A Plan Designed to Provide Security for Retirees of

Ameren Retiree Medical Plan

Standard PPO, Defined PPO, Health Savings PPO, Conventional Plan and Medicare Supplement Plan

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

Purpose

Ameren Corporation (the "Plan Sponsor") maintains the **Ameren Retiree Medical Plan,** a component part of the **Ameren Retiree Welfare Benefit Plan** (the "Plan"), to provide health benefits to its eligible Retirees, their Spouses, and other eligible Dependents.

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

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

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

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

As a Member 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 **Ameren Retiree Medical 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, including current and future Retirees and their Dependents.

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

Your Role in Controlling Healthcare Costs

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

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

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

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

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

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

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

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

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

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

In addition to the medical coverage provided under the Plan, Anthem also offers programs to help You stay healthy and/or manage disease. To learn more about these programs go to **www.anthem.com** or call **877.403.0610** to speak to a Member Services Representative.

Five Tips for Improving Your Overall Health and Wellness

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

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

Medical Benefit Information

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

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

Call the Anthem toll-free Member Services number at **877.403.0610** if You wish to discuss Your medical benefits with the Anthem staff.

Express Scripts can assist You with questions regarding Your prescription drug coverage and benefits administered by Express Scripts. You can reach an Express Script's Customer Service Representative at **888.256.6131**.

Both Anthem and Express Scripts phone numbers are also found on Your ID cards.

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

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

You have the right to:

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

You have the responsibility to:

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

How to Obtain Language Assistance

Anthem is committed to communicating with members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all Member Services Call Centers. Simply call the Member Services phone number on the back of Your ID card (**877.403.0610**) and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services.

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

Identity Protection Services

Identity protection services are available through Anthem. To learn more about these services, visit **www.anthem.com/resources**.

Anthem Non-Discrimination Notice

It's important we treat you fairly. That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help

(TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:

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

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

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùŭn ɓó pídyi. Ɖá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કૉલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n’asụsụ gị n’efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、ID カードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot’i’ t’11 ni nizaad k’ehj7 n7k1 a’doowo[t’11 j77k’e. Naaltsoos bee atah n7l7n7g77 bee n44ho’d0lzingo nanitin7g77 b44sh bee hane’7 bik11’ 1aj8’ hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho’d0lzingo nanitin7g77 b44sh bee hane’7 bik11’ 1aj8’ hod77lnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

Ameren Benefits Center

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

www.myAmeren.com

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

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

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

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

Ameren Retiree Medical Plan

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Ameren Retiree Medical Plan

Eligibility

Several factors determine Your eligibility for coverage under the **Ameren Retiree Medical Plan**. These factors include:

- Your retirement date;
- Your Years of Service at retirement;
- The company You retired from;
- Your status while an active Employee (i.e. union affiliation, management, etc.);
- Your age at retirement;
- Your date of hire; and
- Your participation or eligibility for participation in the group medical plan while an active Employee.

Eligibility for the **Ameren Retiree Medical Plan** for retirees and surviving dependents of active Employees is defined in the following matrixes.

Management Retirees[1]

If You are an Ameren management Employee who retires **on or after January 1, 2007**, You may be eligible for coverage under this Plan if You are age 55 or older on the date You retire and You meet the following criteria:

- You were hired or re-hired prior to October 1, 2015; AND
- You are a Retired Employee; AND

[1]Regardless of the eligibility requirements outlined in this matrix, You are eligible for coverage under this Plan if: (1) You were a management Employee who retired under the 1998 Special Separation Program and had attained age 50 as of December 31, 1998; (2) You were a full-time regular management Employee of Callaway who retired under the 2005 Voluntary Separation Plan (VSP) and had attained age 50 with at least ten (10) Years of Service on July 15, 2005 and elected retiree medical plan coverage upon attainment of Your earliest eligibility date (age 55); (3) You were a management Employee age 50 or older as of December 31, 1998 and retired as part of the Special Grand Tower Separation Plan negotiated with Local 148 I.U.O.E. (CIPS) with at least seven (7) Years of Service after age 45 as an Employee of AmerenCIPS; (4) You were a management Employee who retired under the 2002 Voluntary Retirement Program and had attained age 50 and had at least ten (10) years of service as of 12/31/2002; (5) You were a full-time regular management Employee of AER Generating Company, Ameren Energy Generating Company, or Ameren Energy Marketing Company that was divested to Illinois Power Holdings, LLC (IPH), or a subsidiary of IPH; or Dynegy Operating Company, and had attained age 55 with at least ten (10) Years of Service as December 1, 2013, and elected retiree medical plan coverage within thirty-one (31) days of Your termination or retirement from Illinois Power Holdings, LLC/Dynegy; (6) You were a full-time regular management Employee of the Grand Tower Power Plant that was transitioned to NAES Corporation and had attained age 55 with at least ten (10) Years of Service as January 31, 2014, and elected retiree medical plan coverage within thirty-one (31) days of Your termination or retirement from NAES or (7) You were determined to be eligible under the terms of any other individual special separation agreement. Notwithstanding the eligibility exceptions in this footnote, effective January 1, 2015, You are not eligible for coverage under this Plan if You are age 65 or older and Medicare-eligible.

- Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND
- You accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; OR
- You are a Medicare eligible Dependent of a deceased active management Employee who died on or after January 1, 2007, and who had accrued at least 10 Years of Service as an Employee of Ameren at the time of his or her death, and You were a participant in the **Ameren Employee Medical Plan** for active Employees.

Regardless of the eligibility requirements described above and in the matrix below, effective January 1, 2015, You are not eligible for coverage under this Plan if You are age 65 or older and Medicare-eligible.

If You are eligible to participate in this Plan or in another **Ameren Retiree Medical Plan** program, You must be enrolled in order for Your eligible Dependents to be covered under an **Ameren Retiree Medical Plan** program.

If You are a management Employee who retired **prior to January 1, 2007**, You are eligible for coverage under this Plan if You meet the eligibility criteria described in the following matrix and are under age 65:

Company You retired from	Eligibility Rules
AmerenUE	➢ **You are a Retired Employee who:** ➢ **Retired between January 1, 1992 and through June 30, 1993;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under one of the Company's active group health plans. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Union Electric ("UE") management Employee who died prior to July 1, 1993.
AmerenUE; Ameren Services; AmerenCIPS	➢ **You are a Retired Employee who:** ➢ **Retired between July 1, 1993 and through June 30, 1998;** AND ➢ Were a Participant in "UE" benefit plans prior to July 1, 1998; AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren Services, AmerenUE or AmerenCIPS. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active AmerenUE, Ameren Services or AmerenCIPS Employee who died between July 1, 1993 and through June 30, 1998 and who participated in "UE" benefit plans prior to his/her death.

Company You retired from	Eligibility Rules
AmerenUE; Ameren Services; AmerenCIPS; Ameren Energy Generating Company; Ameren Energy Marketing Company; Ameren Energy Fuels and Services Company and Ameren Energy	➢ **You are a Retired Employee who:** ➢ **Retired on or after July 1, 1998 and through December 31, 2006;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Employee who was, at the time of his death, employed by one of the companies listed in the column to the immediate left and who died on or after July 1, 1998.
Central Illinois Public Service Company (CIPS)	➢ **You are a Retired Employee who:** ➢ **Retired between January 1, 1992 and through June 30, 1998;** AND ➢ Were a Participant in "CIPS" benefit plans prior to July 1, 1998; AND ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND ➢ Were eligible for an early or normal retirement benefit from the CIPS Retirement Income Plan. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased CIPS Retiree who met the eligibility requirements described above.
Ameren CILCO Ameren CILCO InfraServices Ameren Energy Medina Valley Cogen, LLC Ameren Energy Resources Generating Company	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2004;** AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Employee who, at the time of his death, was employed by one of the companies listed in the column to the immediate left and who died on or after January 1, 2004.

Contract Retirees[2]

To be eligible for benefits under this Plan as a Retired Contract Employee of Ameren, You must be age 55 or older on the date You retire and meet the eligibility criteria described in the following matrix.

Regardless of the eligibility requirements described in the matrix below, You and Your eligible Dependents are not eligible to participate in this Plan if:

- You are a former Contract Employee under a collective bargaining agreement between:
  - Amerern Illinois (formerly AmerenCILCO) and IBEW Local Union 51; or
  - UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11), AND

  You were hired or re-hired prior on or after January 1, 2017; OR
- You are a former Contract Employee who retired on or after January 1, 1992 under a collective bargaining agreement that has since expired (or You are an eligible Dependent of a retired former Contract Employee of Ameren who retired on or after January 1, 1992 under a collective bargaining agreement that has since expired); AND
- You are age 65 or older and Medicare-eligible; OR
- You are a former Contract Employee under a collective bargaining agreement between:
  - Ameren Illinois (formerly AmerenCILCO) and IBEW Local Union 51, who retired on or after January 1, 2005;
  - AmerenEnergy Resources Generating Company and IBEW Local Union 51 (Duck Creek, Edwards and Indian Trails), who retired on or after January 1, 2007; or
  - UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11), who retired on or after July 1, 2012; AND
  - You are age 65 or older and Medicare-eligible; OR
- You are an eligible Dependent of one of the groups described above, AND You are age 65 or older and Medicare-eligible.

NOTE: If immediately prior to Your retirement, You were not a regular full-time or part-time Employee of Ameren due to a layoff, You are eligible to participate in this Plan provided You satisfy the applicable eligibility requirements below immediately prior to Your layoff and You retire no later than the first day of the month immediately following 180 days after the date of Your layoff.

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[2]Regardless of the eligibility requirements outlined in the eligibility matrix for Contract Employees, You are eligible for coverage under this Plan if, prior to Your retirement under the Grand Tower Separation Plan, You were an Employee represented by Local 148, I.U.O.E. (CIPS) and had attained age 52 as of June 1, 2001.

Employees represented by a collective bargaining agreement between	Eligibility Rules
Ameren Illinois and: IBEW Local Union 309 (formerly UE) IBEW Local Union 649 (formerly UE) IBEW Local Union 702E – Illini (formerly CIPS) IBEW Local Union 702S – Shawnee (formerly CIPS) IBEW Local Union 702W – Great Rivers (formerly CIPS) IBEW Local Union 51 (formerly CILCO) IBEW Local 51 (IP) (formerly AmerenIP) IBEW Local 309 (formerly AmerenIP) IBEW Local 702 (formerly AmerenIP) Laborers Local12 Counties(formerly AmerenIP) Pipefitters Local 101 (formerly AmerenIP) Pipefitters Local 360 (formerly AmerenIP) Laborers Local 459 (formerly AmerenIP) IBEW 51 MDF (formerly AmerenIP) Laborers Local 100 (formerly AmerenIP)	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2018;** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time Employee covered under one of the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are a under age 65 Medicare-eligible (due to a disability) Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2018.
Ameren Missouri and: IBEW Local Union 2 IUOE Local Union 148 IBEW Local Union 702 (Physical & Clerical) IBEW Local Union 1439 IBEW Local Union 1439 South IBEW Local Union 1455 IBEW Local Union 1455 Region West **Ameren Illinois** and: IBEW Local Union 309 IBEW Local Union 649 IBEW Local Union 702E – Illini IBEW Local Union 702S – Shawnee	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2011;** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time Employee covered under one of the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are a under age 65 Medicare-eligible due to a disability Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2011.

Employees represented by a collective bargaining agreement between	Eligibility Rules
IBEW Local Union 702W – Great Rivers IBEW Local Union 51 **AmerenEnergy Generating Company and:** IBEW Local Union 702 – Newton IBEW Local Union 702 – Newton Clerical IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville and Grand Tower) IUOE Local Union 148 – Coffeen Clerical AmerenEnergy Resources Generating Company and IBEW Local Union 51- Duck Creek and Edwards	
AmerenUE and: IBEW Local 2 IUOE Local 148 IBEW Local 702 Physical IBEW Local 702 Clerical IBEW Local 1455 IBEW Local 1455 Region West IBEW Local 1439 IBEW Local 309 IBEW Local 649 IBEW Local 1439 South	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through June 30, 1994:** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time (1455 and 1455 Region West) Employee covered under the **Ameren Employee Medical Plan**. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died prior to July 1, 1994.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenUE and: IBEW Local 2 IUOE Local 148 IBEW Local 702 Physical IBEW Local 702 Clerical IBEW Local 1455 IBEW Local 1455 Region West IBEW Local 1439 IBEW Local 309 IBEW Local 649 IBEW Local 1439 South	➢ **You are a Retired Employee who:** ➢ **Retired on or after July 1, 1994 and through December 31, 1999;** AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible coverage under the **Ameren Employee Medical Plan** OR part-time (1455 and 1455 Region West) Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren Services, AmerenUE or AmerenCIPS. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after July 1, 1994 and through December 31, 1999 and who participated in "UE" benefit plans prior to his/her death.
AmerenUE and: IBEW Local 2 IUOE Local 148 IBEW Local 702 Physical IBEW Local 702 Clerical IBEW Local 1455 IBEW Local 1455 Region West IBEW Local 1439 IBEW Local 309 IBEW Local 649 IBEW Local 1439 South **AmerenCIPS and:** IBEW Local 702E – Illini IBEW Local 702S – Shawnee IBEW Local 702W – Great Rivers **AmerenEnergy Generating Company and:** IBEW Local 702 – Newton IBEW Local 702 – Newton Clerical IUOE Local 148 IUOE Local 148 – Coffeen Clerical	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2000 and through December 31, 2010;** AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR part-time (1455 and 1455 Region West) Employee covered under the **Ameren Employee Medical Plan;** AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2000 and through December 31, 2010.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenCIPS and: IBEW Local 702E - Illini IBEW Local 702S – Shawnee IBEW Local 702W – Great Rivers **AmerenEnergy Generating Company** and: IBEW Local 702 – Newton IBEW Local 702 – Newton Clerical IUOE Local 148 IUOE Local 148 – Coffeen Clerical	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through December 31, 1999;** AND ➢ Were a Participant in "CIPS" benefit plans prior to January 1, 2000; AND ➢ Were eligible for an early or normal retirement benefit from the Central Illinois Public Service Retirement Income Plan; AND ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased IBEW Local 702 (CIPS) Retiree or IUOE Local 148 (CIPS) Retiree who met the eligibility requirements described above.
AmerenCILCO and: IBEW Local 51	➢ **You are a Retired Employee who:** ➢ **Was hired prior to January 1, 2017;** AND ➢ **Retired on or after January 1, 2005;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active contract Employee listed to the left who died on or after January 1, 2005.
AmerenEnergy Resources Generating Company and: IBEW Local 51 (formerly NCF&O Local 8)	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2007;** AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after **reaching** age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active contract Employee (listed to the left) who died on or after January 1, 2007.

Employees represented by a collective bargaining agreement between	Eligibility Rules
UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11	➢ **You are a Retired Employee who:** ➢ **Was hired prior to January 1, 2017**; AND ➢ **Retired on or after July 2, 2012;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan; AND** ➢ Accrued at least 10 Years of Service after **reaching** age 45 as an Employee of Ameren**.** ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active contract Employee listed to the left who died on or after July 2, 2012.
AmerenEnergy Generating Company and: IBEW Local Union 702 – Newton IBEW Local Union 702 – Newton Clerical IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville) IUOE Local Union 148 – Coffeen Clerical AmerenEnergy Resources Generating Company and IBEW Local Union 51- Duck Creek and Edwards	➢ **You are a Retired Employee who:** ➢ **Retired on or after December 1, 2013; OR** ➢ **Were on long term disability on December 2, 2013 and retired on or after December 2, 2013; AND** ➢ Were formerly represented by a collective bargaining agreement between the following Ameren companies and local labor unions when AER Generating Company, Ameren Energy Generating Company, or Ameren Energy Marketing Company were divested to Illinois Power Holdings, LLC (IPH) or a subsidiary of IPH; or, Dynegy Operating Company on December 2, 2013: ➢ 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); **AND** **On December 1, 2013 You:** ➢ Were age 55 or older; AND ➢ Were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Contract Employee (listed above) who died on or after December 2, 2013.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenEnergy Generating Company and: IUOE Local Union 148 (Grand Tower)	➢ **You are a Retired Employee who:** ➢ **Retired on or after February 1, 2014; OR** ➢ **Were on long term disability on January 31, 2014 and retired on or after January 31, 2014; AND** ➢ Were formerly represented by a collective bargaining agreement between AmerenEnergy Generating Company and IUOE Local Union 148 (Grand Tower); **AND** ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are a Medicare-eligible Dependent of a deceased active Contract Employee (listed above) who died on or after February 1, 2014.

Medicare-Eligible Dependents of Deceased Active Employees

However, Medicare-eligible Dependents of deceased active Employees are not eligible for coverage under the Plan if:

- the deceased Employee had less than 10 Years of Service at his or her time of death, except as provided below; OR
- the deceased Employee was not covered under the Ameren Employee Medical Plan at the time of his or her death; OR
- the Medicare-eligible Dependent was not covered under the Ameren Employee Medical Plan at the time of the deceased Employee's death; OR
- the Medicare-eligible Dependent was not covered under the Ameren Employee Medical Plan at the time he or she become eligible for Medicare.

The 10 Years of Service requirement does not apply to Medicare-eligible surviving Dependents of deceased active AmerenUE management Employees who died between January 1, 1992 and June 30, 1993, and deceased active AmerenUE Contract Employees who died between January 1, 1992 and June 30, 1994.

Dependents

If You enroll in the Plan as a Retired Employee, Your eligible Dependents are also eligible for coverage provided they are not serving in the active services of any armed forces of any country and You enroll them according to the appropriate procedures. If You are in a group described in one of the charts above that is eligible to participate in this Plan, but would not be eligible to participate if You are age 65 or older and Medicare-Eligible, then regardless of Your age, Your Dependent is not eligible to participate in this Plan if Your Dependent is age 65 or older and Medicare-eligible. You must remain enrolled in an **Ameren Retiree Medcial Plan** program in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to Your:

- Spouse; however, a Spouse who is covered under another Ameren-sponsored medical plan is not eligible for coverage under this Plan.
- Unmarried Dependent Children who have not reached age 19 and are dependent upon You for more than half of their support.
- Unmarried Dependent Children from their 19th birthday to their 25th birthday who live with You and are dependent upon You for more than half of their support.
- Unmarried Dependent Children over age 25 who are not capable of self-sustaining employment due to a disability continue to be eligible for coverage under the Plan beyond the limiting age, provided they continue to be dependent upon You for more than half of their support. Proof of the disability or handicap must be furnished to Anthem within 31 days of the date they would otherwise cease to be eligible. 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 25th birthday are not eligible for coverage.

  Disabled Dependent children who are dropped from coverage after age 25 may not re-enroll in the future.

A child with a full-time job, generally defined to be 30 or more hours per week, will not be considered dependent on You for any support. Temporary absences due to special circumstances, including absences due to illness, education or vacation are not treated as absences for purposes of determining whether the Dependent Child lives with You.

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

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

A Spouse or Dependent Child who works for Ameren and who is eligible for coverage under the

Ameren Employee Medical Plan as an Employee, or under the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan** as a Retiree, cannot be covered as Your Dependent under this Plan. No person can be covered as a Dependent of more than one Employee/Retiree. No person can be covered under more than one medical plan option in the **Ameren Retiree Medical Plan**. Additionally, no person can be covered under the **Ameren Retiree Medical Plan, the Ameren Retiree Health Reimbursement Account Plan** and/or the **Ameren Employee Medical Plan** at the same time.

Enrollment Provisions

Retirees

In order to elect or decline coverage in the **Ameren Retiree Medical Plan**, You must make Your elections on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). To obtain medical coverage, You will be required to provide a valid Social Security number for Yourself and each Dependent that You wish to cover. A Social Security number is required for a child who is six (6) months and older.

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

- Decline coverage
- You Only
- You + Spouse
- You + Child(ren)
- You + Family

Upon Your retirement, You must elect one of the above coverage categories no later than thirty-one (31) days from the date of Your Enrollment Worksheet. The effective date of Your coverage is the date of Your retirement. No medical exam or other proof of good health is required to enroll in this Plan. If You decline coverage, You will not be eligible to enroll in the Plan in the future, and Your dependents will lose eligibility and not be eligible to enroll in the Plan in the future. If You do nothing, You will be defaulted to the Plan option listed below.

NOTE: Throughout this Summary Plan Description (SPD) for this Plan, all references to eligibility for and enrollment in either the Medicare Supplement Plan or the Conventional Plan with or without prescription drug coverage is subject to eligibility rules as stated in the ELIGIBILITY section of this document.

Category	Default Plan Option (if You don't make an election when You first retire)
Retirees and Dependents who were participating in the **Ameren Employee Medical Plan** (Options Program; Basic Program) and who are not Medicare eligible.	Medical plan option most similar to the Plan You were participating in the day before Your retirement date.

Category	Default Plan Option (if You don't make an election when You first retire)
Retirees and/or any Dependents who were participating in the **Ameren Employee Medical Plan** (Options Program; Basic Program), who are Medicare eligible, and eligible for coverage under this Plan as stated in the Eligibility Section of this document.	Medicare Supplement with the same PRESCRIPTION DRUG option You were participating in the day before Your retirement date. If You were participating in the Health Savings PPO You will be enrolled in the Medicare Supplement with the Coinsurance RX option. If one person is not Medicare eligible, he/she will be enrolled in the same plan he/she was participating in the day before Your retirement date (except for the Health Savings PPO), while the other person will be enrolled in the Medicare Supplement Plan. Participants in the Health Savings PPO will go into the Standard PPO with the same PRESCRIPTION DRUG coverage as the Medicare eligible participant.

Once You are retired, when You or Your Spouse becomes Medicare eligible, generally at age 65, and eligible for coverage under this Plan as stated in the Eligibility Section of this document, You must elect another option. However, the following coverage will be implemented for the Medicare eligible Member who does not make an election:

Retiree who is Currently Enrolled In:	Default Plan Option (if You don't make an election when You or Your Dependent first becomes Medicare eligible and You are not eligible for the Ameren Retiree Health Reimbursement Account Plan)
Standard PPO or Defined PPO	Medicare Supplement Plan with same prescription drug coverage You were enrolled in prior to Your age 65
Health Savings PPO	Medicare Supplement Plan with Coinsurance prescription drug option

If You are covering a Dependent, and only one of You is Medicare eligible, the non-Medicare eligible person will remain in the current plan they are enrolled in, unless it is the Health Savings PPO. If they are participating in the Health Savings PPO, they will default to the Standard PPO with the Coinsurance prescription drug option.

COBRA Continuation Option

Covered Employees who lose coverage under the **Ameren Employee Medical Plan** due to their retirement have the right to temporarily continue their coverage in the **Ameren Employee Medical Plan** for up to 18 months at their own expense pursuant to a Federal law known as COBRA. If You elect to continue Your coverage in the **Ameren Employee Medical Plan**, You will not be allowed to enroll in the **Ameren Retiree Medical Plan** at the end of the temporary 18-month continuation period.

Dependents

Unless You elect otherwise, Your Dependents who had Dependent coverage in the **Ameren Employee Medical Plan** on the day before You retired will be automatically enrolled in the **Ameren Retiree Medical Plan** as of the same date You are enrolled in the Plan as long as they meet the eligibility rules for this **Ameren Retiree Medical Plan** as stated in the ELIGIBILITY section of this document.

It is important to note that eligibility rules for the **Ameren Employee Medical Plan** are different from the **Ameren Retiree Medical Plan** and the **Ameren Retiree Health Reimbursement Account Plan**, so You should verify whether Your Dependents are eligible before You make the decision to retire. If they are not eligible for the **Ameren Retiree Medical Plan**, they may be eligible to elect COBRA continuation coverage under the **Ameren Employee Medical Plan;** however the cost for COBRA coverage is different than what You would pay for Dependent coverage under the **Ameren Retiree Medical Plan**.

You will have 31 days from the date of Your Enrollment Worksheet to enroll any Eligible Dependents in the Plan who were not covered under the **Ameren Employee Medical Plan** as a Dependent on the day before Your retirement. If You fail to enroll any such Eligible Dependent within the 31 day time period, such Dependent cannot be enrolled in the Plan in the future except under the circumstances described below under ADDING DEPENDENTS AFTER RETIREMENT below.

NOTE: If You and/or Your eligible Dependent is eligible for retiree medical benefits from Ameren under the **Ameren Retiree Health Reimbursement Account Plan** and not this Plan, enrollment through the Aon Retiree Health Exchange needs to occur prior to Your retirement date and/or the 65th birthdate to prevent a gap in coverage.

Adding Dependents After Retirement

If You were an AmerenUE management Employee who retired on or after January 1, 1992, but prior to July 1, 1993, or an AmerenUE Contract Employee who retired on or after January 1, 1992, but prior to July 1, 1994, You may enroll any eligible Dependents in the future as long as You are covered under this Plan, and Your Dependent is eligible for this Plan. Coverage will begin on the date You enroll the Dependents for coverage under the Plan. You can enroll a Dependent at any time by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**) or by going to "Healthcare and Life Benefits" at **www.myAmeren.com**.

For all other Retirees eligible for coverage under this Plan:

If, at the time of retirement, You elected not to provide coverage under this Plan for an eligible Dependent (including Your Spouse) because he or she had other healthcare coverage, You may enroll the Dependent in this Plan in the future (provided he or she qualifies as an eligible Dependent) if the Dependent loses or will lose the other healthcare coverage and is not eligible for coverage under another employer's plan, provided that You:

- Are covered under the Plan.
- Request enrollment of the Dependent within 31 days after the other coverage ends (either through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

- Certify that Your Dependent is not eligible for coverage under another employer's plan. The Plan may request that Your Dependent provide a statement from his/her present or previous employer regarding eligibility for coverage.

Example: At the time of retirement, You did not enroll Your Spouse in the **Ameren Retiree Medical Plan** since he/she was employed and had medical coverage through his/her employer. At the time of Your Spouse's termination of employment,

- Your Spouse is not eligible for any medical coverage through that employer; therefore, You may add Your Spouse to the Plan.
- If however, Your Spouse has medical coverage available through that employer (regardless of the cost of coverage or the benefits provided under that plan), You may NOT add Your Spouse to the Plan.

Coverage for the Dependent will be effective as of the date the other coverage was lost, provided You timely request enrollment for such Dependent.

If You acquire a new Dependent through marriage, birth, adoption or Placement for Adoption after You retire and while You are covered under the Plan, You may enroll the newly acquired Dependent within 31 days of the marriage, birth, adoption or Placement for Adoption (provided he/she qualifies as an eligible Dependent). In the case of the birth, adoption or Placement for Adoption of a child, Your Spouse may also be enrolled as a Dependent if he/she is otherwise eligible for coverage. To enroll a new Dependent, You must:

- Request enrollment of the Dependent within 31 days of the event.
- If enrolling a new Spouse, You may be asked to provide a copy of the marriage certificate.
- If enrolling a new child, You may be asked to provide a copy of the birth certificate or adoption papers.

Coverage for the newly enrolled Dependents will be effective as of the date of marriage, birth, adoption or Placement for Adoption, provided You timely request enrollment.

Any Covered Dependent who is subsequently dropped from coverage for any reason may not be re-enrolled in this Plan nor any other **Ameren Retiree Medical Plan** option at any time in the future.

To request enrollment, You should call the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**) or go to **www.myAmeren.com**.

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.

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

Qualified Medical Child Support Orders

This Plan will also extend benefits to a Covered Retiree's non-custodial child, as required by any 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 by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

Annual Enrollment Period

Each November, during the annual enrollment period, You will be given the opportunity to change Your medical coverage option. For example, if You are enrolled in the Standard PPO Plan, You could enroll in the Health Savings PPO or the Defined PPO. Medicare-eligible Retirees who are eligible for this Plan as stated in the ELIGIBILITY section of this document could elect to move from the Conventional Plan into the Medicare Supplement Plan, or vice versa. This would also be the time that You could evaluate and change Your prescription drug coverage. Changes in elections made during annual enrollment will be effective January 1 of the following year and will be in effect for the full year as long as You continue to be eligible for this Plan. You cannot elect coverage for other Dependents during the annual enrollment period. New Dependents can only be enrolled in accordance with the provisions described above in ADDING DEPENDENTS AFTER RETIREMENT. If You drop or decline coverage under this Plan, or any **Ameren Retiree Medical Plan** program, at any time, You are not eligible to participate in this Plan, or any other **Ameren Retiree Medical Plan** program in the future. Additionally, if You drop or decline coverage under this Plan, or any **Ameren Retiree Medical Plan** program, Your Dependents will no longer be eligible to participate in this Plan or any **Ameren Retiree Medical Plan** program.

Cost of Coverage for Retirees

If You are an Employee who was represented by a collective bargaining agreement between AmerenCILCO and IBEW Local 51 and retired on or after January 1, 2005, You and the Company currently share in the cost for this coverage. You pay for Your portion of the cost of this coverage through billing statements or direct debit from Your bank account. See APPENDIX A for the current contribution schedule.

If You are an Employee who was represented by a collective bargaining agreement between AmerenEnergy Resources Generating Company and NCF&O Local 8 and retired on or after January 1, 2007, the Company currently pays a portion of the cost of this coverage for You and Your Covered Dependents. You pay the remainder of the cost for this coverage through billing statements or direct debit from Your bank account. See APPENDIX A for the current contribution schedule.

For all other Retirees who retired on or after January 1, 1992 and are eligible for coverage under this Plan (see ELIGIBILITY), the Company currently pays a portion of the cost of this coverage for You and Your Covered Dependents. You pay the remainder of the cost for this coverage through billing statements or direct debit from Your bank account. See APPENDIX A for the current contribution schedule.

Your cost of coverage for You and any Covered Dependents under the **Ameren Retiree Medical Plan** is subject to change at any time. Additionally, if 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. If You have overpaid the amount of premium, a refund or credit will be arranged. Similarly, if You have underpaid the amount of premiums, the underpayment of premiums will need to be paid by You to Ameren.

Is Your Dependent Child a 'Qualified Tax Dependent'?

Coverage for Eligible Dependents under this Plan is generally excludable from gross income, however, You are strongly encouraged to consult Your tax advisor for questions about this matter.

Cost of Coverage for Surviving Dependents of Deceased Retirees

For Surviving Dependents of Deceased Retirees who were represented by a collective bargaining agreement between AmerenCILCO and IBEW Local 51 and retired on or after January 1, 2005 the Company currently pays a portion of the cost of this Coverage for Your surviving Dependents. The remainder of the cost of this coverage is collected through billing statements or direct debit from Dependent's bank account. Information about the cost of this coverage is outlined in APPENDIX A.

Surviving Dependents of Deceased Retirees who were represented by a collective bargaining agreement between AmerenEnergy Resources Generating Company and IBEW Local 51 (formerly NCF&O Local 8) and retire on or after January 1, 2007, the Company currently pays a portion of the cost of this Coverage for Your surviving Dependents. The remainder of the cost of this coverage is collected through billing statements or direct debit from Dependent's bank account. Information about the cost of this coverage is outlined in APPENDIX A.

For surviving dependents of all other deceased Ameren Retirees who are eligible for coverage under this Plan (see ELIGIBILITY), the Company currently pays a portion of the cost of this coverage for Your surviving Dependents. The remainder of the cost of this coverage is collected through billing statements or a direct debit from Dependent's bank account. Information about the cost of this coverage is outlined in APPENDIX A.

Contribution rates may be adjusted from time to time by the Company for each of the groups stated above.

Coverage Identification Card

Once You are enrolled in the Plan, You will be issued ID cards which provide information about Your medical and prescription drug coverage. You should carry the ID cards with You at all times, and show them to Your providers when You go to the Physician, Hospital, or Pharmacy. If You lose Your medical plan ID card, You may obtain a replacement by calling Anthem at **877.403.0610**, or by visiting **www.anthem.com**. If You lose Your prescription drug coverage ID card, You

may obtain a replacement by calling Express Scripts at **888.256.6131**, or by visiting **www.express-scripts.com**. To obtain an ID Card through Anthem's or Express Script's secure website, You must first register with a unique login and password.

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. Adverse Benefit Determination also includes any reduction or termination of a covered service.

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

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

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

Ameren means Ameren Corporation and includes only the following current or former subsidiaries: Ameren Services, Ameren Missouri, Ameren Illinois, AmerenUE, AmerenCIPS, AmerenEnergy Generating Company, AmerenEnergy Resources Generating Company, AmerenEnergy Fuels and Services Company, AmerenEnergy, AmerenEnergy Marketing Company, AmerenCILCO, AmerenCILCO InfraServices, AmerenEnergy Medina Valley Cogen, LLC, and AmerenIP.

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

Average Semi-Private Charge means:

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

Average Wholesale Price (AWP) means the published cost of a drug product to the wholesaler.

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

- provides prenatal care, delivery, and immediate postpartum care;

- operates under the direction of a Physician who is a Specialist in obstetrics and gynecology;
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing Services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and staff members being aware of such procedures.

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

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

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

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

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

Contract Employee means an Employee covered by a collective bargaining agreement.

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

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

Cosmetic Treatment or Service means treatment or service to change:

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

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

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

Covered Expenses mean charges for the types of treatment or service listed under Covered Expenses section to the extent the charges do not exceed the Maximum Allowed Amount. The treatment or service must be required for the treatment of a sickness, injury, or certain routine care and must be considered by the Claims Administrator to be Medically Necessary Care.

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

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

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

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

Deductible; Deductible Amount for purposes of medical plan coverage means a specified dollar amount of medical Covered Expenses (and covered prescription drug expenses if enrolled in the Health Savings PPO plan) that must be incurred by You or one of Your Covered Dependents before benefits will be payable under this Plan for all or part of the remaining Covered Expenses during the calendar year. For purposes of the prescription drug program, it means the dollar amount for each calendar year that a Member is responsible for paying under the Coinsurance option before any prescription drug benefits are payable.

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

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

Dependent means Your Spouse or Dependent Child, if that Spouse or child is not covered under this Plan as a Retiree, or under the **Ameren Employee Medical Plan** as an Employee.

Dependent Child means: Your natural child; Your stepchild who resides with You; an adopted child; a child who has been placed with You for adoption; a child for whom You or Your Spouse have been appointed legal guardian or custodian by a court order; a child who is recognized under a qualified medical child support order (QMCSO) or National Medical Support Notice (NMSN), as defined by ERISA § 609 (a), as having a right to enrollment under the Plan. In all cases the child must depend upon You for more than half of his or her support and care. However, when a court recognizes a child as a QMCSO-child, the child will be considered Your eligible Dependent regardless of whether or not the child is living with You or receiving more than half of his or her support from You.

When a court or administrative order determines paternity and establishes upon You a duty to support Your natural child, the child will be considered Your eligible Dependent.

Developmental Delay means the statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching 0age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an injury.

Durable Medical Equipment means equipment that:

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

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

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

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

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

Episode of Hospice Care means the period of time:

- beginning on the date a Hospice Care Program is established for a terminally ill Member; and
- ending on the earlier of the date six months after the date the Hospice Care Program is established, the date the attending Physician withdraws approval of the Hospice Care Program, the date the Member recovers or the date the individual dies; and

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

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

Formulary means the list of FDA-approved prescription drugs and supplies developed by Express Scripts, Inc.'s Pharmacy and Therapeutics Committee and/or customized by the Plan which represents the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In Your pharmacy benefit plan, the Formulary drug list is used as a guide for determining Your Copay or Coinsurance amount for each prescription, with drugs listed on the Formulary typically available to You at a lower Copay or Coinsurance to You. The Formulary may change from time to time. To obtain information about prescription drugs on Express Scripts' Formulary, You may call toll-free **888.256.6131** or visit Express Scripts' website at **www.express-scripts.com**.

The Formulary does not apply to Members who are Medicare eligible and who do not elect a drug plan option.

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

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

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

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

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

Health Professional or Health Care Professional means an individual who:

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

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

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

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

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

Hospice means a facility, agency, or service that:

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

Hospice Care Program means a program:

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

to meet the special physical, psychological, and spiritual needs of terminally ill Members.

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

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

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

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

Hospital Confinement Charges mean Covered Expenses billed by a Hospital for room, board, and other usual services while a Member is confined in a Hospital. The charges must be

incurred while the Member is confined for a period of at least 23 consecutive hours (for any cause).

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

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

Ineligible Provider means a Provider which does not meet the minimum requirements to become a contracted provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment by the Plan.

Infertile or Infertility means the condition of a presumably healthy person who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

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

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

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

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

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

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

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

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

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

Member means a Covered Retiree and Covered Dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician means Doctor of Medicine (MD); Doctor of Osteopathy (DO); Audiologist; Certified Registered Nurse Anesthetist (CRNA); Chiropractor; Dentist; Certified Midwife; Occupational Therapist; Optometrist; Physician Assistant; Physical Therapist; Podiatrist (DPM); Psychologist*;* and Speech Pathologist.

Physician Visit means a face-to-face meeting between a Physician or Physician's staff and a Member for the purpose of medical treatment or service.

Physician Visit Charges means Covered Expenses for treatment or service furnished at a Physician's clinic or office. Such services include charges for: dressings; supplies; equipment; injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations (including professional components that are billed by a pathologist in connection with the laboratory testing); x-ray, radium, and radioactive isotope therapy.

Placement for Adoption; Placement 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 **Ameren Retiree Medical Plan,** a component part of the **Ameren Retiree Welfare Benefit Plan**.

Plan Administrator means the Administrative Committee, or its delegate.

Plan Sponsor means Ameren Corporation.

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.

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

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

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

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

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

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

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

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

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

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

Retired Employee/Retiree means an Employee who is retired, if such Employee was age 55 or older on the date of retirement and belongs to a group described in the ELIGIBILITY section of this booklet. **NOTE**: See footnotes in the ELIGIBILITY section for circumstances where certain Employees were eligible for retirement prior to reaching age 55.

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

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

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

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

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

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

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

Transplant Network or Network Transplant Provider means a provider that has been designated as a Center of Excellence for Transplants by the Claims Administrator and/or a provider selected to participate as a Network Transplant Provider by a designee by the Blue Cross Blue Shield Association. Such provider has entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to You for the Transplant Network. A provider may be a Network Transplant Provider with respect to certain covered transplant procedures or all covered transplant procedures. An Out-of-Network Transplant

Provider means any provider that has not been designated as a Center of Excellence for Transplants by the Claims Administrator nor has been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

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

Urgent Review means a review that must be completed sooner than a Pre-Service Review in order to prevent serious jeopardy to the Member's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Claims Administrator's decision using the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

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

Year of Service for purpose of determining eligibility for a Retiree means a calendar year in which the Retiree worked at least 1000 hours for Ameren as an active Employee; however, any service as an Employee of AmerenEnergy or AmerenEnergy Marketing Company before January 1, 2003 is disregarded.

Credit for Years of Service will be included if the Retiree has a break in service and is re-hired prior to the dates stated in the ELIGIBIILTY section. Each year in which the Retiree worked at least 1000 hours for Ameren as an active Employee after age forty-five (45) will count in determining eligibility, regardless of the length of the break in service.

If the Retiree worked for a company acquired by Ameren, the Retiree must have been employed as an active Employee of the acquired company on the date of the acquisition, to have any Year of Service in which 1000 hours within a calendar year after age 45 count toward eligibility.

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

For purpose of determining premiums for Retirees and eligible surviving Dependents, Year of Service means the length of time which is used in the calculation of benefits under the Ameren Retirement Plan.

You/Your for purposes of eligibility and enrollment means a Retiree who is eligible to participate in the Plan; however in the context of receiving Plan benefits, You/Your is intended to refer to any Member, unless the context clearly dictates otherwise.

Retiree Medical Program Options

The **Ameren Retiree Medical Plan** offers several medical plan options for Retirees and their Dependents. Covered Retirees and their Covered Dependents also participate in the Prescription Drug Program, unless enrolled in the Health Savings PPO which already includes prescription drug coverage. The applicable medical plan option, plus the prescription drug benefits comprise Your current Plan benefits.

If You and/or Your Dependents are not eligible for Medicare, Your three medical plan options are:

- Standard PPO
- Health Savings PPO with prescription drug coverage included
- Defined PPO

If You and/or Your Dependents are eligible for Medicare and eligible for this Plan as stated in the ELIGIBILITY section of this document, Your two choices are:

- Conventional Plan
- Medicare Supplement Plan

If one Member in a family is Medicare eligible and one is not, the Medicare eligible person should elect his/her coverage from the two choices shown above. Any non-Medicare eligible family members can stay in their current PPO medical plan option. The exception to this is non-Medicare Members in the Health Savings PPO when the Medicare eligible Member is eligible for this Plan. Those non-Medicare eligible Members must choose another option, either the Standard PPO or the Defined PPO. All Members must have the same prescription drug coverage, either three tier or coinsurance.

However, if one Member is age 65 or over and Medicare eligible and eligible for the **Ameren Retiree Health Reimbursement Account Plan**, the non-Medicare Member eligible for this Plan may choose to enroll in the Health Savings PPO.

If all family members are eligible for Medicare, and eligible for this Plan as stated in the ELIGIBILITY section of this document, there are two additional choices available. These choices allow You to participate in a medical plan option, but not the Prescription Drug Program. They are:

- Conventional Plan without RX
- Medicare Supplement Plan without RX

Anthem Network Programs

The Standard PPO, Health Savings PPO and Defined PPO option plans are designed to help You reduce healthcare expenses whenever You use a Physician or Hospital that is a member of the Anthem Network of healthcare Providers. Anthem is able to reduce healthcare costs because, due to the number of people in the program, it can negotiate discounts with Physicians and Hospitals and then pass these discounts on to Members.

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

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

An Anthem National Network Provider directory is available by accessing Anthem's website at **www.anthem.com** or by calling **877.403.0610**.

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

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

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

It is recommended that You always verify Your Provider's participation in the Network when You make Your appointment, and be sure to show Your medical ID card when visiting the Physician or Hospital.

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

Under the BlueCard® Program, when You receive Covered Expenses within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But,

the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

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

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

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

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

Negotiated (non–BlueCard Program) Arrangements

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

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

Special Cases: Value-Based Programs

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

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

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

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

Nonparticipating Providers Outside the Claims Administrator's Service Area

The pricing method used for nonparticipating provider claims incurred outside the Anthem Service Area is described in Claims Payment**.**

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

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

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

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

Call the Service Center in these non-emergent situations:

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

Payment Information

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

Claim Filing

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

Claim Forms

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

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

Medicare Part A and Part B

It is very important that You enroll in Parts A and B of Medicare as soon as You become eligible for Medicare benefits[3]. If You are eligible for Medicare but don't enroll, You will still be covered under either the Conventional Plan or Medicare Supplement option just as though You were enrolled in Medicare. This means the Plan will determine and subtract the benefits Medicare would have paid and then pay benefits on the balance of the claim in accordance with Plan provisions. This provision applies to all Covered Retirees and Covered Dependents who become eligible for Medicare. For additional information, refer to the COORDINATION WITH OTHER BENEFITS section of this booklet.

Medicare Part D

Medicare Part D is the prescription drug benefit available to all Medicare participants. It requires enrollment in a Medicare prescription drug plan and payment of a monthly premium. If You elect Three-Tier or Coinsurance Prescription drug coverage under the Plan, You are not required to enroll in Medicare Part D. Such Prescription drug coverage is considered creditable coverage. For Medicare Part D purposes, creditable coverage means that the prescription drug benefits provided under the Plan are at least equal to the benefits provided under Medicare Part D. If You also enroll in a Medicare Part D plan, Medicare will be primary and this Plan will pay secondary.

If You decide to enroll in Medicare Part D, You may want to consider one of the Ameren medical plan options with no prescription drug coverage. This option is only available if all

[3] Effective January 1, 2006, Reimbursement of a portion of Medicare Part B premiums may be available for a grandfathered group of "regular pay" retirees who retired from AmerenCIPS on or after January 1, 1992 and before July 1, 1998 (for management retirees) and December 31, 1999 (for contract retirees). Such retirees must have retired either at their normal retirement date or at an early retirement date, but with at least 25 years of service. Surviving Dependents of these grandfathered retirees are not eligible for Medicare Part B premium reimbursement. Each year, generally in January, the Company will request the information required from the retiree to receive such reimbursement.

covered family members are Medicare eligible. Such medical only option may also be attractive to Members who wish to reduce the prescription drug expenses that apply to the Lifetime Maximum benefit under the Plan.

Plans for Retirees and Dependents not Eligible for Medicare

Standard PPO Schedule of Benefits

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

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
STANDARD PPO PLAN Available to Non-Medicare Eligible Participants only		
PLAN FEATURE	IN-NETWORK	**OUT-OF-NETWORK**
Lifetime Maximum Benefit Includes prescription drug benefits.	$750,000	
Deductible	$400 per person $800 per family	$600 per person $1,200 per family
Network and Non-Network Deductibles reduce each other.		
Out-of-Pocket Maximum (amount of Covered Expenses You could have to pay in a single year, including Deductibles)	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family
Network and Non-Network Out-of-Pocket Expenses reduce each other. Copays, including emergency room Copays, non-covered services, precertification penalties, drug Copays and drug coinsurance amounts, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum.		
Inpatient Hospital (precertification required)	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Outpatient Facility	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Emergency Room Services	You pay $150 Copay per visit if true Medical Emergency, then the Plan pays 100% (the Copay will be waived if admitted). If not true Medical Emergency, as defined by the Plan, the $150 Copay, Deductible and applicable Coinsurance will apply.	
Ambulance	The Plan pays 100%, if true Medical Emergency. If not true Medical Emergency, as defined by the Plan, Deductible and applicable Coinsurance will apply.	

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
STANDARD PPO PLAN (continued) Available to Non-Medicare Eligible Participants only		
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 90%
Office Visits Includes covered diagnostic services performed in the Physician's office.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Maternity Care Includes office Visits/prenatal & postnatal, in-Hospital delivery, and newborn nursery services.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Allergy Injections and Serum	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Chiropractic Services Limited to 25 visits per year.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Physical Therapy Limited to 25 visits per year.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Speech/Occupational Therapy Limited to 20 visits per year for covered diagnoses.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Wellness and Preventive Care Services as recommended (except colonoscopies) Limited to $750 per Member per calendar year.	The Plan pays 90% (Deductible does not apply)	The Plan pays 70% of the Maximum Allowed Amount (Deductible does not apply)
Colonoscopies For both preventive and Medically Necessary reasons.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
STANDARD PPO PLAN (continued) Available to Non-Medicare Eligible Participants only		
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**
Home Health Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Hospice Care	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
X-Ray and Laboratory Services Performed in a Hospital or other independent outpatient facility.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Durable Medical Equipment	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Prescription Drugs	See PRESCRIPTION DRUG PROGRAM FOR STANDARD PPO & DEFINED PPO	
All other Covered Expenses	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

Health Savings PPO Schedule of Benefits

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

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
HEALTH SAVINGS PPO PLAN Available to Non-Medicare Eligible Participants Only		
PLAN FEATURE	IN-NETWORK	**OUT-OF-NETWORK**
Lifetime Maximum Benefit Includes Prescription drug benefits**.**	$750,000	
Deductible • You Only Coverage	$1,400	
• You & Spouse, You & Child(ren), or You & Family Coverage	$2,800 IMPORTANT NOTE: The $1,400 Deductible applies ONLY if You have elected Retiree Only coverage. If You have elected to cover any eligible Dependent family members under the Health Savings PPO, the Plan will not pay benefits until Your annual Deductible of $2,800 has been met, whether by one or more covered Members. Covered Expenses for both medical and prescription drugs apply toward the Deductible.	
Out-of-Pocket Maximum (the amount of Covered Expenses You have to pay in a single year, including Deductibles)	$3,000 per person $6,000 per family	$ 5,000 per person $10,000 per family
Network and Non-Network Out-of-Pocket Expenses reduce each other. Non-covered services, precertification penalties, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum. Covered Expenses for both medical and prescription drugs apply toward the Out-of-Pocket Maximum.		
Inpatient Hospital (precertification required)	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Outpatient Facility	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Emergency Room Services	You pay the Deductible, then the Plan pays 100%, if true Medical Emergency; If not a true Medical Emergency as defined by the Plan the Deductible and applicable Coinsurance will apply.	

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
HEALTH SAVINGS PPO PLAN (continued) **Available to Non-Medicare Eligible Participants Only**		
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**
Ambulance	You pay the Deductible, then the Plan pays 100%, if true Medical Emergency; If not a true Medical Emergency as defined by the Plan, the Deductible and applicable Coinsurance will apply.	
Urgent Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Office Visits Includes covered diagnostic services performed in the Physician's office.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Maternity Care Includes office visits/prenatal & postnatal, in-Hospital delivery, and newborn nursery services.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Allergy Injections and Serum	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Chiropractic Services Limited to 25 visits per year.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Physical Therapy Limited to 25 visits per year.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Speech/Occupational Therapy Limited to 20 visits per year for covered diagnoses.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Home Health Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Hospice Care	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
X-Ray and Laboratory Services - Performed in a Hospital or other independent outpatient facility.	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.		
HEALTH SAVINGS PPO PLAN (continued) Available to Non-Medicare Eligible Participants Only		
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**
Wellness and Preventive Care Services as recommended (except colonoscopies) Limited to $750 per Member per calendar year.	The Plan pays 90% (Deductible does not apply)	The Plan pays 70% (Deductible does not apply)
Colonoscopies For both preventive and Medically Necessary reasons.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
Prescription Drugs **(see** PRESCRIPTION DRUG PROGRAM FOR HEALTH SAVINGS PPO**)**	You pay Deductible, then the Plan pays 80% (You pay 20% of the Express Scripts discounted price until Your reach Your Out-of-Pocket Maximum at which time You pay nothing for covered prescription drugs.) You may obtain up to a maximum supply of 34 days for each prescription for Retail Drugs and up to 90 days for each prescription for Home Delivery Drugs.	
Durable Medical Equipment	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
All other Covered Expenses	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%

Health Savings Account

The Health Savings PPO is a qualified high deductible health plan option. Accordingly, if You enroll for coverage under the Health Savings PPO, You may be eligible to participate in and contribute to a Health Savings Account (HSA). You should consult Your tax advisor about enrolling and contributing to a Health Savings Account. However, IRS rules prohibit the contribution to a Health Savings Account if You are enrolled in Medicare Part A and/or Part B.

Defined PPO Plan Schedule of Benefits

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

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.	
Defined PPO Plan	
SERVICE	**IN-NETWORK**
Lifetime Maximum Benefit Includes prescription drug benefits.	$750,000
Deductible • Per Person • Per Family	 $250 $500
Out-of-Pocket Maximum • Per Person • Per Family	 None None
Inpatient Hospital Precertification required. See UTILIZATION MANAGEMENT REVIEW.	You pay $150 Copay per day to a $600 maximum per hospitalization
Outpatient Facility Hospital Based	You pay $75 Copay per visit
Emergency Room Services	You pay $150 Copay per visit (waived if You are admitted)
Ambulance	No Charge
Urgent Care	You pay $25 Copay per visit
Office Visits Includes covered diagnostic services performed in the Physician's office.	You pay $25 Copay per visit to a Network Provider You pay $40 Copay per visit to a Network Specialist Provider
Outpatient Behavioral Health/Substance Abuse	You pay $25 Copay per visit
Maternity Care Includes office visits (prenatal and postnatal) in-hospital delivery, and newborn nursery services.	You pay $150 Copay per day to a $600 maximum per hospitalization
Allergy Injections and Serum	You pay Deductible, then the Plan pays 100%
Chiropractic Services Limited to 25 visits per year.	You pay $40 Copay per visit
Physical Therapy Limited to 25 visits per year.	You pay Deductible, then the Plan pays 100%
Speech/Occupational Therapy Limited to a combination of 20 visits per year.	You pay Deductible, then the Plan pays 100%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.	
Defined PPO Plan	
SERVICE	**IN-NETWORK**
Wellness and Preventive Care Services as recommended Includes routine colonoscopies	You pay Copay of $25 for physicals and gynecological exams.
Colonoscopies Non-routine only.	You pay $75 Copay for the facility charge
Home Health Care	You pay Deductible, then the Plan pays 100%
Skilled Nursing Facility	You pay Deductible, then the Plan pays 100%
X-Ray and Laboratory Services Non-hospital based.	You pay Deductible, then the Plan pays 100%
Durable Medical Equipment	You pay Deductible, then the Plan pays 100%
Prescription Drugs	See PRESCRIPTION DRUG PROGRAM FOR STANDARD PPO AND DEFINED PPO
All Other Covered Expenses	You pay applicable copays or deductible.

NOTE: For the Defined PPO plan, all Non-Network/Out-of-Network Providers are not covered except as noted below:

- Emergency Room – if true emergency (non-emergency use of Emergency Room is not covered)
- Urgent Care
- Ambulance – (if true emergency)
- Covered Durable Medical Equipment (DME)
- Covered medical supplies – i.e. diabetic supplies obtained through the medical plans.

Anthem Programs for the Non-Medicare Plans

Anthem 360° Health Programs

Anthem has health-based resources to help You become more engaged in Your health and empower You to make the health care decisions that are right for You. The programs are described below. For more information contact Anthem at **877.403.0610** if there is not a phone number listed below the program description.

24/7 NurseLine

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

Future Moms

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

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

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

ConditionCare Core Programs

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

MyHealth Advantage

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

ComplexCare

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

Behavioral Health

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

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

Autism Spectrum Disorders Program

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

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

NOTE: Applied Behavioral Analysis for autism is not a Covered Expense under this Plan.

Important Provisions in the Non-Medicare Plans

Unless otherwise indicated in this section, the provisions listed here apply to the Standard PPO, the Health Savings PPO and the Defined PPO.

Incidental Providers (formerly "RAPS")

For radiologists, pathologists, anesthesiologists and emergency room Physicians, You and Your Covered Dependents will receive the Network level of benefits (up to the Maximum Allowed Amount) when such services are provided at an Network Hospital (inpatient, outpatient, and Hospital emergency room), or Network licensed free-standing surgical center. For example, if You receive treatment at a participating Anthem Hospital, and the radiologist who performs a service for this visit is an Out-of-Network Physician, the radiologist's bill for service will be paid at the Network level of benefits. If the radiologist's charge is higher than what is considered the Maximum Allowed Amount, the most the Plan will pay is based on the Maximum Allowed Amount.

Unlike Network Providers, the Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Network Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket Expenses to You. Contact the Claims Administrator at **877.403.0610** for help in finding a Network Provider, or visit Anthem's website and follow the directions stated above. Additionally, in some cases, some Network Provides may also bill for services or equipment that is above the standard as stated in their Provider contract with Anthem, such as hearing aids that are above the base model. You are responsible for paying the difference between the standard base model and the premium model. We recommend that You always verify with Your provider any amount that You may be responsible for in addition to any Copays or Coinsurance amounts.

Payment Innovation Programs

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

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

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

Care Coordination

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

Out-of-Network for an Emergency Medical Condition

Covered Expenses for care received Out-of-Network for an Emergency Medical Condition or Medical Emergency will be provided at the Network level of benefits. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. Care and treatment provided once You are stabilized is no longer considered a Medical Emergency. Continuation of care, including non-emergency follow-up care once discharged, from a Non-Network Provider beyond that needed to evaluate or stabilize Your condition in an Emergency will be covered as a Non-Network service unless the Claims Administrator authorizes the continuation of care and it is Medically Necessary.

Deductible Amounts

The Deductible Amount is measured by calendar year (January through December). The Deductible for each calendar year depends on the applicable medical benefit schedule (Standard PPO, Defined PPO or Health Savings PPO) and whether or not a Provider is In-Network or Out-of-Network. If a Deductible applies, the Plan will subtract the Deductible Amount from Covered Expenses and will then pay the remaining portion of Covered Expenses as stated in the applicable Schedule of Benefits.

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

For the Health Savings PPO Plan: The individual Deductible Amount applies only if You are enrolled in Employee Only coverage. The family Deductible Amount applies if You and any family members are enrolled, and the family Deductible amount can be satisfied by one individual. Prescription drug purchases can help satisfy the Deductible, but any penalties incurred as a result of failure to comply with Utilization Management requirements may not be used to help satisfy Your Deductible.

For the Defined PPO: The Deductible applies if the Covered Expense is not subject to a specified Copay. You pay one individual Deductible each calendar year. Only amounts up to the

individual Deductible Amount for each Member will apply toward satisfaction of the family Deductible Amount. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount. Copays applied to a Covered Expense cannot be used to help satisfy this Deductible Amount. The Copay and Coinsurance amounts paid under the Prescription Drug Program cannot be used to help satisfy this Deductible Amount. Also, any penalties incurred as a result of failure to comply with Utilization Management requirements may not be used to help satisfy Your Deductible.

Out-of-Pocket Maximums

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

For the Standard PPO:
The Out-of-Pocket Maximum consists of any Deductible payments and the Member's portion of Covered Expenses. Once a Member has incurred the total Out-Of-Pocket Maximum, the Plan will pay 100% of all covered medical expenses for the remainder of the Plan Year.

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

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

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

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

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

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

- the amount You pay because of penalty charges for failure to comply with the Utilization Management Review requirements; and

- expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount.

For the Defined PPO:
There is no Out-of-Pocket Maximum applicable to the Defined PPO Plan.

Lifetime Maximum Benefit

The maximum benefit payable under this Plan for covered Medical and prescription drugs for any non-Medicare eligible Member during his or her lifetime is $750,000. Your Lifetime Maximum follows You from option to option. For example, if in 2018 You are enrolled in the Standard PPO and in 2019 You enroll in the Health Savings PPO, the amount that has been applied to Your Lifetime Maximum under the Standard PPO will also apply to Your Lifetime Maximum under the Health Savings PPO.

Once You become eligible for Medicare, the Lifetime Maximum benefit is re-set to zero. Any amounts previously accumulated under the Lifetime Maximum provision when You or Your Eligible Dependents were not eligible for Medicare is disregarded and You start with a zero balance under the Medicare eligible Plan options. Thereafter if You move from the Conventional Plan to the Medicare Supplement Plan or vice-versa, the Lifetime Maximum will follow You as it did for the non-Medicare eligible options.

It is important to note that the exception to this provision is if a Member reaches the Lifetime Maximum while not yet eligible for Medicare. In that case, the Member is no longer eligible for coverage under the Plan even when he or she becomes eligible for Medicare.

If You reach the Lifetime Maximum at any time, You will no longer have coverage under the Plan. Your eligible Dependents may continue coverage under the Plan as long as they pay the applicable premiums. Participants nearing the Lifetime Maximum will be notified as soon as administratively possible.

Important Note: Covered Expenses incurred by Covered Retirees and their Covered Dependents prior to January 1, 2008 will not apply toward the Lifetime Maximum benefit. This means that on January 1, 2008, all Members were treated as new Members who had not used any of their Lifetime Maximum.

Maximum Allowed Amount

General

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

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

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

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

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

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

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

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

Provider Network Status

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

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

Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Expenses, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copay or Coinsurance. An Anthem National Network Provider directory is available by accessing Anthem's website at **www.anthem.com** or by calling **877.403.0610**.

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

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

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

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

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

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

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

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

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

Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. For help in finding a Network Provider, visit Anthem's website at **www.anthem.com**, or call Anthem at **877.403.0610**.

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

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

Member Cost Share

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

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

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

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

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Expense, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Expenses You receive from an Non-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Expense. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Expenses if You receive services for a Medical Emergency from a Non-Network Provider and are not able to contact the Claims Administrator until after the Covered Expense is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Expense received from an Non-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Anthem at **877.403.0610** for Authorized Services information or to request authorization.

Utilization Management Review

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

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

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

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

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

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

Exceptions to the Utilization Review Program

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

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

Types of Review

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

Precertification – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigational.

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

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

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

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

Treatment and Services Requiring Precertification

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

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

Inpatient Admission:

- Acute Inpatient
- Bariatric procedures
- Elective admissions

- Emergency admissions (Claims Administrator requires Plan notification no later than two (2) business days after admission)
- OB related admissions (complications; excludes childbirth except in cases where inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery) Newborn stays beyond mother (does not include routine maternity stay)
- Inpatient Skilled Nursing Facility
- Long term acute rehab facility
- Rehabilitation facility admissions

Outpatient Services:

- Ambulance Services: Air and Water (excludes 911 initiated emergency transport)
- Bariatric surgery and other treatments for clinically severe obesity
- Lumbar spinal surgeries (fusion only)
- UPPP surgery (uvulopalatopharyngoplasty,uvulopharyngoplasty)
- Plastic/Reconstructive surgeries including but not limited to:
    - Blepharoplasty
    - Rhinoplasty
    - Panniculectomy, Diatasis Recti Repair
    - Insertion/Injection of prosthetic material collagen implants
    - Chin implant, Mentoplasty, Osteoplasty Mandible
- Durable Medical Equipment/Prosthetics:
    - Wheeled mobility devices; deluxe, motorized or powered, ultra lightweight, and accessories
    - Hospital beds, rocking beds, and air beds
    - Prosthetics: electronic or externally powered and select other prosthetics
- Private duty nursing
- Dental anesthesia

Human Organ and Bone Marrow/Stem Cell Transplants

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

Mental Health/Substance Abuse (MHSA):

- Acute inpatient admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive outpatient therapy (IOP)
- Partial hospitalization (PHP)
- Residential care
- Behavioral Health in-home Programs

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96

hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

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

Request Categories:

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

Service Review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

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

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

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

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

For more information, see the CLAIMS FILING PROCEDURES section. You may also call the telephone number on Your medical ID card.

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

1. You are a Member; and
2. the treatment, service or surgery is a Covered Expense under Your medical plan option; and

3. the treatment or service is not subject to an exclusion under Your medical plan option; and
4. You have not have exceeded any applicable limits under Your medical plan option.

Important Information

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

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

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

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

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

Medical Expense Coverage for the Non-Medicare Plans

Unless otherwise specified in this section, the Covered Expenses listed here apply to the Standard PPO, the Health Savings PPO and the Defined PPO. No benefits are available for services that are not specifically described as Covered Expenses in this document. This exclusion applies even if Your Physician orders the service.

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

Covered Expenses include the Maximum Allowed Amount for:

1. Hospital for room and board, Intensive Care Accommodations and necessary services and supplies furnished by the Hospital. The Maximum Allowed Amount does not include charges for private Hospital room and board and general nursing care that exceed the Hospital Room Daily Limit. Precertification is required for all inpatient confinements;
2. Birthing Center services;

3. Ambulatory Surgery Center services;
4. the professional services of a Physician or surgeon;
5. the services of a Health Care Extender;
6. the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.);
7. Physical therapy services up to 25 outpatient visits per calendar year;
8. the services of occupational therapist, licensed speech pathologist, audiologist and speech language therapist up to a combination of 20 visits per calendar year. Speech therapy services will only be covered to restore speech lost or impaired due to:
    - a stroke;
    - an accidental injury; or
    - surgery, radiation therapy or other treatment which affects the vocal chords.
9. chiropractic services up to 25 visits per calendar year;
10. habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living for a diagnosis that is considered a Covered Expense under this Plan. These services may include physical and occupational therapy, speech-language pathology and other services in a variety of Inpatient and/or outpatient settings.
11. nutritional counseling for diabetic education; and, when related to pre- and post- surgery for approved medically necessary bariatric surgery;
12. Treatment for Gender Identity Disorder, including transgender surgery.
13. dugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing (excluding those charges paid under the Express Scripts Prescription Drug Program, if applicable);
14. surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
15. Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, and certain replacement parts such as batteries, cases and tubing, unless damage results from Your or Your Covered Dependent's negligence or abuse of such equipment. Covered Expenses will not include charges which are in excess of the purchase price of the equipment;

    Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Expense, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Expense is Your responsibility.
16. anesthesia;
17. oxygen, nebulizers and related charges;
18. blood transfusions (including the cost of blood and blood plasma);
19. x-ray and laboratory examinations made for diagnostic purposes in connection with the therapeutic treatment. This includes a professional component that is billed by a pathologist in connection with the laboratory testing;

20. colonoscopies (for both preventive and Medically Necessary reasons);
21. x-ray, radium, and radioactive isotope therapy;
22. professional Ambulance Service is subject to Medical Necessity and is a Covered Expense when You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. One or more of the following criteria are met.

    - For ground Ambulance, You are taken:
        - From Your home, the scene of an accident or medical Emergency to a Hospital;
        - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; or
        - Between a Hospital and a Skilled Nursing Facility or other approved facility.

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

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

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

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

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

    NOTE: Air Ambulance Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the air Ambulance Provider charges

Important Notes on Air Ambulance Benefits

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

Hospital to Hospital Transport

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

Non-Emergency Air Ambulance

When using an air Ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air Ambulance provider. If You do not use the air Ambulance provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's, Maximum Allowed Amount.

23. transportation within the continental United States and Canada by railroad or regularly scheduled flight of a commercial airline from the location where the individual becomes disabled due to any covered injury or disease to (but not returning from) a legally constituted Hospital equipped to furnish special treatment for such disability;
24. eye exams or glasses that are necessary to repair damage that was caused solely by an accidental injury that occurred while You or Your Dependent were covered under the Plan and provided such charges are incurred within six months of the date of the accident;
25. Cosmetic Treatment and Services or complications arising therefrom that results from a sickness or an accidental injury, provided the procedure or service is completed within twenty four months after the onset date of that sickness or injury;
26. Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident but did not result from chewing (except where the chewing or biting results from an act of domestic violence or directly from a medical condition). Covered Expenses are limited to the least expensive procedure that would provide professionally acceptable results;
27. dental care provided in a Hospital (including the charges provided by the Hospital, Physician, or nurse) as described under General Anesthesia–Hospital Charges for Dental and subject to utilization review by the Claims Administrator;
28. treatment or service due to any form of temporomandibular joint disorder (TMJ; malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), including but not limited to braces, splints, appliances, or surgery of any type;
29. hearing aids as follows:

- otologic examination of each ear by a Physician;
- audiologic examination and hearing evaluations of each ear by a certified or license audiologist;
- **Standard PPO and Health Savings PPO**: one personal hearing aid for each ear every five years. Covered Expenses will include: ear molds, the hearing aid, the initial batteries, cords and other necessary equipment, a warranty, and follow up consultation within 30 days after delivery of the hearing aid;
- **Defined PPO**: $500 Copay for one or two hearing aids. One personal hearing aid for each ear every five years.

Note: You may be responsible for the cost of hearing aid over the $500 copay. Network Provider contracts may allow the Provider to bill You for hearing aids above the standard basic device. The most the Plan will pay is based on the Maximum Allowed Amount. The Provider may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the amount that exceeds the Maximum Allowed Amount. Check with Your Provider before purchasing the hearing aid for any amounts You may be responsible for in additional to Your Copay or Coinsurance. If You and the hearing aid provider agree on a device with additional features prior to the hearing aid being provided, You may be responsible for the amount over the Allowed Amount.

30. wellness and preventive care services as recommended. Deductible will be waived. Some examples of wellness and preventive care services include, but are not limited to the following:
    - annual physical examination performed in a Physician's office;
    - well-woman care (including pap smears and gynecological exams);
    - mammograms;
    - prostate specific antigen (PSA);
    - well-child care including immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diptheria/tetanus; mumps, measles, rubella and certain others vaccines, at the in-network coverage level, whether obtained by an in-network or out-of-network provider);
    - adult immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diptheria/tetanus; shingles; and certain others vaccines, at the in-network coverage level, whether obtained by an in-network or out-of-network provider); and
    - diagnostic screening tests and x-rays provided during the exams.
31. Home Health Care Plan as described in this booklet;
32. Hospice Care as described in this booklet;
33. Skilled Nursing Facility as described in this booklet;
34. treatment or service related to mental health and alcohol or other substance abuse;
35. human to human transplants as described under Transplant Services in this booklet;
36. treatment or service related to the pregnancy of a Covered Retiree or the Covered Spouse of a Retiree;

37. treatment or service provided in a Veterans Administration Hospital for non-Service connected illness;
38. treatment or service provided while confined in a military medical facility incurred by a U.S. military retiree (and any Covered Dependents); and
39. reconstructive breast surgery in connection with a mastectomy for:
    - reconstruction of the breast on which a mastectomy has been performed;
    - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - prosthetic devices and physical complications of the mastectomy, including lymphedemas;
40. reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment is a Covered Expense under this Plan;
41. one wig per person per Plan year following cancer treatment for malignancy, up to $175 per wig.

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

Autism Spectrum Disorders (ASD) Program

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

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

Education

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

Guidance

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

Coordination

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

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

Case Management

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

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

Multiple Surgical Procedures

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

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

Covered Expenses for an Assistant During Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Covered Expenses for such services will be paid at the following percentages:

For the Standard PPO, 90% of the Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

For the Health Savings PPO, 80% of the Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

For the Defined PPO, 100% of the Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

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

General Anesthesia-Hospital Charges for Dental

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

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

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

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

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

Home Health Care

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

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

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

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

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

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

Hospice Care

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

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

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

Hospice services consist of:

- Care from an interdisciplinary Hospice Care team with the development and maintenance of an Appropriate plan of care; and

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

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

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

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

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

Skilled Nursing Facility Confinement

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

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

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

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

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

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

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

Transplant Services

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

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

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

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

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

Covered Expenses include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be Medically Necessary Care, not to exceed $10,000 per approved transplant.

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

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

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

For the Defined PPO Plan, travel and lodging benefits will be payable at 100% up to a maximum benefit of $10,000 for each approved transplant. There is no Copay.

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

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

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

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

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

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

Prior Approval and Precertification

In order to maximize Your benefits, it is strongly recommended that You contact the Claim Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is a Covered Expense and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Claims Administration at **877.403.0610** and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the covered transplant procedure, You or Your provider must contact the Claims Administrator's transplant department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

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

Expenses Not Covered in the Non-Medicare Plans

Unless otherwise indicated in this section, the Non-Covered Expenses listed here apply to the Standard PPO, the Health Savings PPO and the Defined PPO.

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

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

8. treatment for gene therapy, including any prescription drugs, procedures, healthcare services related to it that introduce or is related to the introduction of genetic material in a person intended to replace or correct faulty or missing genetic material;
9. treatment or services by a Christian Science practitioner;
10. dental services and materials, including dental implants (except as described under COVERED EXPENSES);
11. hearing aids or other implantable devices (except as described under COVERED EXPENSES);
12. eye examinations for the correction of vision or the fitting of glasses or frames or lenses (except as described under COVERED EXPENSES);
13. eyeglasses or contact lenses (except as described under COVERED EXPENSES), including corrective lenses implanted during cataract surgery;
14. acupuncture or acupressure treatment;
15. treatment or service for unattended home sleep studies;
16. drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing;
17. vitamins, minerals, nutritional supplements (even if the only source of nutrition) or special diets (whether they require a Physician's prescription or not);
18. wigs or hair prostheses (except as described under COVERED EXPENSES);
19. treatment or services for Custodial Care;
20. comfort or convenience services and supplies, such as personal hygiene items, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, Hoyer lift, gait belt, bedpans, physical fitness equipment, stair glides, elevators or lifts, motorized carts, motorized wheelchairs (unless medically necessary), scooters, strollers, amigo carts, standing frames, feeding chairs, and feeding equipment, whether or not recommended by a Physician;
21. charges for heating pads, heating and cooling units, ice bags or cold therapy units;
22. Cosmetic Treatment or Service or any complications arising therefrom (except as described under COVERED EXPENSES);
23. treatment or service for educational or training problems, learning disorders, marital counseling, or social counseling (except as provided under HOME HEALTH CARE or HOSPICE);
24. educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood, hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered;
25. applied behavior analysis for autism;
26. applied behavioral treatment, which includes but is not limited to applied behavioral analysis and intensive behavior interventions;

27. treatment or service for Developmental Delay;
28. treatment or service for which You have no financial liability or that would be provided at no charge in the absence of coverage;
29. treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);
30. treatment or service that results from war or act of war, whether declared or undeclared;
31. treatment or service to improve vision by changing the refraction such as, but not limited to: Kerato-Refractive Eye Surgery or LASIK (laser assisted in-situ keratomileusis) for myopia (nearsightedness), hyperopia (farsightedness), or astigmatism, including any complications therefrom;
32. charges for telephone calls and/or telephone consultations;
33. charges for e-mail communication or e-mail consultations;
34. charges for Physician overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment);
35. treatment or service for provider's standby services ("waiting time" by the provider);
36. treatment or service that results from a sickness or injury that is covered by a Workers' Compensation Act, or other similar laws;
37. treatment or service related to the restoration of fertility or the promotion of conception including but not limited to in-vitro fertilization; uterine embryo ravage; embryo transfer; artificial insemination; gamete intrafallopian tube transfer; zygote intrafallopian tube transfer; and low tubal ovum transfer;
38. reversal of elective sterilization;
39. barrier-free home modifications, including but not limited to, ramps, grab bars, or railings, whether or not recommended by a Physician;
41. treatment or service for smoking cessation or nicotine addiction, gambling addiction, or stress management;
42. treatment or service for insertion, removal, or revision of breast implants, unless provided post-mastectomy;
43. missed appointments;
44. treatment or service for any sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the sickness or condition occurs post-mastectomy;
45. non-implantable communicator-assist devices, including but not limited to, communication boards, and computers;
46. treatment or service for work-hardening services or vocational rehabilitation programs;
48. treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained;
49. treatment or services for obesity, (except Medically Necessary Care for morbid obesity, including surgery, will be covered);
50. cryopreservation or storage (except as described under TRANSPLANT SERVICES);

51. treatment or service for and complications related to:
    - human-to-human organ or bone marrow transplants, except as described under Transplant Services; or
    - animal-to-human organ or tissue transplants; or
    - implantation within the human body of artificial or mechanical devices designed to replace human organs;
52. treatment or service related to pregnancy of a Covered Dependent Child of a Retiree;
53. treatment or service that results from the abortion of a pregnancy, except that benefits will be payable for the abortion only if:
    - continuation of the pregnancy would endanger the life of the mother; or
    - medical treatment is required because of complications resulting from an abortion.
54. treatment or service for foot care with respect to: corns, calluses, flat feet, fallen arches, trimming of toe nails, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics). This limitation does not apply for Medically Necessary foot care (including treatment for diabetes, bunions, custom molded orthotics and/or shoes);
55. Residential accommodation to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment center;
56. charges for travel and lodging except as described under Transplant Services; or
57. treatment or service provided outside the United States, except for a Medical Emergency;
58. waiving of Copays, Coinsurance or Deductibles for which You are otherwise responsible for under the terms of this Plan, by Out-of-Network Providers for the purpose of promoting their own business.

Plans for Retirees and Dependents who are Eligible for Medicare

Conventional Plan Schedule of Benefits

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.	
CONVENTIONAL PLAN For Medicare Eligible Participants	
PLAN FEATURE	PROVIDER OF CHOICE
Lifetime Maximum Benefit Includes prescription drug benefits	$200,000
Deductible	$150 per person $300 per family
Hospital (Inpatient and Outpatient)	You pay the Deductible, then the Plan pays 80%
Urgent Care	You pay the Deductible, then the Plan pays 80%
Office Visits	You pay the Deductible, then the Plan pays 80%
Ambulance	You pay the Deductible, then the Plan pays 80%
Chiropractic Services	You pay the Deductible, then the Plan pays 80%
Mammograms One baseline mammogram for women age 35-39 and an annual mammogram for women age 40 and older	You pay the Deductible, then the Plan pays 80%
Eyeglasses Coverage only when eyeglasses are necessary to repair damage caused solely by an accident that occurred while covered under the **Ameren Retiree Medical Plan** and charges are incurred within 6 months of the date of the accident	The Plan pays 80% after Deductible
X-Ray and Lab (medically necessary, not for routine diagnosis)	You pay the Deductible, then the Plan pays 80%
Blood	You pay the Deductible, then the Plan pays 80%

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document	
CONVENTIONAL PLAN (continued) For Medicare Eligible Participants	
PLAN FEATURE	**PROVIDER OF CHOICE**
Provider doesn't accept Medicare Assignment	Covered Expenses for amounts over the Medicare-approved amounts are payable up to the Maximum Allowed Amount
Home Health Care No visit limit	You Pay the Deductible, then the Plan pays 80%
Skilled Nursing Facility Room and board charges are not covered	You pay the Deductible, then the Plan pays 80%
Hospice Care No day or dollar limit	You pay the Deductible, then the Plan pays 80%
Medicare Approved Durable Medical Equipment	You pay the Deductible, then the Plan pays 80%
Foreign Travel Emergency	You pay the Deductible, then the Plan pays 80%
Inpatient and Outpatient Mental Health, Alcohol or Substance Abuse	You pay the Deductible, then the Plan pays 80%
Prescription Drugs It is not necessary to elect prescription drug coverage if You are enrolled or enrolling in a Medicare Part D Drug Plan	See **PRESCRIPTION DRUG BENEFITS FOR MEDICARE ELIGIBLE PARTICIPANTS**
All other Covered Expenses	You pay the Deductible, then the Plan pays 80%

Medicare Supplement Plan Schedule of Benefits

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document. Covered Expenses under this Plan are limited to Medicare-approved charges.	
MEDICARE SUPPLEMENT PLAN For Medicare Eligible Participants	
PLAN FEATURE	PROVIDER OF CHOICE
Lifetime Maximum Benefit Includes prescription drug benefits	$200,000
Deductible	$0 for Part A Equal to the Medicare Part B Deductible ($183 for 2018) *(Medicare changes the Part B deductible each year)*
Hospital (Inpatient and Outpatient)	**Part A** – The Plan pays 100% of eligible Covered Expenses up to the Medicare approved charge less the actual amount paid by Medicare **Part B** – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met
Office Visits	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met
Urgent Care	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met
Ambulance	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met
Chiropractic Services Coverage is only for manipulation of the spine. All other modalities and chiropractic treatment are not covered.	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met.
Routine preventive services, such as: Mammograms Physicals, including gynecological exams Pap smears and PSA testing Certain Immunizations Bone density testing Routine Radiology and Pathology tests Colorectal Cancer screenings, including colonoscopies, sigmoidoscopies, fecal occult tests and barium enemas	The Plan pays 100% only when Medicare covers and pays for these expenses.

Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document. Covered Expenses under this Plan are limited to Medicare-approved charges.	
MEDICARE SUPPLEMENT PLAN For Medicare Eligible Participants	
PLAN FEATURE	**PROVIDER OF CHOICE**
Eyeglasses Coverage is only for one pair of eyeglasses following cataract surgery	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after Part B Deductible is met.
X-Ray and Lab (excluding routine care)	Part A – The Plan pays 100% of Covered Expenses up to the Medicare approved charge less the actual amount paid by Medicare. Part B – The Plan pays 100% of Covered Expenses less the actual amount paid by Medicare after the Part B Deductible is met.
Blood **Coverage is for the first 3 units You receive unless You or someone else donates blood to replace what You use.**	Part A – The Plan pays 100% of Covered Expenses up to the Medicare approved charge (less the actual amount paid by Medicare) Part B – The Plan pays 100% of Covered Expenses (less the actual amount paid by Medicare) after the part B Deductible is met
Provider doesn't accept Medicare Assignment	Covered Expenses for amounts over the Medicare-approved amounts are not covered.
Skilled Nursing Facility	The Plan does not pay benefits for these expenses.
Hospice Care	The Plan pays only when Medicare covers and pays for these expenses.
Home Health Care	The Plan does not pay benefits for these expenses.
Medicare Approved Durable Medical Equipment	Part B – The Plan pays 100% of charges not payable by Medicare after the Part B Deductible is met.
Foreign Travel (Emergency or Non-Emergency Care)	The Plan does not pay benefits for these expenses.
Inpatient and Outpatient Mental Health, Alcohol and Substance Abuse	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met.
Prescription Drugs **It is not necessary to elect coverage if You are enrolling in a Medicare Part D Drug Plan**	See Prescription Drug Benefits for Medicare Eligible Participants

Plan Options When One Participant is Medicare Eligible and the Other is not Medicare Eligible

In the case where one participant is Medicare eligible, and eligible for coverage under this Plan as stated in the Eligibility Section of this document (See ELIGIBILITY), and the other participant is not, the following Plan options are available:

	Option #1	Option #2
Medicare Eligible Participant	Conventional Plan	Medicare Supplement Plan
Non-Medicare Eligible Participant	Standard PPO or Defined PPO	Standard PPO or Defined PPO

In either case, all covered family members must choose the same prescription drug coverage option (either Three-Tier or Coinsurance).

Once a Member turns age 65, and remains eligible for this Plan, he or she will choose one of the Medicare-eligible options (Conventional or Medicare Supplement) at that time. The non-Medicare eligible Spouse or other family member may not remain in the Health Savings PPO. he/she must, at the same time, move into the Standard PPO Plan or the Defined PPO Plan.

However, if one Member is Medicare eligible and eligible for the **Ameren Retiree Health Reimbursement Account Plan**, the non-Medicare eligible Member eligible for this Plan may choose to enroll in the Health Savings PPO.

An enrollment worksheet will be sent to the Medicare-eligible Member. This worksheet will outline the options available and the associated costs. The Member can then make his/her elections through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). If You do not make an election for coverage under the Medicare Supplement or Conventional Plan, You will be defaulted to the Plan option listed below:

Currently enrolled in . . .	Default Medical Plan (if no election is made)	Default Prescription Drug Plan (if You don't make an election)
Standard PPO or Defined PPO	Medicare Supplement Plan	Same Prescription Drug option You were enrolled in prior to Your age 65.
Health Savings PPO	Medicare Supplement Plan	Coinsurance Prescription Drug option

Important Provisions in the Conventional or the Medicare Supplement Plan

Deductible Amounts

The Deductible Amount for each calendar year is the amount specified in the applicable Schedule of Benefits. The Plan will subtract the Deductible Amount from Covered Expenses and will then pay the Covered Expenses as stated in the applicable Schedule of Benefits.

For both the Conventional Plan and the Medicare Supplement Plan, You pay one individual Deductible Amount each calendar year for covered medical expenses. For satisfaction of the family Deductible Amount in the Conventional Plan, no more than one individual Deductible Amount will apply for any one person. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount. A separate Deductible may apply for prescription drugs if You elect the Coinsurance Prescription Drug option. Any coinsurance and copay amounts under the Prescription Drug Program cannot be used to help satisfy the Deductible Amount for covered medical expenses.

Out-of-Pocket Maximums

The Out-Of-Pocket Maximum is the amount of Covered Expenses a Covered Retiree or Dependent would pay in a Plan Year before the Plan begins to pay 100% of covered medical expenses.

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

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

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

- the amount You pay because of penalty charges for failure to comply with the Utilization Management Review Requirements; or
- prescription drug Copays, Coinsurance amounts or Deductibles under the Express Scripts Prescription Drug Program, if applicable; or
- expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount.

Lifetime Maximum Benefit

The maximum benefit payable under this Plan for covered medical and prescription drugs during any Member's lifetime is $200,000 for Medicare eligible participants. Your Lifetime Maximum is re-set to zero when You become Medicare eligible and move into the Conventional Plan or the Medicare Supplement Plan. Any amount previously accumulated before You were eligible for Medicare is disregarded. It is important to note that the exception to this provision is if a Member reaches the Lifetime Maximum while not yet eligible for Medicare. In that case, the Member is no longer eligible for coverage under the Plan even when he or she becomes eligible for Medicare.

Your Lifetime Maximum follows You from option to option. For example, if in 2018 You are enrolled in the Conventional Plan and in 2019 You enroll in the Medicare Supplement Plan, the amount that has been applied to Your Lifetime Maximum under the Conventional Plan will also be applied to Your Lifetime Maximum under the Medicare Supplement Plan.

If You reach the Lifetime Maximum at any time, You will no longer have coverage under the Plan. Your eligible dependents may continue coverage under the Plan as long as they pay the applicable premiums. Participants nearing the Lifetime Maximum will be notified as soon as administratively possible.

Important Note: Covered Expenses incurred by Covered Retirees and their Covered Dependents prior to January 1, 2008 will not apply toward the Lifetime Maximum Benefit. This means that on January 1, 2008, You and Your Covered Dependents were treated as new Members who had not used any of Your Lifetime Maximum.

Medical Expense Coverage for the Conventional or Medicare Supplement Plan

Covered Expenses

Covered Expenses will be the actual cost charged to You or one of Your Covered Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed the Maximum Allowable Amount or the Medicare allowable charge if You are enrolled in the Medicare Supplement Plan. Except for the wellness benefits[4] outlined under Covered Expenses, the expenses must be ordered by a Physician for therapeutic treatment of an injury or sickness and not be listed as an exclusion under Expenses Not Covered in this booklet. If a service is Medically Necessary but not specifically listed and not otherwise excluded, the service is not a Covered Service.

The Covered Expenses listed below are applicable for both Plan options, unless specifically mentioned as an exclusion. Covered Expenses include the Maximum Allowed Amount for:

1. Hospital for room and board, Intensive Care Accommodations and necessary services and supplies furnished by the Hospital. The Maximum Allowed Amount does not include charges for private Hospital room and board and general nursing care that exceed the Hospital Room Daily Limit;
2. Birthing Center services;
3. Ambulatory Surgery Center services;
4. the professional services of a Physician or surgeon;
5. services of a Health Care Extender;
6. services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.);
7. Physical Therapy services
8. occupational and speech therapy services. Speech therapy services will only be covered to restore speech lost or impaired due to:
    - a stroke

[4] Important Note: Wellness and preventive care services are not covered under the Conventional Plan. In addition, under the Medicare Supplement Plan, wellness and preventive care services are only covered if Medicare provides coverage for the service.

- accidental injury, or
- surgery, radiation therapy or other treatment which affects the vocal chords.

9. nutritional counseling for diabetic education; and, when related to pre- and post- surgery for approved medically necessary bariatric surgery;
10. chiropractic services. For Members in the Medicare Supplement Plan: As approved by Medicare, the only covered chiropractic service is manipulation of the spine; all other chiropractic modalities/treatment provided are not covered;
11. drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing (excluding those charges paid under the Express Scripts Prescription Drug Program, if applicable);
12. surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
13. Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, and certain replacement parts such as batteries, cases and tubing, unless damage results from Your or Your Covered Dependent's negligence or abuse of such equipment. Covered Expenses will not include charges which are in excess of the purchase price of the equipment.
14. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Expense, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Expense is Your responsibility.
15. anesthesia and its administration;
16. blood transfusions (including the cost of blood and blood plasma).

    For Participants in the Medicare Supplement Plan: If You are a participant in the Medicare Supplement Plan, only the first three (3) units of blood that You receive as part of an inpatient stay are covered (unless You or someone else donates blood to replace what You use.) Only the costs (after Deductible) for the first three (3) units of blood that You receive as part of an outpatient procedure are covered (unless You or someone else donates blood to replace what You use);
17. oxygen, nebulizers and related charges;
18. x-ray and laboratory examinations made for diagnostic purposes in connection with the therapeutic treatment (including professional components that are billed by a pathologist in connection with the laboratory testing);
19. x-ray, radium, and radioactive isotope therapy;
20. professional Ambulance Service is subject to Medical Necessity and is a Covered Expense when You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. One or more of the following criteria are met.
    - For ground Ambulance, You are taken:
        - From Your home, the scene of an accident or medical Emergency to a Hospital;

- Between Hospitals
- Between a Hospital and a Skilled Nursing Facility or other approved facility.

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

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

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

- For air or water Ambulance, You are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals
  - Between a Hospital and an approved Facility.

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

NOTE: Air Ambulance Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the air Ambulance Provider charges

Important Notes on Air Ambulance Benefits

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

Hospital to Hospital Transport

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

critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You.

Non-Emergency Air Ambulance

When using an air Ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air Ambulance provider. If You do not use the air Ambulance provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's, Maximum Allowed Amount.

21. transportation within the continental United States and Canada by railroad or regularly scheduled flight of a commercial airline from the location where the Member becomes disabled due to any covered injury or disease to (but not returning from) a legally constituted Hospital equipped to furnish special treatment for such disability;
22. eye exams or glasses that are necessary to repair damage that was caused solely by an accidental injury that occurred while You were covered under the Plan and provided such charges are incurred within six months of the date of the accident.

    For Members in the Medicare Supplement Plan: If You participate in the Medicare Supplement Plan, the only Covered Expense for eyeglasses is for one pair of glasses following cataract surgery;
23. Cosmetic Treatment and Services or complications arising therefrom that results from a sickness or an accidental injury, provided the procedure or service is completed within twenty four months after the onset date of that sickness or injury;
24. dental services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing (except where the chewing or biting results from an act of domestic violence or directly from a medical condition). Covered Expenses are limited to the least expensive procedure that would provide professionally acceptable results;
25. Home Health Care as described in this booklet.

    For Members in the Medicare Supplement Plan: If You participate in the Medicare Supplement Plan, Home Health Care Services are not covered;
26. Hospice Care as described in this booklet.

    For Members in the Medicare Supplement Plan: Hospice Care Services are covered only when Medicare covers and pays for the services.
27. Skilled Nursing Facility as described in this booklet.

    For Members in the Medicare Supplement Plan: If You participate in the Medicare Supplement Plan, Skilled Nursing Facility Services are not covered;
28. treatment or service related to mental health and alcohol or other substance abuse;
29. human to human organ or bone marrow transplants not considered Experimental or Investigational;
30. treatment or service related to the pregnancy of a Covered Retiree or the Covered Dependent Spouse of a Retiree;
31. treatment or service provided in a Veterans Administration Hospital for non-service connected illness;

32. treatment or service provided to a Retiree, who is currently or was formerly in the U.S. military, and any Covered Dependent of such Retiree while confined in a military medical facility;
33. For Members in the Medicare Supplement Plan, the following routine preventative care services will be covered, but only if considered a covered service by Medicare and Medicare pays for the service:
    - routine physicals
    - gynecological exams and pap smears;
    - cholesterol screenings;
    - mammograms;
    - colorectal cancer screening;
    - bone density testing;
    - pathology tests;
    - PSA testing and
    - Certain immunizations
34. reconstructive breast surgery in connection with a mastectomy for:
    - reconstruction of the breast on which a mastectomy has been performed;
    - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    - prosthetic devices and physical complications of the mastectomy, including lymphedemas.
35. reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment is a Covered Expense under this Plan;

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

Multiple Surgical Procedures

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

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

Covered Expenses For An Assistant During Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Covered Expenses for such services will be paid at the following percentages:

For the Conventional Plan, 80% of the Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

For the Medicare Supplement Plan, 100% of the Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

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

Home Health Care (For the Conventional Plan Only)

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

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

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

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

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

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

Hospice Care

Hospice Care for Members in the Medicare Supplement Plan is covered only when Medicare approves and covers the services.

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

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

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

Hospice Care Services for the Conventional Plan consists of:

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

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

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

The general exclusions listed in this section under Expenses Not Covered will apply to Hospice Care. In addition, Covered Expenses will not include Hospice Care charges that:

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

Skilled Nursing Facility Confinement (For the Conventional Plan Only)

Covered Expenses will include charges required for treatment, provided the confinement:

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

Covered Expenses will not include room and board charges in a Skilled Nursing Facility for charges incurred after the date:

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

Transplant Services (For the Medicare Supplemental Plan Covered Expenses are Limited to Medicare-Approved Charges.)

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

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

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

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

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

Covered Expenses include cryopreservation and storage of bone marrow or peripheral stem cells when the cryopreservation and storage is part of a protocol of high dose chemotherapy, which has been determined by the Claims Administrator to be Medically Necessary Care, not to exceed $10,000 per approved transplant.

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

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

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

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

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

Expenses Not Covered

Except for the wellness benefits[5] outlined under Covered Expenses, the following list describes Expenses for which no benefits will be paid. This is not an exhaustive list:

1. treatment or service that is not for Medically Necessary Care (except for certain routine preventative services listed under Covered Expenses);
2. treatment or service that is an Experimental or Investigational Measure;
3. any part of a charge for treatment or service that exceeds the Maximum Allowed Amount;
4. **For the Medicare Supplement Plan**, any charges not approved by Medicare;
5. services of any person in Your Immediate Family or any person in Your Covered Dependent's Immediate Family;
6. treatment or services by a Christian Science practitioner;
7. dental services and materials including dental implants (except as described under Covered Expenses);
8. hearing aids or other implantable devices (except as described under Additional Covered Expenses);
9. eye examinations for the correction of vision or the fitting of glasses or frames or lenses (except as described under Covered Expenses);
10. eyeglasses or contact lenses (except as described under Covered Expenses), including corrective lenses implanted during cataract surgery;
11. acupuncture or acupressure treatment;
12. treatment or service for unattended home sleep studies;

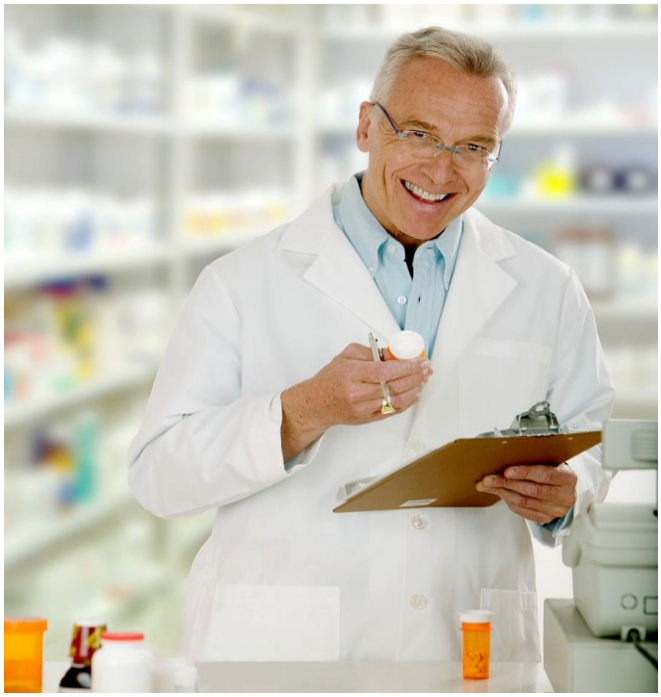
[5] Important Note: Wellness and preventive care services are not covered under the Conventional Plan. In addition, under the Medicare Supplement Plan, wellness and preventive care services are only covered if Medicare provides coverage for the service.

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

31. charges for Physician overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment);
32. treatment or service for provider's standby services ("waiting time" by the provider);
33. treatment or service that results from a sickness that is covered by a Workers' Compensation Act or similar law;
34. treatment or service that results from an injury arising out of or in the course of any employment for wage or profit;
35. treatment or service related to preventive medical expenses such as annual physical exams, except mammograms under the Conventional Plan and except for routine preventative services described under Covered Expenses;
36. treatment or service related to the restoration of fertility or the promotion of conception including but not limited to in-vitro fertilization; uterine embryo ravage; embryo transfer; artificial insemination; gamete intrafallopian tube transfer; zygote intrafallopian tube transfer; and low tubal ovum transfer;
37. reversal of elective sterilization;
38. barrier-free home modifications including, but not limited to, ramps, grab bars, or railings, whether or not recommended by a Physician;
40. treatment or service for smoking cessation or nicotine addiction, gambling addiction, or stress management;
41. treatment or service for insertion, removal, or revision of breast implants, unless provided post-mastectomy;
42. missed appointments;
43. treatment or service for any sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the sickness or condition occurs post-mastectomy;
44. non-implantable communicator-assist devices, including but not limited to, communication boards, and computers;
45. treatment or service for work-hardening services or vocational rehabilitation programs;
47. treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained;
48. treatment or services for obesity, (except Medically Necessary Care for morbid obesity, including surgery, will be covered);
49. cryopreservation or storage (except as described under TRANSPLANT SERVICES);
50. treatment or service for and complications related to:
    - human-to-human organ or bone marrow transplants, except as described under Transplant Services;
    - animal-to-human organ or tissue transplants; and
    - implantation within the human body of artificial or mechanical devices designed to replace human organs;
51. treatment or service related to pregnancy of a Covered Dependent Child of a Retiree;

52. treatment or service that results from the abortion of a pregnancy, except that benefits are payable for the abortion only if:
    - continuation of the pregnancy would endanger the life of the mother or
    - medical Treatment is required because of complications resulting from an abortion
53. treatment or service for foot care with respect to: corns, calluses, flat feet, fallen arches, trimming of toe nails, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics). This limitation does not apply for Medically Necessary foot care (including treatment for diabetes, bunions, custom molded orthotics and/or shoes);
54. Residential accommodation to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment center;
55. charges for travel and lodging except as described under Transplant Service;
56. treatment or service provided outside the United States, except for Medical Emergency;
57. treatment or service that results from participation in criminal activities, as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. However, this exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence;
58. molecular genetic testing (specific gene identification) for purposes of health screening or if not part of a treatment regimen for a specific sickness, unless certain criteria (as determined by the Claims Administrator) have been met and the testing is accompanied by genetic counseling;
59. treatment for gene therapy, including any prescription drugs, procedures, healthcare services related to it that introduce or is related to the introduction of genetic material in a person intended to replace or correct faulty or missing genetic material;
60. additional charges incurred because care was provided after hours, on a Sunday, holidays, or on a weekend;
61. waiving of Copays, Coinsurance or Deductibles for which You are otherwise responsible for under the terms of this Plan, by Out-of-Network Providers for the purpose of promoting their own business.

Prescription Drug Program



Prescription Drugs Administered by a Medical Provider

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

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

Important Details About Prescription Drug Coverage As A Medical Benefit

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

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

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

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

Precertification

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

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

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

Designated Pharmacy Provider

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

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

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

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

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

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

Prescription Drug Program Administered by Express Scripts

The Prescription Drug Program is designed to provide several convenient options for obtaining prescription drugs. Whenever You have a prescription to be filled, use the Prescription Drug Program. If the prescription is needed immediately, You should use the participating retail Pharmacy of Your choice. For ongoing prescriptions taken over longer periods of time (sometimes referred to as maintenance medications), You should consider using the Home Delivery Program. For certain specialty medications, You need to use Express Scripts Specialty Pharmacy, Accredo, to fill Your prescription.

Prescription Drug Benefits for Participants in the Standard PPO and Defined PPO

PRESCRIPTION DRUG PROGRAM **Administered by Express Scripts (ESI)**		
	THREE TIER PRESCRIPTION DRUG PROGRAM	**COINSURANCE PRESCRIPTION DRUG PROGRAM****
Deductible	$0	$250/individual and $500/family This Deductible is separate from any Deductible applicable to medical benefits under the Plan and does not apply toward reaching the Out-of-Pocket Maximum for medical benefits. Amounts You pay for covered prescription drugs obtained at a retail Pharmacy and through Home Delivery are combined for purposes of meeting the Deductible.
Out-of-Pocket Maximum Includes Deductible	None	$750/individual and $1,500/family This Out-of-Pocket Maximum is separate from any Out-of-Pocket Maximum applicable to medical benefits under the Plan. Amounts You pay for covered prescription drugs obtained at a retail Pharmacy and through Home Delivery are combined for purposes of meeting the Out-of-Pocket Maximum.
Retail Drugs 34 day supply*	$10 for Generic Drugs $30 for Preferred Brand Name Drugs $50 for Non-Preferred Brand Name Drugs	You pay Deductible and the Plan pays 80%. You pay 20% of ESI's discounted price for each covered prescription drug up to the Out-of-Pocket Maximum shown above.

PRESCRIPTION DRUG PROGRAM (continued) **Administered by Express Scripts (ESI)**		
	THREE TIER PRESCRIPTION DRUG PROGRAM	**COINSURANCE PRESCRIPTION DRUG PROGRAM****
Home Delivery Program Drugs 90 day supply*	$20 for Generic Drugs $60 for Preferred Brand Name Drugs $100 for Non-Preferred Brand Name Drugs	You pay Deductible and the Plan pays 80%. You pay 20% of ESI's discounted price for each covered prescription drug up to the Out-of-Pocket Maximum shown above.

*__Drug Quantity Management__ –Criteria may apply to determine whether specific drugs are limited to a certain quantity other than the quantity stated in the Schedule of Prescription Drug Benefits. Certain medications that are subject to the Drug Quantity Management Program are subject to a maximum 30 day supply at the Retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section). The criteria are based on Food and Drug Administration (FDA) approved dosing guidelines and the medical literature. Therefore, if Your Physician writes a prescription above the recommended quantity for a particular drug, Your pharmacist will only dispense the limited amount for Your Copay. You should call Express Scripts at **888.256.6131** if You have questions about coverage and/or quantity limits for a specific prescription drug.

**__Coinsurance Prescription Drug Program__ - The Plan will subtract the Deductible Amount from covered prescription drug expenses and will then pay the covered prescription drug expenses as stated in the Schedule of Benefits for the Coinsurance Prescription Drug Program. You pay one individual Deductible Amount for covered prescription drug expenses each calendar year. For satisfaction of the family Deductible Amount, no more than one individual Deductible Amount will apply for any one person. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount.

The Out-of-Pocket Maximum is the amount of covered prescription drug expenses a Covered Retiree or Covered Dependent would pay in a Plan Year before the Plan begins to pay 100% of covered prescription drug expenses. This amount consists of any Deductible payments and the Covered Retiree or Dependent's portion of any covered prescription drug expenses. Once a Covered Retiree or Dependent has incurred the total Out-Of-Pocket Maximum, the Plan will pay 100% of all covered prescription drug expenses for the remainder of the Plan Year for that Member.

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

Prescription Drug Program for Health Savings PPO Plan

If You and Your Covered Dependents are participating in the Health Savings PPO Plan, Your prescription drug program is administered by Express Scripts. The Health Savings PPO medical Plan Deductible of $1,400 for individual coverage or $2,800 if You cover family members must be met before payments begin. This means that You must pay the full cost of the prescription at the time of purchase and the cost will be applied to Your Deductible. Once Your Deductible has been met, You pay 20% of the Express Scripts discounted price for the medication, no matter which category the drug falls into. The prescription drug benefit is electronically integrated with the portion of the Plan providing medical benefits, so most Pharmacies will know if You have met Your Deductible.

For the Health Savings PPO Plan, the Out-of-Pocket Maximum includes covered medical and drug expenses. Once You have met the Out-of-Pocket Maximum, Your covered prescription drugs would be paid by the Plan at 100%.

Preventive Prescription Drugs

You pay 20% coinsurance for preventive medications whether or not You have met Your medical deductible under the Health Savings PPO Plan. The coinsurance You pay for preventive medications will apply toward Your annual out-of-pocket maximum. To determine if Your prescription drug is considered a preventive medication, contact Express-Scripts at **888.256.6131**.

Prescription Drug Benefits for Medicare Eligible Participants

PRESCRIPTION DRUG PROGRAM (Administered by Express Scripts, Inc.) (Cannot be elected alone; must choose a medical option also)			Medical Only Option (No Prescription Drug Coverage)
	Three-Tier Prescription Drug Program (available with Conventional Plan or Medicare Supplement Plan)	**Co-Insurance Prescription Drug Program**** (available with Medicare Supplement Plan only)	**Available Only if enrolled in the Conventional Plan or the Medicare Supplement Plan**
Deductible	**$0**	**$250** per individual **$500** per family This Deductible is separate from any Deductible applicable to medical benefits under the Plan and does not apply toward reaching the Out-of-Pocket Maximum for medical benefits. The Retail Drugs Deductible is combined with the Home Delivery Drugs Deductible.	No prescription drug coverage through the **Ameren Retiree Medical Plan**. Participants **should** enroll in a Medicare Part D plan for prescription drug coverage. This option is available to Members only when **all** covered family members are Medicare-eligible. (For example when the Retiree and Spouse are both Medicare-eligible.)
Out of Pocket Maximum	**None**	**$750** per individual **$1,500** per family Amounts You pay for covered prescription drugs obtained at a retail Pharmacy and through Home Delivery are combined for purposes of meeting the Out-of-Pocket Maximum. The Retail Drugs Out-of-Pocket Maximum is combined with the Home Delivery Drugs Out-of-Pocket Maximum.	
Retail Drugs 34 day supply*	**$10** for generic drugs **$30** for preferred brand name drugs **$50** for non-preferred brand name drugs.	You pay Deductible, then the Plan pays 80%. You pay 20% of ESI's discounted price for each covered prescription drug up to the Out-of-Pocket Maximum.	
Home Delivery Program Drugs 90 day supply*	**$20** for generic drugs **$60** for preferred brand name drugs **$100** for non-preferred brand name drugs. 90 day supply*	You pay Deductible, then the Plan pays 80%. You pay 20% of ESI's discounted price for each covered prescription drug up to the Out-of-Pocket Maximum.	

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

***Drug Quantity Management** – Criteria may apply to determine whether specific drugs are limited to a certain quantity other than the quantity stated in the Schedule of Prescription Drug Benefits. Certain medications that are subject to the Drug Quantity Management Program are subject to a maximum 30 day supply at the Retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section). The criteria are based on Food and Drug Administration (FDA) approved dosing guidelines and the medical literature. Therefore, if Your Physician writes a prescription above the recommended quantity for a particular drug, Your pharmacist will only dispense the limited amount for Your Copay. You may call Express Scripts at **888.256.6131** if You have questions about coverage and/or quantity limits for a specific prescription drug.

****Coinsurance Prescription Drug Program -** The Plan will subtract the Deductible Amount from covered prescription drug expenses and will then pay the covered prescription drug expenses as stated in the Schedule of Benefits for the Coinsurance Prescription Drug Program. You pay one individual Deductible Amount for covered prescription drug expenses each calendar year. For satisfaction of the family Deductible Amount, no more than one individual Deductible Amount will apply for any one person. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount.

The Out-of-Pocket Maximum is the amount of covered prescription drug expenses a Covered Retiree or Covered Dependent must pay in a Plan Year before the Plan begins to pay 100% of covered prescription drug expenses. This amount consists of any Deductible payments and the Covered Retiree or Dependent's portion of any covered prescription drug expenses. Once a Covered Retiree or Dependent has incurred the total Out-Of-Pocket Maximum, the Plan will pay 100% of all covered prescription drug expenses for the remainder of the Plan Year for that Member.

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

If You Have Questions

The following chart is a quick reference for You to use if You have questions about this benefit.

Information Needed	Who to Call	Website Address
If You have questions about: ➢ Retail network Pharmacies ➢ Status of Your claim or Home Delivery prescription ➢ Claim history ➢ How to request a drug through the Home Delivery Program ➢ Your cost or coverage for a drug	Express Scripts Customer Service **888.256.6131** Be sure to identify Yourself as a Member of the **Ameren Retiree Medical Plan** and have available the Retiree's Social Security number, or the Express Scripts assigned alternative identification number.	www.express-scripts.com You can create Your own personal profile so Your information will only be available to You.
Specialty Pharmacy	Accredo Customer Service **866.848.9870**	

Obtaining Prescription Drugs

Prescription Drugs Obtained at a Participating Retail Pharmacy

You may obtain up to a 34-day supply of a covered prescription drug at the retail Pharmacy. Your prescription drug program ID card must be presented to the pharmacist when You have the prescription filled. Certain medications subject to the Drug Quantity Management Program are subject to a maximum 30 day supply at the retail Pharmacy. (See DRUG QUANTITY MANAGEMENT within this PRESCRIPTION DRUG PROGRAM section).

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

Since the Express Scripts organization is recognized nationwide, the Prescription Drug Program will be easy to use wherever You are. Most Pharmacies in the United States participate in the Express Scripts Pharmacy network, but You should contact Your Pharmacy to verify its

participation. You may also call Express Scripts at **888.256.6131** or access their website at www.express-scripts.com to find participating Pharmacies.

If You are told at a retail Pharmacy that the **Ameren Retiree Medical Plan** does not cover Your prescription, please contact Express Scripts at **888.256.6131** to determine the reason.

Prescription Drugs Obtained at a Non-Participating Retail Pharmacy

If You have a prescription filled at a non-participating Pharmacy, (for example, You visit a non-participating Pharmacy while on vacation), the full cost of the prescription must be paid at the time of purchase and a completed claim form must be submitted to Express Scripts for reimbursement within 365 days of the purchase. Claim forms may be obtained either by calling Express Scripts at **888.256.6131** or by visiting www.express-scripts.com.

Reimbursement will be made based on the Ameren negotiated discounted Average Wholesale Price (AWP) of the drug minus the applicable $10, $30, or $50 Copay, or 20% Coinsurance amount, regardless of what is actually paid for the drug. For example, if You fill a generic prescription at a non-participating Pharmacy at a cost of $40, and the discounted Average Wholesale Price of the Generic drug is actually $35, You will be reimbursed $25 (the $35 discounted wholesale cost less the $10 Generic Copay).

Prescription Drugs Obtained Through the Home Delivery Program

All Members in the Prescription Drug Program may purchase prescription drugs through the Express Scripts Home Delivery Program prescription drug service. This program works very well for people who are taking maintenance drugs to treat chronic or long-term health conditions such as arthritis, diabetes, asthma, heart conditions, and high blood pressure. By using the Home Delivery service, Members may obtain up to a 90-day supply of a drug, and pay the equivalent of two retail Copayments if they are participating in the Three Tier Prescription Drug Plan. You will pay the 20% Coinsurance (after applicable Deductible) if You are participating in the Coinsurance Prescription Drug Plan.

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

To enroll in the Home Delivery Program, complete an Express Scripts patient profile/order form and send it with the prescription and applicable Copay to the address printed on the form. The form may be obtained either by calling Express Scripts at **888.256.6131** or visiting the website at www.express-scripts.com. The Copay may be paid either by check or by credit card. The form explains how to pay by credit card. The prescription may also be refilled online by visiting www.express-scripts.com.

All prescriptions are reviewed by a pharmacist, checked for adverse drug interactions, and verified by quality control before they are dispensed and mailed. Generic medication will be

dispensed when available and allowed by law, unless a Physician has indicated on the prescription that a Brand Name Drug must be provided. It will usually take ten (10) to fourteen (14) working days to receive an order. Some drugs cannot be sent through the mail. For example, drugs that require refrigeration must be obtained at a local Pharmacy.

You may call Express Scripts' Customer Service at **888.256.6131** if You have questions or need to check the status of an order. Members must identify themselves as participants in the Plan and must be prepared to provide the Retiree's Social Security number or the Express Scripts assigned alternate identification number.

Prescription Drugs Obtained Through the Smart90 Program

The Smart90 Program allows You the choice to obtain a 90-day supply of designated maintenance medications through Express Scripts' Home Delivery Program, or at participating Walgreens locations for the same Copay or Coinsurance.

If You are enrolled in the Three Tier Prescription Drug Program, You will pay the same Copay whether You obtain Your maintenance medication through the Express Scripts' Home Delivery Program or at a participating Walgreen's retail pharmacy (two Copays for three months of the maintenance medication.) If You are enrolled in the Coinsurance Prescription Drug Program, or enrolled in the Health Savings PPO medical plan option, You may have slightly lower costs if You obtain Your maintenance medication through the Express Scripts' Home Delivery Program, rather than obtaining Your maintenance medication at a participating Walgreens' retail pharmacy.

If You continue to fill a one-month supply of Your maintenance medication instead of a three-month supply, or if You do not use a Walgreens pharmacy or the Express Scripts' Home Delivery Program to fill a designated maintenance medication through the Smart90 Program, You will be responsible for paying the full cost of Your maintenance prescription medication. Full cost is the actual cost of Your prescription medication. For example, if the actual cost of the prescription is $75.00, but Your Copay or Coinsurance is only $20.00, Your cost for the maintenance prescription medication for not using the Smart90 Program would be the actual cost of $75.00.

You can find out if Your prescription medication is a maintenance medication under the Smart90 Program by contacting Express Scripts at **888.256.6131**, or at express-scsripts.com/ameren.

Specialty Pharmacy for Treatment of Chronic Illness

Your prescription drug benefits include a specialty Pharmacy service from Accredo, a subsidiary of Express Scripts.

Accredo specializes in oral and injectable specialty medications that treat certain chronic conditions like multiple sclerosis, rheumatoid arthritis and hepatitis C, and offers many products and services that You don't get from other Pharmacies, such as:

- A patient care coordinator, who serves as Your personal advocate and Your point of contact. This highly trained individual works closely with Your Physician to obtain prior authorizations and coordinate billing. Your coordinator will even contact You when it's time to refill Your prescription.

- A complete specialty Pharmacy inventory, with many specialty medications that aren't readily available at a local Pharmacy.
- Delivery of Your medications directly to You or Your Physician.
- Providing supplies needed to administer Your medications, at no additional cost.
- Clinically based care-management programs, which include consultation with Your Physician, to help You get the most benefit from the specialty medications Your Physician has prescribed.

Accredo provides these services at no additional cost to You. You pay the Copay or Coinsurance (and Deductible, if applicable) required under the prescription drug option for a maximum 30-day supply. If Your Physician prescribes a medication covered by the specialty Pharmacy program, Accredo will be the only covered source for that medication. Specialty medications will not be covered if purchased from other Pharmacies.

To contact Accredo, call **866.848.9870** or have Your Physician fax Your prescription to **800.391.9707**. Your Physician may fax Your prescription to Accredo 24 hours per day; 7 days per week. Customer service hours for Accredo are from 7 a.m. to 10 p.m. Eastern Standard Time (EST), Monday through Friday, and from 7 a.m. to 4 p.m. Eastern Standard Time (EST) on Saturday.

Covered Drugs

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

- Any drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician or other lawful prescriber;
- Compounded medication of which at least one ingredient is a prescription drug;
- Insulin, glucose monitors and other diabetic supplies including pump supplies (however, insulin pumps are covered under the medical portion of the Plan, see DURABLE MEDICAL EQUIPMENT within the COVERED EXPENSES section of this booklet);
- Tretinoin, all dosage forms (e.g. Retin A) for Members through the age of twenty-five (25) years, and as prescribed to Members over age twenty-five (25) as Medically Necessary to treat or control a medical condition and not for cosmetic purposes. Prior authorization is required for Members over age twenty-five (25);
- Smoking Cessation prescription drugs up to a maximum of $500 annually;
- Weight loss prescription drugs when clinically approved and prescribed by a Physician.

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

Drugs Not Covered

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

- Contraceptives, oral or other, whether medication or device, unless Medically Necessary (prescribed to treat or control a medical condition and not used for contraceptive purposes);
- Prescription drugs to treat infertility;

- Over-the-counter drugs or any other drugs (excluding insulin) which do not require a prescription from a lawful prescriber;
- Over-the-counter equivalents obtained with a prescription;
- Vitamins, minerals, nutritional supplements or special diets (whether they require a Physician's prescription or not) and legend homeopathic medications;
- Prescriptions which are classified as cosmetic (this includes drugs for weight loss);
- Charges for the administration or injection of any drug;
- Therapeutic devices or appliances (except as described under Covered Drugs), glucose monitors in excess of one (1) per 365 days;
- Prescriptions which a Member is entitled to receive without charge from any Workers' Compensation Laws, or any municipal, state, or federal program;
- Drugs labeled "Caution-limited by federal law to Investigational use," or Experimental drugs, even though a charge is made to the Member;
- Immunization agents, biological sera, blood, or blood plasma (except as included herein);
- Medication which is to be taken or administered to a Member in whole or in part, while a Member in a licensed Hospital, Skilled Nursing Facility, convalescent Hospital, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- Any prescription refilled in excess of the number specified by a Physician, or any refill dispensed after one year from the Physician's original order;
- Smoking deterrents (except as described under Covered Drugs); or
- Any drug where clinical program criteria are not met (see CLINICAL PROGRAMS section below).

Clinical Programs

The Plan has review programs in place that are designed to provide Members and their Physicians with the latest information about medications and treatment. By monitoring certain medications for safety and effectiveness, as well as potential drug interactions, these programs protect You against potential harm due to prolonged or inappropriate use of certain drugs. These programs work behind the scenes and usually do not require You to do anything; however, on occasion, Your Physician may need to contact Express Scripts and provide additional information for approval. The Plan's clinical programs are described below. For more information, covered individuals may contact Express Scripts at **888.256.6131**.

Drug Utilization Review

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

Drug Quantity Management

Criteria may apply to determine whether specific drugs are limited to a certain quantity. The criteria are based on Food and Drug Administration (FDA) approved dosing guidelines and the medical literature. Therefore if a Physician writes a prescription above the recommended quantity for a particular drug, the pharmacist will only dispense the limited amount for the applicable Copay. You may call Express Scripts if You have questions about coverage and/or quantity limits for a specific prescription drug.

Prior Authorization

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

Step Therapy

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

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

Express Scripts Annual Enrollment Information Tool

You may want some help deciding which prescription drug plan is best for You and Your family. Go online to Express Scripts Annual Enrollment Information tool at express-scripts.com/ameren to:

- Check each plan's formulary and copay amounts.
- View an estimate of Your annual out-of-pocket prescription drug costs.

It only takes about 15 minutes to use this tool. Be sure to have Your prescriptions handy, as You'll need to enter information about each drug and the dosage You take.

General Information About the Plan

Termination of Benefits

Retirees

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

- End of the month that You last paid the required premium for coverage;
- Date You reach the Lifetime Maximum Benefit;
- Date of Your death;
- Date of termination of the **Ameren Retiree Medical Plan**;
- Date the Company amends the **Ameren Retiree Medical Plan** to eliminate coverage for the class of eligible individuals to which You are a member;
- Date You become covered under another Group Plan sponsored by Ameren (for example, You are covered under another active health plan of a company which has been purchased by Ameren, while also covered as a Retiree under this Plan); or
- Date You become eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan**; or
- Date You or a Covered Dependent participates 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.

In addition, Your coverage under Your medical plan option will end on the date You cease to be eligible for such coverage option (for example, You become eligible for Medicare) or the date Your medical plan option is discontinued.

Dependents

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

- Date Your coverage as a Retiree ends except by reason of Your death (See CONTINUATION OF BENEFITS FOR SURVIVING DEPENDENTS OF DECEASED RETIREES);
- Except for legal separation or divorce, the end of the month that Your Dependent ceases to satisfy the eligibility requirements (See ELIGIBILITY);
- In the case of a Covered Spouse, the date of divorce of You and Your Spouse;
- In the case of a Covered Spouse, the date of legal separation of You and Your Spouse;
- End of the month that You last paid the required payroll deduction for Your Dependent's coverage;
- Date of the death of the Covered Dependent;
- Date the Company amends the **Ameren Retiree Medical Plan** to eliminate coverage for the class of eligible individuals to which Your Dependent is a member;
- Date Your Covered Dependent becomes eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan**;
- Date Your Dependent reaches the Lifetime Maximum Benefit; or

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

However, You and Your Covered Dependents may be eligible for temporary healthcare continuation benefits as required by federal law. (See COBRA CONTINUATION in this booklet).

Continuation of Benefits for Surviving Dependents of Deceased Retirees

In the event of Your death, Your Covered Dependents may automatically continue benefits offered by the **Ameren Retiree Medical Plan** or elect the continuation benefits available under federal law (COBRA). If Your Covered Dependents elect a temporary extension of their coverage in the **Ameren Retiree Medical Plan** under COBRA, they will not be allowed to re-enroll in the Plan at any time in the future. The following paragraphs explain the difference between the two types of benefits.

Upon Your death, the Company currently continues coverage under this Plan for Your Covered Dependents until the end of the month in which Your death occurred. Thereafter, Your Covered Dependents may continue their coverage under the Plan by paying the applicable premium for the respective months, provided Your Covered Dependents have not elected to terminate the coverage. If Your Covered Dependents chose to continue the coverage offered by the **Ameren Retiree Medical Plan**, the coverage will end on the earliest of the following dates:

- End of the month in which Your surviving Spouse remarries (coverage ends only for the surviving Spouse);
- End of the month in which Your surviving Dependent becomes covered under any other group medical care plan (coverage ends only for the surviving Dependent with the other coverage);
- End of the month in which Your surviving Dependent Children no longer meet the eligibility requirements for Dependent Children (coverage ends only for the ineligible Dependent);
- End of the month in which Your surviving Dependent fails to pay the required premium on time;
- Date of Your surviving Dependent's death (coverage ends only for the deceased Dependent);
- Date of termination of the Plan; and
- Date the Plan is amended to eliminate continuation coverage for surviving Dependents.

The cost of this coverage is outlined in the section entitled COST OF COVERAGE.

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

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

alternate recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

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

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

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

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

Retiree

A Covered Retiree will have the right to elect COBRA continuation coverage in accordance with this Section if coverage is lost due to the filing of bankruptcy by Ameren Corporation.

Spouses

A Covered Spouse will have the right to elect COBRA continuation coverage in accordance with this Section if coverage is lost for any of the following reasons:

- The death of the Covered Retiree.
- Divorce or legal separation from the Covered Retiree.
- The Covered Retiree becomes entitled to Medicare (Part A or Part B or both).
- Filing of bankruptcy by Ameren Corporation.

Dependent Children

Your Covered Dependent Child has the right to elect COBRA continuation coverage in accordance with this Section if the coverage is lost for any of the following reasons:

- The death of the Covered Retiree.
- Divorce or legal separation of the Covered Retiree.
- The Covered Retiree becomes entitled to Medicare (Part A or Part B or both).
- The Dependent Child ceases to satisfy the Plan Sponsor's eligibility rules for Dependent status.
- Filing of bankruptcy by Ameren Corporation.

Newborn or Adopted Children

A child born to, adopted by or placed for adoption with a Covered Retiree or a Covered Spouse during a period of continuation coverage is considered to be a qualified beneficiary provided that, the Covered Retiree or Covered Spouse is a qualified beneficiary and 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, You must complete the appropriate enrollment process by either calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), or by completing and mailing the appropriate form to **Ameren Benefits Center** at the address listed on the form.

Special Enrollment Rules for Qualified Beneficiaries

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

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

Alternate Recipients under Qualified Medical Child Support Orders

A child of a Covered Retiree who is receiving benefits under the Plan pursuant to a qualified medical child support order received by the Plan Administrator is entitled to the same rights under COBRA as a Covered Dependent child of the Covered Retiree, 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 eligible Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:

  (1) the Covered Retiree's death;

  (2) the Covered Retiree's divorce or legal separation;

  (3) a Dependent Child's ceasing to satisfy rules for Dependent status; or

  (4) the Covered Retiree becoming entitled to Medicare.

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 death of the Retiree, commencement of a proceeding in bankruptcy or the Covered Retiree becoming entitled to Medicare benefits, You are not required to notify the Plan Administrator. However, each Member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status under the Plan within sixty (60) days of the qualifying event. Notice must be provided through "Healthcare and Life Benefits" at www.myAmeren.com or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights and may result in retroactive cancellation of coverage.

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 Retirees 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 Your Plan or Your COBRA continuation coverage rights should be addressed to the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

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

The **Ameren Benefits Center** customer service representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Address Changes

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

Continuation of Coverage under the Trade Act of 1974

Special COBRA rights apply to Retirees 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 Retirees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Participants (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Health Care Reimbursement

Plan coverage ended. If You qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974 or You will lose Your special COBRA rights.

Privacy Practices

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

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

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

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

ANTHEM CALLER VERIFICATION POLICY

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

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

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

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

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

Coordination With Other Benefits

Introduction

This coordination with other benefits provision applies when a Member has health care coverage under more than one health plan (as defined below). This method of Coordination of Benefits is sometimes referred to as the "integration of benefits" method. The intent of this provision is to look at the total covered charges and what this Plan will pay after the other plan as primary plan pays.

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

Definitions

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

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

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

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

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

Integration of Benefits

When this Plan is the primary health plan, it shall provide payment under this Plan without regard to the possibility that another health plan may cover some expenses unless expressly stated otherwise in this Plan.

When this Plan is secondary, benefits under the primary health plan shall be coordinated with coverage provided under this Plan.

This Plan will look at the total covered charges, subtract the amount that the primary health plan has already paid, and then pay the remaining or left over amount at this Plan's normal Coinsurance rate.

The Plan reserves the right to:

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

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

Duty to Notify the Plan of Other Payment

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

Order of Benefit Determination

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

1. The health plan that covers the person as an employee is the primary health plan. The health plan that covers the person as a dependent is the secondary health plan.
2. The health plan that covers a person as an employee who is neither laid-off nor a retired employee (nor that employee's dependent) is the primary health plan. The health plan that covers a person as a laid-off or retired employee or that employee's dependent is the secondary health plan. If the other health plan does not have this rule, and if as a result, the health plans do not agree on the order of benefits, this rule is ignored.
3. The health plan that covers a person as an employee, participant, subscriber, or retiree (or as the person's dependent) is the primary health plan. The health plan that covers a person due to a right of continuation provided by federal or state law is the secondary

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

4. When this Plan and another health plan cover the same child as a dependent of different persons, called "parents":
   a. The primary health plan is the plan of the parent whose birthday is earlier in the year if:
      (1) the parents are married;
      (2) the parents are not separated (whether or not they ever have been married); or
      (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care payment.
   b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care payment and the health plan of that parent has actual knowledge of those terms, that health plan is primary. This rule applies to claim determination periods or calendar years commencing after the health plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      (1) the plan of the custodial parent;
      (2) the plan of the Spouse of the custodial parent;
      (3) the plan of the non-custodial parent; and then
      (4) the plan of the Spouse 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 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 plan began on the same date as the coverage under either or both parents' plan, the order of benefits will be determined by applying the birthday rule in item 4 above.

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

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

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

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

$ 400	Remaining amount of Allowed Charge for Hospital services for Mary
- 125	Ameren Emergency Room Copay (Standard PPO Plan benefit)
$ 275	Amount subject to Ameren's Coinsurance (secondary Plan)
x 100%	Ameren Emergency Room Coinsurance (secondary Plan)
$ 275	Amount payable by **Ameren Retiree Medical Plan**

Medicare Exception

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.

If You are covered under this Plan when You become eligible for Medicare, Medicare will become the primary payer of medical benefits and the **Ameren Retiree Medical Plan** will be the secondary payer. Claims for benefits should be filed with Medicare first and then submitted under this Plan. If You do not enroll in Medicare Part A and Part B, the **Ameren Retiree Medical Plan** will estimate the benefit that would have been payable by Medicare and will consider payment based on the remaining charges. Therefore, it is very important that You enroll in Medicare Parts A and B as soon as You are eligible.

If You are a participant in the Medicare Supplement Plan, Covered Expenses over the Medicare-approved amounts are not covered.

When Medicare is the primary payer for You or a Covered Dependent, You will no longer need to contact the Claims Administrator for precertification. However, Your Covered Dependents who are not eligible for Medicare, if any, will still need to contact the Claims Administrator and/or follow precertification procedures.

TRICARE

TRICARE is government sponsored health care coverage for military personnel on active duty and for retired military personnel. The coordination of Your benefits under TRICARE works differently from the Medicare and National Association of Insurance Commissioners (NAIC) rules. If You or Your Covered Dependents are receiving benefits under TRICARE, generally TRICARE will be the secondary payer with respect to any benefit offered under the Plan. If You are Medicare eligible, generally Medicare will be primary, the **Ameren Retiree Medical Plan** will pay secondary, and TRICARE will pay third. For more information on how TRICARE coordinates with employer provided group health plan coverage, please contact the Plan Administrator.

Subrogation and Reimbursement

Applicability

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

By participating in the Plan or receiving benefits under the Plan, You and Your Covered Dependents consent and agree that the Plan will have the right of subrogation and reimbursement with respect to the full amount of benefits paid to or on behalf of You or a Covered Dependent as a result of an injury, illness, disability or death that is or may be the responsibility of any party. The Plan will also have a lien upon any recovery to the full amount of benefits and expenses paid by the Plan.

Subrogation

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

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

Reimbursement

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

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
    1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
    2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement 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 Sponsor has sole discretion to interpret the terms of the subrogation and reimbursement provision of the Plan in its entirety and reserves the right to make changes as it deems necessary.

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

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

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

Claim and Appeal Procedures for Eligibility

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

All claims related to eligibility must be submitted to:

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

All appeals related to eligibility must be submitted to:

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

Responding to Your Eligibility Claim

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

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

If Your Eligibility Claim Is Denied

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

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

Appealing Your Eligibility Claim

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

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

The Plan Administrator will notify You, in writing, of its decision of Your appeal within a reasonable period of time, but no later than 60 days after its receipt of Your appeal request. If the Plan Administrator determines that an extension of time for processing the claim is needed, it will notify You of the reasons for the extension and the extended due date before the end of the sixty (60)-day period.

If Your Eligibility Appeal Is Denied

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

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

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

Deadline for Taking Legal Action

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

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

Claim Filing Procedures for Medical and Prescription Drug Benefits

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

Medical Claim Filing Procedures

For participants in the Standard PPO, Health Savings PPO and the Defined PPO Plan

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

You are responsible for filing a completed claim form for all other medical claims (for example, claims for services You receive from Non-Network Providers) with the Claims Administrator at the address below in order to obtain payment of Plan benefits.

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

For participants in the Conventional Plan or the Medicare Supplement Plan

You must file all medical claims with the Claims Administrator at the address above in order to obtain payment of Plan benefits after Medicare has processed the claim.

Medical claims under all the coverage options must be received by the Claims Administrator within one year after the end of the year in which the expense is incurred. For example, all expenses incurred during 2018 must be received by the Claims Administrator by December 31, 2019. No benefits are payable for claims filed after the deadline.

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

Prescription Drug Claim Filing Procedures

For Participants in the Standard PPO Plan, Defined PPO Plan, Conventional Plan or Medicare Supplement Plan

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

For participants in the Health Savings PPO Plan

Express Scripts' network Pharmacies will file Your prescription drug claims for You, but if You have not met Your Deductible, You must pay the full cost of the prescription at the time of purchase.

Claim forms may be obtained either by calling Express Scripts at **888.256.6131** or by visiting their website: www.express-scripts.com. Submit those claims to the address shown below.

Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166-6773
Attn: Claims Department

All Pharmacy claims must be received by Express Scripts, the Pharmacy benefits administrator, within one year of the date of prescription purchase. No benefits are payable for claims received after the deadline.

Post-Service Claim

The Claims Administrator will make a benefit determination and notify You or Your authorized representative in writing within 30 calendar days from receipt of a post-service claim. The initial 30-day determination period may be extended up to 15 additional days due to reasons beyond the Claims Administrator's control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing within the initial 30-day period of the reason necessitating the extension and the date by which a decision is expected to be made. If a claim cannot be processed due to incomplete information, the Claims Administrator will send written

notification prior to the expiration of the 30 calendar days explaining the specific information needed. You will have up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

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

Pre-Service Claims

The Claims Administrator will make a benefit determination and notify You or Your authorized representative of its determination (whether adverse or not) within 15 calendar days after receipt of the claim. The 15-day period may be extended up to 15 additional days if the Claims Administrator determines that an extension is necessary due to matters beyond its control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing, prior to the expiration of the initial 15-day period, of the reason necessitating the extension and the date by which a decision is expected to be made. If the extension is needed because You have not submitted all the necessary information, the notice of extension will specifically describe the additional information that is needed. You will be afforded at least 45 days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received. If You did not follow the claims procedures, the Claims Administrator will notify You (or Your authorized representative) of the failure and the proper procedures as soon as possible but not later than 5 days after the claim was received.

Urgent Care Claims

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

Concurrent Care Claims

If an on-going course of treatment involving urgent care was previously approved for a specific period of time or number of treatments, and You (or Your authorized representative) requests that the course of treatment be extended beyond the previously approved period of time or number of treatments, the Claims Administrator will notify You (or Your authorized representative) of its determination (whether adverse or not) as soon as possible taking into

account the medical exigencies but not later than 24 hours after receipt of the request. Your request must be made at least 24 hours prior to the expiration of the approved course of treatment.

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

Notice of Adverse Benefit Determination

If Your claim is partially or wholly denied, the Claims Administrator's notice of the Adverse Benefit Determination (denial) will include:

- 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; and
- information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental Treatment, or about Your right to request this explanation free of charge.
- if the denial relates to a claim involving Urgent Care, a description of the expedited review process applicable to such claims;
- a description of available external review procedures; and,
- disclosure of the availability of and contact information for any applicable ombudsman established under law to assist individuals with the internal claims and appeals and external review procedures.

Informal Inquiries Regarding Claims

For Medical Claims:

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

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

For Prescription Drug Claims:

You may direct informal inquiries regarding denial of prescription drug claims to Express Scripts, Inc. Member Services Department. They are available 24 hours a day, 7 days a week by calling **888.256.6131**.

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

Appeal Rights

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

Internal Appeal Process For Medical Claims

You have the right to appeal an Adverse Benefit Determination (claim denial). 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) does not file an appeal within the 180-day period, You are barred from challenging the Adverse Benefit Determination in the future.

The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of claim involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited review. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your medical ID card and provide at least the following information:

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

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

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

You must include Your Member Identification Number when submitting an appeal.

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

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

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

- You (or Your authorized representative) will be permitted to review the claim file and to present evidence and testimony.
- You (or Your authorized representative) will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance so that You (or Your authorized representative) will have a reasonable opportunity to respond prior to the due date for notice of the final decision on appeal.
- Prior to issuing an adverse benefit determination on a medical claim based on a new or additional rationale, the Plan 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 the appeal, the Claims Administrator will not defer to the initial benefit determination or, for second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

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

Notification of the Outcome of the Appeal

If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

If a claim is partially or wholly denied on appeal, the notice will give the specific reason for the denial and reference Plan provisions on which the denial is based. The notice will include statements as to Your right to obtain upon request, without charge, access to and copies of all documents, records and other information relevant to the claim, to bring a civil action under Section 502(a) of ERISA or to pursue other voluntary alternative dispute resolution options. The notice will also describe any voluntary appeal procedures under the Plan. If the Claims Administrator relied on a rule, guideline, protocol, or similar criterion in denying the appeal, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. Notice of a denial based on Medical Necessity, Experimental treatment or a similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge.

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

Voluntary Second Level Appeals

If You are dissatisfied with the Claims Administrator's appeal decision, a voluntary second level appeal may be available. This voluntary level of appeal will be a panel review, independent

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

Internal Appeal Process for Prescription Drug Claims

If You disagree with a prescription drug claim denial at a retail Pharmacy or through the Home Delivery Program, You should contact Express Scripts at **888.256.6131.** Express Scripts will research the inquiry and will respond providing the rationale behind the denial. It may be necessary for You or Your Physician to provide additional information that will allow reconsideration of the claim.

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

Express Scripts, Inc.
Attn: Pharmacy Appeals
6625 West 78th Street
Mail Route BL0390
Bloomington, MN 55439

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

The appeal must be submitted to the Claims Administrator within 60 calendar days after receipt of the initial claim denial from Express Scripts. If the claim appeal is not filed during this 60-day period, You may lose the right to file suit in federal or state court. The Claims Administrator will take into account all information submitted relative to the claim.

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

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

Upon request, You will be provided with the identification of medical experts whose advice was obtained in connection with the appeal whether or not the Plan relied on their advice.

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

External Review Procedures

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

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

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

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

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

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

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

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

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

Legal Action

When claiming a benefit under the Plan, You must follow the procedures described in this section of this booklet. If Your claim is not paid to Your satisfaction, You have the right to request an appeal, the procedures for which are also described in this booklet 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 appeals process, not including any voluntary level of appeal, before You can file a lawsuit or take other legal action of any kind against the Plan. Further, You may not bring a lawsuit or take other legal action against the Plan after one (1) year has elapsed following the date of the Plan's final decision on the claim or other request for benefits.

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

Facility of Payment

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

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

- If payment amounts remain due upon Your death, those amounts may, at the Plan's option, be paid to Your estate, Spouse, child, parent, or provider of medical and dental services.
- If the Plan Administrator believes You are not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Plan may pay whoever has assumed responsibility for Your care and support .
- Benefits payable to a Network Provider will be paid directly to the Network Provider on Your behalf.
- Benefits payable to a provider in the Transplant Network will be paid directly to the provider. (**Important Note**: The Transplant Network is applicable only to Members participating in the Standard PPO, Health Savings PPO and the Defined PPO Plans.)

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

If a Covered Retiree or a Covered Dependent elects breast reconstruction in connection with a mastectomy, such individual is entitled to coverage under this Plan for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and treatment of physical

complications at all stages of the mastectomy, including lymph edemas. Such services will be performed in a manner determined in consultation with the attending Physician and the patient. This coverage is also addressed within the Medical Expense Coverage, Covered Expenses section of this booklet.

Newborns' and Mothers' Health Protection Act Notice

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

Miscellaneous Provisions

Plan Administration

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

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

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

Plan Amendment or Termination

The Plan Sponsor hopes and expects to continue the **Ameren Retiree Medical Plan** in the years ahead, but cannot guarantee to do so. Ameren Corporation, and any successor corporation which assumes the responsibilities of Ameren Corporation under the Plan, may amend or terminate the Plan or any benefit provided under the Plan from time to time or at any time, without advance notice thereof. Ameren Corporation, Ameren Services Company (as agent for Ameren Corporation), an officer of Ameren Corporation or Ameren Service Company, or such officer's delegate may effect an amendment or termination of the Plan or a benefit provided under the Plan by written instruments describing the terms of such amendment or termination. Such amendment will be incorporated into this document.

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

Verbal Statement May Not Alter Document

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

Applicability

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

Nontransferable Benefits

No person other than the Member is entitled to receive health care service coverage or other benefits to be furnished by the Plan. Such right to health care 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 Member to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

Retiree-Only Plan

This Plan is a retiree-only plan intended to only cover Retirees and eligible Dependents and not current Employees. As a retiree-only plan, most of the provisions of the Affordable Care Act do not apply to the Plan. To the extent the Plan is required to comply with certain aspects of the Affordable Care Act, the Plan is administered and interpreted in a manner consistent with that law.

Lost Distributees

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

Recovery of Excess Payments

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

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

Your Rights Under ERISA

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

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

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

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 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 domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have

sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Administrative Information About the Plan

Plan Name:	Ameren Retiree Medical Plan, a component part of the Ameren Retiree Welfare Benefit Plan.
Type of Plan:	A welfare benefit plan providing medical and prescription drug benefits.
Plan Year:	January 1 through December 3
Plan Number:	511
Funding Medium and Type of Plan Administration:	The Plan is generally funded by contributions made in part by the Plan Sponsor and in part by Plan participants. With the exception of certain Key Retirees, all contributions are paid directly to trusts established for the purpose of providing benefits under the Plan. Plan Sponsor has a contract with Anthem ("Claims Administrator") and Express Scripts, Inc. ("Claims Administrator") to provide certain services to the Plan, including claims administration. Benefits under the Plan are not guaranteed under a contract or insurance policy. The Plan Sponsor is ultimately responsible for providing the Plan benefits, and not the Claims Administrator.
Trustee:	To the extent permitted under applicable law, medical and prescription drug benefits are paid out of trust funds held by The Bank of New York Mellon, located at 135 Santilli Highway, Everett, Massachusetts, 02149. If the trusts are terminated, the remaining assets will be distributed in accordance with the provisions of the trust agreements.
Plan Sponsor:	Ameren Corporation 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)

Plan Sponsor's Employer Identification Number:	43-1723446
Plan Administrator:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Claims Administrator for Medical Benefits:	Anthem BlueCross BlueShield P.O. Box 105557 Atlanta, GA 30348
Claims Administrator for Prescription Drug Benefits:	Express Scripts, Inc. One Express Way St. Louis, MO 63121
COBRA Administrator:	Ameren Benefits Center PO Box 5204 Cherry Hill, NJ 08034-5204 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 Medical Claims and Appeals:	Anthem Blue Cross Blue Shield P.O. Box 105557 Atlanta, GA 30348
Named Fiduciary for Prescription Drug Appeals:	MCMC LLC (as contracted by Express Scripts) Attn: ESI ERISA Plan Fiduciary Team 300 Crown Colony Drive, Suite 203 Quincy, MA 02169
Agent for Service of Legal Process:	General Counsel Ameren Services Company 1901 Chouteau Avenue, Mail Code 1300 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637) Service of Legal Process also may be made upon the Trustee or the Plan Administrator.

Appendix A-How Premiums are Determined

The premiums described in this Appendix apply to the following eligible groups:

Eligible Retiree Group	Retirement Date
All management and contract Employees as described in ELIGIBILITY and their eligible surviving dependents	January 1, 1992 – present
AmerenCILCO management Employees and their eligible surviving dependents	January 1, 2004 -present
AmerenEnergy Resources Generating Company IBEW Local 51 (formerly NCF&O Local 8) and their eligible surviving dependents	January 1, 2007 – present
AmerenCILCO IBEW Local 51 and their eligible surviving dependents	January 1, 2005 – present
UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11 and their eligible surviving dependents	July 2, 2012 – present
Ameren Illinois (formerly AmerenIP) union represented Employees and their eligible surviving dependents	January 1, 2018 - present

Note: The reference to "eligible surviving dependents" above include both the eligible surviving dependents of retirees and those of deceased active Employees as described in the ELIGIBILITY section of this document.

Management Retirees –You are required to pay a portion of the Retiree medical premium to cover Yourself and Your eligible Dependents. If You and Your eligible Dependents are under age 65, and enrolled in this Plan, the minimum amount You are required to pay is 25% of Ameren's total monthly premium to cover Yourself and 50% of Ameren's total monthly premium to cover Your eligible dependents. If You and/or Your eligible Dependent are age 65 or older, refer to the **Ameren Retiree Health Reimbursement Account Plan** Summary Plan Description. (**Note**: If You retired after September 1, 2002, see the section titled RETIREE MEDICAL CAPS below for additional information that may affect the amount of premium You will be required to pay).

Contract Retirees[6] – If You are an AmerenUE (except UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11), Ameren Illinois (formerly AmerenCIPS or AmerenIP) (and except Ameren Illinois (formerly AmerenCILCO Local union 51) or Ameren Energy Generating Company contract Employee and the labor agreement under which You retired has not yet expired,

[6]For Employees represented by IBEW Local 1455 and 1455 Region West who retired July 1, 2012 through June 1, 2013, the Company paid the full cost of retiree medical for the retired Employee, and the retired Employee paid 20% of the total monthly premium for Dependent coverage through June 30, 2015. Effective July 1, 2015, the retired Employee is required to pay the same as any other retiree. The cost for Dependent coverage is adjusted every January 1.

the Company currently will pay the full cost of medical coverage for You. You will be required to pay 20% of the monthly premium for Dependent coverage. The cost You pay for Dependent coverage will be adjusted every January 1, but the amount will not exceed two times the cost in effect in the year in which You retired. Once the labor agreement under which You retired expires, the minimum amount You are required to pay is 25% of Ameren's monthly premium to cover Yourself and 50% of Ameren's monthly premium for Your Covered Dependents. This premium change is based on the original contract expiration date regardless of any extensions during the negotiation process. (**Note**: If You retired after September 1, 2002, see the section titled RETIREE MEDICAL CAPS below for additional information that may affect the amount of premium You will be required to pay).

For all other contract Employees listed as an eligible group above, You are required to pay a portion of the Retiree medical premium to cover Yourself and Your eligible Dependents under this Plan. The minimum amount You are required to pay is 25% of Ameren's monthly premium to cover Yourself and 50% of Ameren's monthly premium for Your Covered Dependents. (Note: If You retired after September 1, 2002, see the section titled RETIREE MEDICAL CAPS below for additional information that may affect the amount of premium You will be required to pay).

Retiree Medical Caps

If You retired after September 1, 2002, the Retiree Medical Cap established by Ameren may also affect Your retiree medical premium calculation. The Retiree Medical Cap represents the up to maximum amount the Company will contribute toward Your monthly retiree medical premium under this Plan regardless of the number of Dependents You cover.

The following Members are subject to the Retiree Medical Cap:

Eligible Group	Retirement Date
Management Employees who are not participants in the Voluntary Retirement Program (VRP) and their surviving dependents	Retired on or after October 1, 2002
AmerenCILCO IBEW Local 51 and their surviving dependents (**Note**: Retiree Medical Caps were effective January 1, 2008 for this group of retirees and eligible dependents.)	Retired on or after January 1, 2005
AmerenEnergy Resources Generating Company IBEW Local 51 (formerly NCF&O Local 8) and their surviving dependents	Retired on or after January 1, 2007
UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11 and their surviving dependents	Retired on or after July 2, 2012
All other contract Employees who are not participants in the Voluntary Retirement Program (VRP), and who have previously been participants in a union in which the contract in effect on their retirement date has expired.	Retired on or after October 1, 2002

Members who are subject to the Retiree Medical Cap may end up paying more than the minimum premiums specified above. The maximum the Company will pay towards Retiree medical coverage for You and Your Eligible Dependents is based on Your age and Years of Service at retirement. (**Note**: For survivors of Retirees, the Retiree Medical Cap is based on the age and years of service of the Retiree at the time of his/her retirement. For survivors of an active Employee, the Retiree

Medical Cap is based on the age and years of service of the Employee at the time of his/her death.) If a Retiree does not have the minimum Years of Service as reflected in the chart below, but is otherwise eligible to participate in the Plan, the minimum number of Years of Service (10) along with the appropriate age at retirement is applied in determining the Company's maximum monthly premium contribution.

Retirees who are subject to the Retiree Medical Cap are responsible for paying the greater of:

a. The minimum Retiree premium described in the applicable section above; OR
b. The amount of the premium that exceeds the Retiree Medical Cap listed in the applicable table below.

Note: In all cases, if You or Your eligible Dependent is under age 65 and enrolled in this Plan, and the other eligible Participant is age 65 or older and enrolled in the **Ameren Retiree Health Reimbursement Account Plan**, the Maximum Amount the Company will credit to the applicable Participant's Retiree Health Reimbursement Account, taking into account the Retiree Medical Cap based on the age and Years of Service of the Retiree at the time of his/her retirement, will be applied first. If there is any amount remaining, it will then be applied to the monthly premium for the under age 65 eligible Participant. When one of the eligible Participants is under age 65 and enrolled in the **Ameren Retiree Medical Plan**, that Participant is limited to the remaining amount available under the Retiree Medical Cap and is responsible for paying the greater of:

a) The Minimum Retiree Premium; OR,
b) The amount of the premium that exceeds the remaining amount of the Retiree Medical Cap listed in the applicable table below.

Retiree Medical Cap for Retirees Under Age 65

The following chart shows the maximum monthly amount Ameren will contribute towards Your Retiree medical premiums if You are under age 65 and were not a participant in the Voluntary Retirement Program (VRP). **Note**: Age and Years of service are rounded down to the nearest year.

	Age at Retirement (rounded down to the nearest year)							
Years of Service	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62 or older**
10	$387	$396	$405	$414	$423	$432	$441	$450
11	426	436	446	455	465	475	485	495
12	464	475	486	497	508	518	529	540
13	503	515	527	538	550	562	573	585
14	542	554	567	580	592	605	617	630
15	581	594	608	621	635	648	662	675
16	619	634	648	662	677	691	706	720
17	658	673	689	704	719	734	750	765
18	697	713	729	745	761	778	794	810
19	735	752	770	787	804	821	838	855
20	774	792	810	828	846	864	882	900
21	813	832	851	869	888	907	926	945
22	851	871	891	911	931	950	970	990
23	890	911	932	952	973	994	1014	1035
24	929	950	972	994	1015	1037	1058	1080
25	968	990	1013	1035	1058	1080	1103	1125
26	1006	1030	1053	1076	1100	1123	1147	1170
27	1045	1069	1094	1118	1142	1166	1191	1215
28	1084	1109	1134	1159	1184	1210	1235	1260
29	1122	1148	1175	1201	1227	1253	1279	1305
30	1161	1188	1215	1242	1269	1296	1323	1350

Retiree Medical Cap for VRP Participants Under Age 65

If You retired under the Voluntary Retirement Program, the chart above does not apply to You. The Company will contribute a maximum of up to $1,550 per month towards Your retiree medical coverage, while You are younger than age 65. Your actual age and Years of Service at the time of retirement are not used to calculate Your retiree medical premium cap.

Retiree Medical Cap for Retirees Age 65 and Older

The following chart shows the maximum monthly amount Ameren will contribute towards Your Retiree medical premiums if You are age 65 and older and were not a participant in the Voluntary Retirement Program (VRP). **Note**: Age and Years of Service are rounded down to the nearest year.

	Age at Retirement (rounded down to the nearest year)							
Years of Service	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62 or older**
10	$172	$176	$180	$184	$188	$192	$196	$200
11	189	194	198	202	207	211	216	220
12	206	211	216	221	226	230	235	240
13	224	229	234	239	244	250	255	260
14	241	246	252	258	263	269	274	280
15	258	264	270	276	282	288	294	300
16	275	282	288	294	301	307	314	320
17	292	299	306	313	320	326	333	340
18	310	317	324	331	338	346	353	360
19	327	334	342	350	357	365	372	380
20	344	352	360	368	376	384	392	400
21	361	370	378	386	395	403	412	420
22	378	387	396	405	414	422	431	440
23	396	405	414	423	432	442	451	460
24	413	422	432	442	451	461	470	480
25	430	440	450	460	470	480	490	500
26	447	458	468	478	489	499	510	520
27	464	475	486	497	508	518	529	540
28	482	493	504	515	526	538	549	560
29	499	510	522	534	545	557	568	580
30	516	528	540	552	564	576	588	600

Retiree Medical Cap for VRP Participants Age 65 and Older

If You retired under the Voluntary Retirement Program, the chart above does not apply to You. The Company will contribute up to a maximum of $700 per month towards Retiree medical coverage, while You are age 65 and older. Your actual age and Years of Service at the time of retirement are not used to calculate Your retiree medical premium cap.

Important Notes

The minimum Retiree premiums and maximum Company contributions described in this Appendix are subject to change.

In all cases, when both You and Your eligible Dependents are covered under an Ameren retiree medical plan program, and either You or Your eligible Dependent is covered under the Ameren Retiree Health Reimbursement Account Plan, the Maximum Amount that the Company contributes to the under age 65 eligible Participants retiree medical premium, and the age 65 or older eligible Participant's Retiree Health Reimbursement Account, is a single amount per family. The Maximum Amount is not per Participant.

Examples

It may be helpful to look at some EXAMPLES of how to estimate what You might pay for medical coverage once You retire:

Example 1

Let's say that Bill is a management Employee who retires on March 1, 2018 at age 55 with 25 Years of Service. Let's also assume that Ameren's total monthly premium is $700 for 2018 for each non-Medicare eligible Participant.

To cover only **himself** in 2018, Bill will pay the *greater of*:

Bill's Minimum Retiree Premium (25% of $700)	**$ 175**	⇐ **Greater**
OR		
Total Monthly Premium (Bill only)	$ 700	
Less Retiree Medical Cap (age 55 with 25 Years of Service)	$ 968	
(Amount that exceeds the cap)	**- $ 268**	

In this first example, Bill's monthly premium is $175. His Minimum Retiree Premium of $175 is *greater than* the amount that exceeds his Retiree Medical Cap (-$268).

Example 2

Now, let's assume that Bill's wife is also covered. That would add an additional $700 to the total monthly premium, bringing the total premium required to cover Bill and his Spouse to $1,400 per month.

To cover both **himself and his Spouse** in 2018, Bill pays the greater of:

Bill's Minimum Retiree Premium (25% of $700)	$ 175	
Plus Spouse's Minimum Premium (50% of $700)	$ 350	
Total Minimum Retiree Premium	**$ 525**	⇐ **Greater**
OR		
Total Monthly Premium ($700 for Bill plus $700 for Spouse)	$1,400	
Less Retiree Medical Cap (age 55 with 25 Years of Service)	$ 968	
(Amount that exceeds the cap)	**$ 432**	

In this second example, Bill pays $525 per month to cover both himself and his Spouse since his Minimum Retiree Premium ($525) is *greater than* the amount that exceeds his cap ($432).

Example 3

Now, let's assume that Bill wants to cover his spouse and his eligible children. Let's assume that in 2018, Ameren's total monthly cost is $400 to cover the children. We will continue to assume that it costs $700 to cover each non-Medicare eligible Participant. In this example, Bill will pay the greater of:

Bill's Minimum Retiree Premium (25% of $700)	$ 175	
Plus Spouse's Minimum Premium (50% of $700)	$ 350	
Plus Child Minimum Premium (50% of $400)	$ 200	
Total Minimum Retiree Premium	**$ 725**	
OR		
Total Monthly Premium ($700 for Bill, $70 for Spouse & $400 for Children)	$1,800	
Less Retiree Medical Cap (age 55 with 25 Years of Service)	$ 968	
(Amount that exceeds the cap)	**$ 832**	⇐ **Greater**

In this third example, Bill pays $832 per month to cover himself, his Spouse and children, because this amount is *greater than* the minimum retiree premium ($725).