

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



**Ameren Retiree Medical Plan  
(Pre-92 Plan Benefits)**

Administered by:  
Anthem Blue Cross Blue Shield  
and  
Express Scripts

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

## Purpose

Ameren Corporation (the "Plan Sponsor") maintains the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)**, a component part of the **Ameren Retiree Welfare Benefits Plan** ("the Plan") to provide health benefits for certain AmerenUE Retirees and their Spouses and other eligible Dependents. AmerenUE Retirees covered under the Plan include only those Retirees defined in the **ELIGIBILITY** Section of this booklet. Retirees of all other Ameren Corporation subsidiaries are not eligible to participate in this Plan.

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

The **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** has been established on a noninsured basis; all liability for payment of benefits is assumed by Ameren. While Anthem BlueCross BlueShield ("Anthem") and Express Scripts, Inc. ("Express Scripts") administer the payment of claims, they have no liability for the funding of the benefit Plan.

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

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

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

**DURATION OF THE PLAN.** The Plan Sponsor hopes and expects to continue the **Ameren Retiree Medical Plan** in the years ahead but cannot guarantee to do so. The Plan Sponsor reserves the right to amend, modify, or terminate the Plan and/or any benefits provided under the Plan at any time with respect to both current and future Retirees and their dependents.

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

## Your Role in Controlling Health Care Costs

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

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

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

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

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

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

Consider Hospital Stay Alternatives. Home Health Care or Home Health Care Plan and Hospice Care or Hospice Care Program Services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

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

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

Be a wise health care consumer. Review Your benefits carefully so You can make informed health care decisions. You can help control health care costs while getting the most the Plan has to offer.

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

## Five Tips For Improving Your Overall Health and Wellness

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

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



## Medical Benefit Information

Anthem can answer questions about Your medical benefit program or specific coverage (except Prescription Drug benefits administered by Express Scripts). The Anthem staff can also provide information on topics such as outpatient surgery, health care alternatives, health care providers, Utilization Management Review, and treatment costs in Your area.

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

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

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

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

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

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

### You have the right to:

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

## **You have the responsibility to:**

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

## **Nondiscrimination**

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

## **How to Obtain Language Assistance**

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

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

## **Identity Protection Services**

Identity protection services are available through Anthem. To learn more about these services, visit [www.anthem.com/resources](http://www.anthem.com/resources).

## **Anthem Non-Discrimination Notice**

**It's important we treat You fairly.** That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a

grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to [compliance.coordinator@anthem.com](mailto:compliance.coordinator@anthem.com). Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> . Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Get Help in Your Language

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

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

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

### Spanish

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

### Albanian

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

### Amharic

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

### Arabic

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

### Armenian

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

### Bassa

Ɖ bédɛ dyí-bèdɛ̀in-dɛ̀n ɓé m̀ ké bǝ̀ nìà kɛ kè gbo-kpá- kpá dyé ɛ́é m̀ bídí-wùdùùn ɓó pídyi. Ɖá mébà jè gbo-gmò Kpòè nòbà nìà nì Dyí-dyoin-bɛ̀ɔ kɔ́ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

### Bengali

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

#### Burmese

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

#### Chinese

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

ID

#### Dinka

Yin nɔŋ yic ba ye lək nē yök ku bē yi kuɔny nē thöŋ yin jām ke cin wëu töu kē piiny. Cɔl rän töŋ  
dē kɔc kē luɔi nē nām̐ba dēn tō nē I.D kat du yic. (TTY/TDD: 711)

#### Dutch

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

#### Farsi

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

#### French

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

#### German

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

#### Greek

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

#### Gujarati

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

#### Haitian

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

Hindi

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

Hmong

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

Igbo

I nwere ikike inweta ozi a yana enyemaka n'asusụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadi NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

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

Indonesian

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

Italian

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

Japanese

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

Khmer

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

Kirundi

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

Korean

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

Lao

**ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງພ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ.** (TTY/TDD: 711)

#### Navajo

Bee n1 ahoot'í t'11 ni nizaad k'éhj7 n7k1 a'doowo[ t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

#### Nepali

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

#### Oromo

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

#### Pennsylvania Dutch

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

#### Polish

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

#### Portuguese-Europe

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

#### Punjabi

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

#### Romanian

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

#### Russian

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

#### Samoan

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

#### Serbian

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

#### Tagalog

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

#### Thai

**ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี**  
**โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ** (TTY/TDD: 711)

#### Ukrainian

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

#### Urdu

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

#### Vietnamese

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

#### Yiddish

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

#### Yoruba

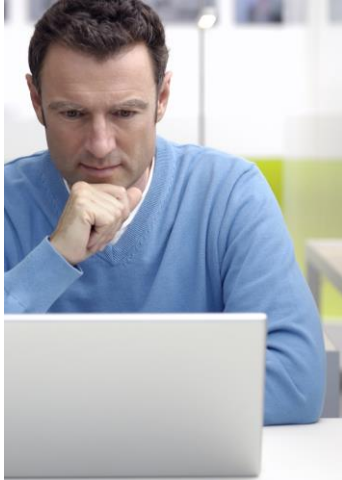
O ní ètọ́ láti gba ìwífún yí kí o sì sẹ̀rànwọ́ ní èdè rẹ̀ lófẹ́ẹ̀. Pe Nọmbà àwọn ìpèsè ọmọ-ẹgbé lórí kààdì ìdánimọ̀ rẹ̀ fún ìrànwọ̀. (TTY/TDD: 711)

## Ameren Benefits Center

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

## www.myAmeren.com

Ameren maintains [www.myAmeren.com](http://www.myAmeren.com) where individuals 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 a Plan participant to view individual benefit information. If You have forgotten Your password, You can request a new password on the logon screen. Questions about Your benefits should be directed to the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

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

## Ameren Retiree Medical Plan

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## Eligibility

### Retirees

You are eligible for coverage under this Plan as a Retired Employee if:

- You retired from Union Electric Company (UE) prior to January 1, 1992; AND
- You were age 55 or older on the date You retired; AND
- On the day before You retired, You were a regular, full-time Employee eligible for active group medical coverage OR You were a part-time Employee covered under one of the Company's medical plans for active Employees.



### Dependents

If You enroll in the Plan as a Retired Employee, Your eligible Dependents are also eligible for coverage provided that they are not serving in the active service of any armed forces of any country and You enroll them according to the appropriate procedures. You must remain enrolled in an **Ameren Retiree Medical Plan** program in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to Your:

- Spouse; however, a Spouse who is covered (or eligible for coverage) under another Ameren-sponsored medical plan is not eligible for coverage under this Plan.
- Unmarried Dependent Children who have not reached age 19 and are dependent upon you for more than half of their support.
- Unmarried Dependent Children from their 19th birthday to their 25th birthday who live with you and are dependent upon you for more than half of their support and care. Temporary absences due to special circumstances, including absences due to illness, education or vacation are not treated as absences for purposes of determining whether the Dependent Child lives with you.
- Unmarried Dependent Children over age 25 who are not capable of self-sustaining employment due to a disability continue to be eligible for coverage under the Plan beyond the limiting age, provided they continue to be dependent upon You for more than half of their support. Proof of the disability or handicap must be furnished to Anthem within 31 days of the date they would otherwise cease to be eligible.

A child is considered disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected either to result in death or last for a continuous period of not less than 12 months.

Disabled Dependent children who were not covered under the Plan upon attainment of age 25 are not eligible for coverage.

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

A child with a full-time job, generally defined to be 30 or more hours per week, is not considered to be dependent on You for support.

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

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

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

### Surviving Dependents

If you are a surviving Dependent of an Employee who died prior to January 1, 1992 while Actively Employed by UE, You are eligible to participate in this Plan once you become Medicare-eligible. However, if You did not elect or continue Your coverage under an Ameren-sponsored medical plan following the Employee's death or You subsequently dropped coverage, You are not eligible to resume coverage as a surviving Dependent under this Plan.



## Enrollment Provisions

### Retirees

In order to elect or decline coverage in the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)**, you must make your elections on-line through "Healthcare and Life Benefits" at [www.myAmeren.com](http://www.myAmeren.com) or by calling the **Ameren Benefits Center** at 877.7my.Ameren (877.769.2637). To obtain medical coverage, You will be required to provide a valid Social Security number for Yourself and each Dependent that You wish to cover. A Social Security number is required for a child who is six (6) months and older.

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

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

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

## **Dependents**

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

You will have 31 days from the date of Your retirement to enroll any eligible Dependents in the Plan who were not covered under one of the Company's group health plans as a Dependent on the day before Your retirement. If You fail to enroll any such eligible Dependent within the 31 day time period, such Dependent cannot be enrolled in the Plan in the future except under the circumstances described under **ADDING DEPENDENTS AFTER RETIREMENT** below.

## **Adding Dependents After Retirement**

You may enroll any eligible Dependents in the future so long as You are covered under the Plan as described in this Summary Plan Description. Coverage will begin on the date you enroll the eligible Dependent. You can enroll the Dependent by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**) or on-line through "Healthcare and Life Benefits" at [www.myAmeren.com](http://www.myAmeren.com).

Any Dependent who is covered under this Plan and is subsequently dropped from coverage for any reason may not be re-enrolled for coverage at any time in the future, except as outlined under **SPECIAL ENROLLMENT RIGHTS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009**.

## **Eligibility for Premium Assistance**

If You or an Eligible Dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state CHIP with respect to coverage under this Plan, You may be able to enroll Yourself and Your eligible Dependent(s) in this Plan by requesting enrollment within 60 days after Your or Your Dependent's determination of eligibility for such assistance. Coverage under the Plan will be effective no later than the first day of the first calendar month beginning after the date the Plan receives your request for special enrollment.

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

If You do not enroll Yourself or Your eligible Dependents during the 31-day or 60-day Special Enrollment Periods described above, enrollment is not permitted until the next Annual Enrollment Period.

### **Qualified Medical Child Support Orders**

This Plan will also extend benefits to a Retiree's non-custodial child, as required by any Qualified Medical Child Support Order (QMCSO), including National Medical Support Notices, as defined by ERISA § 609 (a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants can obtain, without charge, a copy of such procedures by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

### **Cost of Coverage**

The Company currently pays the cost of this coverage for You and Your Covered Dependents.

### **Is Your Dependent Child a 'Qualified Tax Dependent'?**

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

### **Coverage Identification Card**

Once You are enrolled in the Plan, You will be issued ID cards which provide information about Your medical and prescription drug coverage. You should carry the cards with You at all times, and show them to Your providers when You go to the Physician, Hospital, or Pharmacy. If You lose Your medical ID card, You may obtain a replacement by calling Anthem at **877.403.0610**, or by visiting [www.anthem.com](http://www.anthem.com). If You lose Your prescription drug ID card, You may obtain a replacement by calling Express Scripts at **888.256.6131**, or by visiting [www.express-scripts.com](http://www.express-scripts.com). To obtain an ID Card through Anthem's or Express Script's secure website, You must first register with a unique login and password.



## Definitions

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

**Actively Employed** means that the Employee is performing full-time or part-time work for the employer, the duties of the Employee's employment at the place and in the manner in which the duties of the Employee's employment are usually and customarily performed.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Coinsurance** means the percentage of Covered Expenses either paid by the Plan or paid by You (for example, the Plan pays 80% of Covered Expenses and You pay the remaining 20% after You satisfy the Deductible).

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

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

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

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

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

**Cosmetic Treatment or Services** means treatment or service to change:

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

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

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

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

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

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

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

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

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

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

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

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

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

When a court or administrative order determines paternity and establishes upon You a duty to support Your natural child, the child will be considered Your eligible Dependent regardless of whether or not the child is living with You or receiving his or her main support and care from You.

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

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

**Durable Medical Equipment means equipment that:**

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

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

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

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

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

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

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

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

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

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

The Formulary for Medicare participants may be different than the Formulary for non-Medicare participants. To obtain information about prescription drugs on Express Scripts' Formulary, non-Medicare Members may call toll-free **888.256.6131**. Medicare eligible Members may call

toll free **866.792.2737**. Formulary information can also be obtained at the Express Scripts website [www.express-scripts.com](http://www.express-scripts.com)

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

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

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

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

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

**Health Professional or Healthcare Professional** means an individual who:

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

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

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

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

**Hospice** means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage Hospice Care Programs; and
- arranges, coordinates, and/or provides Hospice services for terminally ill Members; and

- maintains records of Hospice services provided and bills for such services on a consolidated basis.

**Hospice Care Program** means a program:

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

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

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

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

**Hospital** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, Custodial Care facility, or training center.

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

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

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

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

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

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

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

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

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

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

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

- medically Appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;
- obtained from a covered Network or Non-network Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;
- cost-effective compared to alternative treatments or service, including no treatment or service. As to the diagnosis or treatment of the Member's illness, injury or disease, the service is: not more costly than an alternative service or sequence of services that is medically Appropriate; or performed in the least costly setting that is medically Appropriate;
- the most Appropriate level of services or supplies that can safely be provided and which cannot be omitted consistent with recognized professional standards of care;
- determined by the Plan Administrator or its delegate, the Claims Administrator, to be Generally Accepted;

- is not Experimental or Investigational; and
- not otherwise subject to an expense not covered under this Plan.

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

**Network Pharmacy** means a Pharmacy that participates in the Express Scripts network identified by the Claims Administrator for this Plan. Network Pharmacies may be different for Medicare eligible participants and non-Medicare eligible Participants.

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

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

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

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

**Notification of Utilization Management Review Services** means receipt of necessary information to initiate review of a request for Utilization Management Review Services, including the patient's name and Your name (if different from patient's name), attending Physician's name, treating facility's name, diagnosis, and date of service.

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

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

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

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

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

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

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

**Physical Handicap** means a Dependent Child's substantial physical or mental impairment, as determined by the Plan Administrator, which:

- results from injury, accident, congenital defect, or sickness; and
- is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

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

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

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

**Physician Visit Charges** means Covered Expenses for treatment or service furnished at a Physician's clinic or office. Such services include charges for: dressings; supplies (other than orthotics and braces); equipment; injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations; x-ray, radium, and radioactive isotope therapy.

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

**Plan** means **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)**, a component part of the **Ameren Retiree Welfare Benefit Plan**.

**Plan Administrator** means the Administrative Committee, or its delegate.

**Plan Sponsor** means Ameren Corporation.

**Plan Year** means the period of time beginning at 12:00 A.M. on January 1 and ending on the following December 31 at 11:59 P.M. With respect to an individual Member's coverage, it does not begin before a Member's effective date and it does not continue after a Member's coverage ends.

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

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

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

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

**Retired Employee/Retiree** means an Employee who is retired, if such Employee was age 55 or older on the date of retirement and belongs to a group described in the **ELIGIBILITY** section of this booklet.

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

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

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

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

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

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

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

**Transplant Network or Network Transplant Provider**, as applicable to the Non-Medicare Plans, means a provider that has been designated as a Center of Excellence for Transplants by the Claims Administrator and/or a provider selected to participate as a Network Transplant Provider by a designee by the Blue Cross Blue Shield Association. Such provider has entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to You for the Transplant Network. A provider may be a Network Transplant Provider with respect to certain covered transplant procedures or all covered transplant procedures. An Out-of-Network Transplant Provider means any provider that has not been designated as a Center of Excellence for Transplants by the Claims Administrator nor has been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

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

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

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

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

## Schedule of Benefits

The benefits payable under the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** differs depending on whether or not You are Medicare-eligible. Schedule A summarizes the benefits under the PPO schedule for Covered Members who are **not** eligible for Medicare. Schedule B summarizes the benefits for Covered Members **who are** eligible for Medicare. In addition, all Members participate in the Prescription Drug Program. The appropriate schedule plus the Prescription Drug benefits comprise Your current Plan benefits.

The following charts compare how benefits are paid for various types of care for each benefit schedule. However, the charts are only a summary of Plan provisions. You should review the additional details on Covered Expenses and exclusions located throughout this booklet. Only commonly used services are listed to help You understand how the Plan pays benefits.

<b>SCHEDULE A (PPO)–BENEFITS FOR PARTICIPANTS NOT MEDICARE ELIGIBLE</b>	
<b>PLAN FEATURE</b>	<b>PROVIDER OF CHOICE</b>
<b>Lifetime Maximum Benefit</b>	\$750,000
<b>Calendar Year Deductible</b> <ul style="list-style-type: none"> <li>• Per Person</li> <li>• Per Family</li> </ul>	\$200 \$400
<b>Out-of-Pocket Maximum</b> (includes the Deductible) <ul style="list-style-type: none"> <li>• Per Person</li> <li>• Per Family</li> </ul>	\$1,700 \$2,650
Utilization Management Review penalties do not apply to the Out-of-Pocket Maximum. Expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount, or services that are not Medically Necessary, are also not included.	
<b>Inpatient Hospital</b>	You pay the Deductible, then the Plan pays 80%
<b>Outpatient Facility</b>	You pay the Deductible, then the Plan pays 80%
<b>Emergency Room Services</b>	You pay the Deductible, then the Plan pays 80%
<b>Ambulance</b>	You pay the Deductible, then the Plan pays 80%
<b>Preadmission Testing Charges</b>	You pay the Deductible, then the Plan pays 80%
<b>Urgent Care</b>	You pay the Deductible, then the Plan pays 80%
<b>Office Visits</b>	You pay the Deductible, then the Plan pays 80%
<b>X-Ray and Laboratory Services</b>	You pay the Deductible, then the Plan pays 80%

SCHEDULE A (PPO)–BENEFITS FOR PARTICIPANTS NOT MEDICARE ELIGIBLE		
PLAN FEATURE	PROVIDER OF CHOICE	
Chiropractic Services, Physical Therapy, and Speech/Occupational Therapy	You pay the Deductible, then the Plan pays 80%	
Home Health Care	You pay the Deductible, then the Plan pays 80%	
Hospice Care	You pay the Deductible, then the Plan pays 80%	
Skilled Nursing Facility Room and Board Charges are not covered.	You pay the Deductible, then the Plan pays 80%	
Mammograms Limited to one baseline mammogram for women age 35 through 39 and one per calendar year for women age 40 and older.	You pay the Deductible, then the Plan pays 80%	
Durable Medical Equipment	You pay the Deductible, then the Plan pays 80%	
All other Covered Expenses	You pay the Deductible, then the Plan pays 80%	
PRESCRIPTION DRUG CARD PROGRAM Administered by Express Scripts (ESI)		
	Retail	Home Delivery
Generic Drugs Brand Name Drugs*	\$3 Copay \$6 Copay	\$6 Copay \$12 Copay
Maximum Supply	Up to 34 days or 100 Unit Doses, whichever is greater, for each Prescription	Up to 90 days for each Prescription

\* A \$3 Copay will apply if You purchase a Brand Name Drug for which there is no generic equivalent at a participating retail Pharmacy. A \$6 Copay will apply if You purchase a Brand Name Drug for which there is no generic equivalent through the Home Delivery drug program.

### **Utilization Management Review Requirements**

Hospital Confinement Charges will be reduced by \$200 unless the pre-certification requirements described in the **UTILIZATION MANAGEMENT REVIEW** section of this booklet are satisfied. This is a Utilization Management Review penalty.

## **Anthem Network Programs**

### **If You are not eligible for Medicare, Anthem is the Provider network for You.**

The PPO schedule of benefits is designed to help You reduce healthcare expenses whenever You use a provider that is a member of the Anthem network of healthcare providers. Anthem is able to negotiate discounts with Physicians and Hospitals and then pass these discounts on to the members. This can mean significant savings for You and the Plan when You use an Anthem provider.

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

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

An Anthem National Network Provider directory is available by accessing Anthem's website at [www.anthem.com](http://www.anthem.com) or by calling **877.403.0610**.

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

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

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

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

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

## **Inter-Plan Arrangements**

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

Anthem has relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association").

Whenever You access healthcare services outside the geographic area the Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

### **Inter-Plan Arrangements Eligibility – Claim Types**

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

### **BlueCard® Program**

Under the BlueCard® Program, when You receive Covered Expenses within the geographic area served by a Host Blue, the Claims Administrator will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

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

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

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

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

### **Negotiated (non–BlueCard Program) Arrangements**

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

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

## **Special Cases: Value-Based Programs**

### *BlueCard® Program*

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

### *Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements*

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

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

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

## **Nonparticipating Providers Outside the Claims Administrator's Service Area**

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

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

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

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

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

### **Call the Service Center in these non-emergent situations:**

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

### **Payment Information**

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

### **Claim Filing**

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

### **Claim Forms**

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

Service Center  
P.O. Box 2048  
Southeastern, PA 19399  
Email Address: [claims@bcbsglobalcore.com](mailto:claims@bcbsglobalcore.com)

### **Important Provisions for the Non-Medicare Eligible Participants**

#### **Incidental Providers (formerly RAPS)**

For radiologists, pathologists, anesthesiologists and emergency room Physicians, You and Your Covered Dependents will receive the Network level of benefits (up to the Maximum Allowed Amount) when such services are provided at an Network Hospital (inpatient, outpatient, and

Hospital emergency room), or Network licensed free-standing surgical center. For example, if You receive treatment at a participating Anthem Hospital, and the radiologist who performs a service for this visit is an Out-of-Network Physician, the radiologist's bill for service will be paid at the Network level of benefits. If the radiologist's charge is higher than what is considered the Maximum Allowed Amount, the most the Plan will pay is based on the Maximum Allowed Amount.

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

### **Payment Innovation Programs**

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

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

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

### **Care Coordination**

The Plan pays Network Providers in various ways to provide covered services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each covered service they provide. The Plan may also pay them one amount for all covered services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, the Plan may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the

Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

### **Out-of-Network for an Emergency Medical Condition**

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

### **Authorized Services**

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

## **Anthem Programs for the Non-Medicare Eligible Participants**

### **Anthem 360° Health Programs**

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

#### **24/7 NurseLine**

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

#### **Future Moms**

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

- 24/7 toll-free access to a registered nurse who'll answer Your questions and discuss any pregnancy-related issues with You.
- A helpful book: Your Pregnancy Week by Week

- Educational materials to help You handle any unexpected events
- A questionnaire to evaluate Your risk for preterm delivery
- Useful tools to help You, Your Physician and Your Future Moms nurse track Your pregnancy and spot possible risks

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

### **ConditionCare Core Programs**

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

### **MyHealth Advantage**

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

### **ComplexCare**

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

### **Behavioral Health**

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

- Psychiatrist
- Psychologist

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

### Autism Spectrum Disorders Program

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

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

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

<b>SCHEDULE B – BENEFITS FOR PARTICIPANTS ELIGIBLE FOR MEDICARE</b>	
<b>PLAN FEATURE</b>	<b>PROVIDER OF CHOICE</b>
<b>Lifetime Maximum Benefit</b>	\$200,000
<b>Calendar Year Deductible</b> <ul style="list-style-type: none"> <li>• Per Person</li> <li>• Per Family</li> </ul>	\$150 \$300
<b>Hospital</b>	You pay the Deductible, then the Plan pays 80%
<b>Skilled Nursing Facility</b> <i>Room and Board Charges are not covered.</i>	You pay the Deductible, then the Plan pays 80%
<b>Hospice Care</b>	You pay the Deductible, then the Plan pays 80%
<b>Medicare Approved Durable Medical Equipment</b>	You pay the Deductible, then the Plan pays 80%
<b>Foreign Travel</b>	You pay the Deductible, then the Plan pays 80%
<b>All other Covered Expenses</b>	You pay the Deductible, then the Plan pays 80%

<b>Prescription Drug Card Program (Administered by Express Scripts)</b>		
	<b>Days Supply</b>	<b>Home Delivery Copay</b>
<b>Retail Generic Drugs</b>	Up to 34 days 35-90 days	\$3 \$6
<b>Retail Brand Name Drugs*</b>	Up to 34 days 35-90 days	\$6 \$12
<b>Home Delivery Generic Drugs</b>	Up to 90 days	\$6
<b>Home Delivery Brand Name Drugs*</b>	Up to 90 days	\$12
<b>Maximum Supply</b>	Up to 90 day supply	Up to 90 day supply

\*A \$3 Copay will apply if You purchase a Brand Name Drug for which there is no generic equivalent at a participating Retail Pharmacy. A \$6 Copay will apply if You purchase a Brand Name Drug for which there is no generic equivalent through the Home Delivery drug program.

### **Medicare Part A and Part B**

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

### **Medicare Part D**

Medicare Part D is the prescription drug benefit available to all Medicare participants. Effective January 1, 2012, The Prescription Drug Program for Medicare eligible participants enrolled in the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** is considered to be Medicare Part D coverage. It is administered by Express Scripts, who contracts with the federal government. As long as you are a participant in the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** You will automatically be enrolled in this Program. See the **PRESCRIPTION DRUG PROGRAM** section.

### **Important Provisions in the Plan**

Unless otherwise specified, the provisions described in this section apply to both Schedule A and Schedule B.

### **Deductible Amounts**

The Deductible Amount for each Plan Year (January through December) is the amount specified in the applicable Schedule of Benefits. If a Deductible applies, the Plan will subtract the Deductible Amount from Covered Expenses and will then pay the Covered Expenses as stated in the applicable Schedule of Benefits.

The Copay amounts paid under the Prescription Drug Program in either Schedule cannot be used to help satisfy this Deductible Amount. Also, for Schedule A, any penalties incurred as a result of failure to comply with Utilization Management requirements may not be used to help satisfy Your Deductible.

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

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

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

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

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

- the amount You pay because of penalty charges for failure to comply with the Utilization Management Review Requirements (Schedule A); or
- prescription drug Copays; or
- expenses not covered by the Plan, including amounts that exceed the Maximum Allowed Amount or charges that are not reimbursed because of Plan maximums or limitations.

### **Lifetime Maximum Benefits**

The maximum benefit payable under this Plan during any Member's lifetime is \$750,000 for non-Medicare eligible Members (Schedule A) and \$200,000 for Medicare eligible Members (Schedule B). The lifetime maximum benefit is re-set to zero when a Member becomes Medicare eligible and moves into Schedule B. Any amounts previously accumulated under the lifetime maximum provision when You or Your eligible Dependents were not eligible for Medicare is disregarded and You start with a zero balance under the Medicare eligible plan option. It is important to note that the exception to this provision is if a Member reaches the lifetime maximum while covered under Schedule A. In that case, the Member is no longer eligible for coverage under the Plan even when he or she becomes eligible for Medicare.

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

### **Reinstatement of Maximum Benefits**

The maximum benefit for any Member is as stated in the Schedule of Benefits. However, Members who have received benefits reducing their medical maximum will be eligible to have their lifetime maximum benefit reinstated annually. The amount of the reinstatement will be \$1,000 per year. At the time You or Your Covered Dependent exceed the Lifetime Maximum

amount, the Claims Administrator will review Your lifetime maximum to determine if any reinstatement is required. In no event shall the Lifetime Maximum Benefit of a Member exceed the amount stated in the Schedule of Benefits.

## **Maximum Allowed Amount**

### **General**

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

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

- that meet the Plan's definition of Covered Expenses, to the extent such services and supplies are covered under the Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, Utilization Management or other requirements set forth in this summary plan description.

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

When You receive Covered Expenses from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Expenses. These rules evaluate the claim information and, among other things, determine the accuracy and Appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Expenses You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

## Provider Network Status

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

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Expenses performed by a Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Expenses. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Expenses, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copay or Coinsurance. An Anthem National Network Provider directory is available by accessing Anthem's website at [www.anthem.com](http://www.anthem.com) or by calling **877.403.0610**.

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

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

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

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

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

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

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

### **Member Cost Share**

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

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

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Expenses from an Non-Network Provider such as a radiologist,

anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Expenses. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

### **Authorized Services**

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

## **Medical Expense Coverage**

### **Covered Expenses**

No benefits are available for services that are not specifically described as Covered Expenses in this Summary Plan Description. This exclusion applies even if Your Physician orders the service. Covered Expenses will be the actual cost charged to You for Medically Necessary care, but only to the extent that the actual cost charged does not exceed the Maximum Allowed Amount. To be covered, expenses must be ordered by a Physician for therapeutic treatment of an injury or sickness and not be listed as an exclusion under **EXPENSES NOT COVERED** in this Summary Plan Description.

Covered Expenses include the Maximum Allowed Amount for:

1. Hospital for room and board, Intensive Care Accommodations and necessary services and supplies furnished by the Hospital. The Maximum Allowed Amount does not include charges for private Hospital room and board and general nursing care that exceed the Hospital Room Daily Limit. Pre-certification is required for all inpatient confinements for Members not eligible for Medicare;
2. Birthing Center services;
3. Ambulatory Surgery Center services;
4. the professional services of a Physician or surgeon;
5. the services of a Health Care Extender;
6. the services of a licensed practical nurse (L.P.N.) or a licensed registered nurse (R.N.);
7. the services of a physical or occupational therapist for therapeutic treatment;
8. the services of licensed speech pathologists, audiologists, and speech language pathologists;

9. the professional services licensed psychologists;
10. certain charges of chiropractors as determined by the scope of their state license;
11. habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living for a diagnosis that is considered a Covered Expense under this Plan. These services may include physical and occupational therapy, speech-language pathology and other services in a variety of Inpatient and/or outpatient settings.
12. nutritional counseling for diabetic education; and, when related to pre- and post-surgery for approved medically necessary bariatric surgery;
13. treatment for gender identity disorder, including transgender surgery.
14. voluntary sterilization;
15. drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing (excluding those charges paid under the Prescription Drug Card Program);
16. surgical dressings, covered orthotics, casts, splints, braces, crutches, artificial limbs, and artificial eyes;
17. Durable Medical Equipment, including repair, adjustment, or replacement of purchased Durable Medical Equipment, unless damage results from the Member's negligence or abuse of such equipment. Covered Expenses will not include charges which are in excess of the purchase price of the equipment.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Expense, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Expense is Your responsibility.
18. anesthesia and its administration, blood transfusions (including the cost of blood and blood plasma), oxygen, nebulizers and related charges;
19. x-ray and laboratory examinations made for diagnostic purposes in connection with the therapeutic treatment;
20. x-ray, radium, and radioactive isotope therapy;
21. professional Ambulance Service is subject to Medical Necessity and is a Covered Expense when You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. One or more of the following criteria are met.
  - For ground Ambulance, You are taken:
    - From Your home, the scene of an accident or medical Emergency to a Hospital;
    - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; or

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

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

- Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Provider are not a Covered Service. Other non-covered Ambulance Services include, but are not limited to trips to:
  - A Provider's office or clinic;
  - A morgue or funeral home.
- For air or water Ambulance, You are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital; or
  - Between a Hospital and an approved Facility.

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

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

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

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

### **Hospital to Hospital Transport**

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

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

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

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

22. eye exams or glasses that are necessary to repair damage that was caused solely by an accidental injury that occurred while the Member was covered under the Plan and provided such charges are incurred within six months of the date of the accident and while a Member;
23. Cosmetic Treatment or Services or complications arising therefrom that results from a sickness or an accidental injury which occurs while the Member claiming benefits is covered under this Plan provided the procedure or service is completed within 24 months after the onset date of that sickness or injury;
24. dental services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing), (except where the chewing or biting results from an act of domestic violence or directly from a medical condition). Covered Expenses are limited to the least expensive procedure that would provide professionally acceptable results;
25. rental of mechanical equipment for therapeutic treatment of respiratory paralysis;
26. mammogram expenses as follows:
  - one baseline mammogram for women age 35 through 39;
  - an annual mammogram for women age 40 and older;
27. Home Health Care Plan as described in this booklet;
28. Hospice Care as described in this booklet;
29. Skilled Nursing Facility as described in this booklet;
30. human to human organ or bone marrow transplants not considered Experimental or Investigational;
31. treatment or service related to the pregnancy of a Retiree or the Covered Dependent Spouse of a Retiree;
32. treatment or service provided in a Veterans Administration Hospital for non-service connected illness;
33. treatment or service provided while confined in a military medical facility incurred by a U.S. military retiree (and any Covered Dependents);
34. treatment or service related to mental health and alcohol or other substance abuse;
35. reconstructive breast surgery in connection with a mastectomy for:
  - reconstruction of the breast on which a mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthetic devices and physical complications of the mastectomy, including lymphedemas.

36. reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment is a Covered Expense under this Plan.

Such services will be performed in a manner determined in consultation with the attending Physician and the patient.

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

### **Autism Spectrum Disorders (ASD) Program**

#### **Applicable to Non-Medicare Eligible Participants Only**

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

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

#### **Education**

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

#### **Guidance**

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

#### **Coordination**

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

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

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

## Case Management

For those Members not eligible for Medicare, Covered Expenses will also include case management services provided pursuant to this Plan, to utilize a more cost effective Generally Accepted form of Medically Necessary care, when compared to use of Covered Expenses contained in this Plan.

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

## Multiple Surgical Procedures

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

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

## Covered Expenses For An Assistant During Surgical Procedures

Benefits will be payable for the services of an assistant to a surgeon if such services are determined by the Claims Administrator to be Medically Necessary. An assistant to a surgeon is considered to be Medically Necessary if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Covered Expenses for such services will be paid at up to 80% of The Maximum Allowed Amount of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

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

## Home Health Care

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

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

but only to the extent that such services and supplies are provided under the terms of a Home Health Care Plan. These Covered Expenses are subject to all provisions of the Plan that would apply to any other medical treatment or service.

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

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

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

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

## **Hospice Care**

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

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

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

Hospice Services consist of:

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

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

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

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

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

### **Skilled Nursing Facility Confinement**

Covered Expenses will not include room and board charges in a Skilled Nursing Facility. The Plan will cover other services required for treatment, provided the confinement:

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

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

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

### **Transplant Services**

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

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

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;

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

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

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

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

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

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

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

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

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

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

## **Prior Approval and Precertification (Applicable to Non-Medicare Participants)**

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

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

## **Expenses Not Covered**

In addition to any limitations or exclusions stated in this summary, expenses for which no benefits are payable under this Plan include but are not limited to (this is not an exhaustive list):

1. treatment or service that is not Medically Necessary;
2. treatment or service that is Experimental or Investigational;
3. any part of a charge for treatment or service that exceeds the Maximum Allowed Amount;
4. services of any person in Your Immediate Family or any person in Your Covered Dependent's Immediate Family;
5. molecular genetic testing (specific gene identification) for purposes of health screening or if not part of a treatment regimen for a specific sickness, unless certain criteria (as determined by the Claims Administrator) have been met and the testing is accompanied by genetic counseling;
6. treatment for gene therapy, including any prescription drugs, procedures, healthcare services related to it that introduce or is related to the introduction of genetic material in a person intended to replace or correct faulty or missing genetic material;
7. treatment or services by a Christian Science Practitioner;
8. dental services and materials including dental implants (except as described under Covered Expenses);
9. hearing aids;

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

27. treatment or service that results from a sickness or injury that is covered by a Workers' Compensation Act, Employer's Liability Benefits, or other similar laws;
28. charges for any injury resulting from employment;
29. treatment or service related to preventive medical expenses such as annual physical exams (except mammograms as described under Covered Expenses);
30. treatment or service related to the restoration of fertility or the promotion of conception including but not limited to in-vitro fertilization; uterine embryo ravage; embryo transfer; artificial insemination; gamete intrafallopian tube transfer; Zygote intrafallopian tube transfer; and low tubal ovum transfer;
31. reversal of elective sterilization;
32. barrier-free home modifications, including, but not limited to, ramps, grab bars, railings, whether or not recommended by a Physician;
33. treatment or service for smoking cessation or nicotine addiction, gambling addiction, or stress management;
34. treatment or service for insertion, removal, or revision of breast implants, unless provided post-mastectomy;
35. charges for missed appointments;
36. treatment or service for any sickness or condition for which the insertion of breast implants or the fact of having breast implants within the body was a contributing factor, unless the sickness or condition occurs post-mastectomy;
37. non-implantable communicator-assist devices, including but not limited to, communication boards, and computers;
38. treatment or service for work-hardening services or vocational rehabilitation programs;
39. treatment or services for maintenance or supportive level of care, or when maximum therapeutic benefit (no further objective improvement) has been attained; or
40. room and board charges during a confinement in a Skilled Nursing Facility;
41. treatment or services for obesity, (except Medically Necessary care for morbid obesity, including surgery, will be covered);
42. treatment or service related to pregnancy of a Dependent Child of a Retiree;
43. treatment or service that results from the abortion of a pregnancy, except that benefits will be payable for the abortion only if:
  - continuation of the pregnancy would endanger the life of the mother. However, if medical treatment is required because of complications resulting from an abortion, benefits will be payable for such medical treatment; or
  - medical treatment is required because of complications resulting from an abortion.
44. treatment or service for foot care with respect to: corns, calluses, flat feet, fallen arches, trimming of toe nails, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics). This limitation does not apply for Medically Necessary foot care (including Treatment for diabetes, bunions, custom molded orthotics and/or shoes);

- 45. additional charges incurred because care was provided after hours, on a Sunday, holidays, or weekend;
- 46. charges for e-mail communication or e-mail consultation;
- 47. charges for Physician overhead, including but not limited to equipment used to perform the particular treatment or service (i.e. laser equipment);
- 48. charges for heating pads, heating and cooling units, ice bags or cold therapy units;
- 49. treatment or service for unattended home sleep studies;
- 50. treatment or services for standby services;
- 51. treatment or service that results from participation in criminal activities, as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. However, this exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence;
- 52. waiving of Copays, Coinsurance or Deductibles for which You are otherwise responsible for under the terms of this Plan, by Out-of-Network Providers for the purpose of promoting their own business.

### Utilization Management Review

**This section does not apply to Medicare Eligible Members.**

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

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

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

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

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

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

### **Exceptions to the Utilization Review Program**

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

If you have any questions regarding the information contained in this section, you may call the Member Services telephone number on Your medical ID card or visit [www.anthem.com](http://www.anthem.com).

### **Types of Requests**

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

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

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

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

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

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

### **Treatment and Services Requiring Precertification**

**The following list of services are *examples* of some of the most common treatments and services that require precertification, and must be determined by the Claims Administrator to be Medically Necessary to be a Covered Expense under the Ameren Retiree Medical Plan (Pre-92 Plan Benefits). The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and Appropriate. The list is not inclusive of all treatments and services that require precertification, and is subject to change from time to time. Please call the Member Services telephone number on Your medical ID Card to confirm the most current list, and whether your service or procedure is considered a Covered Expense.**

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

#### Inpatient Admission:

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

#### Outpatient Services:

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

#### Human Organ and Bone Marrow/Stem Cell Transplants:

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

#### Mental Health/Substance Abuse (MHSA):

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

#### **Statement of Rights: Newborns' and Mother's Health Protection Act**

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

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

### Who is responsible for Precertification?

**You are responsible for precertification regardless if Services are provided by a Network Provider or Out-of-Network/Non-Participating Provider.**

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

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

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

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

#### Request Categories:

- **Urgent** – A request for precertification or predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.
- **Pre-Service** – A request for precertification or predetermination that is conducted prior to the Service, treatment or admission.
- **Continued Stay/Concurrent Review** - A request for precertification or predetermination that is conducted during the course of Outpatient treatment or during an Inpatient admission.
- **Post-Service** - A request for precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Post-Service Review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

#### Decision and Notification Requirements

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

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

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

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

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

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

1. You are a Member; and
2. the treatment, service or surgery must be a Covered Expense under Your medical Plan; and
3. the service cannot be subject to an exclusion under Your Plan; and
4. You have not exceeded any applicable limits under Your Plan.

### **Important Information**

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

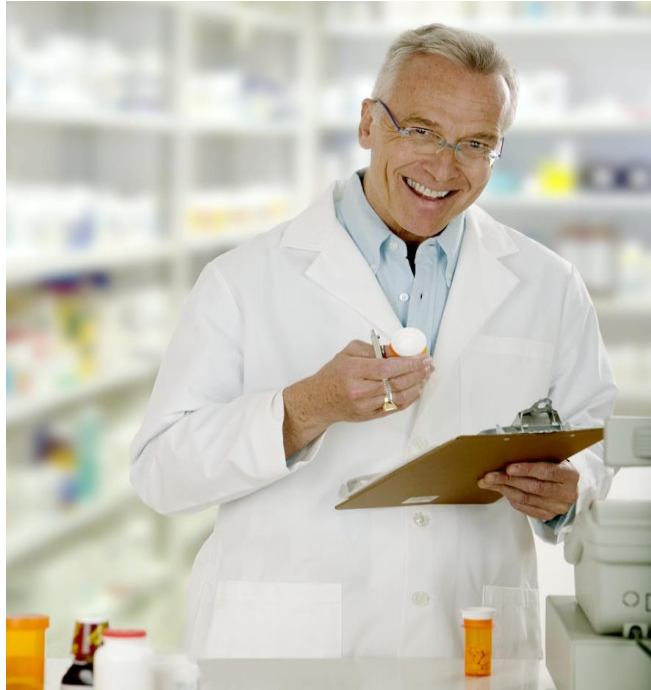
Certain qualifying Providers may be selected to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

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

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

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

## Prescription Drug Program



## Prescription Drugs Administered by a Medical Provider

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

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

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

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

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

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

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

### Precertification

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

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

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

### **Designated Pharmacy Provider**

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

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

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

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

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

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

## Prescription Drugs Administered by Express Scripts Inc.

### Prescription Drug Program for Non-Medicare Participants

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

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

Information Needed	Who to Call	Website Address
If You have questions about: <ul style="list-style-type: none"><li>➤ Retail network pharmacies</li><li>➤ Status of Your claim or Home Delivery prescription</li><li>➤ Claim history</li><li>➤ How to request a drug through the Home Delivery Program</li><li>➤ Your cost or coverage for a drug</li></ul>	Express Scripts Customer Service <b>888.256.6131</b> Be sure to identify Yourself as a Participant in the <b>Ameren Retiree Medical Plan</b> and have available the Retiree's social security number, or the Express Scripts assigned alternative identification number.	<a href="http://www.express-scripts.com">www.express-scripts.com</a>  You can create Your own personal profile so Your information will only be available to You.
Specialty Pharmacy	Accredo Customer Service <b>866.848.9870</b>	

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

### Obtaining Prescription Drugs

#### Prescription Drugs Obtained at a Participating Retail Pharmacy

You may obtain up to a 34-day supply, or 100 unit doses, whichever is greater, of a covered prescription drug at the retail Pharmacy. Your prescription drug ID card must be presented to the pharmacist when You have the prescription filled. Certain medications subject to the Drug Quantity Management Program may be subject to a maximum 30 day supply at the retail Pharmacy. (See **DRUG QUANTITY MANAGEMENT** within this **PRESCRIPTION DRUG PROGRAM** section).

- You pay a \$3 Copay for each prescription or refill of Generic Drugs or for a Brand Name Drug where there is no generic equivalent.
- You pay a \$6 Copay for each prescription or refill of Brand Name Drugs where there is a generic equivalent.

**Note:** You pay no (\$0) Copay for covered diabetic supplies if the supplies are purchased on the same day as the covered insulin. The Copay is applied to the insulin, and, the insulin must be purchased before the covered supplies. If You purchase covered diabetic supplies on a different day than when You purchase the covered insulin, the applicable Copay will also be applied to the covered diabetic supplies.



There are no claim forms to complete if the prescription is purchased from a Pharmacy that honors this Prescription Drug Program. Any Copays You pay for a prescription drug under this Program cannot be used to satisfy any applicable annual Deductible or annual Out-of-Pocket Expense Maximum applicable to medical benefits under this Plan. Under this Program, the prescription quantity dispensed by the pharmacist will be limited to the lesser of the amount normally prescribed by a Physician, or for certain drugs the amount indicated through Clinical Programs (see *Clinical Programs* within this **PRESCRIPTION DRUG PROGRAM** section). Under no circumstance may a retail prescription exceed a 34-day supply or 100 units dose, whichever is greater.

Since the Express Scripts organization is recognized nationwide, the Prescription Drug Program will be easy to use wherever You are. Most pharmacies in the United States participate in the Express Scripts Pharmacy network, but You should contact Your Pharmacy to verify its participation. You may also call Express Scripts at **888.256.6131** or access Express Scripts online at [www.express-scripts.com](http://www.express-scripts.com) to find participating pharmacies.

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

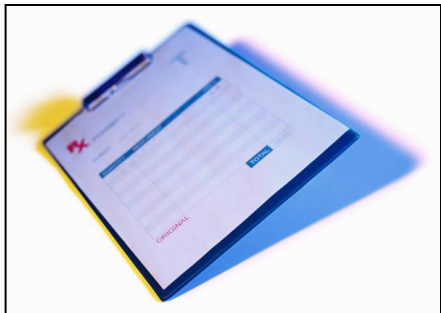
### **Prescription Drugs Obtained at a Non-Participating Retail Pharmacy**

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

Reimbursement will be made based on the Ameren negotiated discounted Average Wholesale Price (AWP) of the drug minus the applicable \$3 or \$6 Copay regardless of what is actually paid for the drug. For example, if You fill a generic prescription at a non-participating Pharmacy at a cost of \$40, and the discounted Average Wholesale Price of the Generic Drug is actually \$35, You will be reimbursed \$32 (the \$35 discounted wholesale cost less the \$3 Generic Copay).

## Prescription Drugs Obtained Through the Home Delivery Program

Members may purchase prescription drugs through the Express Scripts Home Delivery Program prescription drug service. This program works best for people who are taking maintenance drugs to treat chronic or long-term health conditions such as arthritis, diabetes, asthma, heart conditions, and high blood pressure. By using the home delivery service, You may obtain up to a 90-day supply of a drug, and pay the equivalent of two retail Copays.



- You pay a \$6 Copay for each prescription or refill of Generic Drugs or for a Brand Name Drug where there is no generic equivalent (up to a 90 day supply).
- You pay a \$12 Copay for each prescription or refill of Brand Name Drugs where there is a generic equivalent (up to a 90 day supply).

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

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

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

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

## Specialty Pharmacy for Treatment of Chronic Illness

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

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

- A patient care coordinator, who serves as Your personal advocate and Your point of contact. This highly trained individual works closely with Your Physician to obtain prior authorizations and coordinate billing. Your coordinator will even contact You when it's time to refill your prescription.
- A complete specialty Pharmacy inventory, with many specialty medications that aren't readily available at a local Pharmacy.
- Delivery of Your medications directly to You or Your Physician.
- Supplies needed to administer Your medications, at no additional cost.
- Clinically based care-management programs, which include consultation with Your Physician, to help You get the most benefit from the specialty medications Your Physician has prescribed.

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

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

### **Covered Drugs**

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

- A drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician or other lawful prescriber;
- Compounded medication of which at least one ingredient is a prescription drug;
- Insulin, glucose monitors and other diabetic supplies including pump supplies (however, insulin pumps are covered under the medical portion of the Plan, see **DURABLE MEDICAL EQUIPMENT** within the **COVERED EXPENSES** section of this booklet);
- Tretinoin, all dosage forms (e.g. Retin A) for Members through the age of twenty-five (25) years, unless a Member over age twenty-five (25) is prescribed the medication for Medically Necessary Care.

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

### **Drugs Not Covered**

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

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

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

## **Clinical Programs**

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

### Drug Utilization Review

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

## Drug Quantity Management

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

## Prior Authorization

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

## Step Therapy

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

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

## **Prescription Drug Program for Medicare Eligible Participants**



Effective January 1, 2012, The Prescription Drug Program ("Program") is considered to be Medicare Part D coverage for Medicare eligible participants. It is administered by Express Scripts, who contracts with the federal government. As long as you are a participant in the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** and you are eligible for Medicare, you are automatically enrolled in this Program.

If you do not want to participate in the Ameren Prescription Drug Program because you participate in another health plan that includes drug coverage under Medicare and/or you would prefer to join a Part D plan not offered by Ameren, you may choose to opt out. However, if you opt out, you will lose your medical coverage with Ameren and you will not be able to re-enroll at a later date.

If you choose to opt out of the Ameren coverage, and you do not have another Medicare Part D drug plan, you should consider joining a new prescription drug plan as soon as possible. If you

decide not to join a prescription drug plan and have opted out of the Ameren coverage, you may be subject to a late enrollment penalty if you choose to join a Medicare Part D plan later.

You cannot be enrolled in more than one Medicare Part D plan. If you have Medicare medical or drug coverage from any other source, you may be in jeopardy of losing that coverage if you are also enrolled in the Ameren Prescription Drug Program. You must contact Your other plan issuer to let them know that you participate in a Medicare Prescription Drug Plan so that they can make the necessary changes to keep You enrolled.

Generally Medicare has limits as to when you can make changes to your coverage. You can join a new Medicare Prescription Drug Plan or Medicare Health Plan each year from mid-October to early December (dates may vary). You may not be able to join a new plan during other times of the year except in special cases. For example, if Medicare decides that you need extra help with paying plan costs, you may join or leave a Part D plan at any time. And, if Medicare decides that you no longer need extra help, you may make changes for two months after Medicare notifies you of their decision. You can contact 800.MEDICARE **(800.633.4277)** to see if you might qualify for assistance if you have low or limited income.

If it is determined by Medicare that you qualify for extra help with drug plan costs, and you are enrolled in the Ameren Prescription Drug Program, Medicare will tell Express Scripts how much assistance you are receiving and they will send you information on the amount you will pay for your prescriptions under the Ameren Prescription Drug Program.

You will continue to pay your monthly premium to Ameren, if applicable, to continue your participation in the Plan. You must also continue to pay your Medicare Part B premium. Some participants may have to pay an extra amount to Medicare because of their annual income. If you fall into that category, You will receive a letter from the Social Security Administration telling you of the extra amount, and how you must pay it. This amount cannot be paid with your Ameren monthly plan premium.

Your Plan consists of a primary Part D plan and a secondary supplemental plan for the Coverage Gap Stage only. The pharmacy will only need to submit your prescription once to the Primary Part D portion of your Plan. During the Coverage Gap stage, if your prescription is identified as an applicable drug, (usually brand name drugs) the prescription will automatically process under the secondary supplemental coverage. Your correct copay is applied to your prescription in all stages of the benefit. You must present your ID card each time you fill a prescription to make sure that your coverage is applied correctly.

If the prescription is needed immediately, You should use the participating retail Pharmacy of Your choice. For ongoing prescriptions taken over longer periods of time (sometimes referred to as maintenance medication), You should consider using the Express Scripts Home Delivery option. For certain specialty medications, You may wish to use the Accredo specialty Pharmacy to fill Your prescription.

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

Information Needed	Who to Call	Website Address
<p>If You have questions about:</p> <ul style="list-style-type: none"> <li>➤ Retail network pharmacies</li> <li>➤ Status of Your claim or Home Delivery prescription</li> <li>➤ Claim history</li> <li>➤ How to request a drug through the Home Delivery Program</li> <li>➤ Your cost or coverage for a drug</li> </ul>	<p>Express Scripts Customer Service <b>866.792.2737</b></p> <p>Be sure to identify Yourself as a Participant in the <b>Ameren Retiree Medical Plan (Pre-92 Plan Benefits)</b> and have available the Retiree's social security number, or their Express Scripts assigned alternate identification number.</p> <p>If You are a surviving Dependent of a Retiree, have available Your own social security number, or Your Express Scripts assigned alternate identification number.</p>	<p><a href="http://www.express-scripts.com">www.express-scripts.com</a></p> <p>You can create Your own personal profile so Your information will only be available to You.</p>
Specialty Pharmacy	<p>Accredo Customer Service <b>866.848.9870</b></p>	
If you have questions about receiving help with your drug costs:	<p>Medicare <b>800.633.4227</b> 877.486.2048 TTY users</p>	<a href="http://www.medicare.gov">www.medicare.gov</a>
If you have questions about any extra premium amounts payable to Medicare:	<p>Social Security Administration <b>800.772.1213</b> 800.325.0778 TTY users</p>	

### Prescription Drugs Obtained at a Participating Retail Pharmacy

All participating retail pharmacies can provide You with a one month or 34 day supply of a covered prescription drug and certain pharmacies may be able to provide You with a 90 day supply of Your prescription. Certain medications subject to the Drug Quantity Management Program may be subject to a maximum 30 day supply at the retail Pharmacy. (See **DRUG QUANTITY MANAGEMENT** within this **PRESCRIPTION DRUG PROGRAM** section). Your prescription drug ID card must be presented to the pharmacist when You have the prescription filled. The following table provides a summary of your benefits. If you are receiving help from Medicare with prescription drug costs, you may pay something other than what is reflected here.

<b>Initial Coverage Stage</b>	<p><u>Retail Pharmacy (up to a 34 day supply)</u> \$3 Copay: Generic or Brand Name Drug when no Generic is available \$6 Copay: Brand Name Drugs</p> <p><u>Retail Pharmacy (35-90 days supply)</u> \$6 Copay: Generic or a Brand Name Drug when no Generic is available \$12 Copay: Brand Name Drugs</p> <p><u>Home Delivery (90 day supply)</u> \$6 Copay: Generic or a Brand Name Drug when no Generic is available \$12 Copay: Brand Name Drugs</p> <p>For 2018 You remain in this stage until the total cost of your Part D drugs reaches \$3,750. Once you reach this limit, you move on to the Coverage Gap Stage.</p>
<b>Coverage Gap Stage</b>	<p><u>Retail Pharmacy (up to a 34 day supply)</u> \$3 Copay: Generic or Brand Name Drug when no Generic is available \$6 Copay: Brand Name Drugs</p> <p><u>Retail Pharmacy (35-90 days supply)</u> \$6 Copay: Generic or a Brand Name Drug when no Generic is available \$12 Copay: Brand Name Drugs</p> <p><u>Home Delivery (90 day supply)</u> \$6 Copay: Generic or a Brand Name Drug when no Generic is available \$12 Copay: Brand Name Drugs</p> <p>For 2018, you remain in this stage until your out-of-pocket costs reach \$5,000. Once you reach this limit, you move on to the Catastrophic Coverage Stage.</p> <p><b>Note:</b> The secondary supplemental coverage applies the same copays during the Coverage Gap Stage. Manufacturer discounts may be applied to help pay for drug costs. These may appear on your Explanation of Benefits (EOB) under "Medicare Coverage Gap Discount Program" and will also apply to your out-of-pocket amount.</p>
<b>Catastrophic Coverage</b>	<p>The applicable copay prior to reaching the Catastrophic Coverage Stage is \$3 for up to 34 days or \$6 for greater than 34 days.</p>

**Note:** You pay no (\$0) Copay for covered insulin and for covered diabetic supplies, regardless of when they are purchased.

There are no claim forms to complete if the prescription is purchased from a participating retail Pharmacy that honors this Prescription Drug Program. Any Copays You pay for a prescription drug under this Program cannot be used to satisfy any applicable annual Deductible or annual Out-of-Pocket Maximum applicable to medical benefits under the Plan. Under this Program, the

prescription quantity dispensed by the pharmacist is limited to the lesser of the amount normally prescribed by a Physician, or for certain drugs the amount indicated through clinical programs (see **CLINICAL PROGRAMS** within this **PRESCRIPTION DRUG PROGRAM** section).

Since the Express Scripts organization is recognized nationwide, the Prescription Drug Card will be easy to use wherever You are. Most pharmacies in the United States participate in the Express Scripts Pharmacy network, but You should contact Your Pharmacy to verify its participation. You may also call Express Scripts at **866.792.2737** or access Express Scripts online at [www.express-scripts.com](http://www.express-scripts.com) to find participating pharmacies. The participating pharmacies for Medicare eligible Members may be different than for non-Medicare Members.

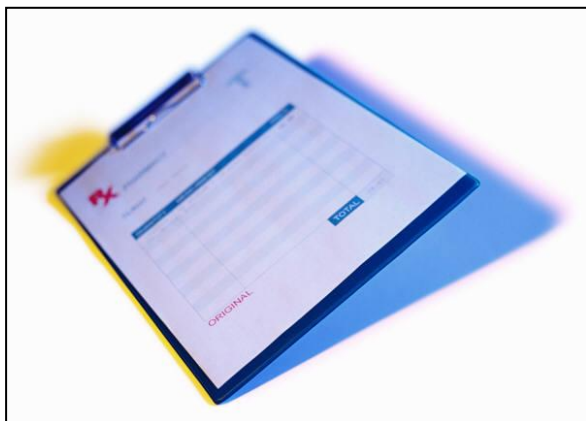
If You are told at a retail Pharmacy that the Plan does not cover Your prescription, please contact Express Scripts at **866.792.2737** to determine the reason.

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

If You have a prescription filled at a non-participating Pharmacy, (for example, You visit a non-participating Pharmacy while on vacation in the United States), the full cost of the prescription must be paid at the time of purchase and a completed claim form submitted to Express Scripts for reimbursement within one year of the purchase. Claim forms may be obtained either by calling Express Scripts at **866.792.2737** or by visiting their website [www.express-scripts.com](http://www.express-scripts.com).

If you have a prescription filled at a pharmacy in a foreign country, you will not be able to receive reimbursement under the Plan due to Medicare regulations prohibiting reimbursement of these types of drug claims.

### **Prescription Drugs Obtained Through the Home Delivery Program**



All Members may purchase prescription drugs through the Express Scripts Home Delivery service. This program works best for people who are taking maintenance drugs to treat chronic or long-term health conditions such as arthritis, diabetes, asthma, heart conditions and high blood pressure. The Plan pays the full cost of Your prescriptions after You pay the applicable Copay. Any Copay You pay for a prescription drug is not reimbursable under any other Plan provision and cannot be applied to the annual Deductible or the Out-of-Pocket Maximum applicable to medical benefits under the Plan.

You pay a \$3 Copay for each prescription or refill of Generic Drugs, or Brand Name Drugs, up to a 34 day supply.

You pay a \$6 Copay for each prescription or refill of Generic or Brand Name drugs for a 35 to a 90 day supply.

Therefore it is most economical for You if Your Physician prescribes a 90-day supply whenever appropriate. A maximum of a 90-day supply of a covered drug may be ordered at a time.

Refills will not be dispensed until 60 days of Your 90-day supply has been used. If You need the medication immediately, ask the Physician to write two prescriptions, one for a 30-day supply and the other for a 90-day supply. Fill the 30-day prescription at a local participating Pharmacy for medication to use until the first Home Delivery arrives.

To enroll in the Home Delivery program, complete an Express Scripts patient profile/order form and send it, together with the prescription and applicable Copay, to the address printed on the form. The form may be obtained either by calling Express Scripts at **866.792.2737** or visiting their website [www.express-scripts.com](http://www.express-scripts.com). The Copay amount may be paid either by check or by credit card. The form explains how to pay by credit card. The prescription may also be refilled on-line (over the Internet) by visiting the Express Scripts web site at [www.express-scripts.com](http://www.express-scripts.com).

All prescriptions are reviewed by a pharmacist, checked for adverse drug interactions, and verified by quality control before they are dispensed and mailed. Generic Drugs will be dispensed when available and allowed by law, unless a Physician has indicated on the prescription that a Brand-Name Drug must be provided. It will usually take ten (10) to fourteen (14) working days to receive Your order.

Some drugs cannot be sent through the mail. For example, drugs that require refrigeration must be obtained at a local participating Pharmacy.

You may call Express Scripts Customer Service at **866.792.2737** if You have questions or need to check the status of an order. Members must identify themselves as participants in the Plan and be prepared to provide the Retiree's Social Security number or the Express Scripts assigned alternate identification number. If You are a surviving Dependent of a Retiree or Employee, have available Your own social security number, or Your Express Scripts assigned alternate identification number.

### **Specialty Pharmacy for Treatment of Chronic Illness**

If Your Physician has prescribed specialty drugs for You, You may obtain them through any specialty drug provider. For convenience, You may wish to use Accredo, a subsidiary of Express Scripts, to meet Your specialty Pharmacy needs.

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

- A patient care coordinator, who serves as Your personal advocate and Your point of contact. This highly trained individual works closely with Your Physician to obtain prior authorizations and coordinate billing. Your coordinator will even contact You when it's time to refill Your prescription.
- A complete specialty Pharmacy inventory, with many specialty medications that aren't readily available at a local Pharmacy.
- Delivery of Your medications directly to You or Your Physician.
- Providing supplies needed to administer Your medications, at no additional cost.

- Clinically based care-management programs, which include consultation with Your Physician, to help You get the most benefit from the specialty medications Your doctor has prescribed.

Accredo provides these services at no additional cost to You. You pay the Copay required under the prescription drug option for a maximum 34-day supply. If Your Physician prescribes a medication covered by the specialty Pharmacy program, Accredo may be used as the covered source for that medication. Accredo can then contact Your Physician to set up the next prescription.

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

### **Covered Drugs**

The Program uses a Formulary, or a list of drugs covered by the Plan to meet patient needs. The Formulary may be different than the Formulary for non-Medicare Members. As a general rule, if a drug is covered under Medicare Part D to treat certain conditions, it would be covered under this Plan. If a drug is considered not covered under Medicare Part D, it would not be covered under the **Ameren Retiree Medical Plan (Pre-92 UE)**.

The Formulary will also change from time to time. For example, drugs may be added or removed, or coverage limits may be applied to certain drugs. If a Formulary change is made that limits Your ability to fill prescriptions, You will be notified before the change is made.

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

1. A drug which under the applicable state or federal law may be dispensed only upon the written prescription of a Physician or other lawful prescriber;
2. Compounded medication of which at least one ingredient is a prescription drug;
3. Insulin, glucose monitors and other diabetic supplies including pump supplies (however, insulin pumps are covered under the medical portion of the Plan, see **DURABLE MEDICAL EQUIPMENT** within the **COVERED EXPENSES** section of this booklet);
4. Tretinoin, all dosage forms (e.g. Retin A) for Members through the age of twenty-five (25) years, unless a Member over age twenty-five (25) is prescribed the medication for Medically Necessary Care.
5. Fertility drugs as allowed under Medicare Part D
6. Serums, toxoids and vaccines as allowed under Medicare part D

### **Drugs Not Covered**

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

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

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

## **Clinical Programs**

The Plan has review programs in place that are designed to provide Members and their Physicians with the latest information about medications and treatment. By monitoring certain medications for safety and effectiveness, as well as potential drug interactions, these programs protect You against potential harm due to prolonged or inappropriate use of certain drugs. These programs work behind the scenes and usually do not require You to do anything; however, on occasion, Your Physician may need to contact Express Scripts and provide additional information for approval. The Plan's current clinical programs are described below and for more information, Members may contact Express Scripts at **866.792.2737**.

### Medication Therapy Management (MTM) Program

The Medication Therapy Management (MTM) program has been designed for Your specific health and pharmacy needs. This Program allows Members who are taking certain maintenance medications prescribed for the management of multiple chronic conditions (for example, asthma, congestive heart failure, diabetes, and hypertension) to review and discuss their medications with a pharmacist or licensed pharmacy intern. If You are identified as eligible to participate in the MTM Program, you will receive a letter explaining how it works. You can choose to opt out of this program but it is recommended that You take full advantage of this covered service if You are selected.

### Drug Utilization Review

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

### Drug Quantity Management

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

### Prior Authorization

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

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

## **Termination of Benefits**

### **Retirees**

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

- End of the month that You last paid the required premium for coverage;
- Date You reach the Lifetime Maximum Benefit; if applicable;
- Date of Your death;
- Date of termination of the **Ameren Retiree Medical Plan (Pre-92 Plan)**;

- Date the Company amends the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** to eliminate coverage for the class of eligible individuals to which You are a member;
- Date You become covered under another medical plan sponsored by Ameren (for example, You are covered under another active health plan of a company which has been purchased by Ameren, while also covered as a retiree under this Plan);
- Date You or a Covered Dependent participate in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent.

## Dependents

Coverage for Your Covered Dependents currently ends on the earliest of the following dates:

- End of the month that Your coverage as a Retiree ends except by reason of Your death (See **CONTINUATION OF BENEFITS FOR SURVIVING DEPENDENTS OF DECEASED RETIREES**);
- Except for divorce, the end of the month that Your Dependent(s) is no longer eligible (See **ELIGIBILITY**);
- Date that Your Dependent reaches the Lifetime Maximum Benefit under the Plan;
- In the case of a Covered Spouse, the date of Your divorce;
- In the case of a Covered Spouse, the date of Your legal separation;
- Date the Company amends the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** to eliminate coverage for the class of eligible individuals to which Your Dependent is a member;
- Date of the death of the Covered Dependent;
- End of the month that You last paid the required premium for Your Dependent's coverage; or
- The date You fail to provide the required proof of Dependent status, in accordance with the procedures determined by the Plan Administrator.

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

## Continuation of Benefits: Surviving Dependents of Deceased Retirees

In the event of Your death, Your Covered Dependents may automatically continue benefits offered by the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** or elect the continuation benefits in compliance with federal law (COBRA). If Your Covered Dependents elect a temporary extension of their coverage in the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** under COBRA, they will not be allowed to re-enroll in the Plan at any time in the future. The following paragraphs explain the difference between the two types of benefits.

Upon Your death, coverage for Your Covered Dependents under the Plan continues until the end of the month in which Your death occurred. The Plan Sponsor currently pays the cost of coverage for Your Covered Dependents during this period. Thereafter, Your Covered Dependents may continue

their coverage under the Plan by paying the applicable premium for the respective months, provided Your Covered Dependents have not elected to terminate the coverage. If Your Covered Dependents chose to continue the coverage offered by the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** following Your death, such coverage will end on the earliest of the following dates:

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

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

#### **Continuation of Benefits: Certain Surviving Dependents of Deceased Active Employees Where Dependent is Now Eligible for Medicare**

When surviving Covered Dependent(s) (of an Employee who died while Actively Employed at Ameren) become eligible for Medicare coverage, Medicare will become primary payer of medical expenses and the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** will be the secondary payer. The surviving Covered Dependent(s) will be required to pay the appropriate monthly premium, subject to the maximum premium provisions of the Plan.

It is very important that Covered Dependent(s) enroll in Medicare when they are eligible for Medicare benefits because if they are eligible for Medicare but don't enroll, they will still be covered under Schedule B (see "Schedule of Benefits") just as though they were enrolled in Medicare. This means the Plan will estimate and subtract the benefits Medicare would have paid and then pay benefits on the balance of the claim in accordance with Plan provisions.

#### **Continuation of Coverage Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

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

beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

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

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

Ameren has partnered with Conduent as the COBRA administrator. Members enrolled in COBRA benefits can obtain information regarding their COBRA benefits through [www.myAmeren.com](http://www.myAmeren.com) or by accessing it directly at [www.benefitsweb.com/ameren.html](http://www.benefitsweb.com/ameren.html). Instructions to access the website are provided when a COBRA event is initiated. The website 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. COBRA participants can also view the status of their account, including payment dates, payment amounts and COBRA coverage begin and end dates. 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 address for the COBRA administrator is:

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

## **Retiree**

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

## **Spouses**

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

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

## Dependent Children

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

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

## Newborn or Adopted Children

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

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

## Special Enrollment Rules for Qualified Beneficiaries

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

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

## Alternate Recipients under Qualified Medical Child Support Orders

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

## Length of Coverage

A qualified beneficiary's coverage may continue under COBRA as follows:

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

- (1) the Covered Retiree's death;
- (2) the Covered Retiree's divorce or legal separation;
- (3) a Dependent Child's ceasing to satisfy rules for Dependent status; or
- (4) the Covered Retiree becoming entitled to Medicare.

### **Notification and Election Requirements**

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

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

### **Address Changes**

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

### **Continuation of Coverage under the Trade Act of 1974**

Special COBRA rights apply to Retirees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These Retirees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family Members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Health Care Reimbursement Plan coverage ended. If You qualify or may qualify for assistance under the Trade Act of 1974, contact the Plan Sponsor for additional information. You must contact the Plan Sponsor promptly after qualifying for assistance under the Trade Act of 1974 or You will lose Your special COBRA rights.

### **If You Have Questions**

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

Questions concerning Your or any of Your Dependents' coverage under COBRA should be addressed to the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). The **Ameren Benefits Center** customer service representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

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

## Privacy Practices

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

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

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

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

## ANTHEM CALLER VERIFICATION POLICY

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

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

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

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

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

## Coordination With Other Benefits

### Introduction

This Coordination with other Benefits provision applies when a Member has health care coverage under more than one plan (as defined below). This method of Coordination of Benefits is sometimes referred to as the "benefit less benefit" or non-duplication of benefits method. The intent of this provision is to provide that the sum of benefits paid by all plans will not exceed the benefits that would have been paid by this Plan if no other coverage existed.

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

### Definitions

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

- **"Health plan"** shall mean any of the following that provides benefits or services for medical care or treatment. However, if separate contracts are used to provide coordinated payment for covered individuals of a group, the separate contracts are considered parts of the same health plan and there is no integration or coordination of benefits among those separate contracts, unless specifically indicated.
- **"Health plans"** are those medical benefits to which You or Your Covered Dependents are entitled through another group benefit plan. The benefits amount must be

subtracted from Covered Expenses before the Plan can determine what benefits are to be paid under the applicable Schedule of Benefits.

➤ **"Health plan"** includes:

- All medical benefits provided by any plan which an employer, Union, association or trustee contributes to or makes payroll deductions for either directly or indirectly. Health plans include any group insurance policy which provides reimbursement of Major Medical Expenses.
- Any group Blue Cross or Blue Shield plan or other hospital or medical benefit or severance plan.
- Any union welfare or other employee benefit organization plan.
- Expenses incurred for medical care, services or supplies which are paid for, payable by or provided by government plans, such as Medicare. If an individual is eligible for these governmental benefits, such as Medicare, the benefits which would have been received had they been applied for will be counted as health plans.

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

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

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

When this Plan is the primary health plan, it shall provide payment under this Plan without regard to the possibility that another health plan may cover some expenses unless expressly stated otherwise in this Plan. When this Plan is secondary, benefits under the primary health plan shall be coordinated with coverage provided under this Plan in order to avoid duplicate payment. If the benefits under the primary health plan for which a Member is seeking payment are less than the coverage set forth in this Plan and this health plan is secondary, this Plan shall cover the difference between such benefits under the primary health plan and the coverage set forth in this document.

The Plan reserves the right to:

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

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

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

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

### **Order of Benefit Determination**

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

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

- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care payment and the health plan of that parent has actual knowledge of those terms, that health plan is primary. This rule applies to claim determination periods or calendar years commencing after the health plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) divorced, the order of benefits is:
  - (1) the plan of the custodial parent;
  - (2) the plan of the Spouse of the custodial parent;
  - (3) the plan of the non-custodial parent; and then
  - (4) the plan of the Spouse of the non-custodial parent.
5. When a Dependent Child has coverage as a dependent under his/her spouse's plan, the plan that covered the Dependent Child the longest is the primary plan, and the plan that covered the Dependent Child the shorter period of time is the secondary plan. In the event the Dependent Child's coverage under the spouse's plan began on the same date as the coverage under either or both parents' plan, the order of benefits will be determined by applying the birthday rule in item 4 above.

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

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

John is an Ameren Retiree with family coverage under the Ameren Retiree Medical Plan, (Pre 92 Plan Benefits) with benefits for Hospital emergency room Services. Mary, his wife, works for ABC Corp., and is covered under another plan with Hospital benefits payable at 80% after a \$250 Deductible.

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

\$1000	Amount of Allowed Charges for Hospital Services for Mary
- 600	Paid by Mary's Plan
\$ 400	Unpaid balance
- 200	Ameren Deductible
\$ 200	Covered Amount subject to 80% Coinsurance
x 80%	
\$ 160	Amount payable by the Ameren Retiree Medical Plan (Pre-92 Benefits)

## Medicare Exception

Federal law generally requires that the Plan pay benefits before Medicare for Employees who are active (rather than retired). The Plan will pay secondary to Medicare, however, whenever permissible by federal law.

When You become eligible for Medicare, Medicare will become the primary payer of medical benefits and the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** will be the secondary payer. Claims for benefits should be filed with Medicare first and then submitted under this Plan. If You do not enroll in Medicare Part A and Part B, the Plan will estimate the benefit that would have been payable by Medicare and will consider payment based on the remaining charges. Therefore, it is very important that You enroll in Medicare Parts A and B as soon as You are eligible.

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

## TRICARE

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

## Subrogation and Reimbursement

### Applicability

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

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

### Subrogation

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

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

## Reimbursement

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

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.
- Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

### **Member and Dependent Obligations**

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Plan Sponsor has sole discretion to interpret the terms of the subrogation and reimbursement provision of the Plan in its entirety and reserves the right to make changes as it deems necessary.

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

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

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

### **Claim and Appeal Procedures for Eligibility**

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

All claims related to eligibility must be submitted to:

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

All appeals related to eligibility must be submitted to:

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

### **Responding to Your Eligibility Claim**

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

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

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

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

- The specific reason(s) for the denial of the claim;

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

### **Appealing Your Eligibility Claim**

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

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

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

### **If Your Eligibility Appeal Is Denied**

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

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

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

### **Deadline for Taking Legal Action**

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

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

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

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

### **Medical Claim Filing Procedures**

#### **For Members Not Eligible for Medicare:**

Participating Anthem Network Providers will file Your claims for You. Those participating providers will send Your claim to Anthem. If they incorrectly submit Your claim to Anthem, Anthem will notify the provider that the claim must be resubmitted to Anthem.

You are responsible for filing a completed claim form for all other medical claims (for example, claims for services You receive from Non-Network Providers with the Claims Administrator at the address below in order to obtain payment of Plan benefits.

Anthem Blue Cross Blue Shield  
P.O. Box 105187  
Atlanta, GA 30348

#### **For Members Eligible for Medicare:**

You must file all medical claims with the Claims Administrator at the address above in order to obtain payment of Plan benefits after Medicare has processed the claim. Your provider may file the claim for You, and once Medicare processes Your claim, it is automatically forwarded to Anthem for consideration. In order for Your claims to process accurately, You must provide Medicare and Anthem with Your coverage information when it is requested, generally in the first 30 days of becoming eligible for Medicare.

In the event that You must file a medical claim Yourself, please be sure Your claim includes the patient's name, Your name (if different from patient's name), provider of services, dates of service, diagnosis, description of treatment or service provided and cost of the service, and an Explanation of Benefits (EOB) from Medicare. The Claims Administrator may request additional information to substantiate Your claim or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in denial of the claim.

#### **Claim Filing Deadline**

All medical claims (regardless of whether the Member is Medicare-eligible) 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.

## Prescription Drug Claim Filing Procedures

Express Scripts' network Pharmacies will file Your prescription drug claims for You. If You purchase prescription drugs at a non-participating retail Pharmacy, You must pay the full cost of the prescription at the time of purchase and submit a completed claim form to Express Scripts for reimbursement. Claim forms may be obtained either by calling Express Scripts at **888.256.6131** or by visiting their website [www.express-scripts.com](http://www.express-scripts.com). Submit those claims to the following address:

Express Scripts, Inc.  
P.O. Box 66773  
St. Louis, MO 63166-6773  
Attn: Claims Department

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

## Determination Periods

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

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

## Urgent Care Claims

The claims administrator will make a benefit determination and notify You (or Your authorized representative) of its determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The Claims Administrator may notify You (or Your authorized representative) orally and then furnish a written notification no more than three calendar days later. If You did not follow the claims procedures or did not provide all of the necessary information, the Claims Administrator will notify You (or Your authorized representative) of the failure and the proper procedures or the specific additional information needed as soon as possible but not later than 24 hours after the claim was received. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide all additional information requested. The Claims Administrator will notify You (or Your authorized representative) of its determination as soon as possible, but not later than 48 hours after the earlier of the time the required

information is received by the Claims Administrator or the expiration of the specified period for providing the additional information.

### **Pre-Service Claims**

The Claims Administrator will make a benefit determination and notify You (or Your authorized representative) of its determination (whether adverse or not) within 15 calendar days after receipt of the claim. The 15-day period may be extended up to 15 additional days if the Claims Administrator determines that an extension is necessary due to matters beyond its control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing, prior to the expiration of the initial 15-day period, of the reason necessitating the extension and the date by which a decision is expected to be made. If the extension is needed because You have not submitted all the necessary information, the notice of extension will specifically describe the additional information that is needed. You will be afforded at least 45 days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received. If You do not follow the claims procedures, the Claims Administrator will notify You (or Your authorized representative) of the failure and the proper procedures as soon as possible but not later than 5 days after the claim was received.

### **Post-Service Claim**

The Claims Administrator will make a benefit determination and notify You (or Your authorized representative) in writing within 30 calendar days from receipt of a post-service claim. The initial 30-day determination period may be extended up to 15 additional days due to reasons beyond the Claims Administrator's control. If such an extension is needed, the Claims Administrator will notify You (or Your authorized representative) in writing within the initial 30-day period of the reason necessitating the extension and the date by which a decision is expected to be made. If a claim cannot be processed due to incomplete information, the Claims Administrator will send written notification prior to the expiration of the 30 calendar days explaining the specific information needed. You will have up to 45 calendar days to provide all additional information requested. The Claims Administrator will render a decision within 15 calendar days of either receiving the necessary information or upon expiration of 45 calendar days if no additional information is received.

In actual practice, benefits under the Plan may be processed and paid within a few days after the Claims Administrator receives the completed claim. If a claim cannot be paid, the Claims Administrator will promptly explain why.

### **Concurrent Care Claims**

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

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

### **Incorrectly Submitted Medical Claims**

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

### **Notice of Adverse Benefit Determination**

If Your claim is partially or wholly denied, the Claims Administrator's notice of the Adverse Benefit Determination (denial) will include:

- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one (1) year of the grievance or appeal decision if You appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge; and
- information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental Treatment, or about Your right to request this explanation free of charge;
- if the denial relates to a claim involving Urgent Care, a description of the expedited review process applicable to such claims;
- a description of available external review procedures; and,
- disclosure of the availability of and contact information for any applicable ombudsman established under law to assist individuals with the internal claims and appeals and external review procedures.

## Informal Inquiries Regarding Claims

### For Medical Claims:

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

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

### For Prescription Drug Claims:

You may direct informal inquiries regarding denial of prescription drug claims to Express Scripts, Inc. Member Services Department. They are available 24 hours a day, 7 days a week by calling **888.256.6131**.

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

## Appeals Procedures

If a medical or prescription drug claim results in an adverse benefit determination, You (or Your authorized representative) may appeal the decision as described below. If You or Your authorized representative does not file an appeal within the specified period, You will be barred from challenging the adverse benefit determination in the future.

### Appeals Process for Medical Claims

You have the right to appeal an Adverse Benefit Determination (claim denial). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

For pre-service claims involving urgent/concurrent care, You may obtain an expedited review. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your medical ID card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;

- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

You or Your authorized representative must submit all other requests for appeals in writing, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. Urgent Care). You or Your authorized representative must submit a request for review to:

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

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

To the extent required by law, the following rules will also apply to the Your appeal:

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

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

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

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

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental, Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination. By appealing the initial denial, You consent to the review of medical information pertinent to the claim by the above-referenced health care professional consulted in connection with the appeal. The identification of any medical experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be provided upon request, without regard to whether the expert's advice was relied upon in making the benefit determination.

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

If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

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

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

If a claim is partially or wholly denied on appeal, the notice will give the specific reason for the denial and reference Plan provisions on which the denial is based. The notice will include statements as to Your right to obtain upon request, without charge, access to and copies of all documents, records and other information relevant to the claim, to bring a civil action under Section 502(a) of ERISA or to pursue other voluntary alternative dispute resolution options. The notice will also describe any voluntary appeal procedures under the Plan. If the Claims Administrator relied on a rule, guideline, protocol, or similar criterion in denying the appeal, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. Notice of a denial based on Medical Necessity, Experimental treatment or a similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge.

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or

harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

### **Appeals Process for Prescription Drug Claims**

If You disagree with a prescription drug claim denial at a retail Pharmacy or through the Home Delivery Drug Program, you should contact Express Scripts at **888.256.6131**. Express Scripts will research the inquiry and will respond providing the rationale behind the denial. It may be necessary for Your or Your physician to provide additional information that will allow reconsideration of the claim.

If it is determined that based upon Express Scripts' analysis, the claim was properly denied, Your (or Your authorized representative) may contact the Claims Administrator for further consideration. A written appeal should be submitted to:

Express Scripts, Inc.  
Attn: Pharmacy Appeals  
6625 West 78<sup>th</sup> Street  
Mail Route BL0390  
Bloomington, MN 55439

Your written appeal should include Your (and retiree's, if applicable) name, the date You attempted to fill the prescription, the prescribing physician's name, the drug name and quantity, the cost for the prescription (if applicable), the reason You believe the claim should be paid, and any other written documentation to support the request for review.

**For Members Not Eligible for Medicare:** the appeal must be submitted to the Claims Administrator within 60 calendar days after receipt of the initial claim denial from Express Scripts.

**For Members Eligible for Medicare:** the appeal must be submitted to the Claims Administrator within 60 calendar days after receipt of the initial claim denial from Express Scripts.

If the claim appeal is not filed during this 60-day period, You may lose the right to file suit in federal or state court. The Claims Administrator will take into account all information submitted relative to the claim.

You have the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.

Appeals will be conducted by an appropriate qualified individual who was not involved with the initial claim decision nor a subordinate to that original decision maker. No deference to the initial claims denial will be given by the reviewer. If the claim was denied based on a medical judgment (including whether a treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or Appropriate), the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in that judgment and who was not consulted on the initial decision. By appealing the initial denial, You consent to review of medical information pertinent to the claim by the above referenced health care professional consulted in connection with the review of the appeal.

Upon request, You will be provided with the identification of medical experts whose advice was obtained in connection with the appeal whether or not the Plan relied on their advice.

The Claims Administrator will advise You of the decision on the appeal in writing within 60 days of receipt of the appeal. All claims decisions made by the Claims Administrator will be final, binding, and conclusive.

### **Voluntary Second Level of Appeals**

If You are dissatisfied with the Claims Administrator's appeal decision, a voluntary second level appeal may be available. This voluntary level of appeal will be a panel review, independent review or other process consistent with the entity reviewing the appeal. If You would like to initiate a second level appeal, You must contact the Claims Administrator in writing and request a second level appeal within 60 calendar days of Your receipt of the denial of the first level appeal. No fees or costs are imposed for this voluntary level of appeal and any statute of limitations or other defense based on timeliness will be tolled during the time that this second appeal is pending. The decision as to whether or not to submit Your benefit dispute to this voluntary level of appeal will have no effect on Your rights to any other benefits under the Plan. The Claims Administrator will not assert that You have failed to exhaust Your administrative remedies if You elect not to participate in this voluntary second appeal. For additional information regarding the availability of a voluntary second level of appeal, please contact the Claims Administrator.

### **External Review Procedures**

You may also have the right to request an external review of a claim following an Adverse Benefit Determination if it was based on medical judgment, or pertained to a rescission of coverage. External review is not available with respect to any denial, reduction, termination, or failure to provide payment for a benefit relating to an individual's failure to meet the Plan's eligibility requirements or based on an interpretation of the Plan's terms.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving Urgent/Concurrent care, You may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

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

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

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

You must include Your Member identification number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

## Legal Action

When claiming a benefit under the Plan, You must follow the claim filing procedures described in this section of this booklet. If Your claim is not paid to Your satisfaction, You have the right to request an appeal, the procedures for which are also described in this booklet section. If Your appeal is denied, You have the right to bring legal action against the Plan. Such legal action can be brought no earlier than 90 calendar days after You filed Your claim for benefits. However, You must exhaust the Plan's appeals process, not including any voluntary level of appeal, before You can file a lawsuit or take other legal action of any kind against the Plan. Further, You may not bring legal action against the Plan after one (1) year has elapsed following the date of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

## Facility of Payment

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

Payment of benefits for Non-Network Providers will be made to You or a Covered Dependent, unless there is an assignment of benefits to be paid directly to that provider providing the service. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Plan to the full extent of those payments.

- If payment amounts remain due upon Your death, those amounts may, at the Plan's option, be paid to Your estate, Spouse, child, parent, or provider of medical and Dental Services.
- If the Plan believes You are not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Plan may pay whoever has assumed responsibility for Your care and support.
- Benefits payable to an Anthem Network Provider will be paid directly to the Anthem Network Provider on behalf of You or a Covered Dependent.

### **Important Notice for Mastectomy Patients-Women's Cancer Rights Act of 1998**

If a Covered Retiree or a Covered Dependent elects breast reconstruction in connection with a mastectomy, such individual is entitled to coverage under this Plan for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Such services will be performed in a manner determined in consultation with the attending Physician and the patient. This coverage is also addressed within the **MEDICAL EXPENSE COVERAGE, COVERED EXPENSES** section of this booklet.

### **Miscellaneous Provisions**

#### **Plan Administration**

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

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

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

#### **Plan Amendment or Termination**

The Company hopes and expects to continue the **Ameren Retiree Medical Plan (Pre-92 Plan Benefits)** in the years ahead, but cannot guarantee to do so. Ameren Corporation, and any successor corporation which assumes the responsibilities of Ameren Corporation under the Plan, may amend or terminate the Plan or any benefit provided under the Plan from time to time or at any time, without advance notice thereof. Ameren Corporation, Ameren Services Company (as

agent for Ameren Corporation), an officer of Ameren Corporation or Ameren Service Company, or such officer's delegate may effect an amendment or termination of the Plan or a benefit provided under the Plan by written instruments describing the terms of such amendment or termination. Such amendment will be incorporated into this document.

The Administrative Committee may also amend the Plan through the issuance of revised Benefit Program booklets, enrollment materials, brochures, or Certificates.

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

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

### **Applicability**

The provisions of this document shall apply equally to the Covered Retiree and Dependents and all benefits and privileges made available to Covered Retiree shall be available to Covered Retiree's Dependents.

### **Nontransferable Benefits**

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

### **Severability**

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

### **Waiver**

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

### **Retiree-Only Plan**

This Plan is a retiree-only plan intended to only cover Retirees and eligible Dependents and not current Employees. As a retiree-only plan, most of the provisions of the Affordable Care Act do not apply to the Plan. To the extent the Plan is required to comply with certain aspects of the Affordable Care Act, the Plan is administered and interpreted in a manner consistent with that law.

### **Lost Distributees**

If any person to whom a check is issued in payment of a benefit under the Plan cannot be located or does not present the check for payment, the amount of the check may be applied to other Plan

purposes; provided, if any such person subsequently appears and makes demand for such payment, the Plan Administrator shall direct that such payment be made in full as soon as practical.

### **Recovery of Excess Payments**

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

### **Your Rights Under ERISA**

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

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for Yourself, Your Spouse or Your 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 the people who are responsible for the operation of the employee benefit plan. The people 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, 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 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, if, for example, it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

### General Information About the Plan

<b>Plan Name:</b>	Ameren Retiree Medical Plan (Pre-92 Benefits), a component part of the Ameren Retiree Welfare Benefit Plan.
<b>Type of Plan:</b>	A welfare benefit plan providing medical and prescription drug benefits.
<b>Plan Year:</b>	January 1 through December 31
<b>Plan Number:</b>	511
<b>Funding Medium and Type of Plan Administration:</b>	<p>The Plan is funded by contributions made by the Plan Sponsor. With the exception of certain Key Retirees, all contributions are paid directly to trusts established for the purpose of providing benefits under the Plan.</p> <p>Plan Sponsor has a contract with Anthem ("Claims Administrator") and Express Scripts, Inc. ("Claims Administrator") to provide certain services to the Plan, including claims administration. Benefits under the Plan are not guaranteed under a contract or insurance policy. The Plan Sponsor is ultimately responsible for providing the Plan benefits, and not the Claims Administrator.</p>

<b>Trustee:</b>	To the extent permitted under applicable law, medical and prescription drug benefits are paid out of trust funds held by The Bank of New York Mellon, located at 135 Santilli Highway, Everett, Massachusetts, 02149. If the trusts are terminated, the remaining assets will be distributed in accordance with the provisions of the trust agreements.
<b>Plan Sponsor:</b>	Ameren Corporation 1901 Chouteau Avenue Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
<b>Plan Sponsor's Employer Identification Number:</b>	43-1723446
<b>Plan Administrator:</b>	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149; Mail Code 533 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
<b>Claims Administrator for Medical Benefits:</b>	Anthem BlueCross BlueShield P.O. Box 105557 Atlanta, GA 30348
<b>Claims Administrator for Prescription Drug Benefits:</b>	Express Scripts One Express Way St. Louis, MO 63121
<b>COBRA Administrator:</b>	Ameren Benefits Center PO Box 5204 Cherry Hill, NJ 08034-5204 1.877.769.2637 <a href="http://www.myameren.com">www.myameren.com</a>
<b>Named Fiduciary:</b>	Administrative Committee c/o Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
<b>Named Fiduciary for Medical Claims and Appeals:</b>	Anthem Blue Cross Blue Shield P.O. Box 105557 Atlanta, GA 30348

<b>Named Fiduciary for Prescription Drug Appeals</b>	MCMC LLC (as contracted by Express Scripts) Attn: ERISA Plan Fiduciary Team 300 Crown Colony Drive Suite 203 Quincy, MA 02169
<b>Agent for Service of Legal Process:</b>	General Counsel Ameren Services Company 1901 Chouteau Avenue Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)  Service of Legal Process also may be made upon the Trustee or the Plan Administrator.