clinician-led care team to better understand your treatment and manage your condition and
- Access to pharmacists available for emergency consultations 24 hours a day, 365 days a year.

For more information about the CVS Caremark Specialty Pharmacy, please call toll-free, **1-800-237-2767** (fax: 1-800-323-2445).

Some Specialty Medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such Specialty Medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Covered Drugs

The following is a list of the types of drugs covered under the Prescription Drug Program:

- Any drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician or other lawful prescriber;
- Insulin, glucose monitors, other diabetic supplies, disposable insulin pumps, including pump supplies (however, traditional insulin pumps are covered under the medical portion of the Plan, see DURABLE MEDICAL EQUIPMENT within the COVERED EXPENSES section of this booklet);
- Tretinoin, all dosage forms (e.g., Retin A) for Members through the age of thirty-five (35) years, and as prescribed to members over age thirty-five (35) to treat or control a medical condition and not for cosmetic purposes;
- Contraceptive medications or devices;
- Generic FDA-approved contraceptives prescribed by a Physician or other lawful prescriber, including some over-the-counter drugs (such as sponges or spermicides) are covered at 100% without being subject to Copayments, Coinsurance or Deductibles;
- Smoking cessation prescription drugs and over-the-counter drugs with a prescription;
- Weight loss prescription drugs when clinically approved and prescribed by a Physician.
- Generic Prescription Drug and over-the-counter aspirin prescribed by a Physician or other lawful prescriber, to prevent cardiovascular disease, colorectal cancer and pre-eclampsia. Age and gender restrictions may apply.
- Brand and Generic Prescription Drug oral fluoride supplementation prescribed by a Physician or other lawful prescriber, for children from birth through five (5) years old;
- Generic Prescription Drug and over-the-counter folic acid supplementation prescribed by a Physician or other lawful prescriber, for women of childbearing age eighteen (18) to fifty-five (55);
- Generic Prescription Drugs and over-the-counter medications prescribed by a Physician or other lawful prescriber, for use in preparation for a screening colonoscopy are covered at 100% without being subject to Copayments, Coinsurance or Deductibles, for Members age forty-five (45) through age seventy (70).
- Generic preventive statins drug prescriptions (for high cholesterol) can be refilled at no cost to You if filled at a CVS retail pharmacy or through the CVS Caremark Mail Service Pharmacy in a ninety (90) day supply.

Additional criteria will apply to determine whether specific drugs are covered and in what dosage or quantity amount (see CLINICAL PROGRAMS within this section).

Drugs Not Covered

The following drugs are not covered under the Prescription Drug Program:

- Any infertility services or supplies beyond the benefit maximum. Benefits for infertility services are limited to $25,000 (medical and prescription drug combined) per Covered Person during the entire time You are covered under the Plan.
- Compound drugs, except when approved by CVS Caremark as medically necessary;
- Over-the-counter drugs or any other drugs (excluding insulin) which do not require a prescription from a Physician or lawful prescriber (except as described under COVERED DRUGS);
- Over-the-counter equivalents obtained with a prescription;
- Vitamins, minerals, nutritional supplements or special diets (whether they require a Physician's prescription or not, and except as described under COVERED DRUGS) and legend homeopathic medications;
- Prescriptions which are classified as cosmetic;
- Charges for the administration or injection of any drug;
- Therapeutic devices or appliances (except as described under COVERED DRUGS), glucose monitors in excess of one (1) per 365 days;
- Prescription digital therapeutics;
- Prescriptions which a Member is entitled to receive without charge from any Workers' Compensation Laws, or any municipal, state, or federal program;
- Drugs labeled "caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the Member;
- Immunization agents, biological sera, blood, or blood plasma (except as included herein);
- Medication which is to be taken or administered to an individual in whole or in part, while a Member is in a licensed Hospital, Skilled Nursing Facility, convalescent Hospital, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any prescription refilled in excess of the number specified by a Physician, or any refill dispensed after one year from the Physician's original order;
- Any drug where clinical program criteria are not met (see CLINICAL PROGRAMS section below).

Clinical Programs

The Plan has review programs in place that are designed to provide Members and their Physician with the latest information about medications and treatment. By monitoring certain medications for safety and effectiveness, as well as potential drug interactions, these programs protect You against potential harm due to prolonged or inappropriate use of certain drugs. These programs work behind the scenes and usually do not require You to do anything; however, on occasion, Your Physician may need to contact CVS Caremark and provide additional information for approval. The Plan's Clinical Programs are described below and for more information, covered individuals may contact CVS Caremark, at **877.817.0479**.

Drug Utilization Review

Clinical drug therapy is monitored for various drug interactions, duplicate therapy, high use of addictive substances, and other potential drug therapy concerns. If concerns are identified, a Physician will receive notification of the concern that was identified along with the most current information to address the issue.

Drug Quantity Management

Criteria may apply to determine whether specific drugs are limited to a certain quantity other than the quantity stated in the Schedule of Prescription Drug Benefits. Certain medications that are subject to the Drug Quantity Management Program are subject to a maximum 30-day supply at the Retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section). The criteria are based on Food and Drug Administration (FDA) approved dosing guidelines and the medical literature. Therefore, if a Physician writes a prescription above the recommended quantity for a particular drug, the pharmacist will only dispense the limited amount for the applicable Copay. You may call CVS Caremark if You have questions about coverage and/or quantity limits for a specific prescription drug. Additionally, certain medications within the Drug Quantity Management program are limited to a thirty (30) day supply.

Prior Authorization

Prior authorization is a program which ensures certain medications are covered for only proven, Medically Necessary uses. If a Physician prescribes a drug that requires prior authorization, online messaging will instruct the pharmacist that the Physician needs to contact CVS Caremark's Prior Authorization Services for approval. If a medication is not approved for coverage, You will have to pay the full cost of the drug or the Physician may change the prescription to another covered drug. Contact CVS Caremark for the most current list of drugs that require prior authorization.

Step Therapy

For selected drugs that Your Physician prescribes, before these drugs can be approved and covered, You and Your physician must first try certain medications as specified by the Plan. These are drugs that are generally known to be successful for treating Your condition. If these specified medications don't work for You, then You and Your Physician can step up to other medications. Your pharmacist will inform You if Step Therapy applies to Your medication.

These programs are subject to change at any time without notice in order to keep up to date with current medical practice.

CVS Caremark's Annual Enrollment Information Tool

You may want some help deciding which prescription drug plan is best for You and Your family. Go online to CVS Caremark's Annual Enrollment Information tool at: https://info.caremark.com/oe/ameren to:

- Check your formulary and copay amounts.
- View an estimate of Your annual out-of-pocket prescription drug costs.
- Find a local pharmacy.

Be sure to have Your prescriptions handy, as You'll need to enter information about each drug and the dosage You take.