A Plan Designed to Provide Security for Employees of

Ameren Employee Assistance Program

for

Regular Full-time and Regular Part-time Ameren Employees

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

Ameren Employee Assistance Program
Table of Contents

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 Services maintains **www.myAmeren.com** where active and retired 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, a password is required to view your 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 don't 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**).

Ameren Employee Assistance Program

Introduction

The **Ameren Employee Assistance Program (EAP)** is designed to provide problem assessment and Brief Counseling on a confidential basis to help you and your Family Members with a wide range of personal problems, and also provide tools and resources to balance both work and home responsibilities by:

- Providing the opportunity to talk to a professional counselor about your concerns –e.g., parenting concerns, marriage and family distress, alcohol and drug misuse, stress related to financial and legal problems, emotional stress, conflicts at work or home, life crises, and other personal problems.

- Serving as your resource for finding appropriate community services, including financial services, legal services, community referral resources, and mental health/chemical dependency care that is convenient, affordable and confidential.

Eligibility

You are eligible for coverage under the **Ameren Employee Assistance Program** if you are an active regular, full-time or part-time Employee of Ameren. There is no waiting period for the coverage under this program.

Your Family Members are also eligible for benefits under the program.

Enrollment

You are automatically enrolled in the **Ameren Employee Assistance Program** upon meeting the eligibility requirements outlined above.

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.

Ameren means Ameren Corporation and its subsidiaries.

Brief Counseling means a problem-focused form of individual or family outpatient counseling that (a) seeks resolution of problems in living (e.g., parenting concerns, emotional stress, marital and family distress, alcohol- and drug-related problems, legal, or financial) rather than basic character change; (b) emphasizes counselee skills, strengths and resources; (c) involves setting and maintaining realistic goals that are achievable in a one to five month period; (d) encourages counselees to practice behavior outside the counseling session to promote therapeutic goals; and (e) in which the counselor provides structure, interprets behavior, offers suggestions, and assigns "homework" activities.

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

Covered Dependent means a dependent child or spouse who lives with a Covered Employee.

Covered Employee means an Employee who meets the Plan's eligibility requirements set forth in this Summary Plan Description.

Covered Person means a Covered Employee or covered household/family member, whose coverage under the Plan became effective and has not terminated.

EAP means Employee Assistance Program.

Employee generally means any person who is classified by Ameren as a regular 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.

Family Members means Covered Dependents, covered Spouse, and covered household members. However, there is limited coverage for covered household members under COBRA continuation – (see COBRA Continuation).

Plan Administrator means the Administrative Committee, or its delegate.

Plan Sponsor means the same as "Company".

Spouse means a person to whom the Employee is currently married by a marriage procedure which was solemnized by a person authorized by law to solemnize marriages. Spouse includes a same-sex spouse who is considered your married Spouse for federal tax purposes pursuant to applicable 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 Employee is not currently married.

Cost

The Company pays the full cost of your coverage.

Additionally, there are no copayments, coinsurance or deductibles applicable to the benefits provided under the **Ameren Employee Assistance Program**. However, if you and the Magellan Healthcare counselor decide additional services not covered by this program are necessary, and you are enrolled in the **Ameren Employee Medical Plan**, you should contact Anthem Blue Cross Blue Shield at **844.344.7410** to find out how claims for benefits will be processed under your medical plan.

Covered Services

Magellan Healthcare, Inc. ("Magellan Healthcare") administers your program.

EAP Counseling

You can call the EAP at any time at **800.289.1109** to arrange for a confidential consultation. When you call, an EAP consultant answers the phone and, after talking with you to clarify the problem, arranges for appropriate assistance:

- If you request in-person counseling with an EAP counselor or if the EAP consultant recommends in-person counseling, you will be offered an in-person appointment with an EAP counselor within three (3) to seven (7) business days of your call.

- Depending upon the specific issue, telephonic EAP counseling of up to six (6) thirty (30) minute sessions per issue are available. Telephonic EAP counseling sessions do not count against the six (6) in-person counseling sessions.

- For immediate issues, the EAP consultant facilitates on-the-spot assistance. If necessary, arrangements will be made for an in-person appointment with an EAP counselor within 24 hours.

- In a crisis, you are referred immediately to a treatment provider in the community.

In addition to the initial telephone conversation, each Covered Person can have up to six (6) free in-person counseling sessions per year, as clinically appropriate, with a licensed clinician for each unique problem. The EAP counselor helps you evaluate and work through your problem.

Your assigned EAP counselor will assist you in the resolution of personal problems. For most problems, a plan of action can be developed in 3 – 4 sessions and the problem is resolved within the six (6) free sessions. However, sometimes the plan may involve referral to a resource outside of the EAP – when a specialized resource, longer term assistance, or hospitalization is needed. In such cases, you may be referred out of the EAP after 1 or 2 sessions.

Telehealth

Telehealth is a convenient and confidential service that provides online virtual appointments with a counselor at no cost to you. If you have a smartphone or a computer with a webcam and high-speed internet access, Telehealth allows you to meet with a counselor via teleconference in the privacy of your own home, car or office for a real-time, two-way conversation.

Counselors who provide Telehealth accessibility are typically available for appointments sooner than face-to-face appointments with a counselor. Many times, counselors who provide Telehealth services are available evenings and on weekends, enabling you or your family to arrange an appointment at time that works for your schedule.

Telehealth appointments count toward the six (6) free in-person EAP counseling sessions per year as described above.

To take advantage of the Telehealth services:

- Visit MagellanHealth.com/member.
- If prompted, register or enter as a guest.

- Click on "Providers";
- Go to provider search;
- Select "Choose a Provider List"; then
- "Select Telehealth".

When using the Provider Search tool, a Telehealth icon by provider names listed under specialties indicate if they accept Telehealth appointments.

- Complete the online Employee Assistance Program referral form and call the provider to schedule an appointment.

OR

- Call the EAP at any time at **800.289.1109**, and ask to be referred to an EAP provider who provides Telehealth services.

Web-Based Confidential Care

You have access to Web-based confidential programs to help you or your family members receive the support you need, when you need it and in a way that is most comfortable to you. You can access this Web-based confidential assistance by visiting MagellanHealth.com/member.

This Web-based assistance, called cognitive behavioral therapy, is organized into interactive programs that address the following areas of emotional health:

***Feeling Depressed* -** This is a four (4) -session program for mild to moderate depression that helps you identify signs and symptoms of depression, challenge negative thoughts, manage relapse and schedule pleasant activities.

***Struggling with Substance Use* -** This is a nine (9)-week program for individuals suffering from alcohol, substance use and depression that helps by promoting long-lasting, skill-based changes in behavior and thinking.

***Dealing with Anxiety* -** This is a nine (9)-step program for anxiety, panic and phobias. The program provides explanations of the body's reaction to anxiety, and personal examples of individuals on the road to recovery.

***Trouble Sleeping* -** This is a six (6)-week program for sleep problems and insomnia. The program provides videos on how to get a better night's sleep, as well as tools to measure sleep time and improve sleep.

***Struggling with Obsessive Compulsive Disorder (OCD)* -** A 9-session program for obsessive compulsive disorder. The program provides interactive videos and user success stories that make the exercises easy to follow.

Focused on You Choice and Coordination

These programs provide a choice, when appropriate, to accessing support. You may be more comfortable moving through the online program in a self-guided, self-paced way. You can even work with your care provider to use these programs before, along-side or after working face-to-face with a care provider.

Anytime, Anywhere

The programs can be accessed any time, day or night from anywhere with internet access on a device with a seven inch screen or larger.

Feeling Better, Being Better

Online cognitive behavioral therapy programs use clinical techniques that have been proven to help individuals attain new skills that enhance outcomes and resiliency for the long run.

Work-Life Services

Magellan will assist you in finding the right services, resources and practical solutions that work for you. Whether it's finding child or elder care resources, locating summer camps or college information, to utilizing pre-negotiated discounts on over 3,500,000 products and services, your Work-Life services are here for you.

Your program provides legal and financial consultation services to you and your family. Your legal and financial benefits can help with numerous types of issues. Just call 800-289-1109 for assistance.

You can talk with an attorney to discuss your legal concerns. You may choose to have a phone or in-person consultation with a local attorney. Either way, the initial 60 minute session is provided at no cost to you.

Exclusions: This program does not include advice on issues regarding your program, its Employees, providers or attorneys. It does not cover matters relating to your job or business concerns. This program does not provide advice on any matter that is frivolous, harassing, or otherwise would be a violation of ethical rules. This program covers only one free initial in-person consultation per separate subject per year.

If you need additional legal assistance, you may retain an attorney from this program at a discounted rate. The program's professionals will provide services at a 25% discount of their usual fees. You always have the option to find your own attorney.

You can be connected with a financial expert for a telephone consultation through your program. You may speak with someone right away, or a financial counselor will call you back Phone consultations are at no cost to you and are completed in 60 minutes. Identity Theft assistance provides a variety of support services to guide members through fraud-related emergencies. Call 800-289-1109 to access the following interactive online tools including:

- Member Discount Center with pre-negotiated work-life related discounts and extreme deals
- Thousands of resources including online articles, published guides, interactive webinars, podcasts and more
- Advanced search features to locate helpful information on community resources

Non-Covered Services

The EAP provides only assessment, Brief Counseling, referral to treatment providers for long-term or specialized treatment, and follow-up on referrals. The following list of services is not provided by the EAP Plan. This list includes, but is not limited to:

- Evaluations required by any state or federal judicial officer or other governmental official or agency mandating that a participant undergo counseling;
- Court-mandated counseling; evaluations or recommendations to be used in child custody proceedings, child abuse proceedings, criminal proceedings, workers' compensation proceedings, or any legal actions of any kind;
- Evaluations for fitness for duty determinations or excuses for leaves of absence or time off;
- Medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis);
- Inpatient treatment;
- Services by providers who are not part of Magellan's EAP Counselor network;
- EAP sessions for which the participant did not open a case with Magellan;
- Group counseling sessions;
- Psychological, psychiatric, neurological, educational, or IQ testing;
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skill disorders, language disorders, mental retardation, motor skill disorders, or communication disorders; behavioral training; cognitive rehabilitation;
- Medication or medication management;
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), or obtaining any kind of insurance coverage;
- Testimony in legal proceedings or creation of records for legal proceedings or other preparation for legal proceedings;
- Guidance on workplace issues when the participant sues, or threatens to sue, Ameren;
- Acupuncture;
- Biofeedback or hypnotherapy.

Termination of Benefits

Employees

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

- The end of the month of your termination of employment;
- The end of the month prior to your date of retirement;
- Date of your death;
- The end of the month of transfer to an Employee group not covered by the Plan;
- The date the Plan terminates;
- Date the Company amends the Plan to eliminate coverage for the class of eligible individuals to which you are a member;

- The date of expiration of the Labor Agreement, for Employees represented by a collective bargaining agreement.

Dependents

Coverage for your eligible Family Members under this Plan will end on the earliest of the following dates:

- The date your coverage ends;
- Except for divorce or legal separation, the end of the month in which your Dependent(s) is no longer eligible;
- In the case of a Covered Spouse, the date of divorce;
- In the case of a Covered Spouse, the date of legal separation;
- The end of the month in which your dependent(s) are no longer eligible as covered Family Members;
- Date of death of the Dependent;
- The date the Plan terminates.

If an individual's coverage is terminated, all rights to receive benefits under this Plan will end as of the date of the individual's termination of coverage. However, you and your covered Family Members may be eligible for up to the six (6) counseling sessions for an identified problem, as clinically appropriate, if you or your covered family member has scheduled an appointment with an EAP counselor for that specific problem prior to the last date of eligibility as specified above.

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

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Depending on the type of qualifying event, you, your Covered spouse and Covered Dependent children may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

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

Ameren has partnered with Conduent as the COBRA administrator. Members enrolled in COBRA benefits can obtain information regarding their COBRA benefits through "Healthcare and Life Benefits" at **www.myAmeren.com** or by accessing it directly at **www.benefitsweb.com/ameren.html**. COBRA participants can also check on the status of their account by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). **Ameren Benefits Center** customer service representatives are available Monday through

Friday, from 8:00 a.m. to 6:00 p.m. Central Standard Time (CST). The website also allows COBRA participants the ability to update addresses, print forms to add or drop dependents due to a qualifying status change, or update dependent information.

Employees

A Covered Employee will become a qualified beneficiary if coverage is lost under the Plan because of one of the following qualifying events:

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

Spouses

A Covered spouse of a Covered Employee will become a qualified beneficiary if coverage is lost under the Plan because of any of the following qualifying events:

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

Dependent Children

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

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

Newborn or Adopted Children

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

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

Special Enrollment Rules for Qualified Beneficiaries

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

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

Alternate Recipients under Qualified Medical Child Support Orders

A child of a Covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order received by the Plan Administrator during the Covered Employee's period of employment is entitled to the same rights under COBRA as a Covered Dependent child of the Covered Employee, regardless of whether that child would otherwise be considered a Dependent.

Length of Coverage

A Qualified Beneficiary's coverage may continue under COBRA as follows:

- Coverage for the Covered Employee and Dependent(s) may be continued for up to eighteen (18) months, if coverage is terminated due to the Covered Employee's:

  (1) termination of employment, other than for gross misconduct; or
  (2) reduced work hours.

  The eighteen (18) month period of continuation coverage may be extended for up to an additional eleven (11) months if a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. If the disabled individual has non-disabled family members who are also receiving COBRA continuation coverage, the non-disabled qualified beneficiaries are also entitled to extend their COBRA continuation coverage from eighteen (18) to twenty-nine (29) months. The required contribution for the eleven (11) month extension may be increased, up to one hundred fifty percent (150%) of the cost of the Plan Sponsor's cost of providing coverage under the Plan for "similarly situated" covered individuals. However, if the disabled qualified beneficiary does not continue coverage, then any other qualified beneficiary continuing coverage due to the disability may be charged up to only 102% of the cost for the extended period of coverage.

  Each Covered Employee and each Covered Dependent has the responsibility to inform the Plan Sponsor of a Social Security Administration disability determination. Proof of disability must be provided within sixty (60) days from the date the Social Security Administration makes the determination and within the initial eighteen (18) month period of continuation coverage.

  If, during the initial eighteen (18) month period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines that the qualified beneficiary is no longer disabled after the initial eighteen (18) month period,

the period of continuation coverage ends the first (1st) day of the month that begins more than thirty (30) days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed twenty-nine (29) months.

- Coverage for Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:

  (1) the Covered Employee's death;

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

  (3) a dependent child's ceasing to satisfy rules for Dependent status.

- If the qualifying event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement.

- If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, a Covered spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the Covered spouse and any Dependent children receiving continuation coverage if the Covered Employee or former Covered Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Covered Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Notification and Election Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the termination of employment or reduction of hours of employment, or death of the Employee, the Employer must notify the Plan Administrator of the qualifying event. When the qualifying event is a divorce, legal separation, or a child losing Dependent status under the Plan, each Member has a responsibility to notify the Plan Administrator within sixty (60) days of the qualifying event. Notice must be provided 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 notification of a qualifying event to the Plan Administrator within sixty (60) days will result in the loss of continuation coverage rights.

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

If You Have Questions

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

Address Changes

In order to protect your rights, you should keep the Plan Administrator informed of any address changes, either by going on-line 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 Covered Dependents (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 EAP or group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

In compliance with the provisions of the Family Medical Leave Act (FMLA), coverage under the Plan for a Covered Employee and his/her Covered Dependents may be continued during a period of leave under the FMLA just as if the Covered Employee were actively employed. In the case of a paid FMLA leave, any required contributions for coverage during the leave period will continue to be deducted from the Covered Employee's pay. If the FMLA leave is unpaid, the Plan Administrator will provide the Covered Employee with one or more of the following methods to pay any required contributions: (1) pay the contribution amounts that will be due during the leave period before the commencement of the FMLA leave; (2) make regular periodic payments during the period of FMLA leave; or (3) upon return from the leave, pay the amounts advanced by the Company for the cost of any coverage maintained during the leave. The Plan Administrator will also make available any payment methods available to individuals on non-FMLA leaves of absence.

The Covered Employee's and his/her Dependents' coverage under the FMLA will cease due to the nonpayment of any required contributions or once the Plan or Plan Sponsor is notified or otherwise determines that the Covered Employee has terminated employment, exhausted FMLA leave entitlement, or does not intend to return from leave.

If the Covered Employee does not return to active employment with Ameren after his/her FMLA leave has expired or if the Plan Administrator is notified or otherwise determines that the

Covered Employee is not returning to employment, coverage under the Plan may only be continued under COBRA (See COBRA CONTINUATION section of this booklet). The period of coverage during FMLA leave will not be counted toward the maximum number of months of coverage permitted under COBRA.

If the Covered Employee fails to return to active employment with Ameren following his/her FMLA leave, the Plan may recover any premiums it paid on behalf of the Covered Employee and his/her Dependents during the period of FMLA leave, unless the Covered Employee's failure to return was based upon the continuation, recurrence, or onset of a serious health condition of the Covered Employee or his or her family member, or a serious injury or illness of a family member in the military, which would otherwise qualify the Covered Employee for leave under the FMLA.

If coverage under the Plan was terminated during the Covered Employee's FMLA leave or the Covered Employee elected not to continue coverage, coverage under the Plan will be reinstated on the date the Covered Employee returns to active employment with Ameren, provided the Covered Employee (1) returns to active employment immediately upon expiration of his or her FMLA leave, (2) re-enrolls for coverage within 30 days of the Covered Employee's return to active employment, and (3) makes the required contribution.

Continuation of Coverage Under the Uniformed Services Employment & Re-Employment Rights Act of 1994 (USERRA)

In the event a Covered Employee is absent from employment for military service, USERRA affords the Covered Employee the right to elect continuous health coverage for the Covered Employee and his/her Covered Dependents for up to twenty-four (24) months or the period of military service, whichever period is shorter. The period of military service begins on the date the Covered Employee's absence begins from employment due to military service, including Reserve and National Guard Duty, and ends upon the Employee's return to active employment with the Company or upon the Employee's failure to return for service or failure to apply for a position of reemployment as provided in the USERRA regulations.

A Covered Employee may be required to pay a portion of the cost of his/her benefits. If your military service is less than thirty-one (31) consecutive days, your healthcare coverage continues as if you remained employed, and you will be required to pay only your normal share of the premium for this period of coverage. If your military service is 31 days or more, your healthcare coverage under the Plan will terminate on the last day of the month coincident with or next following 31 days of military service. However, you may elect to continue healthcare coverage for yourself and your Covered Dependents by paying the required premiums. You will be required to pay up to one hundred two percent (102%) of the full premium for your own coverage. Dependents will be required to pay the normal Employee share of the premium for the first twelve (12) months of continuation. After the first twelve (12) months, Covered Dependents will also be required to pay up to one hundred two percent (102%) of the full premium for coverage.

If the Covered Employee elects to have coverage under the Plan reinstated upon reemployment, no exclusions or waiting periods will be applied. The only exception to USERRA's prohibition of exclusions is for an illness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during performance of military service. If the Covered Employee returns to active employment during the same Plan Year in which he/she left, eligible charges the Covered Employee had accumulated towards satisfying

deductibles and out-of-pocket maximums will be taken into account in determining benefits for that Plan Year.

A Covered Employee must notify the Plan Administrator that he/she will be absent from employment due to military service unless the Covered Employee cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. A Covered Employee must also notify the Plan Administrator that he/she wishes to elect continuation coverage for himself/herself and his/her Covered Dependents under the provisions of USERRA.

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

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the **Ameren Benefits Center** by calling 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).

Complaints

If you have a complaint or a dispute regarding any service provided by Magellan Healthcare, you may call **800.201.3957** or send a letter to:

Manager, Appeals and Complaints Department
Magellan Healthcare, Inc.
P.O. Box 2128
Maryland Heights MO 63043

If possible, Magellan Healthcare will respond to your inquiry immediately. Magellan Healthcare will offer you a resolution, explaining the reasons for the resolution, within thirty (30) calendar days following receipt of your complaint. If you are not satisfied with Magellan Healthcare's response, you may file an administrative appeal by contacting Magellan's Appeals and Complaints Department. Magellan Healthcare will offer you a resolution, explaining the reasons for the resolution, within thirty (30) calendar days following receipt of your appeal request. If your appeal is of an urgent nature, Magellan Healthcare will conduct an expedited review and provide you with a written statement of Magellan Healthcare's resolution within three (3) business days of receipt of the appeal request.

Claim and Appeal Procedures for Eligibility

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

All claims related to eligibility must be submitted to:

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

All appeals related to eligibility must be submitted to:

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

Responding to Your Eligibility Claim

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

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

If Your Eligibility Claim Is Denied

If your claim is denied, in whole or in part, the Plan Administrator will send you a written notice of its decision, which will include:

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

Appealing Your Eligibility Claim

If your claim for eligibility under the Plan is denied in whole or in part, and you do not agree with the decision of the Plan Administrator, you will have sixty (60) days following the receipt of the denial notice to file a written appeal with the Plan Administrator. The following procedures will apply in considering your appeal.

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

The Plan Administrator will notify you, in writing, of its decision of your appeal within a reasonable period of time, but no later than 60 days after its receipt of your appeal request. If the Appeals Reviewer determines that an extension of time for processing the claim is needed, it will notify you of the reasons for the extension and the extended due date before the end of the sixty (60)-day period.

If Your Eligibility Appeal Is Denied

If your appeal is denied, you will receive written notice of the decision, including the following information:

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

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

Deadline for Taking Legal Action

If your benefit or 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 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.

Miscellaneous Provisions

Plan Administration

The Administrative Committee 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, insurance company, 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, insurance company or other person, entity, or group, the determination of such claims administrator, insurance company, 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.

Amendment or Termination of the Plan

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

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

Waiver

The failure of Contract 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.

Applicability

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

Nontransferable Benefits

No person other than the Covered Employee, Covered Dependent, and covered family/household member is entitled to receive coverage or other benefits to be furnished by the Plan. Such right to service coverage or other benefits is not transferable.

Collective Bargaining Agreements

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

Your Rights Under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and the updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself and any other Qualified Beneficiaries if there is a loss of coverage under the Plan as a result of a Qualifying Event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon those who are responsible for the operation of the employee benefit plan. Those who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (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 case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or

Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. 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 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 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.

General Plan Information

Plan Name:	Ameren Employee Assistance Program, a component of the Ameren Miscellaneous Healthcare and Fringe Benefit Plan.
Type of Plan:	A Welfare Benefit Plan that provides professional counseling services and is subject to the provisions of ERISA.
Plan Year:	January 1 through December 31. Plan records are maintained on this basis.
Plan Number:	503
Funding Medium and Type of Plan Administration:	The Company pays the full cost of coverage under this Plan
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)
Plan Administrator's Employer Identification Number:	43-1799279
Contract Administrator:	Magellan Healthcare, Inc. 14100 Magellan Plaza Maryland Heights, MO 63043 800.450.7281

COBRA Administrator:	Ameren Benefits Center PO Box 5204 Cherry Hill, NJ 08034-5204 1.877.769.2637 www.myameren.com
Named Fiduciary:	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)
Agent for Service of Legal Process:	General Counsel Ameren Services Company 1901 Chouteau Avenue, Mail Code 1300 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637) Service of Legal Process also may be made upon the plan administrator.