A Plan Designed to Provide Security for Employees of

Ameren Vision Plan Options Design

Administered by:
Vision Service Plan Insurance Company

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

AMEREN VISION PLAN

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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.

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

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

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

Company means Ameren Corporation.

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

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.

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

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

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

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

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

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

Dependent Child means: Your 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 QMCSO 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.

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.

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.

Maximum Plan Allowance means the amount determined by VSP as the allowed amount for a particular procedure, service or item for the particular doctor or service provider. The allowed amount for a particular doctor or service provider depends on its, his or her participation status (e.g., VSP Network Provider or Non-Network Provider).

Member means a Covered Employee or Covered Dependent.

Network Provider/In-Network Provider means a doctor (optometrist or ophthalmologist) or service provider who has agreed to participate in the VSP network and who has agreed to accept payment for Covered Services.

Non-Network/Out-of-Network Provider means a doctor (optometrist or ophthalmologist) or service provider who does not participate in the VSP network under a participation agreement with a VSP plan for rendering vision care.

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

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 Vision Plan**, a component of 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.

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.

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

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

You/Your means an Employee who is eligible to participate in the vision Plan 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 **Ameren Vision Plan**, a component of the **Ameren Employee Medical Plan** (the "Plan") to provide vision benefits to its eligible Employees, their Spouses, and other eligible Dependents. All references herein to the "Ameren Vision Plan" and the "Plan" refer to the Vision Program component of the Plan.

This booklet (including any subsequent supplements) constitutes the Summary Plan Description ("SPD") for 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 Vision Service Plan ("VSP") administers the payment of claims, VSP has no liability for the funding of the Plan.

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

The Administrative Committee of the Company serves as Plan Administrator. The Plan Administrator has complete and sole discretion to construe or interpret all Plan provisions, to determine eligibility for benefits, to grant or deny benefits, and to determine the type and extent of benefits, if any, to be provided. The Plan Administrator's decisions in such matters shall be controlling, binding, and final. The Plan Administrator has also delegated discretionary authority for the administration of vision benefit claims and appeals to VSP.

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

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

DURATION OF THE PLAN. 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 SPD 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.

myAmeren Benefits

myAmeren Benefits is Ameren's employee benefits customer call center. When You have questions about Your 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).

www.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 time 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 Ameren as either:

- 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 UGSOA Local Union 11; or
  - Ameren Illinois (CILCO) and IBEW Local Union 51; 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 (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 Local 12 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.
  - 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

[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.

- a participant in the "Temporary Voluntary Reduced Hours Program".

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

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. You must be enrolled in the **Ameren Vision Plan** in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to Your:

1) Spouse;
2) 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 877.7my.Ameren (877.769.2637).[3]
3) 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;
4) Dependent Children who are not capable of self-sustaining employment due to a disability and are therefore dependent upon You for support, are eligible to continue their coverage under the Plan beyond age 26. Proof of the disability must be furnished to the Plan Administrator no later than 31 days after the date of the child's 26th birthday. A child is considered disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected either to result in death or last for a continuous period of not less than 12 months;

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

Important Note: Spouse/Domestic Partner who is eligible for coverage under the Plan as an Employee cannot be covered as Your Dependent under this Plan, whether or not they chose to enroll in the Plan for which they are eligible.

[3] 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 an Ameren vision or dental/vision 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. No person can be covered under more than one Ameren-sponsored vision plan at the same time.

Enrollment Provisions

Employees

In order to elect or waive coverage in the 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**). 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 or transfer from an ineligible Ameren union represented position to a management position), You must elect a coverage category (including waive coverage) no later than thirty-one (31) days from the date of Your Enrollment Worksheet. Your coverage will be effective on Your eligibility date.

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

Important Note: If You become eligible to participate in a new vision option in this Plan due to a qualified status change and were covered under another Ameren sponsored vision or dental/vision plan immediately prior to Your change in employment status, Your Covered Dependents will also become covered under this new option if they were 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).

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

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

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

Annual Enrollment Period

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

Qualified Medical Child Support Orders

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

Cost of Coverage

The Company currently pays a portion of the cost of this coverage for You and Your 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

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

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

If You cover a child under the 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**).

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.

Procedure for Making Changes

If You have a status change and want to enroll Yourself, add a new Dependent or elect a new vision 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.

Schedule of Benefits

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

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

The following chart shows how benefits are paid:

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

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

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

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

Diabetic Eyecare Plus Program

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

Frames

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

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

Contact Lenses

When You choose contact lenses instead of glasses, Your $200 Maximum Plan Allowance applies to the cost of Your contacts. You will be responsible for paying the difference at the time of Your doctor's visit.

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

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

Visually Necessary Contact Lenses

The Plan pays 100% of the professional fees and materials (after $10 Copay) for Visually Necessary contact lenses obtained from a VSP Network Provider, subject to prior authorization. When Visually Necessary contact lenses are obtained from a Non-Network Provider, the Maximum Plan Allowance the Plan covers is $210 (after $10 Copay). You will be responsible for paying the difference at the time of Your doctor's visit.

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

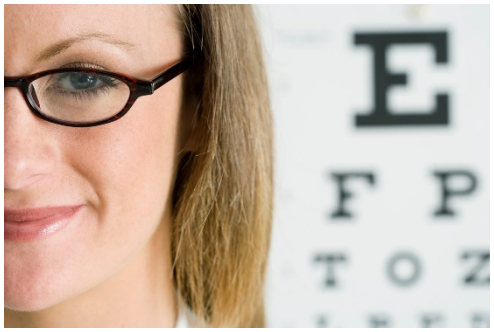
Why is the contact lens exam not covered as part of my routine eye exam?

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

Extra Discounts Available From VSP Network Providers

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

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



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

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

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

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

Receive an additional $50 allowance for certain featured frame brands. You may also be eligible for an additional 20% discount on the amount over the Plan's Maximum Plan Allowance.

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

Low Vision Benefit

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

- Supplementary testing (complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated). These services are covered in full if provided by a VSP Network Provider. If these services are provided by a Non-Network Provider, they are covered up to a $125 Maximum Plan Allowance. You will be responsible for paying the difference at the time of Your doctor's visit.

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

Benefit Maximum

The maximum low vision benefit available is $1,000 per Member (excluding Copay) every two years.

How to Receive Vision Benefits

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

How To Verify Participation in VSP Network

In order to verify if Your doctor is a Network Provider, You can:

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

You do not need to notify VSP when You choose or change Your VSP Network Provider. When You are ready, simply make an appointment with another VSP Network Provider.

VSP Savings Statement

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

Covered Expenses

Your vision benefits will pay a specific amount of Covered Expenses, up to Your benefit maximum each benefit period. The amount the Plan pays depends on the type of services provided (see SCHEDULE OF BENEFITS). You will be responsible for the remaining Coinsurance amount. The following are Covered Expenses under the Plan:

1. Annual eye examinations - complete vision analysis which includes an Appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Vision care materials, including single vision, bifocal, trifocal and lined lenticular lenses. These materials are available once per Plan Year, beginning on January 1.
3. Frames – once per Plan Year, beginning on January 1.
4. The following professional services as are necessary for lenses and frames:
    a. Prescribing and ordering proper lenses;
    b. Assisting in selection of frames;
    c. Verifying the accuracy of the finished lenses;
    d. Proper fitting and adjustment of frames;
    e. Subsequent adjustments to frames to maintain comfort and efficiency; and
    f. Progress or follow-up work as necessary.

5. Contact lenses – available once per Plan Year, beginning on January 1, in lieu of all other lens and frame benefits. Members will be eligible for lenses and frames during the next Plan Year unless he or she opts again to receive contact lenses.
6. Low vision supplementary testing and supplemental care aids, subject to prior approval by the Claims Administrator.
7. Additional diagnostic services for Members who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, following routine eye examination by a VSP Network Provider.

Expenses Not Covered

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

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

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

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

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

Coverage Limitations

If You receive care from more than one doctor for the same procedure, benefits will not exceed what would have been paid for one doctor for that procedure.

If alternative treatments are available, the Plan shall be liable for the least costly professionally satisfactory treatment.

Coordination of Benefits

Introduction

The Plan provides for Coordination of Benefits with other group vision plans which cover You and Your Covered Dependents. For all vision plan options, vision 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 vision 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 vision plan;

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

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

Definitions

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

- **"Vision plan"** shall mean any of the following that provides benefits or services for vision 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 vision plan and there is no integration or Coordination of Benefits among those separate contracts, unless specifically indicated.
- **"Vision plan"** includes: group insurance, closed panel or other forms of group or group-type payment (whether insured or uninsured); vision benefits under group or individual automobile contracts; and Medicare, Medicaid or other governmental benefits as permitted by law.
- **"Vision plan"** does not include: Medicare supplement policies, Medicaid policies and payment under other governmental plans, unless permitted by law.

Each contract for payment under this section is a separate vision 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 vision plan.

Coordination of Benefits for Participants

When this Plan is secondary, this Plan will look at the total Covered Expenses, subtract the amount that the primary vision 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 vision plan.

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

- Obtain reimbursement from any other vision plan(s) for the cost of the covered services provided, which are payable under the other vision 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 vision plan; and
- Pay to other vision plan(s) any amount that the Plan determines will satisfy the intent of these Coordination of Benefits 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 vision plans, as well as the benefits payable under such vision 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 Network Providers. The Plan shall have the right to release to, or receive from any doctor, 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 vision plan(s) and benefits provided by such vision plan(s).

Order of Benefit Determination

When a Member is eligible for coverage under more than one vision plan, this Plan shall be the secondary vision plan, unless the other vision plan has rules for the Coordination of Benefits with the coverage of this Plan and both the other vision 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 vision plan. A vision 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 vision plan that covers the person as an employee is the primary vision plan. The vision plan that covers the person as a dependent is the secondary vision plan.
2. The vision 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 vision plan. The vision plan that covers a person as a laid-off or retired employee or that employee's dependent is the secondary vision plan. If the other vision plan does not have this rule, and if as a result, the vision plans do not agree on the order of benefits, this rule is ignored.

3. The vision plan that covers a person as an employee, participant, subscriber, or retiree (or as the person's dependent) is the primary vision plan. The vision plan that covers a person due to a right of continuation provided by federal or state law is the secondary vision plan. If the other vision plan does not have this rule, and if as a result, the vision plans do not agree on the order of benefits, this rule is ignored.
4. When this Plan and another vision plan cover the same child as a dependent of different persons, called "parents":
   a. The primary vision 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 healthcare payment.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's vision care expenses or vision care payment and the vision plan of that parent has actual knowledge of those terms, that vision plan is primary. This rule applies to claim determinations periods or calendar years commencing after the vision 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 vision plan that covered the individual for the longer period of time is the primary vision plan.

Medicare Coverage For Members

An active Covered Employee age 65 or older or an active Covered Employee's Spouse who is age 65 or older is eligible for the same vision 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 vision coverage, his or her vision coverage and the coverage of his or her Dependents under the Plan will end on the date the Employee is enrolled in Medicare.

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 vision plan coverage, please contact the Plan Administrator.

Payment of Benefits

If You receive services from a provider who participates in the VSP network, payment of benefits will be made directly to the provider. When services are received from an Out-of-Network Provider, You will be required to pay the provider in full at the time of Your appointment and submit a claim to VSP for a partial reimbursement for all Covered Expenses under the Plan. If You decide to see a provider not in the VSP network, we suggest You first call VSP at **800.877.7195** to discuss the benefits of using In-Network Providers versus Out-of-Network Providers.

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

How to File a Claim

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

VSP Network Providers have agreed to file claims directly with VSP on Your behalf and benefits will be paid directly to them. You are only responsible for Your share of the bill. VSP Network Providers can charge You only for Copays, Deductibles, Your Coinsurance, any amounts over Plan maximums, and any non-Covered Expenses.

If You use a Non-Network Provider, You will need to send a claim to the address below:

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

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

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

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

Any questions about a vision claim should be directed to VSP at 800.877.7195.

All claims for vision benefits must be received by VSP within one (1) year after the date on which the Covered Expense was incurred. If a claim is denied due to a VSP Network Provider's failure to make a timely submission, You will not be liable to such Network Provider for the amount which would have been payable by the Plan, provided You advised the Network Provider of Your eligibility for benefits under the Plan at the time of treatment.

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

Termination of Benefits

Employees

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

1) End of the month of Your termination of employment;
2) For management Employees, end of the month of Your termination of employment due to Your retirement;
3) For all union represented Employees, end of the month prior to the date of Your retirement;
4) Date of Your death;

5) End of the month that You no longer satisfy the eligibility requirements as specified in the ELIGIBILITY section of this booklet (for example, if Your status changes from full-time to part-time);

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

7) End of the month in which You commence an unpaid leave of absence (See CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT & RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA) for information on termination of coverage for Employees who are on an unpaid leave of absence due to military service, and CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA));

8) Date of transfer to an Employee group not covered by the Plan;

9) The date the Plan terminates;

10) Date the Company amends the Plan to eliminate coverage for the class of eligible individuals to which You are a member;

11) Date You or a Covered Dependent participate in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent; or

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

Dependents

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

1) The date Your coverage ends;

2) Except for divorce or legal separation, the end of the month in which Your Dependent(s) is no longer eligible (See ELIGIBILITY);

3) In the case of a Covered Spouse, the date of divorce;

4) In the case of a Covered Spouse, the date of legal separation;

5) In the case of a Domestic Partner, the date of no longer meeting the Affidavit of Domestic Partnership requirements;

6) End of the month in which You last paid the required payroll deduction for Your Dependent's coverage;

7) Date of death of the dependent.

8) 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.

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

10) 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).

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

This section contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Depending on the type of qualifying event, You, Your Covered Spouse and Covered Dependent Children may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under a 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 vision 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** or by accessing it directly at **www.benefitsweb.com/ameren.html**. COBRA participants can also check on the status of their account by calling **myAmeren Benefits** at 7877.7my.Ameren (**877.769.2637**). **myAmeren Benefits** customer service representatives are available Monday through Friday, from 700 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 Partners

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; 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; or
- The Covered Employee becomes entitled to a Medicare plan that includes vision benefits.

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

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

makes the determination and within the initial eighteen (18) month period of continuation coverage.

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

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

- If another qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, a Covered Spouse, Domestic Partner and Dependent Children can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the Covered Spouse, Domestic Partner and any Dependent Children receiving continuation coverage if the Covered Employee or former Covered Employee dies, becomes entitled to Medicare vision benefits, 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 vision benefits, 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, and parents may elect COBRA continuation coverage on behalf of their children.

If You Have Questions

Questions concerning the Plan or Your COBRA continuation coverage rights should be addressed to the Plan Administrator or COBRA Administrator. For more information about Your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Address Changes

In order to protect Your rights, You should keep the Plan Administrator informed of any address changes, either by going on-line at **www.myameren.com**, or by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

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 group health, vision, or dental 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.

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

Privacy

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 Sponsor, 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 at **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.

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 850512
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

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.

Claims Procedure and Appeals for Vision Benefits

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

Claim Determinations

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

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

Notification of Denial

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

- sufficient information to identify the claim involved, including the date of service, the provider, and the claim amount (if applicable);

- the specific reason(s) for the denial;
- 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;
- if the denial is based on medical necessity, experimental treatment 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; and
- a description of available appeal procedures and Your right to bring a civil action under Section 502(a) of ERISA.

Right to Appeal

If Your claim for benefits under the Plan has been denied, in whole or in part, You or Your authorized representative may appeal the decision as described below. If You or Your authorized representative do not file an appeal within the specified period, You will be barred from challenging the Adverse Benefit Determination in the future. All requests for appeals should be submitted in writing by You (or Your authorized representative). You (or Your authorized representative) must submit a request for review to:

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

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.

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.

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 determination for a 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. 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.

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 vision professional who has the appropriate training and experience in the vision field involved in making the judgment. The vision 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 vision professional consulted in connection with the appeal. The identification of any vision experts whose advice was obtained on behalf of the Plan in connection with the denied claim 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

Notification of the Outcome of the Appeal

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.

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.

Subrogation and Reimbursement

Applicability

These provisions apply when the Plan pays benefits 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' Your or Your Covered Dependents' injury or expenses, 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 for injuries or expenses that are 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 Covered 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 injuries or expenses. 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 for any injuries or expenses, and regardless of whether the payments You receive make You whole for Your losses, injuries, or expenses.
- 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, injuries, or expenses.
- 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 Member 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 Member's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the Member, 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 vision 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

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 Covered Employee and Covered Dependent is entitled to receive vision coverage or other benefits to be furnished by the Plan. Such right to vision care service coverage or other benefits is not transferable.

Severability

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

Waiver

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

Lost Distributees

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

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) coverage once You (or Your Dependents) become covered under the Plan. However, Your Dependents) coverage under the 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 coverage for fraud or an intentional misrepresentation of a material fact, Plan Administrator will provide at least 30 days advance written notice to each Member 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 the 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 health care coverage for Yourself and any other qualified beneficiaries if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this 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. 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, but only after You have exhausted the Plan's claims and appeals procedures. 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, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Information About the Plan

Plan Name:	Ameren Vision Plan, a component of the Ameren Employee Medical Plan
Type of Plan:	An employee welfare benefit plan providing vision benefits.
Plan Year:	January 1 through December 31
Plan Number:	510
Funding Medium and Type of Plan Administration:	The Plan is generally funded from contributions made in part by the Plan Sponsor and in part by Plan participants. All contributions are paid directly to a trust established for the purpose of providing benefits under the Plan. The Plan Sponsor has a contract with Vision Service Plan ("Claims Administrator") to 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, vision 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, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Plan Sponsor's Employer Identification Number:	43-1723446
Plan Administrator:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149, Mail Code 533 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Claims Administrator:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195 www.vsp.com
COBRA Administrator:	**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, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)

Named Fiduciary for Claims and Appeals:	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 800.877.7195 www.vsp.com
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.