A Plan Designed to Provide Security for Employees of

Ameren Cafeteria Plan

Summary Plan Description. The following is a Summary Plan Description for the **Ameren Cafeteria Plan**. This Summary Plan Description, effective January 1, 2018, supersedes all prior summary plan descriptions. The official Plan Document contains all details about the benefits provided by the Plan and governs actual Plan operations.

Every attempt has been made to assure accuracy. However, if there is any conflict between this description and the legal Plan document, the provisions of the legal Plan document will govern.

Purpose

Ameren Corporation ("Ameren") maintains the **Ameren Cafeteria Plan** to allow eligible Employees to elect coverage under the **Ameren Dependent Care** and **Healthcare Reimbursement Accounts** (sometimes called Dependent Care or Healthcare Flexible Spending Accounts or FSAs) and also to allow them the opportunity to pay their portion of healthcare premiums and the cost of supplemental group-term life insurance and AD&D coverage with pre-tax dollars under the **Ameren Pre-Tax Healthcare Contribution Plan**.

This document is a brief description of the **Ameren Cafeteria Plan,** which includes the **Pre-Tax Healthcare Contribution Plan, Healthcare Reimbursement Plan** and the **Dependent Care Reimbursement Plan**, and is a component of the **Ameren Miscellaneous Healthcare and Fringe Benefit Plan** (the "Plan").

The Administrative Committee of Ameren Services Company (the "Company"), serves as the Plan Administrator within the meaning of ERISA. The Plan Administrator has complete and sole discretion to construe or interpret all Plan provisions, to determine eligibility for benefits, to grant or deny benefits, and to determine the type and extent of benefits, if any, to be provided. The Plan Administrator's decisions in such matters shall be controlling, binding, and final. In any action to review any such decision by the Plan Administrator, the Plan Administrator shall be deemed to have exercised its discretion properly unless it is proved duly that the Plan Administrator has acted arbitrarily and capriciously.

As a participant in the Plan, your rights and benefits are determined by the provisions of the Plan. This booklet briefly describes those rights and benefits. It outlines what you must do to be covered. It explains how to file claims. Fidelity Workplace LLC ("Fidelity") and WageWorks, Inc. ("WageWorks") administers the reimbursement of 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 Summary Plan Description, please contact the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

DURATION OF THE PLAN. Ameren hopes and expects to continue the **Ameren Cafeteria Plan** in the years ahead but cannot guarantee to do so. Ameren reserves the right to amend, modify, or terminate the Plan.

This Summary Plan Description supersedes all prior Summary Plan Descriptions and outlines the provisions and benefits afforded under the Plan as of January 1, 2018. The Company reserves the right to unilaterally amend or terminate the Plan and/or any benefits provided under the Plan at any time. The Plan shall be construed and administered to comply in all respects with applicable federal law.

Ameren Benefits Center

The **Ameren Benefits Center** is Ameren's employee benefits customer call center. When you have a question about your benefits, call the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), Option 2. The **Ameren Benefits Center** is available Monday through Friday from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

www.myAmeren.com

Ameren maintains **www.myAmeren.com** where Plan participants can enroll, view, or make changes to elected benefit coverage through "Healthcare and Life Benefits". The website is generally available 24 hours a day, seven days a week. (Note: There may be short maintenance periods during which benefits information will not be available.)

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

If you do not have access to a computer or an HR Web Station, you can manage your benefits by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

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Eligibility

Healthcare Reimbursement Plan and/or Dependent Care Reimbursement Plan (Reimbursement Plans are also referred to as Flexible Spending Account plan, or "FSAs").

You are eligible to participate in the FSAs if you are:

- a full-time regular Employee of the Plan Sponsor or a participant in the "Temporary Voluntary Reduced Hours Program";
- a part-time regular Employee who works at least 20 hours a week and is represented by a collective bargaining agreement with Ameren Illinois (formerly AmerenIP); or
- a full-time temporary Employee who is represented by a collective bargaining agreement with Ameren Illinois (formerly AmerenIP):
    - Ameren Illinois (formerly AmerenIP) and IBEW Local 51 (IP); or
    - Ameren Illinois (formerly AmerenIP) and IBEW Local 309 (IP); or
    - Ameren Illinois (formerly AmerenIP) and IBEW Local 702 (IP); or
    - Ameren Illinois (formerly AmerenIP) and Laborers Local 12 Counties (IP); or
    - Ameren Illinois (formerly AmerenIP) and Pipefitters Local 101 (IP); or
    - Ameren Illinois (formerly AmerenIP) and Pipefitters Local 360 (IP); or
    - Ameren Illinois (formerly AmerenIP) and Laborers Local 459 (IP); or
    - Ameren Illinois (formerly AmerenIP) and IBEW 51 MDF (IP); or
    - Ameren Illinois (formerly AmerenIP) and Laborers Local 100 (IP);

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

You may use either or both FSAs to reimburse yourself for eligible expenses whether or not you are covered under an Ameren-sponsored medical plan.

Pre-tax Healthcare Contribution Plan

If you participate in the **Ameren Employee Medical Plan** and/or a dental, vision or dental/vision plan sponsored by Ameren, you are eligible to participate in the **Pre-Tax Contribution Plan** and pay for such coverage(s) on a pre-tax basis through the Plan.

Enrollment Provisions

Healthcare or Dependent Care Reimbursement Plan

To enroll in a FSA, you must complete the appropriate enrollment process, either by enrolling on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**), Option 2.

As part of the enrollment process you must indicate how much money you want to contribute to either or both accounts for the upcoming Plan Year. Your election must be made during Annual Enrollment or, if you are a new employee or a newly eligible employee, within 31 days from the date on your Enrollment Worksheet. The minimum annual contribution amount is $240 to each account.

Important Note: If you are enrolled in the Ameren Health Savings PPO Medical Plan option (see **Ameren Employee Medical Plan** Summary Plan Description) for more information on the Health Savings PPO), you are limited to reimbursement only for eligible dental and/or vision expenses through a Limited Purpose Healthcare Reimbursement account under the **Healthcare Reimbursement Plan**. A Limited Purpose Health Reimbursement account is designed to complement your Ameren Health Savings PPO Medical Plan and Health Savings Account ("HSA") coverage by allowing you to pay for certain dental or vision expenses that are not eligible for reimbursement through any other source. Note that you can only participate in the Limited Purpose Health Reimbursement account if you are enrolled in the Ameren Health Savings PPO Medical Plan option.

Enrollment in either FSA is optional. You must re-enroll in the **Healthcare** and/or **Dependent Care Reimbursement Plan** for each subsequent Plan Year that you want to participate. If you do not re-enroll in the **Healthcare** and/or **Dependent Care Reimbursement Plan** for the subsequent Plan Year, you will not have coverage under the **Healthcare** and/or **Dependent Care Reimbursement Plan**.

If You Don't Enroll

If you fail to enroll in an FSA when first eligible, you may not enroll until the next annual enrollment unless you have a Change in Status or become entitled to a special enrollment right.

Pre-tax Contribution Plan

If you pay any premiums for healthcare coverage through payroll deduction, you will be automatically enrolled in the **Pre-Tax Contribution Plan**, unless you elect in writing that you do not want to participate. Your enrollment and participation in the **Pre-Tax Healthcare Contribution Plan** will continue for subsequent Plan Years unless, during Annual Enrollment, you elect in writing that you do not want to participate.

When Contributions Begin

Your contributions will be deducted on a pre-tax basis in equal installments (from each regular paycheck) beginning with the first pay period of the Plan Year or, if later, the first pay period after you become eligible and enroll as explained above. By the end of the Plan Year, your total elected contribution will have been deposited in your account(s) and/or used to pay your share of the cost for healthcare coverage(s).

Change in Status and Special Enrollment

Change in Status

You may not change your coverage in any way during the Plan Year unless there is a Change in Status, as defined by the Internal Revenue Service ("IRS"), that results in a change in coverage. The change in coverage must be on account of and consistent with your Change in Status. You must make the change within 31 days of the Change in Status event. Any timely **Healthcare or Dependent Care Reimbursement Plan** or **Pre-Tax Contribution Plan** change will be effective on the date the Plan Administrator receives a timely completed election form (other than a Change in Status due to birth, adoption or placement for adoption, in which case the change will be effective on the date of the Change in Status). Qualifying Changes in Status include, but are not limited to:

- A change in legal marital status, including marriage, death of your spouse, divorce, annulment or legal separation;
- A change in the number of your dependents, including birth, death, adoption or placement of a child for adoption;
- A change in employment status of you, your spouse or your dependent, including termination or commencement of employment, commencement or return from an unpaid leave of absence, a change in worksite or a change that affects the eligibility under the Plan or another plan;
- An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements;
- A change in the place of residence of you, your spouse or dependent;
- A significant change in cost or coverage with respect to benefits available under the Plan (other than the **Healthcare Reimbursement Plan**) or a plan available to your spouse or dependent through their employment, including an enrollment period for your spouse's plan which occurs during the Plan Year;
- A change required by a qualified medical child support order;
- Entitlement to or loss of eligibility for Medicare or Medicaid;
- A leave of absence under the Family and Medical Leave Act;
- With respect to the **Dependent Care Reimbursement Plan**, a significant increase in the cost of care imposed by a non-relative caregiver, reduction in need for child care or a change in dependent care provider; or with respect to the **Pre-Tax Contribution Plan**, you qualify for annual or special enrollment in Health Insurance Marketplace coverage, with Marketplace coverage to begin no later than the day

following the termination of your coverage under the **Ameren Employee Medical Plan**.

You may also be entitled to make the appropriate coverage change if there is a change required pursuant to a Qualified Medical Child Support Order.

The Plan Administrator has the discretionary authority to make a determination as to whether a Change in Status has occurred in accordance with the rules and regulations of the IRS. To initiate a change, log onto **www.myAmeren.com** and through "Healthcare and Life Benefits" select the 'Life Events' page, or call the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). The Plan Administrator may require documentation of a Change in Status as a condition of allowing an election change.

If you are a member of a union and participate in a work stoppage, you will be deemed to have had a Change in Status and elected to stop your contributions to your FSA(s) for the duration of the work stoppage.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself (if not currently enrolled) in the **Healthcare Reimbursement Plan** by submitting an election form to the Plan Administrator within 31 days after the marriage, birth, adoption or placement for adoption. If enrolled within the 31-day period, coverage for you and your eligible dependents in the **Healthcare Reimbursement Plan** will commence on the date of enrollment or, if earlier, the date of birth, adoption or placement for adoption. If you do not enroll yourself within the 31-day period, you will not be eligible to enroll until the next annual enrollment.

If you do not enroll in the **Healthcare Reimbursement Plan** because of other health coverage, you may in the future be able to enroll yourself after your other coverage ends. You must request this special enrollment within 31 days after your other coverage ends.

If you decline coverage under the **Healthcare Reimbursement Plan** because of other health coverage under Medicaid or a state Children's Health Insurance Program ("CHIP"), you may be able to enroll yourself in the **Healthcare Reimbursement Plan** if you lose eligibility for the other coverage. You must request enrollment in the Plan within 60 days after the Medicaid or CHIP coverage ends. Coverage under the **Healthcare Reimbursement Plan** will be effective as of the first day of the month immediately following the date the Plan Administrator receives a timely completed election form. If you do not request enrollment within this 60-day special enrollment period, you cannot enroll in the **Healthcare Reimbursement Plan** until the next Annual Enrollment Period.

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

Paid or Unpaid Leave Of Absence or Long Term Disability

Paid Leave Of Absence

During any period of leave of absence granted by your employer and during which your regular pay is continued, you are eligible to continue your participation in the **Healthcare and Dependent Care Reimbursement Plan**, and/or the **Pre-Tax Contribution Plan**. Your coverage will continue without interruption and any required contributions will continue to be deducted from your pay as usual. If you elect to discontinue coverage under the **Healthcare Reimbursement Plan** and/or **Dependent Care Reimbursement Plan** during your leave, you may not file claims for any medical and/or dependent care expenses incurred during the leave period.

Unpaid Leave of Absence

If you are on an unpaid leave of absence, you may continue to participate only in the **Healthcare Reimbursement Plan**. You are not eligible to participate in the **Dependent Care Reimbursement Plan** or **Pre-Tax Healthcare Contribution** until you return to work. A strike, lockout, and work stoppage are considered to be unpaid leaves of absence.

If you return from an unpaid leave of absence during the same Plan Year in which you participated in the **Dependent Care Reimbursement Plan** or the **Pre-Tax Healthcare Contribution Plan**, your contributions will resume unless you have changed your elections under the Change in Status rules. Your payroll deductions will be recalculated upon your return so that the total of your FSA deductions for the Plan Year will equal the amount of your annual contribution you elected during your enrollment.

If you return from an unpaid leave of absence in a new Plan Year and participated in the **Healthcare Reimbursement Plan** during your leave of absence, you must pay Healthcare contributions attributable to your coverage in the prior Plan Year on an after-tax basis. Any make-up contributions attributable to the Plan Year in which you return will be on a pre-tax basis.

Long Term Disability

If you are on long term disability, you are not eligible to participate in the **Healthcare or Dependent Care Reimbursement Plan**. If you return to work, you may make a new election to again participate in these FSA plans. If your long term disability benefit is paid by Ameren, you may continue to participate in the **Pre-tax Healthcare Contribution Plan**.

Military Leave

Uniformed Services Employment and Reemployment Act

You may continue participation in the **Healthcare Reimbursement Plan** during a military service leave of absence through the end of the current Plan Year. You must notify the Plan Administrator that you will be absent from employment due to military service unless such notice cannot be given because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You must also notify the Plan Administrator that you wish to elect continuation coverage for yourself and your eligible Dependents under the provisions of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Contributions to the continued coverage will be made with after-tax dollars.

Qualified Reservist Distribution under the Heart Act

You may request a qualified reservist distribution ("QRD") of all or a portion of the contributions you have made to your **Healthcare Reimbursement Plan** account if all the following requirements are met:

- the contributions in your account exceed the reimbursements you have already received for the Plan Year as of the date of your request;
- your military leave is going to last at least 180 days or for an indefinite period by reason of being a member of the Army National Guard, Army Reserve, Navy Reserve, Marine Corp Reserve, Air National Guard, Air Force Reserve, Coast Guard Reserve, or the Reserve Corps of the Public Health Service;
- you have provided Ameren with a copy of the order or call to active duty; and
- you elect in writing a Qualified Reservist Distribution. The election must be made during the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year during which the order or call occurred.

If all the above requirements are met, you will receive your QRD no later than sixty days after the date of your request. The amount of the QRD will be equal to your contributions to your account as of the date of the request, less any reimbursements you have already received from your account for the Plan Year. This distribution will be made without regard to whether medical, dental or vision expenses have been incurred. However any portion of the distribution that is not a reimbursement for substantiated expenses will be included in your gross income and wages.

Once you have received a QRD, you may not receive reimbursement for eligible medical, dental and/or vision expenses incurred during the Plan Year and on or after the date of your distribution request. However, you may claim reimbursement for medical care expenses incurred during the Plan Year and before the date of the distribution request, even if the claims are submitted after the date of your distribution. The dollar amount of such claims must not exceed the amount of your election under the Plan for the Plan Year, less the sum of your QRD under this provision and the reimbursements you have already received from your account for the Plan Year.

Family and Medical Leave Act of 1993

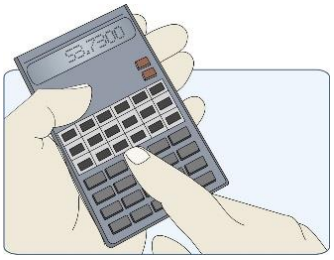
Special rules apply if your leave of absence is protected by the Family and Medical Leave Act of 1993 ("FMLA"). If you are out on FMLA leave, your participation in the Plan will continue on the same terms and conditions as though you were still an active employee. You have the option to continue your coverage(s) during your period of FMLA leave by paying your share of the contribution with after-tax dollars while on leave if the length of your leave is thirty days or greater; or, by paying your share of the contribution for the duration of the leave, on either a pre-tax salary reduction basis out of post-leave compensation or on an after-tax basis upon your return to work. If you elect not to continue your coverage(s) during your FMLA leave, you will be eligible to re-enter the Plan on the same basis as your participation in the Plan prior to your FMLA leave.

Before You Open An FSA

If you want to take advantage of FSAs, first determine how much you plan to spend on eligible expenses in a given Plan Year. Include only those expenses you expect to incur between January 1 and December 31 of the applicable year (or for the period of time you are participating in the Plan, if not a full calendar year). In estimating your expenses for the **Healthcare Reimbursement Plan**, be sure to subtract any portion of the expense that would be payable from other sources, such as medical, dental or vision coverage available from Ameren, another employer (including your spouse's employer) or insurance.

Any amounts which are payable from these other plans are not eligible for reimbursement under the **Healthcare Reimbursement Plan**. Note that if you are enrolled in the Ameren Health Savings PPO Medical Plan option, your reimbursable healthcare expenses are limited to eligible dental and vision expenses only, through a Limited Purpose Healthcare Reimbursement account.

IRS Limitations



Be realistic when you estimate your expenses. Because of the tax advantages offered by these kinds of accounts, the IRS regulates their use. These regulations, described below, are intended primarily to ensure that the accounts are used only for eligible expenses.

Money contributed to your **Healthcare Reimbursement Plan** must be used only for healthcare expenses and money contributed to your Dependent Care Reimbursement Plan must be used for only for dependent care expenses. You cannot transfer money between accounts.

Once you begin contributing to an FSA, you can't stop, increase or decrease your contributions during the year unless you have a change in status, your employment with Ameren or its affiliates ends, or you are no longer eligible to participate in the FSAs. (See Change in Status).

If you don't use all of the money you contribute to your accounts during a Plan Year for

eligible expenses incurred during that Plan Year, you must forfeit it at the end of the year. Any forfeited amounts will be used to offset the ongoing costs of administering the FSA for all participants.

You can see why it is important to accurately estimate your FSA expenses and therefore your contributions. You may want to consult a professional tax advisor for help.

When Coverage Ends

Your coverage under the Plan ends on the earliest of the following:

- the date you cease to be eligible to participate in the Plan for any reason, including termination of employment;
- the date you fail to timely pay any required premiums or contributions toward the cost of coverage;
- the date you elect to terminate such coverage, provided such election is permissible under the Plan;
- the date the Plan is terminated; or
- the date you participate in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of you or a covered dependent.

In addition, your participation in the FSAs automatically stops at the end of each Plan Year. If eligible to do so, you may re-enroll for the next year during annual enrollment.

Dependent Care Reimbursement Plan

If your participation in the **Dependent Care Reimbursement Plan** ends during the Plan Year due to your termination of employment or other Change in Status event, your contributions to this account will stop. However, you may continue to submit reimbursement claims for eligible dependent care expenses incurred during the Plan Year prior to your termination of employment or change in eligibility if you have an account balance as of the date your coverage ends. An expense is incurred when the dependent care service is provided, not when you are billed, charged or pay for the service provided. The maximum reimbursement available to you will be the amount you contributed to your account prior to the date your participation ended, less any amounts that had already been reimbursed for the Plan Year.

Healthcare Reimbursement Plan

If your participation in the **Healthcare Reimbursement Plan** ceases during the Plan Year due to your termination of employment or other Change in Status event (See Change in Status) your before-tax contributions to this account will stop and only expenses incurred during the Plan Year prior to your termination of employment may be reimbursed. An expense is incurred when the healthcare service is provided, not when you are billed, charged or pay for the service provided. The maximum reimbursement available to you will be your election amount as of January 1, or the actual election date if first eligible after January 1,

less any amounts already reimbursed. However, you may have the option of continuing your full coverage during the remainder of the Plan Year under COBRA.

Under the Pre-tax Healthcare Coverage Plan

If your employment with Ameren ends, your active participation in the **Pre-Tax Healthcare Contribution Plan** will end, and you will not be able to make any more contributions on a pre-tax basis for any benefits elected under the Plan.

Rehire

If your employment with Ameren or its affiliates ends and you are rehired more than 30 days after your employment ended or in a different Plan Year, you will be treated as a new hire and will have 31 days from the date of your Enrollment Worksheet to enroll in the **Healthcare and/or Dependent Care Reimbursement Plan**, as long as you are otherwise eligible to participate. You will be automatically enrolled under the Pre-Tax Contribution Plan if you enroll in the **Ameren Employee Medical Plan**, dental, vision or dental/vision plan, if applicable, unless you elect in writing not to participate.

If you are rehired within 30 days of your termination of employment and within the same Plan Year, and you were previously enrolled in the Plan, your elections that were in effect when you terminated employment, will continue in effect for the remainder of the Plan Year. You may not make new elections unless you experience a Change in Status.

Impact on Social Security Benefits

Your participation in the Plan may have a slight effect on your Social Security benefits. This is because you pay Social Security taxes on your earnings after your contributions are deducted. This means that your future Social Security benefits, which are based on the taxes you pay, could be reduced. You may want to consult a professional tax advisor if you have questions about this.

Nondiscrimination Requirements

The IRS imposes certain nondiscrimination requirements that are designed to ensure that employees at all pay levels benefit on an equitable basis with respect to participation in each of the FSAs. If any of these requirements are not met, Ameren may take any action necessary to ensure compliance, including reducing the amount that more highly compensated employees may contribute to their FSAs.

Your Healthcare Reimbursement Plan

As a participating employee, you can use the **Healthcare Reimbursement Plan** to reimburse yourself for any eligible healthcare expenses incurred by you and any eligible dependents, up to a maximum annual contribution amount of $2,500.

Eligible Dependents

For purposes of the **Healthcare Reimbursement Plan**, eligible dependents are limited to:

- your spouse;

- your child, stepchild, adopted child (or a child placed with you for adoption) or foster child who has not attained age 27 by the end of the calendar year;
- your unmarried child, stepchild, adopted child (or a child placed with you for adoption) or foster child over age 26 who is permanently and totally disabled, has the same principal residence as you for more than half of the tax year and does not provide for more than half of his or her own support; and
- any other child, relative or individual (including a grandchild, sibling, niece or nephew) for whom you provide more than half of his or her support and could claim as a dependent for federal income tax purposes if disregarding any income limitation used to determine whether that individual is your tax dependent.

However, a special rule applies for children of parents who are divorced or legally separated under a divorce decree or written separation agreement and live apart during the last six months of the calendar year. Such child satisfies any support and residency requirements if he or she is in the custody of one or both parent(s) for more than half of the calendar year and receives over one-half of his or her support from his or her parents.

For purposes of the **Healthcare and Dependent Care Reimbursement Plans**, "spouse" refers only to the individual to whom you are legally married by a marriage procedure which was solemnized by a person authorized to solemnize marriages. Spouse includes a same-sex spouse who is considered your married spouse for federal tax purposes. Spouse does not include an individual from whom you are legally separated under a decree of divorce or separate maintenance nor does it include, for purposes of the **Dependent Care Reimbursement Plan**, an individual who, although married to you, files a separate federal income tax return, maintains a separate residence during the last six months and does not furnish more than one-half of the cost of maintaining the principal residence of the individual for whom expenses are eligible for reimbursement under the **Dependent Care Reimbursement Plan**.

Eligible Expenses

Eligible expenses include only those eligible healthcare expenses that are not reimbursed through your medical, dental and vision coverage, whether or not you are covered under an Ameren-sponsored plan. Under the **Healthcare Reimbursement Plan**, eligible healthcare expenses incurred by you, your spouse and any eligible dependent for a wide variety of healthcare services, equipment and supplies are eligible for reimbursement.

However, if you are enrolled in the Ameren Health Savings PPO Medical Plan option, reimbursable healthcare expenses are limited to eligible dental and vision expenses only, through a Limited Purpose Healthcare Reimbursement account.

Basically, eligible healthcare expenses are those expenses incurred for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body. However, eligible healthcare expenses does not include items that are merely beneficial for the general health of an individual (i.e., vitamins, dietary supplements), toiletries and items used for cosmetic purposes (i.e., Propecia, Rogaine, moisturizers, teeth whiteners, etc.) and over-the-counter drugs or medicines (other than

insulin) that are obtained without a prescription. Premiums for accident or health coverage under any other plan or policy or long-term care services also are not eligible healthcare expenses.

Additionally, you may not be reimbursed for:

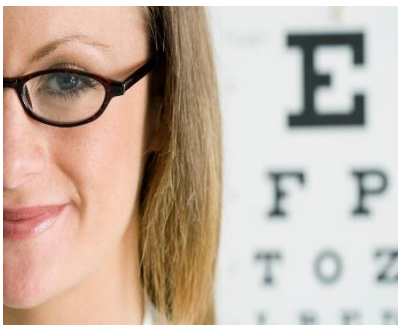
- expenses incurred prior to the date you begin participating in the **Healthcare Reimbursement Plan**;
- expenses incurred after you stop participating in the **Healthcare Reimbursement Plan** (except as provided under COBRA); or
- expenses incurred during any period for which you have not paid contributions to your Healthcare Reimbursement Plan and for which you are not obligated to pay contributions.

See Orthodontia Reimbursement Under the Healthcare Reimbursement Plan for special rules regarding orthodontia expenses.

Any expenses reimbursed through your **Healthcare Reimbursement Plan** cannot also be claimed as a deduction on your federal income tax returns. Also, you may not use your FSA for expenses that could be reimbursed under any insurance plan (See How Reimbursement Works Under the FSAs.)

Note: Employees represented by a bargaining agreement between AmerenUE and Locals 1439 and 1439 South who are eligible for benefits under the **Dental Optical Reimbursement Plan (DORP),** must exhaust benefits under the **DORP** prior to requesting reimbursement under the **Healthcare Reimbursement Plan**.

The following is a list of some of the most common eligible expenses for which you may use your **Healthcare Reimbursement Plan**:



- deductibles and co-payments for your medical plan;
- amounts over your medical plan's maximum limit;
- amounts over usual and customary charges;
- visits to a doctor or clinic;
- routine physicals;
- prescription drugs;
- immunizations/well-child care;
- over the counter medicines and drugs prescribed by a physician;
- dental care and medically necessary orthodontia;
- vision and hearing care;
- special care equipment for a disabled person;
- sterilization or vasectomy;

- nursing home (if entered for medical treatment);
- birth control pills or other prescribed birth control items;
- acupuncture;
- alcohol and substance abuse treatment;
- guide dog, excess cost of Braille books over regular editions and adapters for closed caption services;
- smoking cessation programs and prescription drugs to alleviate nicotine withdrawal;
- non-prescription nicotine gum and nicotine patches with a physician's prescription; and
- weight loss programs (weight reduction group & attendance at periodic meetings) if it is treatment of a specific disease diagnosed by your physician – i.e. obesity, hypertension or heart disease.

Ineligible Expenses

Although your **Healthcare Reimbursement Plan** will reimburse you for a wide range of healthcare expenses, there are certain kinds of expenses that are not reimbursable, even when prescribed or recommended by your doctor. For example, some ineligible expenses are:

- over-the-counter medicines and drugs not prescribed by a physician;
- vitamins, dietary supplements, toiletries and items used for cosmetic purposes (i.e., Propecia, Rogaine, moisturizers, teeth whiteners, etc.);
- travel expenses for healthcare, except for transportation costs directly related to receiving medical care;
- health club programs -- including resort hotels, gyms or steam baths for your general health;
- household help;
- illegal operations, treatments or drugs;
- dancing, swimming or other types of lessons;
- marriage counseling;
- programs for losing weight to improve one's general health or to relieve physical or mental discomfort not related to a particular diagnosed medical condition;
- items such as toothpaste, cosmetics and bottled water;
- premiums for coverage under another health plan;
- non-prescription nicotine gum and nicotine patches, unless prescribed by a physician; or
- cosmetic procedures -- such as cosmetic surgery, dental bleaching and veneers.

For more information about what items are eligible and ineligible healthcare expenses, you

can refer to IRS Publication 502 Medical and Dental Expenses; however, the publication is intended to assist taxpayers in determining which medical expenses can be deducted for federal income tax purposes, not what is reimbursable under a healthcare reimbursement plan. Due to several fundamental differences between what is deductible and what is reimbursable as medical care, some of the statements in the publication are not applicable for determining whether a healthcare expense is reimbursable from the **Healthcare Reimbursement Plan**. Also, keep in mind that tax laws, regulations and the government interpretation of them are complex and subject to change.

You should consult your attorney or professional tax advisor for tax advice when you plan to reimburse a large expense through your Healthcare Reimbursement Plan.

Your Dependent Care Reimbursement Plan

If you have dependents that require supervision, the **Dependent Care Reimbursement Plan** can help you pay for their care so you and your spouse -- if you are married -- can work, look for work, or attend school full-time. The dependent care account is an "at-work" benefit only, so it will not reimburse you for expenses you incur while involved in non-work activities. Additionally, dependents must meet special requirements in order for you to cover their care.

Contribution Limitations

Your maximum annual contribution to your Dependent Care Reimbursement Plan depends on your tax filing status:

If You Are:	Your Limit Is:
Single	$5,000
Married and your spouse earns less than $5,000	100% of your spouse's income but not more than $2,500 if you file separate returns
Married and your spouse earns more than $5,000	$5,000 if you file a joint return $2,500 if you file separate return

If your spouse is a full-time student or is disabled and has no income, he or she is deemed to have income of $250 a month if you claim expenses for one dependent, and $500 a month if you claim expenses for two or more dependents.

In any case, you may not contribute more to your **Dependent Care Reimbursement Plan** than the amount of your earned income or the earned income (or deemed earned income) of your spouse, whichever is less, subject to the minimum annual contribution amount.

Eligible Dependents

You may use your **Dependent Care Reimbursement Plan** to pay for the care of your qualifying dependents. For purposes of the **Dependent Care Reimbursement Plan**, qualifying dependents are limited to the following:

- your dependent child under age 13 whom you claim as a dependent on your federal income tax return;
- your spouse if he or she is physically or mentally incapable of self-care and has the same principal place of residence as you for more than one-half of the year; and
- a relative or any other individual who is physically or mentally incapable for self-care, has the same principal place of residence as you for more than one-half of the year, and for whom you provide over half of his or her financial support and could claim as a dependent for federal income tax purposes if disregarding the income limitation used to determine whether an individual is a tax dependent.

A relative includes a child, grandchild, sibling, niece, nephew, parent, grandparent, aunt or uncle, and in-law. Child includes your biological child, adopted child (or a child placed with you for adoption) or foster child.

In the case of a child whose parents are divorced or legally separated under a divorce decree or written separation agreement, and live apart during the last six months of the calendar year, the child is the qualifying dependent of the custodial parent.

Expenses for your same-sex spouse, and/or his or her children will not be eligible for reimbursement under your **Dependent Care Reimbursement Plan** unless they qualify as your dependents for federal income tax purposes.

At Work Requirement

In order for any dependent care expense to be eligible for reimbursement, you, and your spouse if you are married, must be at work or looking for work during the time your dependents are receiving care. If your spouse is an eligible disabled dependent or a full-time student, only expenses incurred while your spouse is disabled or in school will be reimbursed.

In addition, if you work full-time and your spouse works part-time for four hours a day, only expenses incurred during those four hours will be reimbursed.

Eligible Expenses

You may use the **Dependent Care Reimbursement Plan** to pay for care given while you and your spouse are at work, looking for work or attending school full time. Eligible expenses are the same as those eligible for a federal dependent care income tax credit. The dependent care can be provided by the following institutions and individuals:

- Day care centers, nursery schools, and summer day camps are all eligible institutions – however, the institution must comply with all applicable state and local laws and regulations;
- Dependent care may be provided in your home, by any individual including a relative, provided the care giver is not your child under age 19, or a dependent; or

- Day care centers for dependent adults who are physically or mentally incapable of self-care are eligible, provided such dependent regularly spends at least eight hours a day in your home. Custodial or residential care, such as a nursing home, is not eligible for reimbursement.

Ineligible Expenses

Dependent care does not include:

- Amounts you pay to an immediate family member under age 19, or to any person you claim as a dependent on your federal tax return;
- Cost for dependent care when your spouse is not working, unless your spouse is a full-time student, actively looking for work, or is incapable of caring for himself or herself;
- Cost for dependent care when you are not working;
- Education expenses for children in kindergarten and above;
- Charges for overnight camps;
- Charges for a convalescent or nursing home for a parent;
- Charges for any dependent care where the care provider does not have a social security or tax identification number, with the exception of religious organizations;
- Dependent care if your spouse is employed, but could provide care because his or her work hours do not coincide with yours;
- Any expenses you plan to take as a dependent care tax credit on your income tax return; and
- Any expenses incurred prior to the date you begin participating in the **Dependent Care Reimbursement Plan**.

When you file for reimbursement from your **Dependent Care Reimbursement Plan** account, you must provide the name of your dependent care provider. When you file your annual federal income tax return, you will also be required to provide this information along with their address and Social Security or taxpayer identification number. Remember, the contributions you make to this account will reduce your expenses -- dollar-for-dollar -- that are eligible for a dependent care tax credit.

You should consult your attorney or professional tax advisor on tax advice when you plan to use a **Dependent Care Reimbursement Plan**.

IRS Tax Alternatives

There are other ways to get tax benefits for healthcare and dependent care expenses. You may be entitled to:

- a federal income tax deduction for medical expenses; or
- federal and state tax credits for dependent care expenses.

Because FSA contributions and tax credits will differ in how they affect your taxes, and because tax laws are complex and subject to change, you may want to seek the advice of a professional tax advisor. The Company cannot offer you tax advice or advise you on FSA-related decisions. This is to protect you by ensuring that you always get the most up-to-date advice, and that advice is only available from a professional tax advisor.

IRS Healthcare Deduction

The IRS allows you to deduct certain medical expenses on your federal income tax return (if they were not paid through an FSA) based on a percentage of your adjusted gross income.

With the Healthcare Reimbursement Plan, you are limited to the amount you can contribute -- but you save taxes beginning with the first dollar you spend on an eligible healthcare expense.

Keep in mind that expenses reimbursed by your **Healthcare Reimbursement Plan** may not be credited toward the IRS threshold and do not qualify for the medical deduction on your federal income tax return.

IRS Dependent Care Tax Credit

The IRS currently offers a dependent care tax credit. The exact amount of your tax credit depends on your adjusted gross income.

With the **Dependent Care Reimbursement Plan**, you can set aside up to $5,000 -- depending on your tax filing status -- for any number of dependents and reduce your federal, state and Social Security tax bills on this entire amount.

You won't be able to take a tax credit for any expense you pay through your **Dependent Care Reimbursement Plan**. Any expense you pay through your account reduces the amount for which you can claim a credit, dollar for dollar. Still, for most families, the Dependent Care Reimbursement Plan usually presents a greater tax savings opportunity than the tax credit.

For further information comparing the dependent care tax credit and the **Dependent Care Reimbursement Plan,** you should consult your professional tax advisor.

How Reimbursement Works under the FSAs

You can manage your **Healthcare and Dependent Care Reimbursement Plan** Accounts - FSAs - through WageWorks online or over the phone.

Creating an Online Account

You can create and access your online **Ameren Healthcare and Dependent Care Reimbursement Plan** accounts through WageWorks' website at **www.wageworks.com**.

To register for your online account with WageWorks follow the steps below:

- Visit **www.wageworks.com**;
- Click "Login/Register";
- Select "Employee Registration"; and,
- Create a username and password.

  Note: Your ID code is the last four (4) digits of your Ameren employee number.

Your online account allows you to review your most recent FSA activity as well as:

- Updating your account preferences and personal information
- Viewing your transaction and account history
- Schedule payments to healthcare and dependent care providers
- Check the complete list of eligible expenses for your FSA program
- Order additional WageWorks Healthcare Cards for your family
- Download the EZ Receipts smartphone or mobile device app to file claims and Healthcare Card required documents.

Request for Healthcare Reimbursement Using Your WageWorks Healthcare Card

For your convenience, you will receive a debit card ("WageWorks Healthcare Card") from WageWorks, the claims administrator, loaded with your current Plan Year's funds for your **Healthcare Reimbursement Plan**. You cannot use your debit card to pay for dependent care expenses under your **Dependent Care Reimbursement Plan**. Your card can be used to pay for eligible healthcare expenses such as prescription drugs, office visit copays, and other reimbursable items at the time that you purchase them or receive the service. For example, if you pick up a prescription at a retail pharmacy, you can use your debit card for the applicable copay. Your account is immediately debited for the copay amount.

You may use your Healthcare Card instead of cash or credit at healthcare providers and pharmacies for eligible services, goods, and prescriptions. You can also use the Healthcare Card at general merchants and drug stores that have an industry standard (IIAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to **www.sigis.com** to review a list of qualified merchants, like drug stores, supermarkets, and warehouse stores, that accept the Healthcare Card. When you swip your Healthcare Card at the checkout, choose "credit" even though it isn't a credit card.
- Pay for services or purchases on the same day you receive them. If the health plan you are enrolled in covers a portion of the cost, make sure you know what amount you need to pay before using the Healthcare Card by presenting your health plan member ID card first. The provider can identify your copay or coinsurance amount and ensure the service is claimed to your healthcare, dental, or vision insurance plan.
- Save your receipts or digital copies for tax purposes. Even when your Healthcare Card is approved, a detailed receipt may still be requested to verify the reimbursement.

- If you have lost or cannot produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan or the amount of the transaction.
- If you use your Healthcare Card at an eye doctor's or dentist's office, you will most likely be asked to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to submit the requested information my result in your Healthcare Card being suspended.
- If you should lose your Healthcare Card at any time, contact WageWorks immediately and request a new Card. You are responsible for any charges incurred on the lost Healthcare Card until that loss is reported to WageWorks.

You cannot use your debit card for healthcare expenses incurred during a prior Plan Year. For example, if you have money left in your Healthcare Reimbursement account from 2018, you must submit your claims for the 2018 expenses directly to WageWorks, and not use your debit card that contains 2019 funds. You should also be careful in the last few days of the year because the provider where you use your debit card may wait to process the transaction until after the first day of the new Plan Year, thus having the expense come out of the new Plan Year's funds. These situations are considered improper card transactions under IRS rules governing these types of plans.

The debit card is a great convenience and allows you to have immediate access to your money, but IRS regulations require that all FSA debit card transactions be substantiated. It is important to save your receipts in case the IRS or WageWorks requests them. If you get a request for itemized receipts or other documents, you should promptly submit the requested items to WageWorks. Failure to submit receipts upon request is considered an improper card transaction or an overpayment under IRS rules, and you will be required to pay back the reimbursements that you were paid. If you do not respond to WageWorks' request for documentation of an outstanding transaction, it may result in your debit card being suspended.

You have several options in which to access the funds in your **Ameren Healthcare Reimbursement Plan** account.

Paying Online

You can pay many of your eligible healthcare and dependent care expenses directly from your **Ameren Healthcare and/or Dependent Care Reimbursement Plan** account with no need to submit a paper claim form. However, you must provide appropriate documentation. To pay a provider directly:

Log into your **Ameren Healthcare and/or Dependent Care Reimbursement Plan** account at **www.wageworks.com**.

- Click "Submit Receipt or Claim"
- Request "Pay My Provider" from the menu and follow the instructions
- Make sure to provide an invoice or appropriate documentation

- WageWorks will schedule the checks to be sent in accordance with the payment guidelines. You may pay for eligible recurring expenses by following the online instruction so set up automatic payments.

EZ Receipts - Using Your Smartphone or Mobile Device

With the EZ Receipts mobile app from WageWorks, you can file and manage your reimbursements claims paperwork anywhere using your smartphone or mobile device camera.

To use EZ Receipts:

- Go to **www.wageworks.com/employees/go-mobile** to learn more
- Download the app at the Apple App Store, or Google Play
- Log into your account
- Choose the type of receipt from the menu
- Enter the requested information about the claim or the Healthcare Card transaction
- Use your smartphone camera or device to capture the documentation
- Submit the image and details to WageWorks.

Filing A Claim Online

You can file a claim online to request reimbursement for your eligible healthcare expenses.

- Go to **www.wageworks.com**
- Log into your account
- Click "Submit Receipt or Claim"
- Select "Pay Me Back"
- Complete the information requested on the form and submit
- Scan or take a photo of your receipts, Explanation of Benefits (EOBs) and other supporting documentation

  (NOTE: For each claim item being submitted all documents for that claim need to be included in one photo.)
- Attach supporting documentation to your claim by using the upload utility
- Your supporting documentation must include the five (5) following pieces of information as required by the IRS:
  - Date of service or purchase
  - Detailed description of expense
  - Provider or merchant name
  - Patient name
  - Patient portion or amount owed

Most claims are processed within one to two (1 – 2) business days after they are received, and payments are sent shortly thereafter.

Filing A Paper Claim Via Fax or Mail

You can submit a paper claim by fax or mail to request reimbursement for your eligible healthcare expenses.

- Download a Healthcare Pay Me Back Claim Form
- Complete the information requested on the form and sign it
- Fax or mail the form, along with copies of your receipts, to:

  Claims Administrator
  P.O. Box 14053
  Lexington, KY, 40512
  Fax: 877-353-9236

It is important that you retain all supporting documentation of expenses submitted for reimbursement from your FSA accounts with your tax records, in the event of an IRS audit or if requested by WageWorks.

Direct Deposit

When you submit claims for reimbursement from your **Healthcare Reimbursement Plan** or your **Dependent Care Reimbursement Plan**, you can arrange to have your reimbursement deposited directly into your bank account after your claim has been reviewed and approved. When your claim has been paid, WageWorksr will send you an e-mail "notification of payment issued". Sign up with WageWorks for direct deposit reimbursements for quicker claim processing by going online at **www.wageworks.com** and click on "Profile", then "Reimbursement Method".

You can go to **www.wageworks.com** anytime to look at the details of your FSA account. Once you are logged in, you will be able to tell which of your transactions are approved and which are waiting on receipts. You can access FSA forms and also request new cards.

Orthodontia Reimbursement Under the Healthcare Reimbursement Plan

When you request reimbursement from your **Healthcare Reimbursement Plan** for orthodontia services, you will need to submit to WageWorks a copy of the orthodontia contract which shows the services, down payment, and other related coverage expenses. You will be reimbursed for approved out-of-pocket expenses based on the terms of the contract, but taking into account the amount insurance is expected to pay for the services (if any). Under your **Healthcare Reimbursement Plan** account, you will be reimbursed according to one of the following methods:

Pay with Your WageWorks Healthcare Card

You may use your Healthcare Card for eligible orthodontic expenses. It's important to save all detailed receipts and payment contracts provided by your orthodontist. In some cases

the IRS may require you to verify your Healthcare Card transactions, submit a claim, and verify expenses.

Pay Your Orthodontist Directly

You may pay your orthodontist directly from your Healthcare FSA using the "Pay My Provider" feature of your account. You may make a single payment to your orthodontist, or set up recurring payments.

Monthly Payments:

To set up monthly payments to your orthodontist, elect a recurring monthly request using the "Pay My Provider" feature through your WageWorks online account. Recurring payment requests can be made up to ten (10) days prior to when your orthodontia service begins, but not before the service begins.

Submit a copy of your orthodontia service contract to WageWorks to set up monthly recurring payments. The contract needs to include the following information:

- Provider name
- Patient name
- Description of service payment schedule, including the date of service, and the payment amount.

One-Time Payment

Once your orthodontic service has begun, you may elect a one-time payment to your orthodontist directly from your Healthcare FSA using the "Pay My Provider" feature of your account. Your provider will be paid as soon as you submit your payment documentation, usually a detailed receipt and an orthodontia service contract, and your documentation is verified.

To Pay Your Provider Directly

Request a "Pay My Provider" Payment by:

- Log into your account at **www.wageworks.com**. If you have not already set up an account, click "Register with WageWorks Now" and follow the instructions.
- Click "Submit Receipt or Claim" and select "Pay My Provider" from the menu
- Select which account to pay from and the frequency with which to pay
- Request "One-time" or "Recurring Monthly" payment
- Enter the required payment information, including service type "Orthodontia", confirm, and select "Submit Claim"
- Upload receipts to submit the appropriate invoice image from your computer
- Complete the process by submitting the receipts.

To Request "Pay Me back" Reimbursements

You may request reimbursement for the amount you paid out-of-pocket for orthodontia service provided during the current Play Year. There are three (3) ways to submit a claim:

Submit a Claim Online

Log into your **Ameren Healthcare Reimbursement Account** at **www.wageworks.com**.

- Click "Submit Receipt or Claim" and select "Pay Me Back"
- Request "Pay My Provider" from the menu and follow the instructions
- Enter the required payment information, including service type: Orthodontia, confirm, and select Submit Claim
- Upload digital copies of your invoice or receipts.

Submit A Claim By Fax or Mail

You can file a claim online to request reimbursement for your eligible orthodontia expenses.

- Go to **www.wageworks.com** and navigate to Employees > Support Center > Important Forms
- Under "Healthcare Claim Forms" download and print the "Healthcare Account Claim Form"
- Complete the information requested on the form and sign it
- Along with the appropriate documentation, such as monthly payment receipt or coupon, detailed invoice or payment contract, fax or mail the form to:

  Claims Administrator
  P.O. Box 14053
  Lexington, KY, 40512
  Fax: 877-353-9236

Submit a Claim Using Your Smartphone or Mobile Device

With the EZ Receipts mobile app from WageWorks, you can file and manage your reimbursements claims paperwork anywhere using your smartphone or mobile device camera.

To use EZ Receipts

- Go to **www.wageworks.com/employees/go-mobile** to learn more
- Download the app at the Apple App Store, or Google Play
- Log into your **Ameren Healthcare Reimbursement Plan** account
- Click on "Submit New Receipt" and then "Healthcare Claim"
- Follow the steps outlined in the app to submit your receipts and other documentation.

Reimburse Yourself for Payments You've Already Made

You may be reimbursed for eligible orthodontia expenses you've paid out-of-pocket using the "Pay Me Back" feature of your Healthcare FSA. If you paid a lump sum to your orthodontist in the prior calendar year and were reimbursed a prorated amount, the unclaimed amount

can be reimbursed in the current Play Year, if you are still receiving orthodontia services, by providing a copy of the payment information, claim form, and a letter indicating the amount you were reimbursed in the prior year.

In call cases, in order to be eligible for the reimbursement of orthodontia, you must be enrolled in the **Healthcare Reimbursement Plan** in the year the orthodontic treatment begins. To continue receiving reimbursement, you must continue to enroll in the **Healthcare Reimbursement Plan** in subsequent treatment years. For example, if your treatment begins in January 2018 and you are enrolled in the **Healthcare Reimbursement Plan** for 2018, you would be eligible for reimbursement of eligible orthodontic expenses incurred through December 2018. To continue receiving reimbursements in 2019, you will need to re-enroll in the **Healthcare Reimbursement Plan** for 2019.

If your orthodontia treatment began before you were enrolled in the **Healthcare Reimbursement Plan**, and you paid the dentist in full by taking out a loan from a financial institution or charging the expense on a credit card, you cannot claim that expense under your current **Healthcare Reimbursement Plan**. The treatment began prior to your coverage, and you paid the provider in full at the time services began. You cannot be reimbursed for payments you are making for orthodontia treatments unless you are making them directly to the dentist.

When You Are Reimbursed

You may submit claims for either Reimbursement Account Plan until March 31 after the close of the Plan Year in which the expenses were incurred.

Claims may be submitted as long as the expense was incurred during the Plan Year that just ended and while you were enrolled in the applicable FSA. An expense is incurred when the healthcare or dependent care service is provided, not when you are billed, charged or pay for the service provided. After you have incurred an expense, you will be reimbursed from the appropriate account in the following manner:

- When you submit a claim for reimbursement from your **Healthcare Reimbursement Plan**, you will be reimbursed for the amount of the claim up to the full unused amount of the annual contribution that you elected.
- When you submit a claim for reimbursement from your **Dependent Care Reimbursement Plan**, your reimbursement will depend on the value of your account at the time of the claim:
  - If your claim is for less than the balance of your Dependent Care account, you will be reimbursed for the full amount of the expense.
  - If your claim is for more than the current balance of your Dependent Care account, you will be reimbursed up to the amount currently in your account. You will be reimbursed automatically for the remainder of your claim (up to your full annual contribution) as more money is credited to your account during the Plan Year.

Direct Deposits: All payments made directly to your bank account can take up to three (3) or more business days from the date payment is made. You should verify that the funds have been deposited in your bank account before spending these funds. WageWorks is not responsible for overdraft fees associated with rejected deposits, deposits accepted into closed accounts or similar personal matters.

Paper Checks: You may request reimbursement in the form of a paper checks for claims.

Keeping Track of Your Account

During the fourth quarter of each Plan Year you will receive a balance email reminder from WageWorks to review your account for any remaining funds that need to be claimed. You may also download a statement from your online account at anytime to view:

- year-to-date contributions; and
- year-to-date payments made to reimburse you.

No interest is paid on the amounts credited to your accounts.

Claims Procedures and Appeals

The claims and appeals procedures described in this section apply only to benefits under the **Healthcare Reimbursement Plan**.

Claim Determinations

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

All claims must be received by the claims administrator within one year after the end of the year in which the expense is incurred. For example, all expenses incurred during 2018 must be received by the claims administrator by December 31, 2019. No benefits are payable for claims filed after the deadline.

If Your Claim Is Denied

Notification of Denial

If your claim is partly or entirely denied, you will receive a written notice from the claims administrator. The notice of denial will contain the following information: the specific reason(s) for the denial; a reference to the specific provision(s) in the **Healthcare Reimbursement Plan** on which the denial is based; a description of additional material or

information necessary to perfect the claim and an explanation of why the material or information is needed; and an explanation of the procedure to appeal the denial.

Right to Appeal

If your claim for benefits under the **Healthcare Reimbursement Plan** has been denied, in whole or in part, you or any person you authorize to represent you, may appeal the denial of healthcare reimbursement benefits by submitting a written appeal setting forth the basis for your claim to the claims administrator at the following address:

WageWorks Claims Appeal Board
PO Box 991
Mequon, WI 53092
Appeal Fax: 877.220.3248

You should include with your request for review any comments, documents, records or other information you would like to have considered.

Deadline for Filing Appeal

Your appeal must be submitted to the claims administrator in writing within 180 days after receipt of the notice of denial. Failure to file an appeal within the 180-day period shall constitute a waiver of your right to appeal the denial. During the appeal process, you will have the opportunity to submit written comments, documents, records and other information relating to your claim, whether or not this information was submitted or considered in the initial benefit determination. Additionally, you will be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.

Decision on Appeal

A decision on the appeal will be made by the claims administrator within 60 days after receipt of your written appeal.

Notification of Determination on Appeal

You will be advised of the determination on the appeal in writing, stating the specific reason(s) for the decision and the specific reference(s) to the Plan provision(s) on which the decision is based. The decision of the claims administrator on appeal shall be final and binding.

If your claim appeal is denied, in whole or in part, and you do not agree with the final determination, you have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974. For a description of additional rights and protections to which you may be entitled, see ERISA INFORMATION.

Legal Action

When claiming a benefit under the Plan, you must follow the procedures described in this section of this booklet. If your claim is not paid to your satisfaction, you have the right to 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, 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.

COBRA Continuation

This Section Applies to Healthcare Reimbursement Plan Participants Only.

COBRA continuation coverage is a temporary extension of coverage under the **Healthcare Reimbursement 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. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

COBRA coverage consists of the **Healthcare Reimbursement Plan** coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan Year. The maximum COBRA coverage period ends on the last day of the Plan Year in which the qualifying event occurs. Qualified beneficiaries may not enroll in the **Healthcare Reimbursement Plan** at annual enrollment.

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

Employees

A covered employee will become a qualified beneficiary if coverage is lost under the **Healthcare Reimbursement Plan** because of one of the following qualifying events:

- Employee's termination of employment (except for gross misconduct).
- Employee's layoff or reduction in hours of employment, resulting in loss of coverage.

Spouses

A covered spouse of a covered employee will become a qualified beneficiary if coverage is lost under the **Healthcare Reimbursement Plan** because of any of the following qualifying events:

- The death of the covered employee.
- Termination of the covered employee's employment, other than for gross misconduct; or reduction in the covered employee's hours of employment.
- Divorce or legal separation from the covered employee.

Dependent Children

Your covered dependent child will become a qualified beneficiary if he or she loses coverage under the **Healthcare Reimbursement Plan** because of any of the following Qualifying Events:

- The death of the covered employee.
- Termination of the covered employee's employment, other than for gross misconduct; or reduction in the covered employee's hours of employment.
- Divorce or legal separation of the covered employee.
- Your dependent child ceases to satisfy the Plan Sponsor's eligibility rules for dependent status.

When is COBRA Coverage Available?

COBRA coverage under the **Healthcare Reimbursement Plan** is available only to qualified beneficiaries losing coverage who have underspent accounts. An account is underspent if the annual limit elected by a covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of premiums for Healthcare Reimbursement COBRA coverage that will be charged for the remainder of the Plan Year.

Notification and Election Requirements

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the qualifying event is the termination of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event. When the qualifying event is a divorce, legal separation, or a child losing Dependent status under the **Healthcare Reimbursement Plan**, each covered individual is responsible for notifying the Plan Administrator within sixty (60) days of the qualifying event. Notice must be provided through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights.

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

Termination of Coverage

Under federal law and under this Plan, COBRA continuation coverage will end on the first of the following dates:

- The date the Plan Sponsor terminates all group health plans.
- The end of the month in which a required premium or contribution is due and not paid on time.
- The last day of the Plan Year in which the qualifying event occurred.

Address Changes

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

Continuation of Coverage under the Trade Act of 1974

Special COBRA rights apply to Employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Participants (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Healthcare 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 COBRA continuation coverage rights under the Healthcare Reimbursement Plan should be directed 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).

Miscellaneous

Definitions of "Ameren" and "Company"

For purposes of this Plan, "Ameren" means Ameren Corporation and its subsidiaries. "Company" means Ameren Services Company, as agent for Ameren Corporation and its subsidiaries or any successor or successors.

Collective Bargaining Agreements

Benefits provided under the plans with respect to participants who are covered by a collective bargaining agreement are subject to the terms and conditions of the relevant provisions of such agreements. A copy of the appropriate collective bargaining agreement is available for inspection from the Plan Administrator upon request.

Plan Administration

The Administrative Committee has the authority to administer the Plan on a day-to-day basis. Except where the Administrative Committee has delegated the final discretionary authority for adjudicating claims to a claims administrator or other entity, the Administrative Committee has discretionary authority to construe and interpret the Plan, grant or deny benefits, construe any ambiguous provision of the Plan, correct any defect, supply any omission or reconcile any inconsistency in such manner and to such extent as the Administrative Committee in its sole and absolute discretion may determine, and to decide all questions of eligibility and to make all determinations as to the right of any person to a benefit.

To the extent the Administrative Committee has delegated such final and binding discretionary authority to a claims administrator or other person, entity, or group, the determination of such claims administrator or other person, entity or group, shall be final and binding, unless otherwise required by law.

In a review of any decision of the Claims Administrator or other person, entity or group to which the Administrative Committee has delegated final and binding discretionary authority, such Claims Administrator, person, entity or group shall be deemed to have exercised its discretion properly unless it is proved duly that such action was arbitrary and capricious.

No Contract of Employment

No provision in this document is intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Plan Sponsor to the effect that you will be employed for any specific period of time.

Plan Amendment or Termination

The Plan Sponsor hopes and expects to continue the **Ameren Cafeteria Plan** and each of its component plans in the years ahead but cannot guarantee to do so. Ameren Corporation, and any successor corporation which assumes the responsibilities of Ameren Corporation under the Plan, may amend or terminate the Plan or any benefit provided under the Plan from time to time or at any time, without advance notice thereof. Ameren Corporation, Ameren Services Company (as agent for Ameren Corporation), an officer of Ameren Corporation or Ameren Services Company, or such officer's delegate may effect an amendment or termination of the Plan or a benefit provided under the Plan by written instruments describing the terms of such amendment or termination. Such amendment will be incorporated into this document.

The Administrative Committee may also amend the Plan through the issuance of revised benefit program booklets, SPDs, 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.

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.

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 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.

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.

Your Rights Under ERISA

As a participant in the **Ameren Healthcare Reimbursement Plan**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Healthcare Reimbursement 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and the updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue healthcare coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description and the documents governing the plans on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon those who are responsible for the operation of the employee benefit Plan. Those who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (welfare) benefit or exercising your rights under ERISA

If your claim for a (welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy

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

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

The **Healthcare Reimbursement Plan** is permitted to use and disclose your protected health information without your consent or authorization, as necessary, to carry out its Plan functions and duties. For example, the **Healthcare Reimbursement 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 **Healthcare Reimbursement Plan** may use your protected health information and disclose it to third parties.

The use of protected health information by the **Healthcare Reimbursement Plan** shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et. seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

WAGEWORKS CALLER VERIFICATION POLICY

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

To authorize an individual with whom WageWorks can discuss your Healthcare Reimbursement account, go online to www.wageworks.com to the Form and Eligible Expenses, download the **HIPAA Authorization Form**, complete the requested information and submit to WageWorks.

The policy requires that the person requesting information must provide WageWorks with some of the following information:

- The last four digits of the Member's Employee Number
- Address
- Employer's Name
- Recent transactions

General Plan Information

Plan Name:	Ameren Cafeteria Plan, which consists of the following three components: the Ameren Pre-Tax Contribution Plan, the Ameren Healthcare Reimbursement Plan and the Ameren Dependent Care Reimbursement Plan, is a component of the Ameren Miscellaneous Healthcare and Fringe Benefit Plan.
Type of Plan:	The Ameren Cafeteria Plan is intended to constitute a Section 125 Plan under the Internal Revenue Code. Only the Ameren Healthcare Reimbursement Plan is an employee welfare benefit plan subject to the provisions of ERISA.
Plan Year:	January 1 through December 31
Plan Number:	503
Funding Medium and Type of Plan Administration:	All reimbursements paid under the Ameren Healthcare Reimbursement Plan and Ameren Dependent Care Reimbursement Plan are paid from general assets of Ameren and its participating affiliates. Plan Sponsor has a contract with Fidelity and WageWorks ("Claims Administrator") to process claims under the Ameren Healthcare Reimbursement Plan and Ameren Dependent Care Reimbursement Plan. Claims Administrator does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to the Claims Administrator. It processes the claims, then requests and receives funds from Ameren to pay the claims.
Plan Sponsor:	Ameren Corporation 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.ameren (877.769.2637)
Plan Sponsor's Employer Identification Number:	43-1723446

Plan Administrator:	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.ameren (877.769.2637)
Claims Administrator:	WageWorks, Inc. 1100 Park Place 4th Floor San Mateo, CA 94403 1.650.577.5200
COBRA Administrator:	Ameren Benefits Center PO Box 199434 Dallas, TX 75219-9434 1.877.769.2637 www.myameren.com
Agent for Service of Legal Process (Service of Legal Process may also be made upon the Plan Administrator):	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)