

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



**Ameren Retiree Medical Plan  
(Post-92)**

**Standard Plan, Health Savings Plan, Health Savings Plan – Value,  
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.

## Ameren Retiree Medical Plan

### Table of Contents

<b>Ameren Retiree Medical Plan</b> .....	<b>2</b>
<b>Table of Contents</b> .....	<b>2</b>
<b>Definitions</b> .....	<b>4</b>
<b>Purpose</b> .....	<b>16</b>
<b>Your Role in Controlling Healthcare Costs</b> .....	<b>17</b>
<b>Five Tips for Improving Your Overall Health and Wellness</b> .....	<b>18</b>
<b>Medical Benefit Information</b> .....	<b>19</b>
<b>Your Rights And Responsibilities As An Anthem Blue Cross Blue Shield Member</b> .....	<b>19</b>
<b>myAmeren Benefits</b> .....	<b>21</b>
<b>myAmeren.com</b> .....	<b>21</b>
<b>Eligibility</b> .....	<b>22</b>
<b>Enrollment Provisions</b> .....	<b>37</b>
<b>Retiree Medical Program Options</b> .....	<b>43</b>
<b>Anthem Network Programs</b> .....	<b>44</b>
<b>Plans for Retirees and Dependents not Eligible for Medicare</b> .....	<b>49</b>
<b>Standard Plan – Schedule of Benefits</b> .....	<b>50</b>
<b>Health Savings Plan – Schedule of Benefits</b> .....	<b>53</b>
<b>Health Savings Plan – Value – Schedule of Benefits</b> .....	<b>56</b>
<b>Anthem Programs for the Non-Medicare Plans</b> .....	<b>59</b>
<b>Important Provisions in the Non-Medicare Plans</b> .....	<b>61</b>
<b>Utilization Management Review</b> .....	<b>68</b>
<b>Medical Expense Coverage for the Non-Medicare Plans</b> .....	<b>74</b>
<b>Expenses Not Covered in the Non-Medicare Plans</b> .....	<b>85</b>
<b>Plans for Retirees and Dependents who are Eligible for Medicare</b> .....	<b>89</b>
<b>If You are Eligible for Medicare and for Alight Retiree Health Solutions</b> .....	<b>90</b>
<b>Conventional Plan – Schedule of Benefits</b> .....	<b>91</b>
<b>Medicare Supplement Plan – Schedule of Benefits</b> .....	<b>93</b>
<b>Important Provisions in the Conventional or the Medicare Supplement Plan</b> .....	<b>95</b>
<b>Medical Expense Coverage for the Conventional or Medicare Supplement Plan</b> .....	<b>96</b>
<b>Expenses Not Covered</b> .....	<b>105</b>
<b>Prescription Drug Program</b> .....	<b>109</b>
<b>Prescription Drugs Administered by a Medical Provider</b> .....	<b>110</b>
<b>Prescription Drug Program Administered by CVS Caremark</b> .....	<b>112</b>
<b>Prescription Drug Benefits for Participants in the Standard Plan</b> .....	<b>112</b>
<b>Prescription Drug Program for Health Savings Plan</b> .....	<b>113</b>
<b>Prescription Drug Program for Health Savings Plan – Value</b> .....	<b>113</b>
<b>Prescription Drug Benefits for Medicare Eligible Participants</b> .....	<b>114</b>
<b>Obtaining Prescription Drugs</b> .....	<b>115</b>
<b>General Information About the Plan</b> .....	<b>121</b>
<b>Termination of Benefits</b> .....	<b>122</b>
<b>Continuation of Benefits for Surviving Dependents of Deceased Retirees</b> .....	<b>123</b>
<b>COBRA Continuation – Continuation of coverage Under COBRA</b> .....	<b>123</b>
<b>Privacy Practices</b> .....	<b>128</b>
<b>Coordination With Other Benefits</b> .....	<b>129</b>
<b>Subrogation and Reimbursement</b> .....	<b>133</b>

**Claim and Appeal Procedures for Eligibility .....135**  
**Claim Filing Procedures for Medical and Prescription Drug Benefits .....137**  
**Important Notice for Mastectomy Patients-Women's Cancer Rights Act of 1998...148**  
**Newborns' and Mothers' Health Protection Act Notice .....148**  
**Miscellaneous Provisions .....148**  
**Your Rights Under ERISA.....150**  
**Administrative Information About the Plan .....152**  
**Appendix – Understanding Your Retiree Medical Plan Choices, Cost of Coverage and  
Retiree Health Reimbursement Account.....154**  
**COVID-19 Emergency Provisions Supplement .....193**

## Definitions

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

**Adverse Benefit Determination** means a denial of a request for service or failure to provide or make payment (in whole or in part) for a Covered Expense or any reduction or termination of a covered service.

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

**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 the Company and all control group affiliates of the Company, including those control group affiliates that have not adopted the Plan.

**Ameren Company** means the Company and all control group affiliates of the Company that have adopted the Plan.

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

**Average Semi-Private Room Charge** means:

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

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

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

**Brand Name Prescription Drug/Brand Name Drug** means a drug listed on Your Formulary that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration ("FDA") has given general marketing approval.

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

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

**Company** means Ameren Corporation.

**Concurrent Review** means a Utilization Management Review conducted during a Participant'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 Participant 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 or Service includes, but is not limited to, surgery, pharmacological regimens, and all related charges.

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

**Covered 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** means a specified dollar amount of medical Covered Expenses (and covered prescription drug expenses if enrolled in the Health Savings 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 Participant is responsible for paying under the Coinsurance option before any prescription drug benefits are payable.

**Dental Services** means any treatment or service for removal of impacted teeth, alveolectomy, alveoplasty, or any services as the result of an injury, provided such treatment or service is rendered within 12 months of the injury and while a Participant.

**Dependent** means Your Spouse, Domestic Partner, or Dependent Child, if that Spouse, Domestic Partner, or Dependent Child is not covered under this Plan as a Retiree, nor covered under the **Ameren Employee Medical Plan** as an Employee.

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

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

**Developmental Delay** means the statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching 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.

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

- are at least 18 years of age and not related to each other by blood;
- are not married to another person under statutory or common law;
- are not in another domestic partnership;
- have been in an exclusive, committed relationship with each other for at least 12 consecutive months and intend to remain so indefinitely;
- have shared the same principal residence for at least 12 consecutive months;
- and are jointly responsible for financial obligations and for each other's common welfare.

**Durable Medical Equipment** means equipment that:

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

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

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

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

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

**Episode of Hospice Care** means the period of time:

- beginning on the date a Hospice Care Program is established for a terminally ill Participant; 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 Participant recovers or the date the Participant dies; and

Two or more Episodes of Hospice Care for the same Participant 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 Participant.

**Experimental or Investigational** means 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 CVS Caremark'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 CVS Caremark' Formulary, You may call toll-free **877.817.0479** or visit CVS Caremark' website at [www.caremark.com](http://www.caremark.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 that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature;
- 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 Drug 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 mean 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 an 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 Participants; 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 Participants.

**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 Medically Necessary.

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

**Hospital Room Daily Limit** means Covered Expenses charged 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 Participant's Spouse/Domestic Partner, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

**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** means a clinical review conducted by appropriately 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 are made.

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

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

- medically Appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease, or injury;
- obtained from a covered Network or Non-network Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease, or injury;
- cost-effective compared to alternative treatments or service, including no treatment or service. As to the diagnosis or treatment of the Participant'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.

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

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

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

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

**Participant** means a Covered Retiree or Covered Dependent.

**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.

**Participant** means a Covered Retiree, Covered Dependent or Covered Surviving Dependent.

**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) days 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 ("M.D."); doctor of osteopathy ("D.O."); audiologist; certified registered nurse anesthetist; chiropractor; dentist; certified midwife; occupational therapist; optometrist; physician assistant; physical therapist; podiatrist; psychologist; social worker; or speech pathologist.

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

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

**Plan** means the **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 Participant's coverage, it does not begin before a Participant's effective date, and it does not continue after a Participant's coverage ends.

**Pre-Service Review** means a review conducted prior to a Participant's stay in a Hospital or other health care 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 health care facility or has received services or completed a course of treatment.

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

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

**Recovery** means but is not limited to, monies received from any person or party, any person 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 R.N. or licensed vocational nurse ("LVN")/licensed practical nurse ("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 fulltime basis by an M.D., D.O., or an 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 a 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 Utilization Management Review that must be completed sooner than a Pre-Service Review in order to prevent serious jeopardy to the Participant's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant 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, health care 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 1,000 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 **ELIGIBILITY** section. Each year in which the Retiree worked at least 1,000 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 1,000 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 the 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.

For purposes of determining retiree medical premium for Employees who have had a break in service, 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 **ELIGIBILITY** section. Credit will be given for each year in which the Retiree worked at least 1,000 hours for Ameren as an active Employee.

**You/Your** for purposes of eligibility and enrollment means a Retiree who is eligible to participate in the Plan as set forth in this SPD; however, in the context of receiving Plan benefits, You/Your is intended to refer to any Participant.

## Purpose

Ameren Corporation (the "Plan Sponsor" or the "Company") maintains the **Ameren Retiree Medical Plan**, a component part of the **Ameren Retiree Welfare Benefit Plan** (the "Plan"), to provide health benefits for certain Retirees, their Spouses, and other eligible Dependents. All references herein to the "Ameren Retiree Medical Plan" and the "Plan" refer to the Medical Plan component of the Plan.

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

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

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

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

As a Participant of the Plan, Your rights and benefits are determined by the provisions of the Plan. This SPD 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.

If You have any questions after reading this SPD, please contact the **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**).

**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 both current and future Retirees and their dependents. The Plan Sponsor's rights include the right to obtain coverage and/or administrative services from additional or difference insurance carriers, HMOs, third party administrators, inc., at any time, and the right to revise the amount of employee contributions. Participants will be notified of any material modification to the Plan.

**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.



## Your Role in Controlling Healthcare Costs

Making choices about Your health can sometimes be difficult. When You seek health care, 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 health care 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 Drugs or 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 or 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 is Your body. To make wise health care 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 health care consumer. Review Your benefits carefully so You can make informed health care decisions. You can help control health care 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](http://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 food and the right mix of foods from all five food groups (grains, vegetables, fruits, milk, and meat and beans).
2. **Get moving.** Everyone knows that they should exercise, but actually fitting it into our daily lives is often another story. Nevertheless, exercise is an essential part of creating a healthy lifestyle. The American Academy of Physicians recommends that You exercise 4 – 6 times a week for 30 – 60 minutes.
3. **Maintain a healthy weight.** Determining if Your weight is normal has to do with more than just pounds – it also has to do with Your height. You can use a body mass index calculator to get a more complete idea of Your weight.
4. **Reduce stress.** Stress is a common part of everyday life, and a certain amount of stress is actually good for You. Too much stress can negatively affect Your digestive, immune, nervous and cardiovascular systems. Look for Your stress triggers and work to change Your reaction to them.
5. **Know Your health status and take steps to improve it.** By taking an active role in managing Your health, You can help prevent or delay the onset of chronic conditions. Go to the doctor each year for a physical and get all recommended preventive health screenings and tests. Ask Your 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 benefit program or specific coverage, except Prescription Drug benefits administered by CVS Caremark. The Anthem staff can also provide information on topics such as outpatient surgery, health care alternatives, health care Providers, Utilization Management Review, 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.

CVS Caremark can assist You with questions regarding Your prescription drug coverage and benefits administered by CVS Caremark. You can reach a CVS Caremark's customer service representative at **877.817.0479**.

Both Anthem and CVS Caremark phone numbers can also be 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 is 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 Care Professionals.
- Tell Your doctors or other Health Care Professionals if You don't understand any care You are 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.

## **How to Obtain Language Assistance**

Anthem is committed to communicating with Participants 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 Participants. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Rights and Responsibilities statement.

## **Identity Protection Services**

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

## **Anthem Non-Discrimination Notice**

**It's important we treat fairly.** That is 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 aid and services. For people whose primary language is not 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](mailto:compliance.coordinator@anthem.com). Or can file a

complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD:1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### **Get Help in Your Language**

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

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

### **myAmeren Benefits**

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

### **myAmeren.com**

The Company maintains [myAmeren.com](http://myAmeren.com) where Plan Participants can initially enroll, view, or make changes to elected benefit coverage. The website is generally available 24 hours a day, seven days a week.

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

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

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

# Ameren Retiree Medical Plan

## Eligibility

Several factors determine Your eligibility for coverage under the 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 Plan for retirees and surviving dependents of active Employees is defined in the following matrix.

Company You retired from	Eligibility Rules
Management Retirees <sup>1</sup>	<p>If You are an Ameren management Employee who retires <b>on or after January 1, 2007</b>, 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:</p> <ul style="list-style-type: none"> <li>➤ You were hired prior to October 1, 2015; provided, however, if You thereafter have a break in service and were then re-hired by an Ameren Company, You must have been re-hired prior to October 1, 2015; AND</li> <li>➤ You are a Retired Employee; AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ You accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND</li> <li>➤ You were covered under the <b>Ameren Retiree Medical Plan</b> until Your 65<sup>th</sup> birthday if You retired prior to the age of 65; OR;</li> <li>➤ You were age 65 or older at the time of Your retirement; AND</li> <li>➤ You are Medicare-eligible based on Your age of 65 years or older.</li> <li>➤ You are eligible for coverage under this Plan if You are an under 65 Medicare-eligible Dependent of a deceased active management Employee who died on or after January 1, 2007 and You were a Participant in the <b>Ameren Employee Medical Plan</b> for active Employees prior to their death, subject to the deceased employee's hire date, age at date of death, and years of service provisions.</li> </ul>

<sup>1</sup> Regardless of the eligibility requirements outlined in this matrix, You are eligible for coverage under this Plan if You are Age 65 or older, unless specifically stated otherwise, from the time of Your retirement until Your 65<sup>th</sup> birthday You were covered under the Ameren Retiree Medical Plan, and: (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 December 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 of 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 of 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 under age 65.

Regardless of the eligibility requirements described above and, in the below matrix, 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 or Union Electric	<ul style="list-style-type: none"> <li>➤ <b>You are a Retired Employee who:</b> <ul style="list-style-type: none"> <li>➤ <b>Retired between January 1, 1992 and through June 30, 1993;</b> AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR a regular part-time Employee covered under one of the Company's active group health plans.</li> </ul> </li> <li>➤ 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.</li> </ul>
AmerenUE or Union Electric ("UE"); Ameren Services; Central Illinois Public Service ("CIPS")	<ul style="list-style-type: none"> <li>➤ <b>You are a Retired Employee who:</b> <ul style="list-style-type: none"> <li>➤ <b>Retired between July 1, 1993 and through June 30, 1998;</b> AND</li> <li>➤ Were a Participant in "UE" benefit plans prior to July 1, 1998; AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR a regular part-time Employee covered under the <b>Ameren Employee Medical Plan;</b> AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren Services, AmerenUE or AmerenCIPS.</li> </ul> </li> <li>➤ 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.</li> </ul>



Company You retired from	Eligibility Rules
<p>AmerenUE; Ameren Services; AmerenCIPS; Ameren Energy Generating Company; Ameren Energy Marketing Company; Ameren Energy Fuels and Services Company and Ameren Energy</p>	<ul style="list-style-type: none"> <li>➤ <b>You are a Retired Employee who:</b> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after July 1, 1998 and through December 31, 2006;</b> AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time Employee covered under the <b>Ameren Employee Medical Plan;</b> AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> </li> <li>➤ You are an under age 65 disabled Medicare-eligible Dependent of a deceased active Employee who was, at the time of his or her death, employed by one of the companies listed in the column to the immediate left and who died on or after July 1, 1998 and on or prior to December 31, 2006.</li> </ul>
<p>Central Illinois Public Service Company (CIPS)</p>	<ul style="list-style-type: none"> <li>➤ <b>You are a Retired Employee who:</b> <ul style="list-style-type: none"> <li>➤ <b>Retired between January 1, 1992 and through June 30, 1998;</b> AND</li> <li>➤ Were a Participant in "CIPS" benefit plans prior to July 1, 1998; AND</li> <li>➤ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND</li> <li>➤ Were eligible for an early or normal retirement benefit from the CIPS Retirement Income Plan.</li> </ul> </li> <li>➤ You are an under age 65 disabled Medicare-eligible Dependent of a deceased CIPS Retiree who met the eligibility requirements described above.</li> </ul>
<p>Central Illinois Light Company (CILCO or Ameren CILCO) Ameren CILCO InfraServices Ameren Energy Medina Valley Cogen, LLC Ameren Energy Resources Generating Company</p>	<ul style="list-style-type: none"> <li>➤ <b>You are a Retired Employee who:</b> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after January 1, 2004 and through December 31, 2006;</b> AND</li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time Employee covered under the <b>Ameren Employee Medical Plan;</b> AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> </li> <li>➤ 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 and on or prior to December 31, 2006.</li> </ul>

## Contract Retirees<sup>2</sup>

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:
    - Ameren Illinois and IBEW Local 51 (IP-Physical & Clerical), IBEW Local 309 (IP), IBEW Local 702 (IP), Laborers Local 12 Counties (IP), Pipefitters Local 101 (IP), Pipefitters Local 360 (IP), Laborers Local 459 (IP), IBEW 51 MDF (IP), Laborers Local 100 (IP); IBEW Local Union 309 (CIPS), IBEW Local Union 649 (CIPS), IBEW Local Union 702<sup>3</sup>; **or**
    - Ameren Missouri and IBEW Local Union 2, IUOE Local Union 148, IBEW Local Union 702 (Physical & Clerical), IBEW Local Union 1439, IBEW Local Union 1455; **AND**
    - You were hired or re-hired on or after January 1, 2020; **OR**
  - You are a former Contract Employee under a collective bargaining agreement between:
    - Ameren Illinois (formerly AmerenCILCO) and IBEW Local Union 51; **or**
    - Ameren Missouri Callaway Energy Center and UGSOA Local Union 11), **AND**
    - You were hired or re-hired 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; **OR**
      - AmerenEnergy Resources Generating Company and IBEW Local Union 51 (Duck Creek, Edwards, and Indian Trails), who retired on or after January 1, 2007; **or**
      - Ameren Missouri Callaway Energy Center and UGSOA Local Union 11), who retired on or after July 1, 2012;
- AND**
- You are age 65 or older and Medicare-eligible, **OR**

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<sup>2</sup> 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, and are under the age of 65.

<sup>3</sup> IBEW Local Union 702E – Illini, 702S – Shawnee, 702W – Great Rivers

- 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.

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>Ameren Illinois</b> and:</p> <p>IBEW Local 51 (IP-Physical &amp; Clerical)  IBEW Local 309 (IP)  IBEW Local 702 (IP)  Laborers Local 12 Counties (IP)  Pipefitters Local 101 (IP)  Pipefitters Local 360 (IP)  Laborers Local 459 (IP)  IBEW 51 MDF (IP)  Laborers Local 100 (IP)</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Was hired on or before December 31, 2019</b>, provided, however, if You thereafter have a break in service and were then re-hired by an Ameren Company, You must have been re-hired on or prior to December 31, 2019; AND</li> <li>➤ <b>Retired on or after January 1, 2018</b>; AND</li> <li>➤ Were age 55 or older on the date You retired; AND</li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time Employee covered under one of the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> <p>➤ You are eligible for coverage under the Plan if You are an under 65 Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2018, and You were a Participant in the Ameren Employee Medical Plan for active Employees prior to their death, subject to the deceased employee's hire date, age at date of death, and years of service provisions.</p>

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>Ameren Missouri</b> and:</p> <p>IBEW Local Union 2  IUOE Local Union 148  IBEW Local Union 702 (Physical &amp; Clerical)  IBEW Local Union 1439  IBEW Local Union 1439 South (combined with Local 1439 1/1/2023)  IBEW Local Union 1455  IBEW Local Union 1455 Region West (combined with Local 1455 11/22/2019)</p> <p><b>Ameren Illinois</b> and:</p> <p>IBEW Local Union 309 (CIPS)  IBEW Local Union 649 (CIPS)  IBEW Local Union 702<sup>4</sup> (CIPS)</p> <p><b>AmerenEnergy Generating Company</b> and:</p> <p>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</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Was hired on or before December 31, 2019</b>, provided, however, if You thereafter have a break in service and were then re-hired by an Ameren Company, You must have been re-hired on or prior to December 31, 2019; <b>AND</b></li> <li>➤ <b>Retired on or after January 1, 2011</b>; AND</li> <li>➤ Were age 55 or older on the date You retired; AND</li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time Employee covered under one of the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li>   <li>➤ You are eligible for coverage under the Plan if You are an under 65 Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2011, and You were a Participant in the Ameren Employee Medical Plan for active Employees prior to their death, subject to the deceased employee's hire date, age at date of death, and years of service provisions.</li> </ul>

<sup>4</sup> IBEW Local Union 702E – Illini, 702S – Shawnee, 702W – Great Rivers

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>AmerenCILCO</b> and IBEW Local 51</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Was hired on or before December 31, 2016</b>, provided, however, if You thereafter have a break in service and were then re-hired by an Ameren Company, You must have been re-hired on or prior to December 31, 2016; AND</li> <li>➤ <b>Retired on or after January 1, 2005;</b> AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> <ul style="list-style-type: none"> <li>➤ You are eligible for coverage under the Plan if You are an under 65 Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2005, and You were a Participant in the Ameren Employee Medical Plan for active Employees prior to their death, subject to the deceased employee's hire date, age at date of death, and years of service provisions.</li> </ul>

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>Ameren Missouri Callaway Energy Center, Unit 1</b> and UGSOA Local Union 11</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Was hired on or before December 31, 2016</b>, provided, however, if You thereafter have a break in service and were then re-hired by an Ameren Company, You must have been re-hired on or prior to December 31, 2016; AND</li> <li>➤ <b>Retired on or after July 2, 2012</b>; AND</li> <li>➤ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ Accrued at least 10 Years of Service after <b>reaching</b> age 45 as an Employee of Ameren.</li> </ul> <p>➤ You are eligible for coverage under the Plan if you are an under 65 Medicare-eligible Dependent of a deceased active Contract Employee (listed to the left) who died on or after July 2, 2012, and You were a Participant in the Ameren Employee Medical Plan for active Employees prior to their death, subject to the deceased employee's hire date, age at date of death, and years of service provisions.</p>
<p><b>Union Electric or AmerenUE</b> 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</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after January 1, 1992 and through June 30, 1994</b>; AND</li> <li>➤ Were age 55 or older on the date You retired; AND</li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time (1455 and 1455 Region West) Employee covered under the <b>Ameren Employee Medical Plan</b>.</li> </ul> <p>➤ 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.</p>

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>Union Electric or AmerenUE and:</b></p> <p>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</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after July 1, 1994, and through December 31, 1999; AND</b></li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible coverage under the <b>Ameren Employee Medical Plan</b> OR part-time (1455 and 1455 Region West) Employee covered under the <b>Ameren Employee Medical Plan; AND</b></li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren Services, AmerenUE or AmerenCIPS.</li> <li>➤ 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.</li> </ul>
<p><b>Union Electric or AmerenUE and:</b></p> <p>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</p> <p><b>AmerenCIPS and:</b></p> <p>IBEW Local 702E – Illini  IBEW Local 702S – Shawnee  IBEW Local 702W – Great Rivers</p> <p><b>AmerenEnergy Generating Company and:</b></p> <p>IBEW Local 702 – Newton  IBEW Local 702 – Newton Clerical  IUOE Local 148  IUOE Local 148 – Coffeen Clerical</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after January 1, 2000 and through December 31, 2010; AND</b></li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b> OR part-time (1455 and 1455 Region West) Employee covered under the <b>Ameren Employee Medical Plan; AND</b></li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> <li>➤ 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.</li> </ul>



Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>Central Illinois Public Service Co. or AmerenCIPS</b> and:</p> <p>IBEW Local 702E - Illini  IBEW Local 702S – Shawnee  IBEW Local 702W – Great Rivers</p> <p><b>AmerenEnergy Generating Company</b> and:</p> <p>IBEW Local 702 – Newton  IBEW Local 702 – Newton Clerical  IUOE Local 148  IUOE Local 148 – Coffeen Clerical</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after January 1, 1992, and through December 31, 1999;</b> AND</li> <li>➤ Were a Participant in "CIPS" benefit plans prior to January 1, 2000; AND</li> <li>➤ Were eligible for an early or normal retirement benefit from the Central Illinois Public Service Retirement Income Plan; AND</li> <li>➤ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date.</li> </ul> <p>➤ 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.</p>
<p><b>AmerenEnergy Resources Generating Company</b> and:</p> <p>IBEW Local 51 (formerly NCF&amp;O Local 8)</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after January 1, 2007;</b> AND</li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan;</b> AND</li> <li>➤ Accrued at least 10 Years Of Service after <b>reaching</b> age 45 as an Employee of Ameren.</li> </ul> <p>➤ 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.</p>

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>AmerenEnergy Generating Company</b> and:</p> <p>IBEW Local Union 702 – Newton</p> <p>IBEW Local Union 702 – Newton Clerical</p> <p>IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville)</p> <p>IUOE Local Union 148 – Coffeen Clerical</p> <p>AmerenEnergy Resources Generating Company and IBEW Local Union 51-Duck Creek and Edwards</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after December 1, 2013, OR</b></li> <li>➤ <b>Were on long term disability on December 2, 2013, and retired on or after December 2, 2013; AND</b></li> <li>➤ 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: <ul style="list-style-type: none"> <li>➤ AmerenEnergy Generating Company and IBEW Local Union 702 – Newton; or</li> <li>➤ AmerenEnergy Generating Company and IBEW Local Union 702 – Newton Clerical; or</li> <li>➤ AmerenEnergy Generating Company and IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville, and Grand Tower); or</li> <li>➤ AmerenEnergy Generating Company and IUOE Local Union 148 – Coffeen Clerical; or</li> <li>➤ AmerenEnergy Resources Generating Company and IBEW Local Union 51 (Duck Creek and Edwards); <b>AND On December 1, 2013 You:</b> <ul style="list-style-type: none"> <li>➤ Were age 55 or older; AND</li> <li>➤ Were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b>; AND</li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> </li> </ul> </li> </ul> <p>➤ 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.</p>

Employees represented by a collective bargaining agreement between	Eligibility Rules
<p><b>AmerenEnergy Generating Company</b> and: IUOE Local Union 148 (Grand Tower)</p>	<p><b>You are a Retired Employee who:</b></p> <ul style="list-style-type: none"> <li>➤ <b>Retired on or after February 1, 2014; OR</b></li> <li>➤ <b>Were on long term disability on January 31, 2014 and retired on or after January 31, 2014; AND</b></li> <li>➤ Were formerly represented by a collective bargaining agreement between AmerenEnergy Generating Company and IUOE Local Union 148 (Grand Tower); <b>AND</b></li> <li>➤ Were age 55 or older on the date You retired; <b>AND</b></li> <li>➤ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the <b>Ameren Employee Medical Plan</b>; <b>AND</b></li> <li>➤ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren.</li> </ul> <p>➤ You are a Medicare-eligible Dependent of a deceased active Contract Employee (listed above) who died on or after February 1, 2014.</p>

**Medicare-Eligible Dependents of Deceased Active Employees**

**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.

Note: For applicable populations, the 10 Years of Service after the age of 45 requirement does not apply to **under age 65** Medicare-eligible surviving Dependents of deceased active employees who were enrolled in the Ameren Employee Medical Plan at the time of the employee's death and meet all other eligibility criteria for coverage. Once the under age 65 Medicare-eligible surviving

dependent reaches age 65, they are no longer eligible for coverage under the Ameren Retiree Medical Plan if the deceased employee did not have 10 years of service after age 45 requirement at the time of death.

## Dependents

If You enroll in the Plan as a Retired Employee, Your eligible Dependents are also eligible for coverage provided they are not actively serving in any armed forces of any country. 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 Medical Plan** program in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to You:

- Spouse; however, a Spouse who is covered under another Ameren-sponsored medical plan (Active or Retiree Plan) is not eligible for coverage under this Plan.
- Domestic Partner who meets (and continues to meet) all the requirements on the Ameren Affidavit of Domestic Partnership form. You and Your Domestic Partner must sign and submit an accurate and complete Affidavit of Domestic Partnership form on-line at [myAmeren.com](http://myAmeren.com). A form can also be obtained by calling **myAmeren Benefits** at 877.my.Ameren (877.769.2637);<sup>5</sup>
- Dependent Children who have not reached age 26. A child and/or spouse/domestic partner of any Dependent Children are not eligible for coverage under the Plan.
- Dependent Children who are not capable of self-sustaining employment due to a disability and are therefore dependent upon You for support are eligible to continue their coverage under the Plan beyond age 26. Proof of the disability must be furnished to Anthem no later than 31 days after the date of the child's 26<sup>th</sup> birthday. A child is considered disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected either to result in death or last for a continuous period of not less than 12 months.



Disabled Dependent children who were not covered under the Plan upon attainment of their 26<sup>th</sup> birthday are not eligible for coverage.

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

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

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<sup>5</sup> The Employer cost of coverage for Your covered Domestic Partner and covered Children of Your Domestic Partner is considered imputed income by the IRS.

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

**Important Note:** A Spouse/Domestic Partner or Dependent Child 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 or 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 waive coverage in the Plan, You must make Your elections on-line at [myAmeren.com](http://myAmeren.com) or by calling **myAmeren Benefits** 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:

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

Upon Your retirement, You must elect one of the above coverage categories no later than 31 days from the date of when You become eligible for this Plan. The effective date of Your coverage is the date of Your retirement. 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 either. If You do nothing, You will be defaulted to the Plan option shown in the Appendix "Understanding Your Retiree Medical Plan Options, Cost of Coverage and Retiree Health Reimbursement Account".

**Note:** Throughout this 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.

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

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 option they are enrolled in.

## 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 retirement 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 Alight Retiree Health Exchange needs to occur prior to Your retirement date and/or the 65<sup>th</sup> 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 **myAmeren Benefits** at 877.7my.Ameren (877.769.2637) or by going to [myAmeren.com](http://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/Domestic Partner) 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 at [myAmeren.com](http://myAmeren.com) or by calling **myAmeren Benefits** 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, establishment of a domestic partnership, 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 or Domestic Partner 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 Domestic Partner, You and Your Domestic Partner must sign and submit an accurate and complete Affidavit of Domestic Partnership form.
- If enrolling a new Dependent 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 **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**) or go to [myAmeren.com](https://myAmeren.com).

### **Domestic Partner Becoming Spouse After Retirement**

If, after You retire and while You and Your Domestic Partner are covered under the Plan, Your Domestic Partner becomes Your Spouse through marriage, You may change your Domestic Partner's Dependent status to Spouse within 31 days of the marriage. To change your Domestic Partner's status to Spouse, You must:

- Request the status change of the Dependent from Domestic Partner to Spouse within 31 days of the marriage (either at [myAmeren.com](https://myAmeren.com) or by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**); AND
- Provide a copy of the marriage certificate.

Your Domestic Partner's Dependent status as Spouse will be effective as of the date of marriage, provided You timely request the change in status.

If You do not request the change in status within 31 days of the marriage, You have an opportunity during Annual Enrollment to change Your Domestic Partner's status to Spouse and provide the required documentation above for an effective date of January 1 of the following year.

NOTE: The Employer cost of coverage for Your covered Domestic Partner will no longer be considered imputed income by the IRS upon Your timely request to change Your Domestic Partner to Your Spouse as of the date of Your marriage.

### **Eligibility for Premium Assistance**

If You or an Eligible Dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state Children's Health Insurance Program 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 at [myAmeren.com](https://myAmeren.com) or by calling **myAmeren Benefits** 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 **myAmeren Benefits** 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 or drop/waive coverage. For example, if You are enrolled in the Standard Plan, You could enroll in the Health Savings Plan. 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 the **APPENDIX** 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 the **APPENDIX** 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 the **APPENDIX** for the current contribution schedule.

Your cost of coverage for You and any Covered Dependents under the 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.

## 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 the [APPENDIX](#).

**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 the [APPENDIX](#).

**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 the [APPENDIX](#).

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](http://www.anthem.com). If You lose Your prescription drug coverage ID Card, You may obtain a replacement by calling CVS Caremark at **877.817.0479**, or by visiting [www.caremark.com](http://www.caremark.com). To obtain an ID Card through Anthem's or CVS Caremark's secure website, You must first register with a unique login and password.



## 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 Plan or Health Savings Plan – Value which already includes prescription drug coverage. The applicable medical plan option, plus the prescription drug benefits comprise Your current Plan benefits.

**Important Note:** See the **APPENDIX** Section 4 for "Missouri Retirees Under Active Contract – Plan Choices", Section 5 for "Illinois Retirees Under Active Contract – Plan Choices" and Section 6 for "Management and Expired Contract Retirees – Plan Choices".

**If You and all Your Dependents are not eligible for Medicare,** Your medical plan options are:

- Standard Plan;
- Health Savings Plan, with prescription drug coverage included;
- Health Savings Plan – Value, with prescription drug coverage included.

**If You and all of Your Dependents are age 65 or over and eligible for Medicare** and eligible for this Plan as stated in the **ELIGIBILITY** section of this document, Your medical plan options are:

- Alight Retiree Health Solutions (**not** available for Missouri Union Retirees under contract\*);

\* The plan options for Missouri Union Retirees under contract are the Conventional Plan, with or without prescription drug coverage and the Medicare Supplement Plan, with or without prescription drug coverage. See the **APPENDIX** for more information.

**If You and Your Dependents have split eligibility with some Participants Medicare eligible and some not,** the Medicare eligible person(s) should elect coverage from the following options:

- Conventional Plan, with or without prescription drug coverage;
- Medicare Supplement Plan, with or without prescription drug coverage

Any non-Medicare eligible Participants should elect coverage from the following options:

- Standard Plan;
- Health Savings Plan, with prescription drug coverage included;
- Health Savings Plan – Value, with prescription drug coverage included

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

## Anthem Network Programs

The Standard Plan, Health Savings Plan, and Health Savings Plan – Value options 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 health care 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 Participants.

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 Participant. 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](http://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 [myAmeren.com](http://myAmeren.com) and then click on "Anthem.com"; or
- Visit the Anthem website at [www.anthem.com](http://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.

We recommend 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. Participants seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes. Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Network Provider charges, unless such charges relate to treatment that qualifies as an Emergency Medical Condition or Medical Emergency (as explained later in this SPD). This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket Expenses to You. Contact the Claims Administrator at **844.344.7410** for help in finding a Network Provider or visit Anthem's website and follow the directions stated above. Additionally, in some cases, some Network Providers may also bill for services or equipment that is above the standard as stated in their Provider contract with Anthem,

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

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

## **Inter-Plan Arrangements**

### **Out-of-Area Services**

Anthem has relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the 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. 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](http://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 traveling 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 Blue Cross Blue Shield Global Core hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copays and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Physician, and Inpatient care not arranged through the Blue Cross Blue Shield Global Core Service Center. Then You can complete a Blue Cross Blue Shield Global Core claim form and send it with the original bill(s) to 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 Core Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

### **Claim Forms**

International claim forms are available from the Claims Administrator, the Blue Cross Blue Shield Global Core Service Center, or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

The address for submitting claims is:

Service Center  
P.O. Box 2048  
Southeastern, PA 19399  
Email Address: [claims@bcbsglobalcore.com](mailto: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<sup>6</sup>. 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 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.

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<sup>6</sup> 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.



## Plans for Retirees and Dependents not Eligible for Medicare



## Standard Plan – Schedule of Benefits

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

<b>Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.</b>		
<b>STANDARD PLAN</b>		
<b>Available to Non-Medicare Eligible Participants only</b>		
<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Lifetime Maximum Benefit</b> Includes prescription drug benefits	\$750,000	
<b>Deductible</b>	\$ 600 per person \$1,200 per family	\$ 900 per person \$1,800 per family
	Network and Non-Network Deductibles reduce each other.	
<b>Out-of-Pocket Maximum</b> (amount of Covered Expenses You could have to pay in a single year, including Deductibles)	\$3,500 per person \$7,000 per family	\$ 7,000 per person \$14,000 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.	
<b>Inpatient Hospital</b> (precertification required)	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Outpatient Facility</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Emergency Room Services</b>	You pay Deductible, then the Plan pays 90%	
	If not true Medical Emergency, You pay Deductible, then the Plan pays 90%.	
<b>Ambulance</b>	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 PLAN (continued)**  
**Available to Non-Medicare Eligible Participants only**

<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 90%
<b>Office Visits</b> 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%
<b>Maternity Care</b> 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%
<b>Allergy Injections and Serum</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Chiropractic Services</b> Limited to 25 visits per year.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Physical Therapy</b> Limited to 25 visits per year.	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Speech/Occupational Therapy</b> 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%
<b>Wellness and Preventive Care Services as recommended</b> Including preventive colonoscopies	The Plan pays 100% (Deductible does not apply)	The Plan pays 70% of the Maximum Allowed Amount (Deductible does not apply)
<b>Colonoscopies</b> For 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 PLAN (continued)  
Available to Non-Medicare Eligible Participants only**

<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Home Health Care</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Hospice Care</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Skilled Nursing Facility</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>X-Ray and Laboratory Services</b> 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%
<b>Durable Medical Equipment</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Prescription Drugs</b>	See <b>PRESCRIPTION DRUG PROGRAM FOR STANDARD PLAN</b>	
<b>All other Covered Expenses</b>	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%

## Health Savings Plan – Schedule of Benefits

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

<b>Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.</b>		
<b>HEALTH SAVINGS PLAN Available to Non-Medicare Eligible Participants Only</b>		
<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Lifetime Maximum Benefit</b> Includes Prescription drug benefits	\$750,000	
<b>Deductible</b>  • You Only Coverage  • You & Spouse/Domestic Partner, You & Child(ren), or You & Family Coverage	\$1,550 (2023) \$1,600 (2024) <hr/> \$3,200 <b>IMPORTANT NOTE:</b> The individual Deductible applies <u>ONLY</u> if You have elected Retiree Only coverage. If You have elected to cover any eligible Dependent family members under the Health Savings Plan, the Plan will not pay benefits until Your annual family Deductible has been met, whether by one or more covered Members.  Covered Expenses for both medical and prescription drugs apply toward the Deductible.	
<b>Out-of-Pocket Maximum</b>  (the amount of Covered Expenses You must pay in a single year, including Deductibles)	\$ 4,000 per person \$ 8,000 per family	\$ 6,700 per person \$ 13,400 per family
	Network and Non-Network Out-of-Pocket Expenses reduce each other.  Non-covered services, precertification penalties, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum.  Covered Expenses for both medical and prescription drugs apply toward the Out-of-Pocket Maximum.	
<b>Inpatient Hospital</b> (precertification required)	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Outpatient Facility</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Emergency Room Services</b>	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 PLAN (continued)  
Available to Non-Medicare Eligible Participants Only**

<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Ambulance</b>	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.	
<b>Urgent Care</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Office Visits</b> 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%
<b>Maternity Care</b> 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%
<b>Allergy Injections and Serum</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Chiropractic Services</b> Limited to 25 visits per year	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Physical Therapy</b> Limited to 25 visits per year	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Speech/Occupational Therapy</b> 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%
<b>Home Health Care</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Hospice Care</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>Skilled Nursing Facility</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>X-Ray and Laboratory Services</b> 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 PLAN (continued)  
Available to Non-Medicare Eligible Participants Only**

<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Wellness and Preventive Care Services as recommended</b> Including preventive colonoscopies	The Plan pays 100% (Deductible does not apply)	The Plan pays 70% (Deductible does not apply)
<b>Colonoscopies</b> For Medically Necessary reasons	You pay Deductible, then the Plan pays 90%	You pay Deductible, then the Plan pays 70%
<b>Prescription Drugs</b> (see <b>PRESCRIPTION DRUG PROGRAM FOR HEALTH SAVINGS PLAN</b> )	You pay Deductible, then the Plan pays 80% (You pay 20% of the CVS Caremark discounted price until You 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 CVS Caremark Mail Service Pharmacy Drugs.	
<b>Durable Medical Equipment</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%
<b>All other Covered Expenses</b>	You pay Deductible, then the Plan pays 80%	You pay Deductible, then the Plan pays 60%

## Health Savings Plan – Value – Schedule of Benefits

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

<b>Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.</b>		
<b>HEALTH SAVINGS PLAN- Value Available to Non-Medicare Eligible Participants Only</b>		
PLAN FEATURE	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum Benefit</b> Includes Prescription drug benefits	\$750,000	
<b>Deductible</b>		
• You Only Coverage	\$2,500	
• You & Spouse/Domestic Partner, You & Child(ren), or You & Family Coverage	\$5,000	
	<p><b><u>IMPORTANT NOTE:</u></b> The \$2,500 Deductible applies <u>ONLY</u> if You have elected Retiree Only coverage. If You have elected to cover any eligible Dependent family members under the Health Savings Plan, the Plan will not pay benefits until Your annual Deductible of \$5,000 has been met, whether by one or more covered Members.</p> <p>Covered Expenses for both medical and prescription drugs apply toward the Deductible.</p>	
<b>Out-of-Pocket Maximum</b> (the amount of Covered Expenses You must pay in a single year, including Deductibles)	\$5,000 per person \$10,000 per family	\$7,000 per person \$15,000 per family
	<p>Network and Non-Network Out-of-Pocket Expenses reduce each other.</p> <p>Non-covered services, precertification penalties, and amounts over the Maximum Allowed Amount do not apply to the Out-of-Pocket Maximum.</p> <p>Covered Expenses for both medical and prescription drugs apply toward the Out-of-Pocket Maximum.</p>	
<b>Inpatient Hospital</b> (precertification required)	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Outpatient Facility</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Emergency Room Services</b>	<p>You pay the Deductible, then the Plan pays 100%, if true Medical Emergency;</p> <p>If not a true Medical Emergency as defined by the Plan the Deductible and applicable Coinsurance will apply.</p>	



**Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.**

**HEALTH SAVINGS PLAN – VALUE (continued)  
Available to Non-Medicare Eligible Participants Only**

<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Ambulance</b>	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.	
<b>Urgent Care</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Office Visits</b> Includes covered diagnostic services performed in the Physician's office	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Maternity Care</b> Includes office visits/prenatal & postnatal, in-Hospital delivery, and newborn nursery services	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Allergy Injections and Serum</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Chiropractic Services</b> Limited to 25 visits per year	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Physical Therapy</b> Limited to 25 visits per year	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Speech/Occupational Therapy</b> Limited to 20 visits per year for covered diagnoses	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Home Health Care</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Hospice Care</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Skilled Nursing Facility</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>X-Ray and Laboratory Services</b> Performed in a Hospital or other independent outpatient facility	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%

<b>Note: This chart is only a summary of Plan provisions. Review more details on Covered and Non-Covered Expenses throughout this document.</b>		
<b>HEALTH SAVINGS PLAN- VALUE (continued) Available to Non-Medicare Eligible Participants Only</b>		
<b>PLAN FEATURE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Wellness and Preventive Care Services as recommended</b> Including preventive colonoscopies	The Plan pays 100% (Deductible does not apply)	The Plan pays 50% (Deductible does not apply)
<b>Colonoscopies</b> For Medically Necessary reasons	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>Prescription Drugs</b> (see <b>PRESCRIPTION DRUG PROGRAM FOR HEALTH SAVINGS PLAN</b> )	You pay Deductible, then the Plan pays 70% (You pay 50% of the CVS Caremark discounted price until You 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 CVS Caremark Mail Service Pharmacy Drugs.	
<b>Durable Medical Equipment</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%
<b>All other Covered Expenses</b>	You pay Deductible, then the Plan pays 70%	You pay Deductible, then the Plan pays 50%

### Health Savings Account

The Health Savings Plan and Health Savings Plan - Value are qualified high deductible health plan options. Accordingly, if You enroll for coverage under these Plans, You may be eligible to participate in and contribute to a Health Savings Account. 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.

## 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 will 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 is 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 Participants 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 Participants who are eligible to receive program benefits.

## **Behavioral Health**

Coping with complex behavioral health and medical conditions can be confusing and frustrating. Fortunately, You do not 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 will 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
- Mental health clinical nurse specialist
- Licensed marriage and family therapist
- Licensed professional counselor
- Any agency licensed by the state to provide these services when they have to be covered by law.

## **Autism Spectrum Disorders Program**

The Autism Spectrum Disorders ("ASD") Program (the "ASD Program") offers families touched by Autism resources and support in identifying and navigating appropriate treatment and resources. The program focuses on the individual touched by Autism 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 Program case managers assist with coordination of navigating the complex health care system and addressing the unique challenges of autism. A customized care plan helps to identify available services, secure access to care, and facilitates collaboration between treatment providers.

**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 Plan, the Health Savings Plan, and the Health Savings Plan – Value.

### Incidental Providers

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

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

### Payment Innovation Programs

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

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

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

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

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

## Deductible Amounts

The Deductible Amount is measured by calendar year (January through December). The Deductible for each calendar year depends on the Schedule of Benefits. If a Deductible applies, 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 the Standard Plan:** You pay one individual Deductible each calendar year. Only amounts up to the individual Deductible Amount for each Member will apply toward satisfaction of the family Deductible Amount. The family Deductible is met by any combination of family members, but an individual would never satisfy more than his/her own individual amount. The Copay amounts paid under the 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 Plan and the Health Savings Plan - Value:** The individual Deductible Amount applies only if You are enrolled in Employee Only coverage. The family Deductible Amount applies if You and any family members are enrolled, and the family Deductible amount can be satisfied by one individual. Prescription drug purchases can help satisfy the Deductible, but any penalties incurred as a result of failure to comply with Utilization Management Review requirements may not be used to help satisfy Your Deductible.

### **Out-of-Pocket Maximums**

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

#### **For the Standard Plan:**

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

Only amounts up to the individual Out-of-Pocket Maximum for each Participant 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 Plan and Health Savings Plan - Value:**

The Out-of-Pocket Maximum consists of any Deductible payments and the Participant'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.

### **Lifetime Maximum Benefit**

The maximum benefit payable under this Plan for covered Medical and prescription drugs for any non-Medicare eligible Participant during his or her lifetime is \$750,000. Your Lifetime Maximum follows You from option to option. For example, if in 2023 You are enrolled in the Standard Plan and in 2024 You enroll in the Health Savings Plan, the amount that has been applied to Your Lifetime Maximum under the Standard Plan will also apply to Your Lifetime Maximum under the Health Savings Plan.

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 Participant reaches the Lifetime Maximum while not yet eligible for Medicare. In that case, the Participant 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](http://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 Association rules governing claims filed by certain ancillary Providers.

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

1. An amount based on the Claims Administrator's Non-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the CMS. When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Non-Network Provider.

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

For Covered Expenses rendered outside the Claims Administrator's service area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's

Nonparticipating 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](http://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 a Non-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket Expenses. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

### **Member Cost Share**

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

Your cost share amount and Out-of-Pocket Expense limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this Summary Plan Description for Your cost share responsibilities and limitations or call Anthem at **877.403.0610** to learn how the Plan's benefits or cost share amounts may vary by the type of Provider You use.

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

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

## Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Expense, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Expense You receive from a Non-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Expense. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Expenses if You receive services for a Medical Emergency from a Non-Network Provider and are not able to contact the Claims Administrator until after the Covered Expense is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Expense received from a 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

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

The Plan uses Utilization Review in order to determine when services are Medically Necessary or Experimental/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 Participants the Claims Administrator serves. These processes are described in the following section.

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

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

## Exceptions to the Utilization Review Program

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

If You have any questions regarding the information contained in this section, You may call the Member Services telephone number on Your medical ID Card or visit [www.anthem.com](http://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. Notwithstanding anything else contained in this SPD, precertification will not be required for treatment related to an Emergency Medical Condition or Medical Emergency (including post-emergency stabilization care).

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

**Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment. Both Pre-Service Reviews and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

## Treatment and Services Requiring Precertification

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

**If You or Your Non-Network Provider do not obtain the required precertification for Inpatient Covered Expenses, a \$200 penalty will apply, and Your Out-of-Pocket Expenses 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 care 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, Diastasis 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
- Intensive outpatient therapy
- Partial hospitalization
- 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 contact 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 Participant's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function or subject the Participant 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** Review - A request for precertification that is conducted after the service, treatment or admission has occurred. A Post Service Review for clinical claims is also retrospective. Post-Service Review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.



## Decision and Notification Requirements

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

<b>Request Category</b>	<b>Timeframe Requirement for Decision and Notification</b>
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 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 Participant; and
2. the treatment, service or surgery is a Covered Expense under Your Plan option; and
3. the treatment or service is not subject to an exclusion under Your Plan option; and

4. You have not exceeded any applicable limits under Your Plan option.

### **Important Information**

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

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

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

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

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

### **Medical Expense Coverage for the Non-Medicare Plans**

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

Covered Expenses will be the actual cost charged to You or one of Your Covered Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed the Maximum Allowed Amount. Except for the wellness benefits outlined under Covered Expenses, the expenses must be ordered by a Physician for therapeutic treatment of an injury or sickness and 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 an L.P.N. or an 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. 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 CVS Caremark Prescription Drug Program, if applicable);
14. surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
15. Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, and certain replacement parts such as batteries, cases, and tubing, unless damage results from Your or Your Covered Dependent's negligence or abuse of such equipment. Covered Expenses will not include charges which are in excess of the purchase price of the equipment;
 

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

20. colonoscopies (for both preventive and Medically Necessary reasons);
21. x-ray-, radium, and radioactive isotope therapy;
22. professional Ambulance Service is subject to Medical Necessity and is a Covered Expense when You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by emergency medical technicians, paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. One or more of the following criteria are met.
  - For ground Ambulance, You are taken:
    - From Your home, the scene of an accident or medical Emergency to a Hospital;
    - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; 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. The amount of any Coinsurance or Copay you are responsible for will be counted toward your Deductible and Out-of-Pocket Maximum. You must be taken to the nearest facility that can give care for Your condition. In certain cases, the Claims Administrator may approve benefits for transportation to a facility that is not the nearest facility. Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an Ambulance Service, even if You are not taken to a facility.

## **Important Notes on Air Ambulance Benefits**

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

### **Hospital to Hospital Transport**

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

### **Non-Emergency Air Ambulance**

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

23. transportation within the continental United States and Canada by railroad or regularly scheduled flight of a commercial airline from the location where the 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 Plan, Health Savings Plan, and Health Savings Plan – Value:** one personal hearing aid for each ear every five years. Covered Expenses will include: ear molds, the hearing aid, the initial batteries, cords and other necessary equipment, a warranty, and follow up consultation within 30 days after delivery of the hearing aid;

**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 addition 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-childcare including immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diphtheria/tetanus; mumps, measles, rubella and certain other vaccines, at the in-network coverage level, whether obtained by a Network or Out-of-Network Provider);
- adult immunizations; (the Plan will pay for certain immunization such as the flu, pneumonia, diphtheria/tetanus; shingles; and certain other vaccines, at the in-network coverage level, whether obtained by a 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 SPD;

32. Hospice Care as described in this SPD;

33. Skilled Nursing Facility as described in this SPD;

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

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

#### **Education**

- Educates and engages the family on available community resources, helping to create a system of care around the Participant.
- 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 Participant experience and coordination of care.
- Assistance in exploration of medical services that may help the Participant, 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 Participant to promote quality, Appropriate, cost-effective outcomes. The process involves early intervention and proactively working with the Participant, 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 Participant 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 Plan, 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 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 Health Savings Plan – Value, 70% 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 Participant 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 Participant;

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 Participant 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 Participant's death. Bereavement services are available to surviving Participants of the immediate family for one (1) year after the Participant's death. Immediate family means Your spouse/domestic partner, children, stepchildren, parents, brothers, and sisters.

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

Benefits for Covered Expenses beyond those listed above, such as chemotherapy and radiation therapy given as Palliative Care, are available to a Participant 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 Participant, 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 Participant transplant recipient and a travel companion will be covered if the treating facility is greater than 100 miles one way from the Participant'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 Plan, the Health Savings Plan, and the Health Savings Plan – Value,** travel and lodging benefits will be payable at 100% **after** the Deductible Amount, up to a maximum benefit of \$10,000 for each approved transplant.

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

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 Participant, 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 toenails, 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



## **If You are Eligible for Medicare and for Alight Retiree Health Solutions**

If You are a Medicare eligible Retiree or Dependent of a Retiree and are age 65 or older, instead of enrolling in one of the Plans described in this SPD, You have access to retiree healthcare coverage through the purchase of an individual policy through Alight Retiree Health Solutions with financial assistance from Ameren. You will receive information directly from Alight Retiree Health Solutions regarding the Medicare Open Enrollment Period and opportunities to change Your supplemental Medicare coverage. For questions, contact Alight Retiree Health Solutions at 855.819.0011.

Alight Retiree Health Solutions is a Medicare marketplace where You can shop for additional Medicare insurance, enroll in coverage, and receive support.

- Access national and regional Medicare insurers
- Find coverage, including Medicare Advantage, Medicare Supplement, and prescription drug plans
- Get help evaluating Your options, comparing plans, and enrolling in coverage
- Receive personal guidance so You can make informed decisions about Your benefits

## Conventional Plan – Schedule of Benefits

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

<b>PLAN FEATURE</b>	<b>PROVIDER OF CHOICE</b>
<b>Provider does not accept Medicare Assignment</b>	Covered Expenses for amounts over the Medicare-approved amounts are payable up to the Maximum Allowed Amount
<b>Home Health Care</b> No visit limits	You Pay the Deductible, then the Plan pays 80%
<b>Skilled Nursing Facility</b> Room and board charges are not covered	You pay the Deductible, then the Plan pays 80%
<b>Hospice Care</b> No day or dollar limit	You pay the Deductible, then the Plan pays 80%
<b>Medicare Approved Durable Medical Equipment</b>	You pay the Deductible, then the Plan pays 80%
<b>Foreign Travel Emergency</b>	You pay the Deductible, then the Plan pays 80%
<b>Inpatient and Outpatient Mental Health, Alcohol or Substance Abuse</b>	You pay the Deductible, then the Plan pays 80%
<b>Prescription Drugs</b> It is not necessary to elect prescription drug coverage if You are enrolled or enrolling in a Medicare Part D Drug Plan	See <b>PRESCRIPTION DRUG BENEFITS FOR MEDICARE ELIGIBLE PARTICIPANTS</b>
<b>All other Covered Expenses</b>	You pay the Deductible, then the Plan pays 80%

## Medicare Supplement Plan – Schedule of Benefits

<p><b>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.</b></p>	
<p><b>MEDICARE SUPPLEMENT PLAN For Medicare Eligible Participants</b></p>	
PLAN FEATURE	PROVIDER OF CHOICE
<p><b>Lifetime Maximum Benefit</b> Includes prescription drug benefits</p>	<p>\$200,000</p>
<p><b>Deductible</b></p>	<p>\$0 for Part A Equal to the Medicare Part B Deductible (\$226 for 2023) <i>(Medicare changes the Part B deductible each year)</i></p>
<p><b>Hospital (Inpatient and Outpatient)</b></p>	<p><b>Part A</b> – The Plan pays 100% of eligible Covered Expenses up to the Medicare approved charge less the actual amount paid by Medicare <b>Part B</b> – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met</p>
<p><b>Office Visits</b></p>	<p>Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met</p>
<p><b>Urgent Care</b></p>	<p>Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met</p>
<p><b>Ambulance</b></p>	<p>Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met</p>
<p><b>Chiropractic Services</b> Coverage is only for manipulation of the spine. All other modalities and chiropractic treatment are not covered.</p>	<p>Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met.</p>
<p><b>Routine preventive services, such as:</b> 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</p>	<p>The Plan pays 100% only when Medicare covers and pays for these expenses.</p>

**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**

<b>PLAN FEATURE</b>	<b>PROVIDER OF CHOICE</b>
<b>Eyeglasses</b> 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.
<b>X-Ray and Lab (excluding routine care)</b>	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.
<b>Blood</b> 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
<b>Provider does not accept Medicare Assignment</b>	Covered Expenses for amounts over the Medicare-approved amounts are not covered.
<b>Skilled Nursing Facility</b>	The Plan does not pay benefits for these expenses.
<b>Hospice Care</b>	The Plan pays only when Medicare covers and pays for these expenses.
<b>Home Health Care</b>	The Plan does not pay benefits for these expenses.
<b>Medicare Approved Durable Medical Equipment</b>	Part B – The Plan pays 100% of charges not payable by Medicare after the Part B Deductible is met.
<b>Foreign Travel (Emergency or Non-Emergency Care)</b>	The Plan does not pay benefits for these expenses.
<b>Inpatient and Outpatient Mental Health, Alcohol and Substance Abuse</b>	Part B – The Plan pays 100% of Covered Expenses not payable by Medicare after the Part B Deductible is met.
<b>Prescription Drugs</b> 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 or more Participants are Medicare eligible, and eligible for coverage under this Plan as stated in the Eligibility Section of this document (See **ELIGIBILITY**), and one or more Participants are not, the Medicare and Non-Medicare eligible Participants will make separate elections from the options shown in the **APPENDIX**.

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

Once a Participant turns age 65, and remains eligible for this Plan, he or she will choose one of the Medicare-eligible options as shown in the **APPENDIX** at that time. The non-Medicare eligible Participants may remain in the options for non-Medicare eligible Participants as shown in the **APPENDIX**.

However, if one Participant is Medicare eligible and eligible for the **Ameren Retiree Health Reimbursement Account Plan**, the non-Medicare eligible Participant eligible for this Plan may choose to enroll in an option for non-Medicare eligible Participants as shown in the **APPENDIX**.

The Medicare-eligible Participant can view Plan options available, the associated costs, and make his/her elections at [myAmeren.com](http://myAmeren.com) or by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). If You do not make an election for coverage, You will be defaulted to the Plan option shown in the **APPENDIX**.

## 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 amount 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 Participant 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 CVS Caremark 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 Participant'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 Participant reaches the Lifetime Maximum while not yet eligible for Medicare. In that case, the Participant 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 2023 You are enrolled in the Conventional Plan and in 2024 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 Participants 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<sup>7</sup> outlined under Covered Expenses, the

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<sup>7</sup> 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.



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
  - 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 Participants 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 CVS Caremark 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 Participant 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 Participants 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 Participants 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 Participants 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 Participants 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/Domestic Partner 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 Participants 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 home;
- Custodial Care; or
- transportation services.

### **Hospice Care**

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

**For Participants 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 Participant 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 Participant;

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 Participant 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 Participant's death. Bereavement services are available to surviving Participants of the immediate family for one (1) year after the Participant's death. Immediate family means Your spouse/domestic partner, children, stepchildren, parents, brothers, and sisters.

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

Benefits for Covered Expenses beyond those listed above, such as chemotherapy and radiation therapy given as Palliative Care, are available to a Participant 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 Participant, 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<sup>8</sup> 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;
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;

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<sup>8</sup> 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.

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 Participant, 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 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 CVS Caremark, the information in this section applies only to those prescription drugs that are administered to You under the medical benefits of this Plan.

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

### Important Details About Prescription Drug Coverage As A Medical Benefit

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, 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 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 ID Card. The list will be reviewed and updated from time to time. Including a prescription drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify prescription drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

### **Designated Pharmacy Provider**

The Plan in its sole discretion, may establish one or more “Designated Pharmacy Provider” programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Participants. 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](http://www.anthem.com).

The Claims Administrator and/or its 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 considered in determining Your Copay or Coinsurance.

## Prescription Drug Program Administered by CVS Caremark

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 Drugs, You need to use CVS Caremark Specialty Pharmacy to fill Your prescription.

## Prescription Drug Benefits for Participants in the Standard Plan

PRESCRIPTION DRUG PROGRAM Administered by CVS Caremark	
FOUR TIER PRESCRIPTION DRUG PROGRAM	
<b>Deductible</b>	\$0
<b>Annual Out-of-Pocket Prescription Maximum</b>	\$4,000/\$8,000
<b>Retail Drugs</b> 34 day supply*	\$10 for Generic Drugs \$40 for Preferred Brand Name Drugs \$60 for Non-Preferred Brand Name Drugs \$125 for Specialty Drugs (only available through mail order)
<b>Home Delivery Program Drugs</b> 90 day supply*	\$20 for Generic Drugs \$80 for Preferred Brand Name Drugs \$120 for Non-Preferred Brand Name Drugs

**\*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 CVS Caremark at **877.817.0479** if You have questions about coverage and/or quantity limits for a specific prescription drug.



## Prescription Drug Program for Health Savings Plan

If You and Your Covered Dependents are participating in the Health Savings Plan, Your prescription drug program is administered by CVS Caremark. The Health Savings Plan medical Plan Deductible of \$1,600 for individual coverage or \$3,200 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 CVS Caremark 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 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 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 CVS Caremark at **877.817.0479**.

## Prescription Drug Program for Health Savings Plan – Value

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

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

### Preventive Prescription Drugs

You pay 30% Coinsurance for preventive medications whether or not You have met Your medical Deductible under the Health Savings 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 CVS Caremark at **877.817.0479**.

**Prescription Drug Benefits for Medicare Eligible Participants**

<b>PRESCRIPTION DRUG PROGRAM Administered by CVS Caremark (Cannot be elected alone; must choose a medical option also)</b>		<b>Medical Only Option (No Prescription Drug Coverage)</b>
	<b>Four-Tier Prescription Drug Program</b> (Available with Conventional Plan or Medicare Supplement Plan)	<b>Available Only if enrolled in the Conventional Plan or the Medicare Supplement Plan</b>
<b>Deductible</b>	<b>\$0</b>	No prescription drug coverage through the <b>Ameren Retiree Medical Plan</b> .  Participants <b>should</b> enroll in a Medicare Part D plan for prescription drug coverage.  This option is available to Participants only when <b>all</b> covered family members are Medicare-eligible. (For example, when the Retiree and Spouse/Domestic Partner are both Medicare-eligible.)
<b>Out of Pocket Maximum</b>	<b>None</b>	
<b>Retail Drugs</b> 34-day supply*	<b>\$10</b> for Generic Drugs <b>\$40</b> for Preferred Brand Name Drugs <b>\$60</b> for Non-Preferred Brand Name Drugs <b>\$125</b> for Specialty Drugs (only available through mail order)	
<b>Home Delivery Program Drugs</b> 90-day supply*	<b>\$20</b> for generic drugs <b>\$80</b> for preferred brand name drugs <b>\$120</b> for non-preferred brand name drugs. 90-day supply*	

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 CVS Caremark at **877.817.0479** if You have questions about coverage and/or quantity limits for a specific prescription drug.

## 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
<p>If You have questions about:</p> <ul style="list-style-type: none"> <li>➤ Retail network Pharmacies</li> <li>➤ Status of Your claim or Home Delivery prescription</li> <li>➤ Claim history</li> <li>➤ How to request a drug through the Home Delivery Program</li> <li>➤ Your cost or coverage for a drug</li> </ul>	<p>CVS Caremark Customer Service <b>877.817.0479</b></p> <p>Be sure to identify Yourself as a Member of the <b>Plan</b> and have available the Retiree's Social Security number, or the CVS Caremark assigned alternative identification number.</p>	<p><a href="http://www.caremark.com">www.caremark.com</a></p> <p>You can create Your own personal profile so Your information will only be available to You.</p>
Specialty Pharmacy	CVS Caremark Specialty Pharmacy <b>1.800.238.7828</b>	

## 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 Maximum applicable to medical benefits under the 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 CVS Caremark 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 CVS Caremark Pharmacy network, but You should contact Your Pharmacy to verify its

participation. You may also call CVS Caremark at **877.817.0479** or access their website at [www.caremark.com](http://www.caremark.com) to find participating Pharmacies.

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

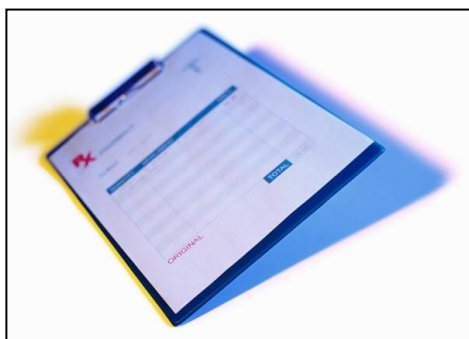
### **Prescription Drugs Obtained at a Non-Participating Retail Pharmacy**

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

Reimbursement will be made based on the Ameren negotiated discounted Average Wholesale Price of the drug minus the applicable \$10, \$40, or \$60 Copay, or 20% Coinsurance amount after Deductible (Health Savings Plan) or 30% Coinsurance amount after Deductible (Health Savings Plan – Value), 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 CVS Caremark Mail Service Pharmacy**

All Members in the Prescription Drug Program may purchase prescription drugs through the CVS Caremark Mail Service Pharmacy. By using the Home Delivery service, Participants 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 Four Tier Prescription Drug Plan. For the Health Savings Plan, You will pay 20% Coinsurance after applicable Deductible, and for the Health Savings Plan – Value, You will pay 30% Coinsurance after applicable Deductible.



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 Mail Service Pharmacy prescription arrives.

To enroll in the Mail Service Pharmacy, complete an CVS Caremark patient profile/order form and send it with the prescription and applicable payment to the address printed on the form. The form may be obtained either by calling CVS Caremark at **877.817.0479** or visiting the website at [www.caremark.com](http://www.caremark.com). The payment may be paid either by check or by credit card. The form explains how to pay by credit card. The prescription may also be refilled online by visiting [www.caremark.com](http://www.caremark.com).

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

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

### **Prescription Drugs Obtained Through the Maintenance Choice Program**

The Maintenance Choice Program allows You the choice to obtain a 90-day supply of designated maintenance medications through CVS Caremark Mail Service Pharmacy or at a participating local CVS retail pharmacy location for the same copay or deductible/coinsurance.

If You are enrolled in the Four Tier Prescription Drug Program, You will pay the same Copay whether You obtain Your maintenance medications through the CVS Caremark Mail Service Pharmacy or at a participating local CVS retail pharmacy location (two Copays for three (3) months of the maintenance medication). If You are enrolled in the Health Savings Plan or the Health Savings Plan – Value You may have slightly lower costs if You obtain Your maintenance medications through the CVS Caremark Mail Service Pharmacy, rather than obtaining Your maintenance medications at a participating CVS retail pharmacy.

If You continue to fill a one-month supply of Your maintenance medication instead of a three (3) months' supply, or if You do not use a CVS retail location or the CVS Caremark Mail Service Pharmacy to fill a designated maintenance medication through the Maintenance Choice 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 Deductible/Coinsurance is only \$20.00, Your cost for the maintenance prescription medication for not using the Maintenance Choice Program would be the actual cost of \$75.00.

You can find out if Your prescription medication is a maintenance medication under the Maintenance Choice Program by contacting CVS Caremark at **877.817.0479** or at [www.Caremark.com](http://www.Caremark.com).

### **Specialty Pharmacy Program**

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

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

- Target chronic, complex and/or rare disease states;

- Require special handling, storage, inventory, distribution and/or administration; administration may be oral, inhaled, infused, or injected; or
- Require customized management for successful usage, including medication utilization review, frequent patient monitoring and training, coordination of care and adherence management.

All Specialty Medications must be approved through the CVS Caremark Specialty Pharmacy Program. The CVS Caremark Specialty Pharmacy Program will work with Your physician to review Your medication and treatment plan, and will provide You with the following services:

- Personally arranged, timely delivery of specialty medications,
- Assistance filing claims,
- Access to education, tools, and support from a clinician-led care team to better understand Your treatment and manage Your condition and
- Access to pharmacists available for emergency consultations 24 hours a day, 365 days a year.

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

Some Specialty Medications may qualify for third-party copayment assistance programs that could lower Your out-of-pocket costs for those products. For any such Specialty Medication where third-party Copayment assistance is used, the Participant shall not receive credit toward their Out-of-Pocket Maximum or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

## Covered Drugs

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

- Any drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician or other lawful prescriber;
- 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 Participants through the age of twenty-five (25) years, and as prescribed to Participants 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 Participants 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 Participant 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 Participant;
- Immunization agents, biological sera, blood, or blood plasma (except as included herein);
- Medication which is to be taken or administered to a Participant in whole or in part, while a Participant 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 Participants 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 CVS Caremark and provide additional information for approval. The Plan's clinical programs are described below. For more information, Participants may contact CVS Caremark at **877.817.0479**.

## Drug Utilization Review

Clinical drug therapy is monitored for various drug interactions, duplicate therapy, high use of addictive substances, and other potential drug therapy concerns. If concerns are identified, 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 FDA approved dosing guidelines and the medical literature. Therefore, if a Physician writes a prescription above the recommended quantity for a particular drug, the pharmacist will only dispense the limited amount for the applicable Copay. You may call CVS Caremark if You have questions about coverage and/or quantity limits for a specific prescription drug.

## Prior Authorization

Prior authorization is a program which ensures certain medications are covered for only proven, Medically Necessary uses. If a Physician prescribes a drug that requires prior authorization, online messaging will instruct the pharmacist that the Physician needs to contact CVS Caremark 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 CVS Caremark for the most current list of drugs that require prior authorization.

## Step Therapy

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

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

## **CVS Caremark Annual Enrollment Microsite**

You may want some help deciding which prescription drug plan is best for You and Your family. Go online to CVS Caremark Annual Enrollment microsite at <https://info.caremark.com/oe/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 Plan;
- Date the Company amends the 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;
- In the case of a Domestic Partner, the date of no longer meeting the Affidavit of Domestic Partnership requirements;
- 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 Plan or elect the continuation benefits available under the Consolidated Omnibus Reconciliation Act of 1974 ("COBRA"). If Your Covered Dependents elect a temporary extension of their coverage in the 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 Plan, the coverage will end on the earliest of the following dates:

- End of the month in which Your surviving Spouse remarries, or Your Domestic Partner marries or enters into a new Domestic Partnership (coverage ends only for the surviving Spouse/Domestic Partner);
- 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 COBRA**

This section contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Depending on the type

of qualifying event, You, Your Covered Spouse and Covered Dependent Children may be qualified beneficiaries. Certain newborns, newly adopted children, and alternate recipients under a QMCSO may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

**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](http://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 Benefitsolver as the COBRA administrator. Participants enrolled in COBRA benefits can obtain information regarding their COBRA benefits at [myAmeren.com](http://myAmeren.com) or by accessing it directly at [www.benefitsweb.com/ameren.html](http://www.benefitsweb.com/ameren.html). COBRA participants can also check on the status of their account by calling myAmeren Benefits at 877.7my.Ameren (877.769.2637). myAmeren Benefits customer service representatives are available Monday through Friday, from 7:00 a.m. to 7:00 p.m. Central Standard Time (CST). The website also allows COBRA participants the ability to update addresses, print forms to add or drop dependents due to a qualifying status change, or update dependent information.

The address for the COBRA administrator is:

myAmeren Benefits  
PO Box 850512  
Minneapolis, MN 55485-0512

## **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 the Company.

## **Spouses/Domestic Partner**

A Covered Spouse/Domestic Partner 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 Affidavit of Domestic Partnership requirements are no longer met.
- The Covered Retiree becomes entitled to Medicare (Part A or Part B or both).
- Filing of bankruptcy by the Company.

## Dependent Children

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

- The death of the Covered 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 the Company.

## Newborn or Adopted Children

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

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

## Special Enrollment Rules for Qualified Beneficiaries

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

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

## Alternate Recipients under Qualified Medical Child Support Orders

A child of a Covered Retiree who is receiving benefits under the Plan pursuant to a QMCSO 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 Covered 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 the Ameren Company must notify the Plan Administrator of the qualifying event. When the qualifying event is a divorce, legal separation, or a child losing Dependent status under the Plan, each Member has a responsibility to notify the Plan Administrator within sixty (60) days of the qualifying event. Notice must be provided at [www.myAmeren.com](http://www.myAmeren.com) or by calling **myAmeren Benefits** 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 Spouse/Domestic Partner and parents may elect COBRA continuation coverage on behalf of their children.

### **Cost of Coverage**

Your Covered Spouse/Domestic Partner and/or Dependent Child(ren) must pay the entire cost of this continuation coverage, including an additional 2% charge to cover administrative expenses. Your Covered Dependent(s) will receive written notice of the cost of continuation coverage at the time of eligibility. They may also request written verification of the cost of continuation coverage at any time during the continuation coverage period. If Your Covered Dependent(s) elect COBRA, they will have 45 days from the date of the election to pay the initial cost for continuation coverage. All continuation coverage payments will be made on an after-tax basis. After this initial 45-day grace period Your Covered Dependent(s) must make the monthly premiums for the cost of continuation coverage by the first day of the month. If these subsequent payments are not received within 30 days of the first day of the month, continuation coverage will be terminated, and Your Covered Dependent(s) will have no further rights to elect continuation coverage. Even if continuation coverage is elected, benefits will not be paid until all payments which are due have been paid without regard to any grace period.

### **Termination Before the End of the Maximum Coverage Period**

Continuation coverage may end prior to the expiration of the maximum coverage period. The following events will cause the elected continuation coverage to terminate immediately:

- The Company no longer provides group health coverage to any of its Retirees;

- Failure to pay the premium for the continuation coverage elected (i.e., within 30 days of the first day of the month);
- Your Covered Dependent(s) becomes covered under another group health plan (as an employee or otherwise) after the date continuation coverage is elected. (This rule applies only to the individual who becomes covered by the other group health plan); or
- Your Covered Dependent(s) become entitled to (i.e., enrolled in) Medicare.

### 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](http://www.myameren.com), or by calling the **Ameren Benefits Center** at 877.7my.Ameren 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 members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Health Care Reimbursement Plan coverage ended. If You qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974 or You will lose Your special COBRA rights.

### If You Have Questions

Questions concerning 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](http://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 [myameren.com](http://myameren.com), or by calling **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**). You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

## Privacy Practices

In addition to this SPD, there are also other formal documents that govern the Plan's operation. One of these documents is a document adopted by the Plan that describes how the Plan may use and disclose certain information that may be considered "protected health information" under 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 [myAmeren.com](http://myAmeren.com). In addition, You have the right to receive a paper copy of this notice by contacting **myAmeren Benefits** at 877.7my.Ameren (**877.769.2637**).

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

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

### **Anthem Caller Verification Policy**

Anthem has a caller verification policy that is set up to ensure that your private health information 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 Participant. Then the caller must provide the Participant'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:

- Participant's address
- Participant'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 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 of Benefits provision applies when a Participant has health care coverage under more than one health plan (as defined below). In simple terms, Coordination of Benefits means that if this Plan is secondary, the amount paid by the primary group health plan will be deducted from the total Allowable Expenses, and the balance of the Allowable Expenses will be paid by this Plan, subject to the following limits:

- The Plan will not pay more under Coordination of Benefits than it would have paid if there were no other coverage under another group health plan;
- The total of benefits paid by both this Plan and any other group health plan will not exceed 100% of Allowable Expenses for that bill.

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

### Definitions

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

- **"Health plan"** shall mean any of the following that provides benefits or services for medical 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 plans"** are those medical benefits to which You or Your Covered Dependents are entitled through another group benefit plan. The benefits amount must be subtracted from Covered Expenses before the Plan can determine what benefits are to be paid under the applicable Schedule of Benefits.
- **"Health plan"** includes:
  - All medical benefits provided by any plan which an employer, Union, association, or trustee contributes to or makes payroll deductions for either directly or indirectly. Health plans include any group insurance policy which provides reimbursement of Major Medical Expenses.
  - Any group Blue Cross or Blue Shield plan or other hospital or medical benefit or severance plan.
  - Any union welfare or other employee benefit organization plan.
  - Expenses incurred for medical care, services or supplies which are paid for, payable by or provided by government plans, such as Medicare. If an individual is eligible for these governmental benefits, such as Medicare, the benefits which would have been received had they been applied for will be counted as health plans.

- **“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.

### **Non-Duplication of Benefits**

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

The Plan reserves the right to:

- Obtain reimbursement from any other group health plan(s) for the cost of the covered services provided, which are payable under the other group 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 Participant to seek payment from the other group health plan; and
- Pay to other group health plan(s) any amount that the Plan determines will satisfy the intent of these Coordination of Benefits provisions, in which case the amount paid will be considered payment for the applicable Coverage and the Plan will have no further liability.

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

### **Duty to Notify the Plan of Other Payment**

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

### **Order of Benefit Determination**

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

1. The health plan that covers the person as an employee is the primary health plan. The health plan that covers the person as a dependent is the secondary health plan.
2. The health plan that covers a person as an employee who is neither laid-off nor a retired employee (nor that employee's dependent) is the primary health plan. The health plan that covers a person as a laid-off or retired employee or that employee's dependent is the secondary health plan. If the other health plan does not have this rule, and if as a result, the health plans do not agree on the order of benefits, this rule is ignored.
3. The health plan that covers a person as an employee, participant, subscriber, or retiree (or as the person's dependent) is the primary health plan. The health plan that covers a person due to a right of continuation provided by federal or state law is the secondary health plan. If the other health plan does not have this rule, and if as a result, the health plans do not agree on the order of benefits, this rule is ignored.
4. When this Plan and another health plan cover the same child as a dependent of different persons, called "parents":
  - a. The primary health plan is the plan of the parent whose birthday is earlier in the year if:
    - (1) the parents are married;
    - (2) the parents are not separated (whether or not they ever have been married); or
    - (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care payment.
  - b. If the specific terms of a court decree state that one of the parents is responsible for the child's 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.

If none of the above rules determine the order of benefits, the health plan that covered the Participant 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 Plan with benefits for Hospital emergency room services. Mary, his wife, works for ABC Corp., and is covered under another plan with Hospital benefits payable at 80% after a \$250 Deductible.

\$ 1,000	Allowable charges for Hospital services for Mary
- 250	Minus Mary's Deductible
<hr/>	
\$ 750	Covered Amount subject to 80% Coinsurance
x 80%	
<hr/>	
<b>= \$ 600</b>	<b>Paid by Mary's Plan with ABC Corp.</b>

\$ 1,000	Amount of allowed charges for Hospital services for Mary
- 600	Paid by Mary's Plan
<hr/>	
\$ 400	Unpaid balance
- 200	Ameren Deductible
<hr/>	
\$ 200	Covered Amount subject to 80% Coinsurance
x 80%	
<hr/>	
<b>= \$ 160</b>	<b>Amount payable by the Plan</b>

### **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.

When You become eligible for Medicare, Medicare will become the primary payer of medical benefits and the 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 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.

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

### **TRICARE**

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

## Subrogation and Reimbursement

### Applicability

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

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

### Subrogation

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

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

### Reimbursement

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

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses, or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your Recovery to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.
- Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

## Participant 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 the Plan Sponsor reserves the right to make changes as it deems necessary.

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

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

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

## Claim and Appeal Procedures for Eligibility

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

### All Eligibility Claims must be submitted to:

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

### All Eligibility Appeals must be submitted to:

Ameren Services  
P.O. Box 66149, MC 533  
St. Louis, MO 63166-6149  
Email: [EBenefits@ameren.com](mailto:EBenefits@ameren.com)

## **Responding to Your Eligibility Claim**

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

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

## **If Your Eligibility Claim Is Denied**

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

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

## **Appealing Your Eligibility Claim**

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

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

The Plan Administrator will notify You, in writing, of its decision of Your Eligibility Appeal within a reasonable period of time, but no later than 60 days after its receipt of Your Eligibility Appeal request. If the 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 Eligibility Appeal is denied, You will receive written notice of the decision, including the following information:

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

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

## **Deadline for Taking Legal Action**

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

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

## **Claim Filing Procedures for Medical and Prescription Drug Benefits**

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

### **Medical Claim Filing Procedures**

#### **For participants in the Standard Plan, Health Savings Plan, or Health Savings Plan - Value**

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 2023 must be received by the Claims Administrator by December 31, 2024. No benefits are payable for claims filed after the deadline.

When filing a medical claim 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 Plan, Conventional Plan or Medicare Supplement Plan**

CVS Caremark' 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 Plan and Health Savings Plan – Value**

CVS Caremark's 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 CVS Caremark at **877.817.0479** or by visiting their website: [www.caremark.com](http://www.caremark.com). Submit those claims to the address shown below.

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

All Pharmacy claims must be received by CVS Caremark, the Pharmacy benefits administrator, within one year of the date of prescription purchase. No benefits are payable for claims received after the deadline.

## Determination Periods

The time period for the Claims Administrator to make a determination on your claim will depend on the type of claim.

<b>Urgent care</b>	Claims in which a delay of determination could seriously jeopardize your life or health or your ability of to regain maximum function or, in the opinion of a physician with knowledge of your condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. This includes requests for pre-certification.
<b>Pre-service</b>	Claims that must be approved before medical care is obtained. This includes requests for pre-certification.
<b>Post-service</b>	Claims that are neither Urgent Care nor pre-service claims.
<b>Concurrent care</b>	Claims related to a previously approved course of treatment to be provided over a period of time or number of treatments.

### 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.

### 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 do 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.

### **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.

### **Concurrent Care Claims**

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

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

### **Incorrectly Submitted Medical Claims**

You will be notified if You do not follow the Plan's procedures for filing a claim (for example, if You do not include all required information). This assumes that Your incorrect claim was received by someone responsible for handling benefit matters and Your claim identified the claimant, the specific treatment, the service, or product for which approval is requested, and the medical basis for the request. Notice of an incorrectly submitted claim will be provided no more than 24 hours

(for Urgent Care claims) or five calendar days (for all other pre-service claims) after the incorrectly submitted claim is received. This notice may be oral unless You request written notification.

### Notice of Adverse Benefit Determination

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

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

### Informal Inquiries Regarding Claims

#### For Medical Claims:

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

A Member Services Representative will review and research the inquiry. You will be informed of the resolution and if the decision is adverse to You, You will be advised of Your rights to request a formal

Appeal. You also have the right to bypass this informal inquiry process and immediately file a formal appeal as described in the **APPEAL RIGHTS** section below.

#### **For Prescription Drug Claims:**

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

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

#### **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 Appeals Process for Medical Claims**

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

The time frame allowed for the Claims Administrator to complete its review depends upon the type of claim involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

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

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

### **How Your Appeal will be Decided**

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

conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is 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. The Health Care Professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. By appealing the initial denial, You consent to the review of medical information pertinent to the claim by the above-referenced Health Care Professional consulted in connection with the appeal. The identification of any medical experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be provided upon request, without regard to whether the expert's advice was relied upon in making the benefit determination.

### **Notification of the Outcome of the Appeal**

If You appeal a claim involving Urgent Care or Concurrent Care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

If a claim is partially or wholly denied on appeal, the notice will give the specific reason for the denial and reference Plan provisions on which the denial is based. The notice will include statements as to Your right to obtain upon request, without charge, access to and copies of all documents, records, and other information relevant to the claim, to bring a civil action under Section 502(a) of ERISA or to pursue other voluntary alternative dispute resolution options. The notice will also describe any voluntary appeal procedures under the Plan. If the Claims Administrator relied on a rule, guideline, protocol, or similar criterion in denying the appeal, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. Notice of a denial based on Medical Necessity, 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 appeal process may be deemed exhausted. However, the appeal 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 CVS Caremark at **877.817.0479**. CVS Caremark will research the inquiry and will respond providing the rationale behind the denial. It may be necessary for You or Your Physician to provide additional information that will allow reconsideration of the claim.

If it is determined that based upon CVS Caremark' 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:

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

Your written appeal should include the Participant'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 CVS Caremark. 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 claim's 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 Care or Concurrent care, You may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile, or other similar method. To proceed with an expedited external review, You or Your authorized representative must contact the Claims Administrator and provide at least the following information:

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

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

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

You must include Your Participant 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 SPD. If Your claim is not paid to Your satisfaction, You have the right to file an appeal, the procedures for which are also described in this 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 internal appeals process, not including any voluntary level of appeal before You can file a lawsuit or take other legal action of any kind against the Plan. Further, You may not bring a lawsuit or take other legal action against the Plan after one (1) year has elapsed following the date of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

### **Facility of Payment**

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

Payment of benefits for Non-Network Providers will be made to You or a Covered Dependent, 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 behalf of You or a Covered Dependent.
- 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 Participants participating in the Standard Plan, Health Savings Plan, and Health Saving Plan – Value)

### 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.

#### Plan Amendment or Termination

The Plan Sponsor hopes and expects to continue the Plan in the years ahead but cannot guarantee to do so. The Company, and any successor corporation which assumes the responsibilities of the Company under the Plan, may amend or terminate the Plan or any benefit provided under the Plan

from time to time or at any time, without advance notice thereof. The Company or its delegate may affect 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 Plan Administrator may also amend the Plan through the issuance of revised benefit program booklets, summary plan descriptions, enrollment materials, brochures, or certificates.

### **Verbal Statement May Not Alter Document**

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

### **Applicability**

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

### **Nontransferable Benefits**

No person other than the Participant is entitled to receive health care service coverage or other benefits to be furnished by the Plan. Such right to health care service coverage or other benefits is not transferable.

### **Severability**

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

### **Waiver**

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

### **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 the 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.

## **Prohibition on Rescissions**

In general, the Plan is not allowed to rescind (i.e., retroactively cancel or terminate) Your (or Your Dependents) medical plan coverage once You (or Your Dependents) become covered under the medical plan. However, Your Dependents) coverage under the medical plan may be rescinded (i.e. cancelled or discontinued with a retroactive effective date) if You (and/or Your Dependents) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of the Plan. If the Plan Administrator seeks to rescind medical coverage for fraud or an intentional misrepresentation of a material fact, Plan Administrator will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded.

## **Recovery of Excess Payments**

In the event payments are made in excess of the amount necessary to satisfy the applicable provision of the Plan, the Plan shall have the right to recover excess payments from any individual, insurance company or other organization to whom excess payments are made. The Plan shall also have the right to withhold payment of future benefits due until the overpayment is recovered.

## **Receiving Advice Disclaimer**

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

## **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 SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for Yourself, Your Spouse/Domestic Partner, 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 SPD and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon 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 an Ameren Company, 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 after You have exhausted the plan's claim and appeals procedures. 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 the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the EBSA, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of EBSA.

## Administrative Information About the Plan

<b>Plan Name:</b>	Ameren Retiree Medical Plan, a component part of the Ameren Retiree Welfare Benefit Plan.
<b>Type of Plan:</b>	A welfare benefit plan providing medical and prescription drug benefits.
<b>Plan Year:</b>	January 1 through December 31
<b>Plan Number:</b>	511
<b>Funding Medium and Type of Plan Administration:</b>	<p>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.</p> <p>Plan Sponsor has a contract with Anthem ("Claims Administrator") and CVS Caremark ("Claims Administrator") to provide certain services to the Plan, including claims administration. Benefits under the Plan are not guaranteed under a contract or insurance policy. The Plan Sponsor is ultimately responsible for providing the Plan benefits, and not the Claims Administrator.</p>
<b>Trustee:</b>	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.
<b>Plan Sponsor:</b>	<p>Ameren Corporation            1901 Chouteau Avenue, Mail Code 533            Post Office Box 66149            St. Louis, MO 63166-6149            877.7my.Ameren (877.769.2637)</p>
<b>Plan Sponsor's Employer Identification Number:</b>	43-1723446
<b>Plan Administrator:</b>	<p>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)</p>
<b>Claims Administrator for Medical Benefits:</b>	<p>Anthem BlueCross BlueShield            P.O. Box 105557            Atlanta, GA 30348</p>



<b>Claims Administrator for Prescription Drug Benefits:</b>	CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 877.817.0479 <a href="http://www.caremark.com">www.caremark.com</a>
<b>COBRA Administrator:</b>	myAmeren Benefits PO Box 850512 Minneapolis, MN 55485-0512 1.877.769.2637 <a href="http://myameren.com">myameren.com</a>
<b>Named Fiduciary for Plan:</b>	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)
<b>Named Fiduciary for Medical Claims and Appeals:</b>	Anthem Blue Cross Blue Shield P.O. Box 105557 Atlanta, GA 30348
<b>Named Fiduciary for Prescription Drug Appeals:</b>	CVS Caremark Appeals Department MC109 P.O. Box 52084 Phoenix, AZ 85072-2084
<b>Agent for Service of Legal Process:</b>	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 – Understanding Your Retiree Medical Plan Choices, Cost of Coverage and Retiree Health Reimbursement Account**

**Section 1 – Retiree Medical Premiums.....156**  
**Section 2 – Retiree Medical Cap Allowances.....158**  
**Section 3 – How Retiree Health Reimbursement Account Credits are Determined 163**  
**Section 4 – Missouri Retirees Under Active Contract – Plan Choices .....166**  
**Section 5 – Illinois Retirees Under Active Contract – Plan Choices .....176**  
**Section 6 – Management and Expired Contract Retirees – Plan Choices and Standard Cost of Coverage .....185**

**READ THIS APPENDIX CAREFULLY.** This Appendix includes information on the following:

- Retiree and Dependent Cost of Coverage under the **Ameren Retiree Medical Plan Post-92**, including information on any applicable special pricing for Retirees and Dependents
- Retiree Medical Cap allowances (the maximum amount the Company will contribute toward Your retiree medical coverage) and how medical cap allowances are calculated
- How the **Retiree Health Reimbursement Account Plan** credits are determined and when the Retiree Medical Cap offsets credits
- Retiree medical plan choices for both Contract and Management Retirees and their eligible dependents
- When certain Retirees and their Dependents become eligible and transition to the **Alight Retiree Health Exchange** and the **Ameren Retiree Health Reimbursement Account Plan**

The table below outlines the information that will be described in this Appendix for each type of Retiree and their eligible dependents:

<b>Contract Retirees*</b>	<b>Management (Non-Contract) Retirees</b>
<ul style="list-style-type: none"> <li>• The Union contract You retire under</li> <li>• Your contract status at the time of Your retirement date</li> <li>• When You and/or Your eligible Dependents remain under the Ameren Retiree Medical Plan or transition to the Alight Retiree Health Exchange</li> <li>• The Retiree medical plan choices available to You and Your eligible Dependents under the Ameren Retiree Medical Plan once You retire</li> <li>• Special pricing for Retiree medical premiums under the Ameren Retiree Medical Plan and when Special pricing applies</li> <li>• How Your Retiree medical cap allowance is calculated and when it is applied to You and/or Your eligible Dependents' Retiree medical premiums</li> <li>• How the maximum amount of Retiree Health Reimbursement Account Credits is determined</li> </ul>	<ul style="list-style-type: none"> <li>• When You and/or Your eligible dependents remain under the Ameren Retiree Medical Plan or transition to the Alight Retiree Health Exchange</li> <li>• The Retiree medical plan choices available to You and Your eligible dependents under the Ameren Retiree Medical Plan once You retire</li> <li>• How Your Retiree medical cap allowance is calculated and when it is applied to You and/or Your eligible dependents' Retiree medical premiums</li> <li>• How the maximum amount of Retiree Health Reimbursement Account Credits is Determined</li> </ul>

*\*Ameren Missouri Callaway Energy Center UGSOA Local Union 11 follows Management (Non-Contract) Retirees.*

## Section 1 – Retiree Medical Premiums

The Retiree medical plan premiums described in this section apply to the following eligible groups:

Eligible Retiree Group	Retirement Date
All management and contract Employees as described in the <b>ELIGIBILITY</b> section of the Ameren Retiree Medical Plan SPD 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 includes both the eligible surviving dependents of retirees and those of deceased active Employees as described in the **ELIGIBILITY** section of the **Ameren Retiree Medical Plan SPD**.

### Management Retirees

You are required to pay a portion of the Retiree medical plan premiums to cover Yourself and Your eligible Dependents. If You and/or Your eligible Dependents are under age 65, and are enrolled in the **Ameren Retiree Medical 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.

**Note:** If You retired after September 1, 2002, see Section 2, **RETIREE MEDICAL CAP ALLOWANCES**, below for additional information that may affect the amount of premium You will be required to pay.

If You and/or Your eligible Dependent(s) are age 65 or older, You and/or Your eligible Dependent(s) are ineligible to continue Retiree medical coverage under the **Ameren Retiree Medical Plan** and will transition to the **Alight Retiree Health Exchange** and the **Ameren Retiree Health Reimbursement Account Plan**. Each person turning age 65 transitions individually when they reach age 65, and the remaining individuals under 65 remain on the **Ameren Retiree Medical Plan** until they individually reach age 65.

For more information on the **Alight Retiree Health Exchange**, please refer to the **Ameren Retiree Health Reimbursement Account Plan** Summary Plan Description.

## Contract Retirees

If You are an Ameren Missouri Contract Retiree<sup>1</sup> or an Ameren Illinois<sup>2</sup> (formerly AmerenCIPS or AmerenIP) Contract Retiree and the labor agreement under which You retired has not yet expired, the Company will pay the full cost of medical coverage for You, but 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 Section 2, **RETIREE MEDICAL CAP ALLOWANCES**, 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 Section 2, **RETIREE MEDICAL CAP ALLOWANCES**, below for additional information that may affect the amount of premium You will be required to pay).

If You and/or Your eligible Dependent(s) are age 65 or older (with the exception of Ameren Missouri Contract Retirees covered under the term of an active contract through December 31, 2026), You and/or Your eligible Dependent(s) are ineligible to continue Retiree medical coverage under the **Ameren Retiree Medical Plan** and will transition to the **Alight Retiree Health Exchange** and the **Ameren Retiree Health Reimbursement Account Plan**. Each person turning age 65 transitions individually when they reach age 65, and the remaining individuals under 65 remain on the **Ameren Retiree Medical Plan** until they individually reach age 65.

For more information on retiree medical plan choices upon reaching age 65, please refer to **SECTION 4 – MISSOURI RETIREES UNDER ACTIVE CONTRACT – PLAN CHOICES** and **SECTION 5 – ILLINOIS RETIREES UNDER ACTIVE CONTRACT – PLAN CHOICES**.

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<sup>1</sup> Except UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11

<sup>2</sup> Including AmerenCILCO Local Union 51 effective 7/1/2022.

## Section 2 – Retiree Medical Cap Allowances

The **Retiree Medical Cap** represents the maximum amount the Company will contribute toward Your monthly retiree medical premium under the **Ameren Retiree Medical Plan**, regardless of the number of Dependents You cover.

The following Ameren Retirees 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 (See below sections for <b>RETIREE MEDICAL CAP FOR VRP PARTICIPANTS.</b> )	Retired on or after October 1, 2002
AmerenCILCO IBEW Local 51 and their surviving dependents ( <b>Note:</b> Although this group became eligible for the Ameren Retiree Medical Plan January 1, 2005, Retiree Medical Caps were not effective until 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
AmerenIP Employees and their surviving dependents	Retired on or after January 1, 2019
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 <u>has expired</u> . (See below sections for <b>RETIREE MEDICAL CAP FOR VRP PARTICIPANTS.</b> )	Retired on or after October 1, 2002

Retirees who are subject to the **Retiree Medical Cap** may end up paying more than the minimum premiums specified above in Section 1, **RETIREE MEDICAL PREMIUMS**. 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.

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:

- The minimum Retiree premium described in Section 1, **RETIREE MEDICAL PREMIUMS**, above, **OR**
- 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:

- The Minimum Retiree Premium; **OR**
- 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).

<b>Age at Retirement (rounded down to the nearest year)</b>								
<b>Years of Service</b>	<b>55</b>	<b>56</b>	<b>57</b>	<b>58</b>	<b>59</b>	<b>60</b>	<b>61</b>	<b>62 or older</b>
<b>10</b>	387	396	405	414	423	432	441	450
<b>11</b>	426	436	446	455	465	475	485	495
<b>12</b>	464	475	486	497	508	518	529	540
<b>13</b>	503	515	527	538	550	562	573	585
<b>14</b>	542	554	567	580	592	605	617	630
<b>15</b>	581	594	608	621	635	648	662	675
<b>16</b>	619	634	648	662	677	691	706	720
<b>17</b>	658	673	689	704	719	734	750	765
<b>18</b>	697	713	729	745	761	778	794	810
<b>19</b>	735	752	770	787	804	821	838	855
<b>20</b>	774	792	810	828	846	864	882	900
<b>21</b>	813	832	851	869	888	907	926	945
<b>22</b>	851	871	891	911	931	950	970	990
<b>23</b>	890	911	932	952	973	994	1014	1035
<b>24</b>	929	950	972	994	1015	1037	1058	1080
<b>25</b>	968	990	1013	1035	1058	1080	1103	1125
<b>26</b>	1006	1030	1053	1076	1100	1123	1147	1170
<b>27</b>	1045	1069	1094	1118	1142	1166	1191	1215
<b>28</b>	1084	1109	1134	1159	1184	1210	1235	1260
<b>29</b>	1122	1148	1175	1201	1227	1253	1279	1305
<b>30+</b>	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 Aged 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 Aged 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 section are subject to change.

In all cases, when both You and Your eligible Dependents are covered under the **Ameren Retiree Medical Plan**, 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 Participant's 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.

### **Note For Survivors:**

- For Surviving Dependents 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 Surviving Dependents 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.

### Section 3 – How Retiree Health Reimbursement Account Credits are Determined

This section does not apply to You if You are eligible to participate in the Plan as described in the **ELIGIBILITY** section, and:

- You were enrolled in the **Ameren Retiree Medical Plan (CILCO)** prior to enrollment in this Plan; or,
- You were enrolled in the **Ameren Retiree Medical Plan – Illinova and AmerGen** prior to enrollment in this plan; or
- You are not a Participant subject to the **Retiree Medical Cap** as defined in the chart in Section 2, **RETIREE MEDICAL CAP ALLOWANCES**, of this Appendix.

Each Plan Year, the Company will determine the Maximum Amount to be credited to each account under the Plan. If this section does not apply to You, as described above, call **myAmeren Benefits** at **877.7my.Ameren** (877.769.2637) for questions about the amount credited to Your RHRA.

If You are listed in the chart in Section 2, **RETIREE MEDICAL CAP ALLOWANCES** above, the Maximum Amount to be credited is also subject to the applicable **Retiree Medical Cap** as described in Section 2 of this Appendix. The Maximum Amount the Company will credit to Your RHRA for 2023 is the lessor of \$2,856 for You, \$1,867 for Your Dependent (the annual credit amounts), or the annualized amount of Your Retiree Medical Cap.

#### Retiree Medical Caps and RHRA Funding

If You retired **after September 1, 2002**, the **Retiree Medical Cap** established by Ameren may affect the amount that is credited to Your Retiree Health Reimbursement Account. The Company will contribute toward Your and Your eligible Dependent's retiree medical coverage under the Plan and the Ameren Retiree Medical Plan the Maximum Amount, which is the lessor of the applicable annual credit amounts (as described above) or the amount of Your **Retiree Medical Cap**, regardless of the number of eligible Dependents who are covered.

The Retiree Medical Cap is based on Your age and Years of Service at retirement. As described above, the Maximum Amount the Company will credit to Your RHRA for You and Your eligible Dependent(s) is the lessor of the applicable annual credit amounts for You and Your Spouse/Domestic Partner or Domestic Partner and/or Dependent Child, and Your **Retiree Medical Cap**.

**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 tables in Section 2, 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 Retiree Health Reimbursement Account credit.

In all cases, if You or Your eligible Dependent is age 65 or older and enrolled in the Plan, and the other eligible Participant is under age 65 and enrolled in the Ameren Retiree Medical Plan, the Maximum Amount to be credited 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 subject to the remaining amount available under the Retiree Medical Cap and is responsible for paying the greater of:

- The Minimum Retiree Premium; **OR**
- The amount of the premium that exceeds the remaining amount of the Retiree Medical Cap listed in the applicable table.

### **Retiree Medical Cap and RHRA Funding for Retirees Under Age 65 with Eligible Dependents Over Age 65**

Section 2, **RETIREE MEDICAL CAP ALLOWANCES**, shows the monthly Retiree Medical Caps. Ameren will contribute the monthly Maximum Amount towards both Your eligible Dependent's Retiree Health Reimbursement Account and then Your retiree medical premiums if:

- You are under age 65; AND
- You were not a participant in the VRP; AND
- You are enrolled in the **Ameren Retiree Medical Plan**; AND
- Your eligible Dependent is age 65 or older and enrolled in the Plan.

Note: Each Plan year, the Company will determine the Maximum Amount to be credited to the **Retiree Health Reimbursement Account Plan** for each eligible Participant. This amount may be less than the maximum Retiree Medical Cap amount shown below and any changes to this amount will be communicated to You during annual enrollment.

### **Retiree Medical Cap for VRP Participants Under Age 65 with Eligible Dependents Over Age 65**

If You retired under the VRP and You are under age 65 and Your Dependent is age 65 or over, the **Retiree Medical Cap for Retirees Under Age 65** chart above does not apply to You, and Your actual age and Years of Service at the time of retirement are not used to calculate Your Retiree Medical Cap and Your Dependent's Retiree Health Reimbursement Account credit amount. Your maximum Retiree Medical Cap is \$1,500 per month. While You are younger than age 65, this is the Maximum Amount the Company will contribute towards Your retiree medical coverage under the Ameren Retiree Medical Plan and Your Dependent's retiree medical coverage under the Plan.

### **Retiree Medical Cap for Retirees Aged 65 and Older with Eligible Dependents Under Age 65**

The chart in Section 2 shows the monthly **Retiree Medical Cap**. The Company will contribute the Maximum Amount towards both Your Retiree Health Reimbursement Account and Your eligible Dependent's retiree medical coverage if:

- You are age 65 or older; AND
- You were not a participant in the VRP; AND
- You are enrolled in the Plan; AND

- Your eligible Dependent is under age 65 and enrolled in the **Ameren Retiree Medical Plan**, or age 65 or older and also enrolled in the Plan.

Note: Age and Years of Service are rounded down to the nearest year.

### **Retiree Medical Cap for VRP Participants Aged 65 and Older**

If You retired under the VRP and You are age 65 or older, the **Retiree Medical Cap for Retirees Age 65 and Older** chart above does not apply to You, and Your actual age and Years of Service at the time of retirement are not used to calculate Your **Retiree Medical Cap** and Your Dependent's Retiree Health Reimbursement Account credit amount, or their retiree medical premium. Your maximum **Retiree Medical Cap** is \$700 per month. This is the Maximum Amount the Company will contribute towards Your retiree medical coverage under the Plan and Your Dependent's retiree medical coverage under the Plan or the **Ameren Retiree Medical Plan**, whichever is applicable based on their age.

### **Important Notes**

The minimum **Retiree Health Reimbursement Account** credits and **Ameren Retiree Medical Plan** premiums, and the maximum Company credits and contributions described in this section are subject to change.

In all cases, when both You and Your eligible Dependents are covered under the Ameren Retiree Medical Plan, the Maximum Amount that the Company contributes to the age 65 or older eligible Participant's Retiree Health Reimbursement Account and the under age 65 eligible Participants retiree medical premium, is a single amount per family. ***The Maximum Amount is not per Participant.***

**Section 4 – Missouri Retirees Under Active Contract – Plan Choices**

This section of the Appendix applies to You if You are eligible to participate in the **Ameren Retiree Medical Plan** and **Retiree Health Reimbursement Account** Plan and the contract that was in place at the time you retired has not yet expired.

Eligible Group	Retirement Date
<p><b>Ameren Missouri</b> and:</p> <p>IBEW Local Union 2                      IUOE Local Union 148                      IBEW Local Union 702 (Physical &amp; Clerical)                      IBEW Local Union 1439                      IBEW Local 1455</p>	<ul style="list-style-type: none"> <li>Retired between January 1, 2023, and December 31, 2026. The active contract for these dates is set to expire on January 1, 2027, and the special provisions of this section will end on that date.</li> <li>With a new contract effective January 1, 2027, a retirement on January 1, 2027, and thereafter (for the duration of the new contract) will be considered under the new contract.</li> </ul>

**Retiree Medical at Retirement - Plan Choices and Default Coverage**

The following table outlines the applicable Retiree medical choices available to you depending on your age, your Dependents' ages, and/or Medicare status based on a disability:

<b>RETIREE ONLY COVERAGE</b>		
<b>Category</b>	<b>Plan Choices</b>	<b>Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)</b>
<p><b>Retiree Pre-65</b> (Medicare Ineligible)</p>	<p><b>Retiree:</b></p> <ul style="list-style-type: none"> <li>Health Savings Plan</li> <li>Health Savings Plan – Value</li> <li>Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>Retirees who were participating in the Ameren Employee Medical Plan (Basic Program) and who are <b>not</b> Medicare eligible will be enrolled in the medical plan most like the plan he or she was enrolled in the day before retiring.</li> </ul>
<p><b>Retiree Pre-65</b> (Medicare Eligible *)</p>	<p><b>Retiree:</b></p> <ul style="list-style-type: none"> <li>Conventional Plan with Rx</li> <li>Conventional Plan without Rx</li> <li>Medicare Supplement Plan with Rx</li> <li>Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>Retirees who were participating in the Ameren Employee Medical Plan (Basic Program), who are Medicare eligible and under age 65, will be enrolled in the Medicare Supplement with Rx.</li> </ul>
<p><b>Retiree Post-65</b> (Medicare Eligible *)</p>	<p><b>Retiree:</b></p> <ul style="list-style-type: none"> <li>Conventional Plan with Rx</li> <li>Conventional Plan without Rx</li> <li>Medicare Supplement Plan with Rx</li> <li>Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>Retirees who were participating in the Ameren Employee Medical Plan (Basic Program), who are Medicare eligible, over 65, and still under an active contract will be enrolled in the Medicare Supplement with Rx.</li> </ul>
<p><b>* Note:</b> Retiree must enroll in Medicare Parts A &amp; B. The Medicare Supplement Plan will pay secondary to Medicare even if the Retiree does not enroll in Medicare.</p>		

<b>RETIREE &amp; DEPENDENT COVERAGE (ALL FAMILY MEMBERS ARE EITHER MEDICARE ELIGIBLE OR NOT MEDICARE ELIGIBLE, I.E., "NON-SPLIT FAMILIES")</b>		
Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
<b>Retiree &amp; Spouse/Domestic Partner, AND/OR Dependent Children &lt;26</b> (all Medicare Ineligible)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees, Spouse/Domestic Partner, and Dependent Child(ren) under 26 who were participating in the Ameren Employee Medical Plan (Basic Program) AND <b>ALL ARE NOT</b> MEDICARE ELIGIBLE will be enrolled in the medical plan most like the plan they were enrolled in the day before retiring.</li> </ul>
<b>Pre-65: Retiree, Spouse/Domestic Partner, AND/OR Dependent Children &lt; 26</b> (all Medicare Eligible *)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees, Spouse/Domestic Partner, and Dependent Child(ren) who were participating in the Ameren Employee Medical Plan (Basic Program) AND <b>ALL ARE</b> MEDICARE-ELIGIBLE DUE TO DISABILITY (NOT AGE) will be enrolled in a Medicare Supplement with Rx plan.</li> </ul>
<b>Post-65: Retiree, Spouse/Domestic Partner, AND/OR Dependent Children</b> (all Medicare Eligible *)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees, Spouse/Domestic Partner, and disabled Dependent Child(ren) who were participating in the Ameren Employee Medical Plan (Basic Program), who are <b>ALL</b> Medicare eligible due to Age 65 will be enrolled in the Medicare Supplement with RX plan.</li> </ul>
<p><b>* Note:</b> The Retiree, Spouse/Domestic Partner, and Dependent Child(ren) eligible for Medicare must enroll in Medicare Parts A &amp; B. The Medicare Supplement Plan will pay secondary to Medicare, even if the Retiree, Spouse/Domestic Partner, and/or Dependent Child(ren) do not enroll in Medicare.</p>		

**RETIREE & DEPENDENT COVERAGE (ONE OR MORE COVERED FAMILY MEMBERS ARE MEDICARE ELIGIBLE WHILE OTHER COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, I.E., "SPLIT FAMILIES")**

Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
<b>Retiree Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Eligible *) <b>AND/OR</b> <b>Dependent Child(ren) under 26</b> (Medicare Ineligible)	<b>Retiree &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree and Dependent Child(ren) are not Medicare eligible, the Retiree and Dependent Child(ren) will be enrolled in the most similar option to the plan he or she was enrolled in the day before retiring, while the Spouse/Domestic Partner will be enrolled in the Medicare Supplement Plan with Rx.</li> </ul>
<b>Retiree Pre-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Dependent Child(ren) under 26</b> (Medicare Ineligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul> <b>Spouse/Domestic Partner &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>• If the Spouse/Domestic Partner and/or Dependent Child(ren) are not Medicare eligible, the Spouse/Domestic Partner and/or Dependent Child(ren) will be enrolled in the most similar option to the plan he or she was enrolled in the day before retirement while the Retiree will be enrolled in the Medicare Supplement Plan with Rx.</li> </ul>
<b>Retiree Pre-65</b> (Medicare Ineligible) <b>AND</b> <b>Spouse/Domestic Partner Post-65</b> (Medicare Eligible *) <b>AND/OR</b> <b>Dependent Child(ren) Pre-65</b> (Medicare Eligible)	<b>Retiree &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree is not Medicare eligible, the Retiree will be enrolled in the most similar option to the plan he or she was enrolled in the day before retirement.</li> <li>• A Spouse/Domestic Partner who was participating in the Ameren Employee Medical Plan (Basic Program), who is Medicare eligible due to age (over 65), and still under an active contract, will be enrolled in the Medicare Supplement plan with Rx</li> <li>• Disabled Dependent Child(ren) who were participating in the Ameren Employee Medical Plan (Basic Program), who are Medicare eligible, under 65, and still under an active contract, will be enrolled in the Medicare Supplement plan.</li> </ul>



<b>RETIREE &amp; DEPENDENT COVERAGE (ONE OR MORE COVERED FAMILY MEMBERS ARE MEDICARE ELIGIBLE WHILE OTHER COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, I.E., "SPLIT FAMILIES")</b>		
Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
<b>Retiree Post-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Dependent Child(ren) Pre-65</b> (Medicare Eligible)	<b>Retiree &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan – Value</li> <li>• Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Retirees who were participating in the Ameren Employee Medical Plan (Basic Program), who are Medicare eligible due to age (over 65), and still under an active contract, will be enrolled in the Medicare Supplement plan with Rx.</li> <li>• Disabled Dependent Child(ren) who were participating in the Ameren Employee Medical Plan (Basic Program), who are Medicare eligible, under 65, and still under an active contract, will be enrolled in the Medicare Supplement plan with Rx.</li> <li>• If the Spouse/Domestic Partner is not Medicare eligible, the Spouse/Domestic Partner will be enrolled in the most similar option the Retiree was participating in the day before their retirement date.</li> </ul>
<b>Retiree Pre-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Post-65</b> (Medicare Eligible *)	<b>Retiree &amp; Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree is pre-65 and Medicare eligible, and the Spouse/Domestic Partner is post-65 and Medicare eligible, both the Retiree and Spouse/Domestic Partner will be enrolled in a Medicare Supplement with Rx plan for the duration of the contract the Retiree retired under.</li> </ul>
<b>Retiree Post-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Eligible *)	<b>Retiree &amp; Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree is post-65 and Medicare eligible and the Spouse/Domestic Partner is pre-65 and Medicare eligible, both the Retiree and Spouse/Domestic Partner will be enrolled in a Medicare Supplement with Rx plan for the duration of the contract the Retiree retired under.</li> </ul>
<p><b>* Note:</b> The Retiree and/or Spouse/Domestic Partner and/or Dependent Child(ren) eligible for Medicare must enroll in both Medicare Parts A &amp; B. The Medicare Supplement Plan will pay secondary to Medicare even if the Retiree and/or Spouse/Domestic Partner and/or Dependent Child(ren) do not enroll in Medicare.</p>		

## Special Pricing

**Special pricing** is applicable for the period of the current active contract period and consists of a fixed percentage of the total monthly premium under the **Ameren Retiree Medical Plan** that You and Your eligible dependents pay for the duration of the Union contract that You retired under. With special pricing, the Company will pay the full cost of medical coverage for You, and You will be required to pay 20% of the monthly cost 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 union contract under which you retired expires, You and Your dependents are no longer eligible for the special pricing. For information about your monthly cost once the contract expires, see Section 6, **STANDARD COST OF COVERAGE**, in this Appendix that describes Retiree Medical Monthly Cost.

<b>2023 and 2024 Monthly Premiums and Special Pricing</b>						
<b>Medicare INELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>		<b>Child(ren)</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing*</b>	<b>Total Premium</b>	<b>Special Pricing*</b>
Standard Plan	\$1,031	\$0	\$1,031	\$206	\$515	\$103
Health Savings Plan	\$760	\$0	\$760	\$152	\$380	\$76
Health Savings Plan - Value	\$683	\$0	\$683	\$137	\$343	\$69
<b>Medicare ELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>		<b>Child(ren)</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing*</b>	<b>Total Premium</b>	<b>Special Pricing*</b>
Conventional w/4 Tier Rx	\$571	\$0	\$571	\$114	\$523	\$105
Conventional w/o Rx	\$196	\$0	\$196	\$39	\$196	\$39
Medicare Supp w/4 Tier Rx	\$590	\$0	\$590	\$118	\$523	\$105
Medicare Supp w/o Rx	\$217	\$0	\$217	\$43	\$217	\$43

\* 20% of Total Premium

### **Retiree Medical Plan After the Contract Under Which You Retire Expires**

When the Contract under which you retire expires, the following changes will result:

- 1) Special Pricing as outlined above ends; standard pricing for retiree medical benefits will be initiated.
- 2) Participants aged 65 and over when the contract expires will transition to the Alight Retiree Health Exchange.

You will be provided with information about this change shortly before the contract ends.

## Active Missouri Union Contract Retirees – Matrix

The following table outlines the plan design option applicable based on age and Medicare status during the life of the active contract. In all cases, special pricing will apply, as applicable to the specific plan, for the life of the contract under which the retiree retired.

Retiree Under Age 65 Medicare Ineligible	Retiree Under Age 65 Medicare Eligible (due to Disability)	Retiree Age 65+ Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan.</li> </ul>	<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan but moves to the Medicare Supplement design.</li> </ul>	<ul style="list-style-type: none"> <li>The Ameren Retiree remains with Ameren Retiree Medical Plan but moves to the Medicare Supplement design until the end of the contract under which they retired.</li> </ul>
Retiree's Spouse/Domestic Partner Under Age 65 Medicare Ineligible	Retiree's Spouse/Domestic Partner Under Age 65 Medicare Eligible (due to Disability)	Retiree's Spouse/Domestic Partner Age 65+ Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan.</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's Spouse/Domestic Partner who is under 65 and Medicare eligible due to disability remains with Ameren Retiree Medical Plan but will move to the Medicare Supplement.</li> </ul>	<ul style="list-style-type: none"> <li>The Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan but will change to the Medicare Supplement design, until the end of the contract under which the Ameren Retiree retired.</li> </ul>
Retiree's Under Age 26 Dependent Child Medicare Ineligible	Retiree's Under Age 65 Dependent Child Medicare Eligible (due to Disability)	Retiree's Over Age 65 Dependent Child Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Retiree's eligible child under age 26 remains with Ameren Retiree Medical Plan through the duration of the Missouri union contract that the Ameren Retiree retired under if the child remains under 26 for the duration of the contract.</li> <li>If the Retiree's child attains age 26 while the contract is still active, the Retiree's child will be terminated from coverage at the end of the month in which they turn 26 and be offered COBRA.</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's totally or permanently disabled child* under age 65 remains with Ameren Retiree Medical Plan but will move to the Medicare Supplement design.</li> </ul> <p><i>*Refer to Disabled Child(ren) section of the document for ongoing plan eligibility.</i></p>	<ul style="list-style-type: none"> <li>The Retiree's totally or permanently disabled child* over age 65 remains with Ameren Retiree Medical Plan (Medicare Supplement design) until the end of the contract under which the Retiree retired.</li> </ul> <p><i>*Refer to Disabled Child(ren) section of the document for ongoing plan eligibility.</i></p>

## 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:

#### **ACTIVE CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Under Age 65 and Medicare ineligible**

Let us assume that:

- Susan, a Missouri Union Retiree defined in the table above, retires on September 30, 2023, at age 61 with 40 years of service; AND
- Susan retires under a Missouri union contract in effect at the time of her retirement; AND
- Susan is Medicare ineligible due to age **and** having no record of disability; AND
- Susan's Spouse/Domestic Partner, Michael, is under age 65 and Medicare ineligible due to age and having no record of disability.

In this example, Susan (under 65, Medicare ineligible) and her Spouse/Domestic Partner, Michael (under 65, Medicare ineligible), will **both** remain on the Ameren Retiree Medical Plan for the duration of the Missouri Union contract term that Susan retired under **and** pay the special pricing amounts towards retiree medical coverage under the **Ameren Retiree Medical Plan**.

For this example, we will assume that Susan and Michael are enrolled in the Retiree Health Savings Plan. Through the duration of the Missouri Union contract that Susan retired under, Susan will pay \$0 for her Retiree Health Savings Plan coverage (0% of the total monthly premium for the Retiree Health Savings Plan), and Michael will pay \$152 for his coverage as a Spouse/Domestic Partner under the Retiree Health Savings Plan (20% of the total monthly premium for the Retiree Health Savings Plan).

<b>Medicare INELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing</b>
Health Savings Plan	\$760	\$0	\$760	\$152

### Example 2:

#### **ACTIVE CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Under Age 65 and Medicare ineligible; 2 Dependent Children Under 26 and Medicare ineligible**

Now let us assume that:

- Jane, a Missouri Union Retiree defined in the table above, retires on September 30, 2023, at age 61 with 40 years of service; AND
- Jane retires under a Missouri union contract in effect at the time of her retirement; AND

- Jane is Medicare ineligible due to age **and** having no record of disability; AND
- Jane's Spouse/Domestic Partner, Michael, is under age 65 and Medicare ineligible due to age and having no record of disability; AND
- Jane and Michael have 2 dependent children, Sarah and Ethan, who are both under age 26 and Medicare ineligible.

In this example, Jane (under 65, Medicare ineligible), her Spouse/Domestic Partner, Michael (under 65, Medicare ineligible), and both Sarah and Ethan (both under 26 and Medicare ineligible) will **all** remain on the Ameren Retiree Medical Plan:

- Jane (Retiree) and Michael (Spouse/Domestic Partner) will remain on the **Ameren Retiree Medical Plan** for the duration of the Missouri Union contract term that Jane retired under **and** pay the special pricing amounts towards both of their retiree medical coverage.
- Sarah and Ethan (both dependent children under age 26 and Medicare ineligible) will remain on the **Ameren Retiree Medical Plan** for the duration of the Missouri Union contract term that Jane (Retiree) retired under **and** pay the special pricing amounts towards both of their retiree medical coverage **unless they reach age 26 prior to the Missouri Union contract term's expiration.**
  - The age 26 dependent child will no longer be an eligible dependent on the **Ameren Retiree Medical Plan** and will be offered COBRA continuation coverage.

For this example, we will assume that Jane, Michael, Sarah, and Ethan are enrolled in the Retiree Standard Plan.

Through the duration of the Missouri Union contract that Susan retired under:

- Jane (Retiree) will pay \$0 for her Retiree Standard Plan coverage premium (0% of the total monthly premium or the Retiree Standard Plan); AND
- Michael (Spouse/Domestic Partner) will pay \$206 for his coverage as a Spouse/Domestic Partner under the Retiree Standard Plan (20% of the total monthly premium for the Retiree Standard Plan); AND
- Sarah and Ethan (dependent children) will pay \$103 for their coverage as dependent children under the Retiree Standard Plan (20% of the total monthly premium for the Retiree Standard Plan).

Medicare INELIGIBLE Retiree Choices Plan	Retiree		Spouse/Domestic Partner		Child(ren)	
	Total Premium	Special Pricing	Total Premium	Special Pricing	Total Premium	Special Pricing
Standard Plan	\$1,031	\$0	\$1,031	\$206	\$515	\$103

### Example 3:

#### **ACTIVE CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Over Age 65 and Medicare eligible (due to age)**

Let us assume that:

- David, a Missouri Union Retiree defined in the table above, retires on December 31, 2023, at age 55 with 25 years of service; AND
- David retires under a Missouri union contract in effect at the time of his retirement; AND
- David is Medicare ineligible due to age **and** having no record of disability; AND
- David's Spouse/Domestic Partner, Karen, is over age 65 and Medicare eligible due to age.

In this example, David (under 65, Medicare ineligible) and his Spouse/Domestic Partner, Karen (over 65, Medicare eligible due to age), will **both** remain on the Ameren Retiree Medical Plan for the duration of the Missouri Union contract term that David retired under **and** pay the special pricing amounts towards his retiree medical coverage for himself and his Spouse/Domestic Partner.

David, as an under 65, Medicare ineligible retiree, has different Ameren Retiree medical plan choices than his Spouse/Domestic Partner, Karen, who is over 65 and Medicare eligible due to age. For this example, we will say that David (Medicare ineligible, under 65) is in the Retiree Standard plan, and Karen (Medicare eligible, over 65) is in the Medicare Supplement with 4-Tier Rx plan.

Through the duration of the Union contract that David retired under, David pays \$0 for his Retiree Standard plan coverage premium (0% of the total monthly premium for the Retiree Standard Plan), and Karen will pay \$114 for her coverage as a Spouse/Domestic Partner under the Medicare Supplement with 4-Tier Rx plan (20% of the total monthly premium for the Medicare Supplement with 4-Tier Rx plan).

Medicare INELIGIBLE Retiree Plan Choices	Retiree	
	Total Premium	Special Pricing (0%)
Retiree Standard Plan	\$1,031	\$0
Medicare ELIGIBLE Retiree Plan Choices	Spouse/Domestic Partner	
	Total Premium	Special Pricing (20%)
Medicare Supplement with 4-Tier Rx Plan	\$571	\$114

#### Example 4:

**ACTIVE CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible;  
Spouse/Domestic Partner Over Age 65 and Medicare eligible (due to age);  
Dependent Child under Age 26**

Now let us assume that:

- David, a Missouri union co-worker, retires on December 31, 2023, at age 55 with 25 years of service; AND
- David retires under a Missouri union contract in effect at the time of his retirement; AND
- David is Medicare ineligible due to age and having no record of disability; AND
- David's Spouse/Domestic Partner, Karen, is over age 65 and Medicare eligible due to age; AND
- David has an eligible dependent child under 26 years old.

In this example, David (under 65, Medicare ineligible), his Spouse/Domestic Partner, Karen (over 65, Medicare eligible due to age), and their dependent child, Anna, who is age 21, will **all** remain

on the Ameren Retiree Medical Plan for the duration of the Union contract term that he retired under **and** pay the special pricing amounts towards his retiree medical coverage for himself, his Spouse/Domestic Partner, and dependent child under 26.

For this example, we will say that David (Medicare ineligible, under 65) and Anna (dependent child, 21, Medicare ineligible) are both in the Health Savings Plan and Karen (Medicare eligible, over 65) is in the Medicare Supplement with 4 Tier Rx plan.

Through the duration of the Union contract that David retired under, David pays \$0 for his Retiree Health Savings plan coverage premium; Anna will pay \$76 for her Health Savings plan coverage premium for dependent children (20% of the total monthly child premium for the Health Savings Plan) and Karen will pay \$118 (20% of the total monthly premium on the Medicare Supplement with 4-Tier Rx plan) for her coverage.

<b>Medicare INELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Child(ren)</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing</b>
Health Savings Plan	\$760	\$0	\$380	\$76
<b>Medicare ELIGIBLE Retiree Plan Choices</b>	<b>Spouse/Domestic Partner</b>			
	<b>Total Premium</b>		<b>Special Pricing</b>	
Medicare Supp w/4 Tier Rx	\$590		\$118	

## Section 5 – Illinois Retirees Under Active Contract – Plan Choices

This section of the Appendix applies to You if You are eligible to participate in the Ameren Retiree Medical Plan and Retiree Health Reimbursement Plan and You retired under an active Illinois Union contract defined below:

Eligible Group	Retirement Date
Pipefitters Local 360 (IP) Laborers Local 100 (IP) Laborers Local 12 Counties -IP Pipefitters Local 101 (IP) Laborers Local 459 (IP)	<ul style="list-style-type: none"> <li>Follows the IP contract dates (rather than their own contract expiration dates), i.e., retired under an active Illinois union contract effective July 1, 2022 – June 30, 2026.</li> <li>Retired between July 1, 2022, and June 30, 2026. The active contract for these dates is set to expire on July 1, 2026, and the special provisions of this section will end on that date.</li> <li>With a new contract effective July 1, 2026, a retirement on July 1, 2026, and thereafter (for the duration of the new contract) will be considered under the new contract.</li> </ul>
IBEW 51 MDF (IP)	<ul style="list-style-type: none"> <li>Follows the IP contract dates (rather than their own contract expiration dates), i.e., retired under an active Illinois union contract effective July 1, 2022 – June 30, 2026.</li> <li>Retired between July 1, 2022, and June 30, 2026. The active contract for these dates is set to expire on July 1, 2026, and the special provisions of this section will end on that date.</li> <li>With a new contract effective July 1, 2026, a retirement on July 1, 2026, and thereafter (for the duration of the new contract) will be considered under the new contract.</li> </ul>
IBEW Local 51 (formerly 1306 IP) – Clerical IBEW Local 51 (IP) - Physical IBEW Local 309 (IP) IBEW Local 702 (IP) IBEW Local 51 (CIL) IBEW Local 702 (CIPS-Illini) IBEW Local 702 (CIPS-Great River) IBEW Local 702 (CIPS-Shawnee) IBEW Local 309 (CIPS) IBEW Local 649 (CIPS)	<ul style="list-style-type: none"> <li>Retired between July 1, 2022, and June 30, 2026. The active contract for these dates is set to expire on July 1, 2026, and the special provisions of this section will end on that date.</li> <li>With a new contract effective July 1, 2026, a retirement on July 1, 2026, and thereafter (for the duration of the new contract) will be considered under the new contract.</li> </ul>

For all eligible Illinois active union contract retirees described in the table above, this section will describe the applicable **Ameren Retiree Medical Plan** choices and **"special pricing"** that applies to Your Retiree medical plan premiums **for the duration of the contract** that You retire under.



## Initial Retiree Medical Plan Choices at Retirement

Upon your retirement, there are factors that determine You and Your eligible Dependents plan choices, such as Your active contract status that You retired under, You and Your eligible Dependents ages, and Medicare eligibility due to age or disability status.

RETIREE ONLY COVERAGE		
Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
Retiree Pre-65 (Medicare Ineligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>Health Savings Plan</li> <li>Health Savings Plan – Value</li> <li>Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>Retirees who were participating in the Ameren Employee Medical Plan (Options Program) and who are <b>not</b> Medicare eligible will be enrolled in the medical plan most like the plan he or she was enrolled in the day before retiring.</li> </ul>
Retiree Pre-65 (Medicare Eligible *)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>Conventional Plan with Rx</li> <li>Conventional Plan without Rx</li> <li>Medicare Supplement Plan with Rx</li> <li>Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>Retirees who were participating in the Ameren Employee Medical Plan (Options Program), who are Medicare eligible and under 65, will be enrolled in the Medicare Supplement with Rx plan.</li> </ul>
Retiree Post-65 (Medicare Eligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>Alight Retiree Health Solutions</li> </ul>	<ul style="list-style-type: none"> <li>Retiree transitions to Alight Retiree Health Solutions the first of the month in which they turn 65, or if their date of birth falls on the first of the month, then they transition to Alight Retiree Health Solutions the month prior.</li> </ul>
RETIREE & SPOUSE/DOMESTIC PARTNER & DEPENDENT COVERAGE (NON-SPLIT FAMILIES)		
<b>Retiree &amp; Spouse/Domestic Partner Pre-65, AND/OR Dependent Children &lt;26</b> (all Medicare Ineligible)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>Health Savings Plan</li> <li>Health Savings Plan – Value</li> <li>Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>Retirees and dependents who were participating in the Ameren Employee Medical Plan (Options Program) and who are <b>not</b> Medicare eligible will be enrolled in the medical plan most like the plan they were enrolled in the day before retiring.</li> </ul>
<b>Retiree, Spouse/Domestic Partner, AND/OR Dependent Children (All Pre-65)</b> (all Medicare Eligible *)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>Conventional Plan with Rx</li> <li>Conventional Plan without Rx</li> <li>Medicare Supplement Plan with Rx</li> <li>Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>Retirees and dependents who were participating in the Ameren Employee Medical Plan (Options Program), who are Medicare eligible and under 65, will be enrolled in the Medicare Supplement with Rx plan.</li> </ul>
<b>Retiree, Spouse/Domestic Partner, AND/OR Dependent Children (All Post-65)</b> (all Medicare Eligible *)	<b>Retiree, Spouse/Domestic Partner, Child(ren):</b> <ul style="list-style-type: none"> <li>Alight Retiree Health Solutions</li> </ul>	<ul style="list-style-type: none"> <li>Retiree and dependents transition to Alight Retiree Health Solutions the first of the month in which they turn 65, or if their date of birth falls on the first of the month, then they transition to Alight Retiree Health Solutions the month prior.</li> </ul>
* <b>Note:</b> The Retiree, Spouse/Domestic Partner, and Dependent Child(ren) eligible for Medicare must enroll in Medicare Parts A & B. The Medicare Supplement Plan will pay secondary to Medicare, even if the Retiree, Spouse/Domestic Partner, and/or Dependent Child(ren) do not enroll in Medicare.		

<b>RETIREE &amp; DEPENDENT COVERAGE (ONE OR MORE COVERED FAMILY MEMBERS ARE MEDICARE ELIGIBLE WHILE OTHER COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, I.E., "SPLIT FAMILIES")</b>		
Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
<b>Retiree Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Eligible *) <b>AND/OR</b> <b>Dependent Child(ren) under 26</b> (Medicare Ineligible)	<b>Retiree &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan – Value</li> <li>• Standard Plan</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree and Dependent Child(ren) are not Medicare eligible, the Retiree and Dependent Child(ren) will be enrolled in the most similar coverage that the Retiree was participating in the day before their retirement date, while the Spouse/Domestic Partner will be enrolled in the Medicare Supplement Plan.</li> </ul>
<b>Retiree Pre-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Dependent Child(ren) under 26</b> (Medicare Ineligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul> <b>Spouse/Domestic Partner &amp; Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul>	<ul style="list-style-type: none"> <li>• If the Spouse/Domestic Partner and/or Dependent Child(ren) are not Medicare eligible, the Spouse/Domestic Partner and/or Dependent Child(ren) will be enrolled in the most similar coverage that the Retiree was participating in the day before their retirement date, while the Retiree will be enrolled in the Medicare Supplement Plan.</li> </ul>
<b>Retiree Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Spouse/Domestic Partner Post-65</b> (Medicare Eligible *) <b>AND/OR</b> <b>Dependent Child(ren) Pre-65</b> (Medicare Eligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Alight Retiree Health Solutions</li> </ul> <b>Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree is not Medicare eligible, the Retiree will be enrolled in the most similar plan the Retiree was participating in the day before their retirement date, while the Spouse/Domestic Partner will transition to Alight Retiree Health Solutions.</li> <li>• The disabled dependent child(ren) will be enrolled in the Medicare Supplement with Rx Plan.</li> </ul>

<b>RETIREE &amp; DEPENDENT COVERAGE (ONE OR MORE COVERED FAMILY MEMBERS ARE MEDICARE ELIGIBLE WHILE OTHER COVERED FAMILY MEMBERS ARE NOT MEDICARE ELIGIBLE, I.E., "SPLIT FAMILIES")</b>		
Category	Plan Choices	Default Plan Coverage (Automatic enrollment if no election is made within 31 days of Your retirement)
<b>Retiree Post-65</b> (Medicare Eligible *) <b>AND</b> <b>Spouse/Domestic Partner Pre-65</b> (Medicare Ineligible) <b>AND/OR</b> <b>Dependent Child(ren) Pre-65</b> (Medicare Eligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Alight Retiree Health Solutions</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Health Savings Plan</li> <li>• Health Savings Plan - Value</li> <li>• Standard Plan</li> </ul> <b>Dependent Child(ren):</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• The Retiree will transition to Alight Retiree Health Solutions.</li> <li>• The Spouse/Domestic Partner not Medicare eligible will be enrolled in the similar plan the Retiree was participating in the day before their retirement date.</li> <li>• The disabled dependent child(ren) will be enrolled in the Medicare Supplement with Rx Plan.</li> </ul>
Retiree Pre-65 (Medicare Eligible *) <b>AND</b> Spouse/Domestic Partner Post-65 (Medicare Eligible)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Alight Retiree Health Solutions</li> </ul>	<ul style="list-style-type: none"> <li>• If the Retiree is pre-65 and Medicare eligible, the Retiree will be enrolled in a Medicare Supplement with Rx plan.</li> <li>• The post-65 Spouse/Domestic Partner will transition to Alight Retiree Health Solutions the first of the month in which they turn 65, or if their date of birth falls on the first of the month, then they transition to Alight Retiree Health Solutions the month prior.</li> </ul>
Retiree Post-65 (Medicare Eligible) <b>AND</b> Spouse/Domestic Partner Pre-65 (Medicare Eligible *)	<b>Retiree:</b> <ul style="list-style-type: none"> <li>• Alight Retiree Health Solutions</li> </ul> <b>Spouse/Domestic Partner:</b> <ul style="list-style-type: none"> <li>• Conventional Plan with Rx</li> <li>• Conventional Plan without Rx</li> <li>• Medicare Supplement Plan with Rx</li> <li>• Medicare Supplement Plan without Rx</li> </ul>	<ul style="list-style-type: none"> <li>• The post-65 Retiree will transition to Alight Retiree Health Solutions the first of the month in which they turn 65, or if their date of birth falls on the first of the month, then they transition to Alight Retiree Health Solutions the month prior.</li> <li>• If the Spouse/Domestic Partner is pre-65 and Medicare eligible, the Spouse/Domestic Partner will be enrolled in a Medicare Supplement with Rx plan.</li> </ul>
<b>* Note:</b> Only the Retiree and/or Spouse/Domestic Partner and/or Dependent Child(ren) eligible for Medicare must enroll in Medicare Parts A & B. The Medicare Supplement Plan will pay secondary to Medicare even if the Retiree and/or Spouse/Domestic Partner and/or Dependent Child(ren) do not enroll in Medicare.		

### Special Pricing – Active Illinois Union Contract Retirees

**Special pricing** is defined as a fixed percentage of the total monthly premium under the **Ameren Retiree Medical Plan** that You and Your eligible dependents pay for the life of the Union contract that You retired under. With special pricing, the Company will pay the full cost of medical premiums for You, and 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 contract under which You retired expires, You and Your dependents no longer eligible for the special pricing. Please see Section 6, **STANDARD COST OF COVERAGE**, in this Appendix that describes the Standard Pricing once your contract expires.

<b>2023 – 2024 Total Monthly Premiums and Special Pricing</b>						
<b>Medicare INELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>		<b>Child(ren)</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing*</b>	<b>Total Premium</b>	<b>Special Pricing*</b>
Standard Plan	\$1,031	\$0	\$1,031	\$206	\$515	\$103
Health Savings Plan	\$760	\$0	\$760	\$152	\$380	\$76
Health Savings Plan - Value	\$683	\$0	\$683	\$137	\$343	\$69
<b>Medicare ELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>		<b>Child(ren)</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing*</b>	<b>Total Premium</b>	<b>Special Pricing*</b>
Conventional w/4 Tier Rx	\$571	\$0	\$571	\$114	\$523	\$105
Conventional w/o Rx	\$196	\$0	\$196	\$39	\$196	\$39
Medicare Supp w/4 Tier Rx	\$590	\$0	\$590	\$118	\$523	\$105
Medicare Supp w/o Rx	\$217	\$0	\$217	\$43	\$217	\$43

\* 20% of Total Premium

### **Retiree Medical Choices – Active Illinois Union Contract Retirees**

Illinois Union contract Retirees defined in the table above who are age 65 and over, and their Dependents age 65 and over, transition to the **Alight Retiree Health Exchange** upon turning 65 and are ineligible to be enrolled under the **Ameren Retiree Medical Plan**. Active contract status for Illinois Union Contract retirees only applies to special pricing provisions stated above for those under 65 years of age and eligible for the **Ameren Retiree Medical Plan**.

## Active Illinois Union Contract Retirees – Special Pricing Matrix

Retiree Under Age 65; Medicare Ineligible	Retiree Under Age 65; Medicare Eligible	Retiree Age 65+; Medicare Eligible
<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan.</li> </ul>	<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan through age 65 but moves to the Medicare Supplement design.</li> </ul>	<ul style="list-style-type: none"> <li>Ameren Retiree moves to the Alight Retiree Health Exchange on the first of the month they reach age 65 (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month).</li> </ul>
Retiree's Spouse/Domestic Partner Under Age 65; Medicare Ineligible	Retiree's Spouse/Domestic Partner Under Age 65; Medicare Eligible (due to Disability)	Retiree's Spouse/Domestic Partner Age 65+ Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan through age 65 but will move to the Medicare Supplement design</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's Spouse/Domestic Partner who is age 65+ moves to the Alight Retiree Health Exchange on the first of the month they reach age 65 (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month).</li> </ul> <p>The over age 65 Spouse/Domestic Partner moves to the Alight Retiree Health Exchange.</p>
Retiree's Under Age 26 Dependent Child; Medicare Ineligible	Retiree's Under Age 65 Dependent Child; Medicare Eligible (due to disability)	Retiree's Over Age 65 Dependent Child Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Retiree's eligible child under age 26 remains with Ameren Retiree Medical Plan.</li> <li>If the Retiree's child attains age 26, the Retiree's child will be terminated from coverage at the end of the month in which they turn 26 and be offered COBRA.</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's totally or permanently disabled child under age 65 remains with Ameren Retiree Medical Plan but will move to the Medicare Supplement design. *See eligibility provisions for disabled dependent child(ren).</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's totally or permanently disabled child who attains age 65 will move to the Alight Retiree Health Exchange on the first of the reaches age 65 (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month) *See eligibility provisions for disabled dependent child(ren).</li> </ul>

## 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:

#### **ACTIVE CONTRACT Illinois Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Under Age 65 and Medicare ineligible**

Let us assume that:

- Susan, an Illinois Union Retiree defined in the table above, retires on September 30, 2023, at age 61 with 40 years of service; AND
- Susan retires under an Illinois union contract in effect at the time of her retirement; AND
- Susan is Medicare ineligible due to age **and** having no record of disability; AND
- Susan's Spouse/Domestic Partner, Michael, is under age 65 and Medicare ineligible due to age and having no record of disability.

In this example, Susan (under 65, Medicare ineligible) and her Spouse/Domestic Partner, Michael (under 65, Medicare ineligible), will **both** remain on the Ameren Retiree Medical Plan for the duration of the Illinois Union contract term that Susan retired under **and** pay the special pricing amounts towards both of their retiree medical coverage under the **Ameren Retiree Medical Plan**.

For this example, we will assume that Susan and Michael are enrolled in the Retiree Health Savings Plan. Through the duration of the Illinois Union contract that Susan retired under, Susan will pay \$0 for her Retiree Health Savings Plan coverage premium (0% of the total monthly premium for the Retiree Health Savings Plan), and Michael will pay \$152 for his coverage as a Spouse/Domestic Partner under the Retiree Health Savings Plan (20% of the total monthly premium for the Retiree Health Savings Plan).

<b>Medicare INELIGIBLE Retiree Plan Choices</b>	<b>Retiree</b>		<b>Spouse/Domestic Partner</b>	
	<b>Total Premium</b>	<b>Special Pricing</b>	<b>Total Premium</b>	<b>Special Pricing</b>
Health Savings Plan	\$760	\$0	\$760	\$152

Once Susan's Union contract expires that she retired under, her and her Spouse/Domestic Partner are no longer eligible for the special pricing as defined above. Please see Section 6, **STANDARD COST OF COVERAGE**, of this Appendix for examples of the standard pricing premium calculation under the Ameren Retiree Medical Plan once an Illinois union contract expires.

### Example 2:

#### **Illinois Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Over Age 65 and Medicare eligible (due to age)**

Let us assume that:

- Susan, an Illinois union co-worker, retires on September 30, 2023, at age 55 with 10 years of service; AND

- Susan retires under an Illinois union contract in effect at the time of her retirement; AND
- Susan is Medicare ineligible due to age **and** having no record of disability; AND
- Susan's Spouse/Domestic Partner, Michael, is over age 65 and Medicare eligible due to age.

In this example, Susan (under 65, Medicare ineligible) will remain on the Ameren Retiree Medical Plan until she reaches age 65, **and** she is eligible to pay the special pricing amounts towards her retiree medical coverage for herself for the duration of the Union contract that she retired under which is in effect through June 30, 2026

For this example, we will say that Susan (retiree) is enrolled in the Retiree Health Savings Value Plan. **Susan will pay \$0 for her Retiree Health Savings Value plan coverage premium through the duration of the Union contract that Susan retired under.** Susan's Spouse/Domestic Partner, Michael, who is over age 65 and Medicare eligible, is ineligible to be covered as a dependent under Susan's Ameren retiree medical plan. Michael will transition to the Alight Retiree Health Exchange and be provided the applicable monthly credit to his RHRA as a Spouse/Domestic Partner of an Ameren Retiree (see Section 6 of this Appendix).

Medicare Retiree Plan Choices	INELIGIBLE	Retiree	
		Total Premium	Special Pricing
Health Savings Plan - Value		\$683	\$0

### Example 3:

#### **Illinois Union Retiree and Spouse/Domestic Partner Age 65+ and Medicare Eligible**

Let us assume that:

- Susan, an Illinois union co-worker, retired at age 66 with 40 years of service; AND
- Susan retires under an Illinois union contract in effect at the time of her retirement; AND
- Susan is Medicare eligible due to age; AND
- Susan's Spouse/Domestic Partner, Michael, is over age 65 and Medicare eligible due to age.

For this example, Susan and Susan's Spouse/Domestic Partner, Michael, who are both over age 65 and Medicare eligible, are ineligible to be covered under the **Ameren Retiree Medical Plan**. Both Susan and Michael will transition to the Alight Retiree Health Exchange and be provided a monthly retiree and spousal credit to their RHRA.

**Note:** If the total RHRA funding maximum is **less** than the total annualized medical cap allowance amount, then both the Retiree and Spouse/Domestic Partner over 65 will receive the full RHRA funding amount. If the total RHRA funding maximum is greater than the total annual medical cap allowance, then the Retiree's RHRA is funded first up to the annual RHRA maximum amount, and any remaining funds are allocated to the Spouse/Domestic Partner's RHRA up to the spousal annual RHRA maximum.

We must determine Susan's monthly medical cap allowance based on the over-aged 65 med cap chart.

**Retiree Medical Cap for Retirees Over Age 65**

<b>Age at Retirement (rounded down to the nearest year)</b>								
<b>Years of Service</b>	<b>55</b>	<b>56</b>	<b>57</b>	<b>58</b>	<b>59</b>	<b>60</b>	<b>61</b>	<b>62 or older</b>
<b>30+</b>	516	528	540	552	564	576	588	<b>600</b>

Based upon Susan's age of 66 at retirement and her 40 years of service at retirement, her monthly med cap allowance is \$600.

Retiree <b>Current</b> Age:	66
Retiree <b>Age at Retirement</b> :	61
Years of Service at Retirement:	40
Monthly Med Cap Allowance	\$600.00
<b>Annualized Med Cap Allowance:</b>	<b>\$7,200.00</b>

RHRA Funding	<b>2023 Annual Amount</b>	
<b>Maximum</b> Annual Retiree RHRA Funding	\$	3,136.00
<b>Maximum</b> Annual Spouse/Domestic Partner RHRA Funding	\$	2,151.00
	<b>\$</b>	<b>5,287.00</b>

Since the total RHRA funding maximum is less than Susan's total annualized medical cap allowance amount of \$7,200.00, then both Susan and her Spouse/Domestic Partner will receive the full RHRA funding amount of \$5,287.00.



## Section 6 – Management and Expired Contract Retirees – Plan Choices and Standard Cost of Coverage

This section of the Appendix applies to You if You are eligible to participate in the Ameren Retiree Medical Plan and Retiree Health Reimbursement Account Plan and You are a Management Retiree or Contract Retiree who retired under an active contract that is now expired.

### Special Pricing Ineligibility – Expired Contract Retirees and Management Retirees

**Special pricing** is defined as a fixed percentage of the total monthly premium under the **Ameren Retiree Medical Plan** that Contract Retirees pay for the life of the Union contract that You retired under for You and Your eligible dependents. Management Retirees are ineligible for special pricing. Contract retirees are no longer eligible for special pricing when the term of the Contract they retired under ends. At that point, standard pricing applies.

### Standard Pricing for Retiree Medical Premiums

The standard pricing for Retiree medical premiums is determined by the greater of:

- The minimum monthly plan premiums; **OR**
- The total monthly plan premiums *less* the Retiree medical cap allowance.

<b>2023 – 2024 Minimum Retiree Plan Monthly Premiums</b>			
<b>Medicare INELIGIBLE Retiree Plan Choices &amp; Monthly Premium Minimums</b>			
<b>Monthly Minimums</b>	<b>Retiree</b>	<b>Spouse/Domestic Partner</b>	<b>Child(ren)</b>
Standard Plan	\$258	\$515	\$258
Health Savings Plan	\$130	\$261	\$160
Health Savings Plan - Value	\$109	\$217	\$134
<b>Medicare ELIGIBLE Retiree Plan Choices &amp; Monthly Premium Minimums</b>			
<b>Monthly Minimums</b>	<b>Retiree</b>	<b>Spouse/Domestic Partner</b>	<b>Child(ren)</b>
Conventional w/4 Tier Rx	\$143	\$284	\$262
Conventional w/o Rx	\$49	\$98	\$98
Medicare Supp w/4 Tier Rx	\$148	\$296	\$262
Medicare Supp w/o Rx	\$55	\$108	\$109

### Union Retirees Upon Expiration of the Contract Under Which You Retired

Certain Retirees who are over age 65 and who retired under an active union contract, along with their over age 65 dependents, will transition to the **Alight Retiree Health Exchange** upon the expiration of the Union contract under which the Retiree retired.

### Retiree Medical – Management Retirees

Management Retirees defined who are age 65 and over, and their Dependents age 65 and over, transition to the **Alight Retiree Health Exchange** upon turning 65 and are ineligible to be enrolled under the **Ameren Retiree Medical Plan**.

## Management and Expired Contract Retirees – Retiree Medical Matrix

Retiree Under Age 65; Medicare Ineligible	Retiree Under Age 65; Medicare Eligible	Retiree Age 65+; Medicare Eligible
<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan.</li> </ul>	<ul style="list-style-type: none"> <li>Ameren Retiree remains with Ameren Retiree Medical Plan but moves to the Medicare Supplement plan design.</li> </ul>	<ul style="list-style-type: none"> <li>Ameren Retiree moves to the Alight Retiree Health Exchange on the first of the month they reach age 65. (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month).</li> </ul>
Retiree's Spouse/Domestic Partner Under Age 65; Medicare Ineligible	Retiree's Spouse/Domestic Partner Under Age 65; Medicare Eligible (due to Disability)	Retiree's Spouse/Domestic Partner Age 65+ Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>The Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan.</li> </ul>	<ul style="list-style-type: none"> <li>The Retiree's Spouse/Domestic Partner remains with Ameren Retiree Medical Plan but moves to the Medicare Supplement plan design.</li> </ul>	<ul style="list-style-type: none"> <li>The Retiree's Spouse/Domestic Partner moves to the Alight Retiree Health Exchange on the first of the month of the month they reach age 65 (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month).</li> </ul>
Retiree's Under Age 26 Dependent Child; Medicare Ineligible	Retiree's Under Age 65 Dependent Child; Medicare Eligible (due to disability)	Retiree's Age 65+ Dependent Child Medicare Eligible (due to age)
<ul style="list-style-type: none"> <li>Retiree's eligible child under age 26 remains with Ameren Retiree Medical Plan.</li> <li>The Retiree's child will be terminated from coverage at the end of the month in which they turn 26 and be offered COBRA.</li> </ul>	<ul style="list-style-type: none"> <li>Retiree's totally or permanently disabled child* under age 65 remains with Ameren Retiree Medical Plan but will move to the Medicare Supplement plan design.</li> <li>*See eligibility provisions for disabled dependent child(ren).</li> </ul>	<ul style="list-style-type: none"> <li>The Retiree's totally or permanently disabled child moves to the Alight Retiree Health Exchange on the first of the month upon reaches age 65 (or if birthday is on the first of the month, they move to Alight the month prior to their birthday month).</li> </ul>

### Examples:

It may be helpful to look at some EXAMPLES of how to estimate what You might pay for medical coverage as a Management or Expired Contract Retiree.

### Example 1:

#### **EXPIRED CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Under Age 65 and Medicare ineligible**

Let us assume that:

- Judy, a Missouri Union Retiree defined in the table above, retired at age 61 with 40 years of service; AND
- Judy retired under a Missouri union contract that was in effect at the time of her retirement but has now expired; AND
- Judy is Medicare ineligible due to age **and** having no record of disability; AND

- Judy’s Spouse/Domestic Partner, Michael, is under age 65 and Medicare ineligible due to age and having no record of disability.

In this example, Judy (under 65, Medicare ineligible) and her Spouse/Domestic Partner, Michael (under 65, Medicare ineligible), will **both** remain on the Ameren Retiree Medical Plan until they each individually reach age 65, but will no longer be eligible to pay the special pricing amounts towards both of their Retiree medical coverage under the **Ameren Retiree Medical Plan**.

For this example, we will assume that Judy and Michael are enrolled in the Retiree Health Savings Plan. Through the duration of the Missouri Union contract that Judy retired under, Judy was eligible for special pricing and paid \$0 for her Retiree Health Savings Plan coverage premium (0% of the total monthly premium for the Retiree Health Savings Plan), and Michael paid \$152 for his coverage as a Spouse/Domestic Partner under the Retiree Health Savings Plan (20% of the total monthly premium for the Retiree Health Savings Plan).

Now that the term of the Union Contract has expired that Susan retired under as a Missouri Union Retiree, Judy will default to the standard pricing for retiree medical premiums.

The standard pricing for Retiree medical premiums is determined by the greater of:

- The minimum monthly plan premiums; **OR**
- The total monthly plan premiums **less** the Retiree medical cap allowance.

<b>2023 – 2024 Minimum Retiree Plan Monthly Premiums</b>		
<b>Medicare INELIGIBLE Retiree Plan Choices &amp; Monthly Premium Minimums</b>		
<b>Monthly Minimums</b>	<b>Retiree</b>	<b>Spouse/Domestic Partner</b>
Health Savings Plan	\$130	\$261

The monthly minimum premiums for coverage under the Health Savings Plan are \$130 for the Retiree and \$261 for the Spouse/Domestic Partner for a total of **\$391 per month**.

Next, we will compare the total monthly minimums to the total monthly premiums for Retiree and Spouse/Domestic Partner medical coverage, less Judy’s applicable med cap allowance based upon her age and years of service at retirement.

Since Judy is under age 65, the under 65 med cap table will apply to her. We will need to determine what her med cap allowance is by reviewing the under 65 cap table for her years of service and age at retirement.

## Retiree Medical Cap for Retirees Under Age 65

Age at Retirement (rounded down to the nearest year)								
Years of Service	55	56	57	58	59	60	61	62 or older
30+	1161	1188	1215	1242	1269	1296	1323	1350

Based upon Judy's age of 61 at retirement and her 41 years of service at retirement, her monthly med cap allowance is \$1,323.

Retiree <b>Current</b> Age:	61
Retiree <b>Age at Retirement:</b>	61
Years of Service at Retirement:	40
Monthly Med Cap Allowance	\$1,323.00

Retiree Health Savings Plan	
<b>STEP 1 - Calculate Medical Cap Allocation</b>	
Monthly Med Cap Amount (No RHRA Funding)	= \$ 1,323
<b>STEP 2 - Calculate Plan Total Monthly Premium MINUS Remaining Funding</b>	
Retiree Premium	\$ 760
Spouse/Domestic Partner Premium	+ \$ 760
<i>Less Remaining Med Cap Funding Calculated Above</i>	- \$ 1,323
<b>Total Monthly Premiums (less cap allocation)</b>	<b>= \$ 197</b>
<b>STEP 3 - Total Monthly Plan Premium MINIMUMS</b>	
Retiree Monthly Plan Minimum	\$ 130
Spouse/Domestic Partner Monthly Plan Minimum	+ \$ 261
<b>Total Retiree &amp; Spouse/Domestic Partner Monthly Plan Minimums</b>	<b>= \$ 391</b>
<b>FINAL DETERMINATION OF MONTHLY PREMIUMS</b>	
Monthly premiums are the greater of the actual premium less remaining cap OR minimum premium allocation. <b>\$ 391</b>	

Because the total monthly plan premium minimums of \$391 for Judy and her Spouse/Domestic Partner **are greater** than the total monthly premiums **less** Judy's med cap allowance (for a total of \$197), Judy will pay **\$391** for her and her Spouse/Domestic Partner's coverage under the **Ameren Retiree Medical Plan** for the Health Savings Plan.

### Example 2:

#### **EXPIRED CONTRACT Missouri Union Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Over Age 65 and Medicare eligible (due to age)**

Let us assume that:

- David, a Missouri Union Retiree defined in the table above, retired at age 55 with 25 years of service; AND
- David retired under a Missouri union contract in effect at the time of his retirement that has now expired; AND
- David is Medicare ineligible due to age **and** having no record of disability; AND
- David's Spouse/Domestic Partner, Karen, is over age 65 and Medicare eligible due to age.

In this example, David (under 65, Medicare ineligible) remains on the Ameren Retiree Medical Plan until he reaches age 65, but his Spouse/Domestic Partner, Karen (over 65, Medicare eligible due to age), will transition to the **Alight Retiree Health Exchange** and receive a monthly credit to her **Retiree Health Reimbursement Account** as applicable.

For this example, we will assume that David and Karen were enrolled in the Retiree Standard Plan while under an active contract status. Through the duration of the Missouri Union contract that David retired under, David was eligible for special pricing and paid \$0 for his Retiree Standard Plan coverage premium (0% of the total monthly premium for the Retiree Health Savings Plan), and Karen paid \$206 for her coverage as a Spouse/Domestic Partner under the Retiree Standard Plan (20% of the total monthly premium).

Medicare INELIGIBLE Retiree Plan Choices	Retiree		Spouse/Domestic Partner	
	Total Premium	Special Pricing	Total Premium	Special Pricing
Standard Plan	\$1,031	\$0	\$1,031	\$206

Due to the contract term expiring that David retired under as Missouri Union Retiree, David is eligible to continue the Retiree Standard Plan on the standard pricing, but his over 65 Spouse/Domestic Partner will now transition to the Alight Retiree Health Exchange and be provided a monthly credit to her RHRA.

The standard pricing for Retiree medical premiums is determined by the greater of:

- The minimum monthly plan premiums; **OR**
- The total monthly plan premiums **less** the Retiree medical cap allowance.

Medicare INELIGIBLE Retiree Plan & Monthly Premium Minimums	
Monthly Minimums	Retiree
Standard Plan	\$258

The monthly minimum premium for coverage under the Retiree Standard Plan is \$258 for the Retiree **per month**.

We will need to now compare the total monthly minimums to the total monthly premiums for Retiree medical coverage, less David's applicable med cap allowance based upon his age and years of service at retirement AND less his Spouse/Domestic Partner's monthly RHRA credit.

Since David is under age 65, the under 65 med cap table will apply to him. We will need to determine what his med cap allowance is when looking at the under 65 med cap table by looking at his years of service and age at retirement.

## Retiree Medical Cap for Retirees Under Age 65

Age at Retirement (rounded down to the nearest year)								
Years of Service	55	56	57	58	59	60	61	62 or older
25	968	990	1013	1035	1058	1080	1103	1125

Based upon David's age of 55 at retirement with 25 years of service at retirement, and that he is currently under age 65, his monthly med cap allowance is \$968.

Retiree <b>Current</b> Age:	63
Retiree <b>Age at Retirement</b> :	55
Years of Service at Retirement:	25
Monthly Med Cap Allowance	\$968.00

Ameren will also contribute the monthly Maximum RHRA Funding Amount towards David's Spouse/Domestic Partner's Retiree Health Reimbursement Account and then his retiree medical premiums because he is under age 65, not a participant in the VRP, is enrolled in the **Ameren Retiree Medical Plan**, and his Spouse/Domestic Partner is age 65 or older and enrolled in the RHRA Plan.

Retiree Standard Plan		
<b>STEP 1 - Calculate Medical Cap Allocation</b>		
Monthly Under 65 Cap	\$	968
Monthly Spouse/Domestic Partner RHRA Amount	-	\$ 151
<b>Remaining Med Cap Funding Towards Total Premium Cost</b>	<b>\$</b>	<b>817</b>
<b>STEP 2 - Calculate Plan Total Monthly Premium MINUS Remaining Funding</b>		
TOTAL Retiree Plan Premium	\$	1,031
<b>Less Remaining Med Cap Funding Calculated Above</b>	-	\$ 817
<b>Total Premium Minus Cap</b>	<b>= \$</b>	<b>214</b>
<b>STEP 3 - Minimum of Plan Premium</b>		
<b>Retiree Minimum Premium</b>	<b>= \$</b>	<b>258</b>
<b>FINAL DETERMINATION OF MONTHLY PREMIUMS</b>		
<b>Monthly premiums are the greater of the actual premium less remaining cap OR minimum premium allocation.</b>	<b>\$</b>	<b>258</b>

Because the monthly plan premium minimum of \$258 for David for the Retiree Standard Plan **is greater** than the total monthly premiums **less** his med cap allowance and Spouse/Domestic Partner's monthly RHRA funding (for a total of \$214), David will pay **\$258** for his coverage under the **Ameren Retiree Medical Plan** for the Retiree Standard Plan.

### Example 3:

#### NON-CONTRACT Management Retiree Under Age 65 and Medicare ineligible; Spouse/Domestic Partner Over Age 65 and Medicare eligible (due to age)

Let us assume that:

- Patricia, a Management Retiree defined in the table above, retired at age 55 with 27 years of service; AND

- Patricia is Medicare ineligible due to age **and** having no record of disability; AND
- Patricia’s Spouse/Domestic Partner, Charles, is over age 65 and Medicare eligible due to age.

In this example, Patricia (under 65, Medicare ineligible) remains on the Ameren Retiree Medical Plan until she reaches age 65, but her Spouse/Domestic Partner, Charles (over 65, Medicare eligible due to age), will transition to the **Alight Retiree Health Exchange** and receive a monthly credit to his **Retiree Health Reimbursement Account**.

Patricia and Charles were enrolled in the active Standard Plan before Patricia’s retirement.

The standard pricing for Retiree medical premiums is determined by the greater of:

- The minimum monthly plan premiums; **OR**
- The total monthly plan premiums *less* the Retiree medical cap allowance.

<b>2023 – 2024 Minimum Retiree Plan Monthly Premiums</b>	
<b>Medicare INELIGIBLE Retiree Plan Choices &amp; Monthly Premium Minimums</b>	
<b>Monthly Minimums</b>	<b>Retiree</b>
Retiree Standard Plan	\$258

The monthly minimum premium for coverage under the Retiree Standard Plan is \$258 for the Retiree **per month**.

We will need to now compare the total monthly minimums to the total monthly premiums for Retiree medical coverage, less Patricia’s applicable med cap allowance based upon her age and years of service at retirement AND less her Spouse/Domestic Partner's monthly RHRA credit.

Since Patricia is under age 65, the under 65 med cap table will apply to her. We will need to determine what her med cap allowance is when looking at the under 65 med cap table by looking at her years of service and age at retirement.

## Retiree Medical Cap for Retirees Under Age 65

Age at Retirement (rounded down to the nearest year)								
Years of Service	55	56	57	58	59	60	61	62 or older
27	1045	1069	1094	1118	1142	1166	1191	1215

Based upon Patricia's age of 55 at retirement with 27 years of service at retirement, and that she is currently under age 65, her monthly med cap allowance is \$1,045.

Retiree <b>Current</b> Age:	55
Retiree <b>Age at Retirement</b> :	55
Years of Service at Retirement:	27
Monthly Med Cap Allowance	\$1,045.00

Ameren will also contribute the monthly Maximum RHRA Funding Amount towards Patricia's Spouse/Domestic Partner's Retiree Health Reimbursement Account and then her retiree medical premiums because she is under age 65, not a participant in the VRP, is enrolled in the **Ameren Retiree Medical Plan**, and her Spouse/Domestic Partner is age 65 or older and enrolled in the RHRA Plan.

Retiree Standard Plan		
<b>STEP 1 - Calculate Medical Cap Allocation</b>		
Monthly Under 65 Cap	\$	1,045
Monthly Spouse/Domestic Partner RHRA Amount	-	\$ 151
<b>Remaining Med Cap Funding Towards Total Premium Cost</b>	<b>\$</b>	<b>894</b>
<b>STEP 2 - Calculate Plan Total Monthly Premium MINUS Remaining Funding</b>		
TOTAL Retiree Plan Premium	\$	1,031
<b>Less Remaining Med Cap Funding Calculated Above</b>	-	\$ 894
<b>Total Premium Minus Cap</b>	<b>= \$</b>	<b>137</b>
<b>STEP 3 - Minimum of Plan Premium</b>		
<b>Retiree Minimum Premium</b>	<b>= \$</b>	<b>258</b>
<b>FINAL DETERMINATION OF MONTHLY PREMIUMS</b>		
<b>Monthly premiums are the greater of the actual premium less remaining cap OR minimum premium allocation.</b>		<b>\$ 258</b>

Because the monthly plan premium minimum of \$258 for Patricia for the Retiree Standard Plan **is greater** than the total monthly premiums **less** her med cap allowance and Spouse/Domestic Partner's monthly RHRA funding (for a total of \$137), Patricia will pay **\$258** for her coverage under the **Ameren Retiree Medical Plan** for the Retiree Standard Plan.



## COVID-19 Emergency Provisions Supplement

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

As of the effective date of this SPD, the Outbreak Period has ended. The Outbreak Period expired on July 10, 2023. Note that the deadlines that were suspended during the Outbreak Period will begin running again when the Outbreak Period ended.

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

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

Please contact the Benefits Center via telephone at **877.7my.Ameren (877.769.2637)** or in writing at Ameren Benefits Center, PO Box 5204, Cherry Hill, NJ 08034-5204 if you have any questions about COBRA deadlines or timeframes applicable to Your situation or for how this guidance impacts Your right to file a claim or appeal.