Ameren Retiree Health Reimbursement Account Plan

January 1, 2016

Summary Plan Description. The following is a Summary Plan Description for the **Ameren Retiree Health Reimbursement Account Plan**. This Summary Plan Description ("SPD") is effective January 1, 2016. The official Plan Document, which consists of both the Ameren Retiree Medical Plan and this SPD, contains all details about the benefits provided by the Plan and governs actual Plan operations.

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

Purpose

Ameren Corporation ("Ameren") maintains the **Ameren Retiree Health Reimbursement Account Plan** to allow eligible Retirees and their eligible Dependents the opportunity to be reimbursed for Eligible Medical Expenses that You pay out of Your pocket, such as premiums for coverage and Your share of Eligible Medical Expenses, that are not otherwise reimbursed by any other plan or program.

This document is a brief description of the **Ameren Retiree Health Reimbursement Account Plan** (collectively, the "Plan").

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

As a Participant in the Plan, Your rights and benefits are determined by the provisions of the Plan. This booklet briefly describes those rights and benefits. It outlines what You must do to be covered. It explains how to file claims. Aon Hewitt's *Your Spending Account*™ (YSA) administers the reimbursement of claims. This SPD contains a brief description of the principal features of the Plan and is not meant to interpret, extend or change the provisions of the Plan in any way. A copy of the Ameren Retiree Medical Plan document, which together with the SPD consists 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. This SPD shall govern if there is a discrepancy between this SPD and the Ameren Retiree Medical Plan document.

If You have any questions after reading this Summary Plan Description, please contact the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

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

The Company reserves the right to unilaterally amend or terminate the Plan and/or any benefits provided under the Plan at any time. The Plan shall be construed and administered to comply in all respects with applicable federal law.

PLEASE READ THIS 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.

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 for the **Ameren Retiree Health Reimbursement Account Plan**, call the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). The **Ameren Benefits Center** is available Monday through Friday from 8:00 a.m. to 6:00 p.m., Central Standard Time (CST).

Aon Hewitt's – Your Spending Account (YSA)

If You have questions about Your **Ameren Retiree Health Reimbursement Account Plan** balance, claims, reimbursement of claims, etc. call the **Aon Hewitt's *Your Spending Account™*** (**YSA) Customer Service** at **855.819.0011,** Option 1, Monday through Friday**,** from 8:00 a.m. to 8:00 p.m., Central Standard Time (CST).

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Eligibility

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

- Your retirement date;
- Your Years of Service at retirement;
- The Company You retired from;
- Your status while an active Employee (i.e. union affiliation, management, etc.);
- Your age at retirement;
- Your date of hire;
- Your participation or eligibility for participation in the group medical plan while an active Employee;
- Your current age;
- Your enrollment through the Aon Retiree Health Exchange, in a medical and/or prescription drug plan to supplement Your Medicare coverage.

Eligibility for the **Ameren Retiree Health Reimbursement Account Plan** for Retirees and surviving Dependents of active Employees is defined in the following matrixes.

Management Retirees[1]

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

- You were hired prior to October 1, 2015; AND
- You are a Retired Employee; AND
- Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan**; AND
- You accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND
- You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; OR;
- You were age 65 or older at the time of Your retirement; AND
- You are Medicare eligible based on Your age of 65 years or older.

You are eligible for coverage under this Plan if You are a Medicare eligible Dependent based on Your age of 65 years or older, of a deceased active management Employee who died on or after January 1, 2007, and who had accrued at least 10 Years of Service as an Employee of Ameren at the time of his or her death, and You were a Participant in the **Ameren Employee Medical Plan** for active Employees.

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

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

Company You retired from	Eligibility Rules
AmerenUE	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through June 30, 1993;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under one of the Company's active group health plans. ➢ You were age 55 on the date You retired from Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Union Electric ("UE") management Employee who died prior to July 1, 1993.
AmerenUE; Ameren Services; AmerenCIPS	➢ **You are a Retired Employee who:** ➢ **Retired on or after July 1, 1993 and through June 30, 1998;** AND ➢ Were a Participant in "UE" benefit plans prior to July 1, 1998; AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren Services, AmerenUE or AmerenCIPS; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active AmerenUE, Ameren Services or AmerenCIPS Employee who died on or after July 1, 1993 and through June 30, 1998 and who participated in "UE" benefit plans prior to his/her death.

Company You retired from	Eligibility Rules
AmerenUE; Ameren Services; AmerenCIPS; Ameren Energy Generating Company; Ameren Energy Marketing Company; Ameren Energy Fuels and Services Company; and, Ameren Energy	➢ **You are a Retired Employee who:** ➢ **Retired on or after July 1, 1998 and through December 31, 2006;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Employee who was, at the time of his death, employed by one of the companies listed in the column to the immediate left and who died on or after July 1, 1998 and through December 31, 2006.
Central Illinois Public Service Company (CIPS)	➢ **You are a Retired Employee who:** ➢ **Retired prior to January 1, 1992** from Central Illinois Public Service Company ("CIPS") and on the day before You retired**:** ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND ➢ Were eligible for an early or normal retirement benefit from the CIPS Retirement Income Plan; AND ➢ Retired prior to reaching age 60 or retired at age 60 with less than 25 Years of Service ("Full Pay Retiree") ; AND ➢ You were covered under the Ameren Retiree Medical Plan (CIPS) or the Ameren Retiree Medical Plan (Post 1992 Benefits) until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased CIPS Retiree who met the eligibility requirements described above.
Central Illinois Public Service Company (CIPS)	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through June 30, 1998;** AND ➢ Were a Participant in "CIPS" benefit plans prior to July 1, 1998; AND ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND ➢ Were eligible for an early or normal retirement benefit from the CIPS Retirement Income Plan; AND ➢ You were covered under the Ameren Retiree Medical Plan (CIPS) or the Ameren Retiree Medical Plan (Post 1992 Benefits) until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased CIPS Retiree who met the eligibility requirements described above.

Company You retired from	Eligibility Rules
Ameren CILCO Ameren CILCO InfraServices Ameren Energy Medina Valley Cogen, LLC Ameren Energy Resources Generating Company	➢ **You are a Retired Employee who:** ➢ You retired prior to January 1, 2004, and on the day before You retired You were eligible for coverage under the Central Illinois Light Company Employee Welfare Benefit Program for Certain Management, Office and Technical Employees; OR ➢ **You retired on or after January 1, 2004; AND** ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Employee who, at the time of his death, was employed by one of the companies listed in the column to the immediate left and who died on or after January 1, 2004.

Former Contract Employees[2]

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

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

Employees represented by a collective bargaining agreement between	**Eligibility Rules**
Ameren Missouri and: IBEW Local Union 2 IUOE Local Union 148 IBEW Local Union 702 (Physical & Clerical) IBEW Local Union 1439 IBEW Local Union 1439 South IBEW Local Union 1455 IBEW Local Union 1455 Region West **Ameren Illinois** and: IBEW Local Union 309 IBEW Local Union 649 IBEW Local Union 702E – Illini IBEW Local Union 702S – Shawnee IBEW Local Union 702W – Great Rivers **AmerenEnergy Generating Company** and: IBEW Local Union 702 – Newton IBEW Local Union 702 – Newton Clerical IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville and Grand Tower) IUOE Local Union 148 – Coffeen Clerical	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2011;** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time (1455 and 1455 Region West) Employee covered under one of the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older; AND ➢ The collective bargaining agreement under which You retired must have expired. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2011.

[2]Regardless of the eligibility requirements outlined in the eligibility matrix for Contract Employees, You are eligible for coverage under this Plan if, prior to Your retirement under the Grand Tower Separation Plan, You were an employee represented by Local 148, I.U.O.E. (CIPS), had attained age 52 as of June 1, 2001, are age 65 or over, and, from the time of Your retirement until Your 65th birthday, You were covered under the Ameren Retiree Medical Plan.

Employees represented by a collective bargaining agreement between	**Eligibility Rules**
Ameren Illinois and: IBEW Local Union 51 **AmerenEnergy Generating Company** and: IBEW Local Union 51-Duck Creek and Edwards	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 2011;** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time Employee covered under one of the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2011.
AmerenUE and: IBEW Local 2 IUOE Local 148 IBEW Local 702 Physical IBEW Local 702 Clerical IBEW Local 1455 IBEW Local 1455 Region West IBEW Local 1439 IBEW Local 309 IBEW Local 649 IBEW Local 1439 South	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through June 30, 1994:** AND ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the **Ameren Employee Medical Plan** OR a regular part-time (1455 and 1455 Region West) Employee covered under the **Ameren Employee Medical Plan**; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee (listed to the left) who died prior to July 1, 1994.

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

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenCIPS and: IBEW Local 702E - Illini IBEW Local 702S – Shawnee IBEW Local 702W – Great Rivers **AmerenEnergy Generating Company and:** IBEW Local 702 – Newton IBEW Local 702 – Newton Clerical IUOE Local 148 – Coffeen, Meredosia, Hutsonville, Grand Tower IUOE Local 148 – Coffeen Clerical	➢ **You are a Retired Employee who:** ➢ **Retired prior to January 1, 1992;** AND ➢ Were eligible for an early or normal retirement benefit from the Central Illinois Public Service Retirement Income Plan; AND ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND ➢ Retired prior to reaching age 60 or Retired at age 60 with less than 25 Years of Service ("Full Pay Retiree"); AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased IBEW Local 702 (CIPS) Retiree or IUOE Local 148 (CIPS) Retiree who met the eligibility requirements described above.
AmerenCIPS and: IBEW Local 702E - Illini IBEW Local 702S – Shawnee IBEW Local 702W – Great Rivers **AmerenEnergy Generating Company and:** IBEW Local 702 – Newton IBEW Local 702 – Newton Clerical IUOE Local 148 IUOE Local 148 – Coffeen Clerical	➢ **You are a Retired Employee who:** ➢ **Retired on or after January 1, 1992 and through December 31, 1999**; AND ➢ Were a Participant in "CIPS" benefit plans prior to January 1, 2000; AND ➢ Were eligible for an early or normal retirement benefit from the Central Illinois Public Service Retirement Income Plan; AND ➢ Participated in the CIPS Group Medical Plan for at least 10 years prior to Your retirement date; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased IBEW Local 702 (CIPS) Retiree or IUOE Local 148 (CIPS) Retiree who met the eligibility requirements described above.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenCILCO and: IBEW Local 51	➢ **You are a Retired Employee who:** ➢ Retired prior to January 1, 2005, and on the day before You retired You were eligible for coverage under the Central Illinois Light Company Employee Welfare Benefit Program for IBEW CILCO Local 51; OR ➢ **You are a Retired Employee who:** ➢ **Was hired prior to January 1, 2017**; AND ➢ **Retired on or after January 1, 2005;** AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the Ameren Employee Medical Plan; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee listed to the left who died on or after January 1, 2005.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenEnergy Resources Generating Company and: IBEW Local 51 (formerly NCF&O Local 8)	➢ **You are a Retired Employee who:** ➢ You retired prior to January 1, 2007, and on the day before You retired You were eligible for medical benefits under the Central Illinois Light Company Employee Welfare Benefit Program for Members of the NCF&O Local 8; OR ➢ **You are a Retired Employee who:** ➢ Retired on or after January 1, 2007; AND ➢ Immediately prior to retirement, You were a regular, full-time Employee eligible for coverage under the Ameren Employee Medical Plan OR a regular part-time Employee covered under the Ameren Employee Medical Plan; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee (listed to the left) who died on or after January 1, 2007.
UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and: UGSOA Local Union 11	➢ **You are a Retired Employee who:** ➢ **Was hired piror to January 1, 2017**; AND ➢ **Retired on or after July 2, 2012**; AND ➢ Immediately prior to Your retirement, You were a regular, full-time Employee eligible for coverage under the Ameren Employee Medical Plan; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren; AND ➢ You were covered under the **Ameren Retiree Medical Plan** until Your 65th birthday if You retired prior to the age of 65; AND ➢ You are Medicare eligible based on Your age of 65 years or older. ➢ You are a Medicare-eligible Dependent based on Your age of 65 years or older, of a deceased active Contract Employee listed to the left who died on or after July 2, 2012.

Employees represented by a collective bargaining agreement between	Eligibility Rules
AmerenEnergy Generating Company and: IBEW Local Union 702 – Newton IBEW Local Union 702 – Newton Clerical IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville) IUOE Local Union 148 – Coffeen Clerical AmerenEnergy Resources Generating Company and IBEW Local Union 51-Duck Creek and Edwards	➢ **You are a Retired Employee who:** ➢ **Retired on or after December 1, 2013; OR** ➢ **Were on long term disability on December 2, 2013 and retired on or after December 2, 2013; AND** ➢ Were formerly represented by a collective bargaining agreement between the following Ameren companies and local labor unions when AER Generating Company, Ameren Energy Generating Company, or Ameren Energy Marketing Company were divested to Dynegy on December 2, 2013: • AmerenEnergy Generating Company and IBEW Local Union 702 – Newton; or • AmerenEnergy Generating Company and IBEW Local Union 702 – Newton Clerical; or • AmerenEnergy Generating Company and IUOE Local Union 148 (Coffeen, Meredosia, Hutsonville, and Grand Tower); or • AmerenEnergy Generating Company and IUOE Local Union 148 – Coffeen Clerical; or • AmerenEnergy Resources Generating Company and IBEW Local Union 51 (Duck Creek, and Edwards); **AND** ➢ Were age 55 or older on the date You retired; AND ➢ Immediately prior to retirement, You were a regular, full-time employee eligible for coverage under the **Ameren Employee Medical Plan**; AND ➢ Accrued at least 10 Years of Service after reaching age 45 as an Employee of Ameren. ➢ You are a Medicare-eligible Dependent of a deceased active Contract Employee (listed above) who died on or after December 2, 2013.

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

However, age sixty-five (65) and older Medicare-eligible Dependents of deceased active Employees are not eligible for coverage under the Plan if:

- the deceased Employee had less than 10 Years of Service at his or her time of death, except as provided below; OR

- the deceased Employee was not covered under the **Ameren Employee Medical Plan** at the time of his or her death; OR

- the Medicare-eligible Dependent was not covered under the **Ameren Employee Medical Plan** at the time of the deceased Employee's death; OR

- the Medicare-eligible Dependent was not covered under the **Ameren Employee Medical Plan** at the time he or she becomes eligible for Medicare based on age 65.

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

Dependents

If You enroll in this Plan, or in the **Ameren Retiree Medical Plan (Post 1992 Benefits)** or **Ameren Retiree Medical Plan (CILCO)** as a Retired Employee, Your Medicare-eligible Dependents age 65 and older are also eligible for coverage provided they are not serving in the active services of any armed forces of any country and You enroll them according to the appropriate procedures, and no later than thirty-one (31) days from the date of Your retirement. Eligible Dependents are limited to Your:

- Spouse; however, a Spouse who is covered under another Ameren-sponsored medical plan is not eligible for coverage under this Plan.
- Unmarried Medicare-eligible Dependent Children age 65 and older who are not capable of self-sustaining employment due to a disability continue to be eligible for coverage under the Plan, provided they continue to be dependent upon You for more than half of their support and remain disabled. Proof of the disability must be furnished to Anthem within 31 days of the date they would otherwise cease to be eligible under the **Ameren Retiree Medical Plan** or the **Ameren Employee Medical Plan**. 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 **Ameren Retiree Medical Plan** or **Ameren Employee Medical Plan** upon attainment of age 25 are not eligible for coverage.

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

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

The Plan may require at any time that a Retiree furnish proof of eligibility or continued eligibility of any Spouse or Dependent Child(ren). If false or misleading information is provided, it may result in any or all of the following actions: a) You will be required to reimburse Ameren for all benefits received by the ineligible individual under the Plan; b) immediate termination of all coverage under the Plan; and c) other legal action against You.

Enrollment Provisions for the Ameren Retiree Health Reimbursement Account

Retirees

In order to participate in the **Ameren Retiree Health Reimbursement Account Plan**, You must first meet the requirements as stated in the ELIGIBILITY section of this document:

- Be age sixty-five (65) or older; and,
- Enrolled in Medicare Part A and Medicare Part B; and,
- Enroll in an individual medical and/or prescription drug insurance policy through the Aon Retiree Health Exchange to supplement Your Medicare coverage.

Upon Your eligibility for this Plan, You will receive information from the Aon Retiree Health Exchange about how to enroll. You may enroll either by calling the Aon Retiree Health Exchange at an appointed time and use the assistance of a licensed Benefits Advisor, or You may make Your election on-line through **www.retiree.aon.com/ameren**. You must enroll in a supplemental Medicare policy through the Aon Retiree Health Exchange within the enrollment periods as defined by the Centers for Medicare and Medicaid Services (CMS).

However, If You are covered under another employer's active employee group medical plan, You can delay Your enrollment in Medicare Part B and a medical and/or a prescription drug insurance policy through the Aon Retiree Health Exchange and still be eligible for the **Ameren Retiree Health Reimbursement Account Plan**. If You are enrolled in Medicare Part B You are not eligible for this exception. (See RETIREE AND/OR ELIGIBLE DEPENDENT ENROLLED IN OTHER ACTIVE GROUP COVERAGE AND NOT ENROLLED IN MEDICARE PART B).

The effective date of Your eligibility for coverage in the **Ameren Retiree Health Reimbursement Account Plan** is the first day of the month in which You turn age sixty-five (65), or the first of the month following your enrollment if later. If Your birthdate is on the first of the month, Your coverage is effective the first day of the prior month. For your supplemental coverage to be effective the same day as Your Medicare coverage, You must enroll in a policy through the Aon Retiree Health Exchange, no later than the last weekday of the month in which You turn age 65, or the last weekday of the prior month if Your birthday is on the first day of the month. Generally, no medical exam or other proof of good health is required if You enroll within the timelines defined by the Centers for Medicare and Medicare Services (CMS).

If You are covering a Dependent, and only one of You is age 65 or older and Medicare eligible, the under age 65 eligible Participant will remain covered under an option in the **Ameren Retiree Medical Plan**.

Dependents

In order for Your Dependents to participate in the **Ameren Retiree Health Reimbursement Account Plan**:

- You must be a Retiree of an eligible group as provided in the ELIGIBILITY section of this document (See ELIGIBILITY).
- If You are under age 65, You must be enrolled in the **Ameren Retiree Medical Plan**.
- If You are age 65 or older, You must be enrolled in the **Ameren Retiree Health Reimbursement Account Plan**. However, if You are covered under another employer's active employee group medical plan, You can delay Your enrollment in Medicare Part B and a medical and/or a prescription drug insurance policy through the Aon Retiree Health Exchange and still be eligible for the **Ameren Retiree Health Reimbursement Account Plan**. If You are enrolled in Medicare Part B You are not eligible for this exception. (See RETIREE AND/OR ELIGIBLE DEPENDENT ENROLLED IN OTHER ACTIVE GROUP COVERAGE AND NOT ENROLLED IN MEDICARE PART B).
- Your Dependents must be age sixty-five (65) or older; enrolled in Medicare Part A and Medicare Part B; and enroll in a medical and/or a prescription drug insurance policy through the Aon Retiree Health Exchange to supplement their Medicare coverage.
- Your eligible Dependent, who is age sixty-five (65) or older and covered under another employer's active employee group medical plan, can delay enrollment in Medicare Part B and a medical and/or a prescription drug insurance policy through the Aon Retiree Health Exchange, and still be eligible for the **Ameren Retiree Health Reimbursement Account Plan**, as long as the Retiree is enrolled in an Ameren retiree medical program. If Your eligible Dependent is enrolled in Medicare Part B Your Dependent is not eligible for this exception. (See RETIREE AND/OR ELIGIBLE DEPENDENT ENROLLED IN OTHER ACTIVE GROUP COVERAGE AND NOT ENROLLED IN MEDICARE PART B).

Once Your Covered Dependents become eligible and enrolled, both You and Your Covered Dependents must be continuously enrolled in a supplemental individual Medicare medical and/or prescription drug policy purchased through the Aon Retiree Health Exchange in order to maintain eligibility for the **Ameren Retiree Health Reimbursement Account Plan.**

If You retire at age 65 or older:

If You retire at age 65 or older and enroll in the **Ameren Retiree Health Reimbursement Account Plan**, unless You elect otherwise, Your under age 65 eligible Dependents who had Dependent coverage in the **Ameren Employee Medical Plan** on the day before You retired will be automatically enrolled in the **Ameren Retiree Medical Plan** effective the first day of the month coinciding with the month of Your retirement, as long as they continue to meet the eligibility rules for the **Ameren Retiree Medical Plan** (See ELIGIBILITY).

If You retire at 65 or older and enroll in the **Ameren Retiree Health Reimbursement Account Plan**, unless You elect otherwise, Your age 65 or older eligible Dependents who had Dependent coverage in the **Ameren Employee Medical Plan** on the day before You retired, will be eligible to participate on the same day as You in the **Ameren Retiree Health Reimbursement Account Plan**, as long as they continue to meet the eligibility rules for the **Ameren Retiree Health Reimbursement Account Plan** (See ELIGIBILITY).

If You retire prior to age 65:

If You retire prior to age 65, when you attain age 65 and enroll in the **Ameren Retiree Health Reimbursement Account Plan**, unless You elect otherwise, Your eligible Dependents who are under age 65 and were covered as Dependents in the **Ameren Retiree Medical Plan**, will continue their coverage in that Plan, as long as they continue to meet the eligibility rules for the **Ameren Retiree Medical Plan** (See ELIGIBILITY).

If You retire prior to age 65, Your age 65 and older eligible Dependents who had Dependent coverage in the **Ameren Retiree Medical Plan,** will be eligible to participate in the **Ameren Health Reimbursement Account Plan**, as long as they continue to meet the eligibility rules for the **Ameren Retiree Health Reimbursement Account Plan** (See ELIGIBILITY).

Dependent Coverage Effective Date

The effective date of eligibility for coverage for Your eligible Dependents in the **Ameren Retiree Health Reimbursement Account Plan** is generally the first day of the month in which Your Dependent turns age sixty-five (65), or the same day as Your coverage under the **Ameren Retiree Health Reimbursement Account Plan** if You retire after age 65 and they are age 65 or older. They must be enrolled in a supplemental Medicare policy through the Aon Retiree Health Exchange with a coverage effective date which is also the first day of the month in which they turned age 65. If the effective date of coverage for the supplemental Medicare policy through the Aon Retiree Health Exchange is after the month is which he/she turns age 65, but within CMS enrollment guidelines, the effective date of the RHRA is also that date. (See the RETIREE HEALTH REIMBURSEMENT ACCOUNT (RHRA) AMOUNT section of this SPD for more information regarding your RHRA account.)

Generally, no medical exam or other proof of good health is required if You enroll within the timelines defined by the Centers for Medicare and Medicare Services (CMS). If Your Dependent does nothing, declines coverage, or enrolls in coverage with an effective date beyond the CMS timeline, they forfeit their eligibility for the RHRA and will not be able to enroll in the Plan in the future.

Upon Your retirement, You will have no later than 31 days from the date on Your Enrollment Worksheet to notify the Ameren Benefits Center of Your intent to enroll any eligible Dependents who are under age 65 in the **Ameren Retiree Medical Plan**, or who are age 65 or over in the **Ameren Retiree Health Reimbursement Plan**, and who were not covered under the **Ameren Employee Medical Plan** as a Dependent on the day before Your retirement. However, if Your eligible Dependent is age 65 or older, for their coverage under the **Ameren Retiree Health Reimbursement Account Plan** to be effective the first of the month coinciding with Your date of retirement, they must complete the enrollment process in a supplemental Medicare policy through the Aon Retiree Health Exchange prior to Your retirement date. If Your eligible Dependent is under age 65, their coverage under the **Ameren Retiree Medical Plan** is effective the first of the month coinciding with Your month of retirement as long as they are enrolled no later than the 31 day period from the date on Your Enrollment Worksheet. If You fail to notify and/or enroll any such eligible Dependent no later than the 31

day time period, such Dependent cannot be enrolled in the Plan in the future except under the circumstances described below under "ADDING DEPENDENTS AFTER RETIREMENT" below.

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

Adding Dependents After Retirement

The **Ameren Retiree Health Reimbursement Account Plan** does not allow newly acquired Dependents to be added to the Plan. Only Dependents who were covered at the time You became eligible for this Plan remain eligible, except for as described below.

If, at the time of retirement, You elected not to provide coverage under this Plan for an eligible Dependent who is age 65 or older (including Your Spouse) because he or she had other healthcare coverage, You may enroll the Dependent in this Plan in the future (provided he or she qualifies as an eligible Dependent) if the Dependent loses or will lose the other healthcare coverage and is not eligible for coverage under another employer's plan. In the case of an age 65 or older Dependent Child, that Dependent Child must have been considered disabled as of the date he or she would have lost healthcare coverage, with proof of the disability furnished to Anthem within 31 days of the date they would have otherwise ceased to be eligible under the **Ameren Retiree Medical Plan**. (See the **Ameren Retiree Medical Plan** Summary Plan Description for more information regarding eligibility for disabled dependent children, or contact the Ameren Benefits Center at **877.769.2637**, Option 2.) You may enroll an eligible Dependent in the Plan provided that You:

- Are covered under the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan;** or eligible for coverage under the **Ameren Retiree Health Reimbursement Account Plan**, but not yet enrolled due to enrollment under another active employee group health plan; AND
- Request enrollment of the Dependent no later than 31 days after the other coverage ends (either through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). For coverage in the **Ameren Retiree Health Reimbursement Account Plan** to be effective the first of the month following Your Dependent's loss of other coverage, enrollment through the Aon Retiree Health Exchange must be completed by the last day of the month in which the prior coverage was lost; AND
- Certify that Your Dependent is not eligible for coverage under another employer's plan. The Plan may request that Your Dependent provide a statement from his/her present or previous employer regarding eligibility for coverage.

Example: At the time of retirement, You did not enroll Your Spouse in the **Ameren Retiree Medical Plan** or the **Ameren Retiree Health Reimbursement Account Plan** because he/she was employed and had active or retiree group medical coverage through his/her employer. At the time of Your Spouse termination of employment:

- If Your Spouser is not eligible for any active or retiree group medical coverage through their employer, You may add Your Spouse to the Plan.
- If however, Your Spouse has, or is eligible for, active or retiree medical coverage available through his or her employer (regardless of the cost of coverage or the benefits provided under that plan), You may NOT add Your Spouser to this Plan.

Coverage in the **Ameren Retiree Health Reimbursement Account Plan** is effective the first of the month following Your Dependent's loss of other coverage, as long as enrollment through the Aon Retiree Health Exchange is completed by the last day of the month in which the prior coverage was lost. Otherwise coverage will be effective the first of the month following the month of actual enrollment in an individual policy obtained through the Aon Retiree Health Exchange.

In the event You marry after retirement from Ameren, the new Spouse is not eligible for coverage under this Plan nor the **Ameren Retiree Medical Plan**.

If You acquire a new under age 65 Dependent Child through birth, adoption or Placement for Adoption after You retire and while You are covered under this Plan, You may enroll the newly acquired under age 65 Dependent Child in the **Ameren Retiree Medical Plan.**

See the **Ameren Retiree Medical Plan** Summary Plan Description for more information regarding eligibility for Dependent Children, or contact the Ameren Benefits Center at **877.769.2637**, Option 2.

Retiree and/or Eligible Dependent Enrolled in Other Active Group Coverage and Not Enrolled In Medicare Part B[3]

This section is applicable only to those eligible participants who meet the exception rules as stated below and are not enrolled in Medicare Part B. If You are enrolled in Medicare Part B, even though You are enrolled in another employer's active group health plan, this exception does not apply to You.

Per Medicare rules, if You are enrolled in another employer's active employee group health plan, You can delay Your enrollment in Medicare Part B while enrolled in that plan.

If You and/or Your eligible Dependent are otherwise eligible to participate in this Plan, but are enrolled in another employer's active employee group health plan, and not enrolled in Medicare

[3] Regardless of the exception rules as stated in this section "Retiree and/or Eligible Dependent Enrolled in Other Active Group Coverage and Not Enrolled In Medicare part B", You are eligible for this exception if You were: covered under the Ameren Retiree Medicare Plan (Post 1992 Benefits), or the Ameren Retiree Medical Plan (CILCO), or the Ameren Retiree Medical Plan (CIPS), on December 31, 2014; eligible for this Plan effective January 1, 2015, AND; enrolled in both Medicare Part B and in another employer's active employee group health plan.

Part B, You must notify the Ameren Benefits Center no later than thirty-one (31) days following Your eligibility date for this Plan. Although You are not eligible to enroll in a supplemental Medicare policy through the Aon Retiree Health Exchange unless You are enrolled in both Medicare Part A and Part B, You will be eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan**.

When the other group health plan coverage ends, You must notify the Ameren Benefits Center at **877.769.2637**, enroll in Medicare Part B prior to enrolling in supplemental Medicare coverage through the Aon Retiree Health Exchange, and enroll in a supplemental Medicare policy through the Aon Retiree Health Exchange no later than thirty-one (31) days from the loss of the other coverage to continue to be eligible for the **Ameren Retiree Health Reimbursement Account Plan**.

In order to prevent a gap in coverage, You should notify the Ameren Benefits Center and the Aon Retiree Health Exchange, and enroll in a supplemental policy prior to Your last day of coverage under the other plan.

Retiree and/or Eligible Dependent Under Age 65 and Enrolled in Medicare Due to Disability

If You are under age 65 and already enrolled in Medicare due to a disability, Your coverage under the **Ameren Retiree Medical Plan** will end effective the last day of the month prior to the month in which You turn age 65. You must enroll in supplemental Medicare coverage through the Aon Retiree Health Exchange to be eligible for the **Ameren Retiree Health Reimbursement Account Plan.** You must enroll in an individual supplemental insurance policy to Medicare through the Aon Retiree Health Exchange prior to Your last day of coverage under the **Ameren Retiree Medical Plan** in order to prevent a gap in coverage.

Annual Medicare Enrollment Period

Each year, during the general Medicare open enrollment period (typically October 15 – December 7), You and Your Covered Dependent will be given the opportunity to change Your supplemental Medicare insurance policy or prescription drug policy by contacting the Aon Retiree Health Exchange. Changes in elections made during this Medicare open enrollment period will generally be effective January 1 of the following year and will be in effect for the full year. If You drop or decline the coverage You enroll in through the Aon Retiree Health Exchange at any time, Your eligibility for the **Ameren Retiree Health Reimbursement Account Plan** will end, and You are not eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan** in the future. Additionally, eligibility for Your Covered Dependents will also end and they are not eligible to participate in the Plan in the future.

Mid-Year Changes in Individual Supplemental Medicare Policies

Medicare has certain rules regarding joining, switching or dropping supplemental medical and/or prescription drug coverage which are outside of Your initial enrollment period. For specific information about enrollment rules, visit Medicare.gov or call Medicare at **800.633.4227**.

Tax Information

Except as noted below, the Company's contribution to Your RHRA and any expenses reimbursed generally is not taxable to You.

Is Your Dependent Child a 'Qualified Tax Dependent'?

A Dependent Child eligible for coverage under the **Ameren Retiree Health Reimbursement Account Plan** does not necessarily qualify for tax-free coverage under Section 105 of the Internal Revenue Code. If You cover a Dependent Child that does not qualify for tax-free coverage, the fair market value of the coverage provided for the non-qualifying Dependent Child under the Plan (less the portion of any premium You pay for such coverage) will be imputed as income to You.

If Your Covered Dependent Child does not meet the IRS requirements for tax-free health coverage, You can maintain the coverage, but You must inform the **Ameren Benefits Center** of the non-qualified tax status of the Dependent by calling 877.7my.Ameren (**877.769.2637**).

You are strongly encouraged to consult Your tax advisor for questions about this matter.

Medicare Part B Reimbursement Program

Reimbursement of a portion of Medicare Part B premiums may be available for a grandfathered group of "regular pay" retirees who retired from AmerenCIPS on or after January 1, 1992 and before July 1, 1998 (for management retirees) and December 31, 1999 (for contract retirees). Such retirees must have retired either at their normal retirement date or at an early retirement date, but with at least 25 years of service.

You must have retired from AmerenCIPS and were enrolled in either the **Ameren Retiree Medical Plan (CIPS)** or the **Ameren Retiree Medical Plan (Post 1992 Benefits)** on December 31, 2014 and are now enrolled in this Plan.

Each year, generally in April, the Plan or the Plan Sponsor will reimburse You for all or a portion of Your Medicare Part B premium You and Your Covered Dependents paid for the prior year.

Covered Surviving Dependents of eligible Retirees are not eligible for the Medicare Part B Reimbursement Program.

Definitions

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

Ameren means Ameren Corporation and includes only the following 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.

Auto-Reimbursement means if You enroll in a supplemental Medicare policy through the Aon Retiree Health Exchange that offers premium **Auto-Reimbursement**, once You pay Your monthly premium to the insurance company of the policy for which You enrolled, confirmation of Your premium payment will be automatically sent to the Claims Administrator and Your premium will automatically be reimbursed to You from Your RHRA Account.

Calendar Year means the time period of January 1 through December 31 of the same year.

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

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

Contract Employee means an Employee whose terms of employment were covered by a collective bargaining agreement.

Coverage Gap (or "Donut Hole") means a gap in a Medicare Part D prescription drug plan coverage or Medicare Advantage plan coverage during which the Participant is 100% responsible for the cost of his or her prescription drugs.

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

Covered 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.

Dependent means Your Spouse or Dependent Child, if that Spouse or child is not covered under this Plan as a Retiree, or under the **Ameren Retiree Medical Plan** as a Retiree or Dependent, or under the **Ameren Employee Medical Plan** as an Employee. To be eligible for this Plan, Your Dependent must be age 65 or older.

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

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

Eligible Medical Expenses means expenses incurred for Your or Your eligible Dependent's medical care, as that term is defined in Internal Revenue Code Section 213(d) (e.g. medical, dental and vision premiums, and other qualified expenses) that are not reimbursed through any other source. Only Eligible Medical Expenses Incurred while You are a Participant in the Plan may be reimbursed from Your RHRA Account. Eligible Medical Expenses are "Incurred" for the month of insurance coverage or when the medical care is provided, not when You are billed, charged or pay for the expense. **Eligible Medical Expense** does not include copayment or coinsurance for prescription drug coverage. (See the ELIGIBLE MEDICAL EXPENSES section of this SPD for more information.)

Employee generally means a person who is classified by the Company as an Employee of Ameren. Employee does not include, however, any individual classified by the Company as an independent contractor, leased employee, 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.

Ineligible Medical Expenses means expenses incurred for Your or Your eligible Dependent's medical care which are not eligible for reimbursement from the Ameren Retiree Health Reimbursement Account Plan.

Incurred means when the service is provided that creates the Eligible Medical Expense, and not when the service is billed or paid.

Joint Account means a **Retiree Health Reimbursement Account** (RHRA) for the benefit of You and, if applicable, Your Medicare-eligible Spouse, or other Medicare-eligible Dependents who are also eligible for the **Ameren Retiree Reimbursement Account Plan**. It is one RHRA account established in the name of the Retiree and any Covered Dependent to share.

Maximum Amount means the annual maximum amount the Company will credit to Your Ameren Retiree Health Reimbursement Account (RHRA). This amount is the lesser of (1) the applicable annual credit amount determined by the Company for You and Your Dependent; and (2) the annualized Retiree Medical Cap.

Minimum Retiree Premium means the minimum amount You are required to pay for the under age 65 eligible Participant's coverage in the **Ameren Retiree Medical Plan**. The minimum amount is 25% of Ameren's monthly premium to cover Yourself if You are under age 65, or 50% of Ameren's monthly premium for Your Covered Dependents if they are under age 65.

Participant means a Covered Retiree and Covered Dependent.

Plan means the **Ameren Retiree Health Reimbursement Account Plan**.

Plan Administrator means Ameren Services Company, or its delegate.

Plan Sponsor means Ameren Corporation.

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

Recurring Claim Reimbursement means claim reimbursement feature that allows You to receive a monthly reimbursement without having to submit a new claim every month for the following claim.

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

Retiree Health Reimbursement Account; Reimbursement Account; RHRA means an account whose purpose is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed by any other plan or program.

RHRA Balance Reminder/Balance Reminder means a RHRA Account statement in the fourth quarter of each year showing Your available balance and amounts paid to date.

Retiree Medical Cap means the most that the Company will contribute to Your and Your eligible Dependents' retiree medical coverage per month regardless of the number of Dependents You cover.

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 spouses (even if the state recognizes common-law marriages), ex-spouses, Domestic Partners, boyfriends, girlfriends or anyone else to whom the Retiree is not currently married.

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

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

For purpose of determining the RHRA contribution limits for Retirees and eligible surviving Dependents, Year of Service means the length of time which is used in the calculation of benefits under the Ameren Retirement Plan, which sometimes referred to as credited service.

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

Ameren Retiree Health Reimbursement Account Plan (RHRA)

The **Ameren Retiree Health Reimbursement Account Plan (RHRA)** offers You and Your eligible Covered Dependents a way to be reimbursed for certain health care costs that You pay for out of Your pocket, such as premiums for coverage and Your share of Eligible Medical Expenses. (See the ELIGIBLE MEDICAL EXPENSES section for more information.) Generally, there are three options of supplemental Medicare coverage: Medicare Advantage (Medicare Part C), Medicare Supplement (Medigap), and Medicare Prescription Drug coverage (Medicare Part D).

Once You become eligible, You must be continuously enrolled in an individual supplemental Medicare health care policy purchased through the Aon Retiree Health Exchange to maintain Your eligibility for the **Ameren Retiree Health Reimbursement Account Plan**.

When You become eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan**, the Company will credit a RHRA that will be automatically set up in Your name. The Company establishes a notional bookkeeping account for You and Your eligible Dependents that keeps record of the amounts allocated to Your account and reimbursements made to You under the Plan. Aon Hewitt's *Your Spending Account™* administers the RHRA.

You will receive enrollment information from the Aon Retiree Health Exchange before the first day of the month in which You become Medicare eligible, or at retirement if You are age 65 or older. Since the medical and prescription drug policies offered are individual supplemental Medicare health care policies, the enrollment period is defined by the Centers for Medicare and Medicaid Services (CMS).

If You have an age 65 Medicare-eligible Spouse or Dependent Child, You will receive a Company credit for them in Your RHRA, effective the first day of the month in which they each become Medicare-eligible, or at the time of Your retirement, as long as You remain eligible, and both You and Your Dependent are enrolled in an individual medical and/or prescription drug policy through Aon Retiree Health Exchange. This RHRA is a Joint Account.

If Your age 65 Medicare-eligible Spouse is also a Retiree of the Company, a separate RHRA will be established by the Company for each of You.

If You have any questions about the RHRA and how it works, contact the Aon Hewitt's *Your Spending Account™* **at 855.819.0011**, Option 1. You can also obtain information at the www.retiree.aon.com/ameren web site.

Retiree Health Reimbursement Account (RHRA) Amount

Each Plan Year, the Company allocates a certain amount of credit to a **Retiree Health Reimbursement Account** (RHRA) in Your name. You will also receive a credit for Your eligible Dependent in Your RHRA effective as of the first day of the month in which they each become Medicare-eligible and enroll in a policy through the Aon Retiree Health Exchange. Additional credit may be allocated for eligible Dependents. Reimbursement is available for Eligible Medical Expenses Incurred by both the Retiree and eligible Dependents. This credit can then be used to reimburse Eligible Medical Expenses Incurred by You, and Your eligible

Dependents who are also enrolled in a supplemental Medicare policy through the Aon Retiree Health Exchange.

When You first become a Participant, and on the first day of each Plan Year thereafter, the Company credits a specified amount to Your RHRA Account. The annual credited amount is based on the Company You retired from, the date of Your retirement, and/or age and Years of Service at the time of retirement. Separate credits will be made for an Eligible Retiree and his or her Eligible Spouse subject to certain maximums; however, the credits will be made to a Joint Account. In the event that both Spouses are Retirees of the Company, each Spouse will have their own RHRA and receive a separate credit to their RHRA. The amount Ameren credits to the RHRA is based on the number of covered months within that calendar year. The maximum amount that can be credited to your RHRA Account is described in the Appendix. To verify the amount credited to Your account, call the Aon Retiree Health Exchange at **855.819.0011**, Option 1.

You will receive information about the amount to be credited to Your RHRA along with your initial enrollment information, and then for each new Plan Year prior to January 1 of that year. The Plan allows You to carry over unused amounts from the previous Plan Year into the current Plan Year. A Plan Year begins on January 1 and ends on December 31.

For each calendar year that You are an eligible and enrolled Participant in the Plan, the Company will credit the full year's amount to Your RHRA as of January 1. If You turn age 65 and become Medicare eligible and a Participant in the Plan during the year, the credit to Your RHRA will be pro-rated based on the number of months you are a Plan Participant for that year. For example, if Your RHRA is established on March 1, Your credit will be 10/12ths of the amount that would have been credited if the RHRA had been established on January 1.

If Your age 65 or older Spouse or Dependent Child is a Participant in the Plan and then loses eligibility under the Plan, the amount credited to Your RHRA for Your Spouse or Dependent Child will remain credited to Your RHRA, as long as You are still an eligible and enrolled Participant in the Plan. Once Your Spouse or Dependent Child is no longer eligible, however, no further credits for Your Spouse or Dependent Child will be made to Your RHRA account. Reimbursement for Eligible Medical Expenses of Your Spouse or Covered Dependent Child will only be paid if the expenses were Incurred prior to the date of termination of that Participant's coverage under the Plan.

The amount in Your RHRA Account will be reduced from time to time by the amount of any Eligible Medical Expenses for which You are reimbursed under the Plan. At any time, You may receive reimbursement for Eligible Medical Expenses up to the amount in Your RHRA Account. Note that the law does not permit You to make any contributions to Your RHRA Account.

A RHRA account is merely a notional account on the Company's records. Your benefit under the Plan is limited to the credited amounts without any additional interest or earnings.

Expenses Incurred before You are enrolled for Plan coverage are not eligible for reimbursement.

Using Your RHRA

After You have enrolled in an individual insurance policy through the Aon Retiree Health Exchange, and paid Your medical and/or prescription drug premiums directly to the insurance carrier for the policy in which You have enrolled, you may submit a request for reimbursement to the Plan. (See HOW TO RECEIVE REIMBURSEMENT UNDER THE PLAN). As soon as payment of Your premium has been verified by the Claims Administrator, You can then receive reimbursement of those premiums from Your RHRA. You will be reimbursed up to the balance in Your RHRA. If You use Your entire balance, You will not be reimbursed for any additional premiums or expenses for that Plan Year, which is January 1 through December 31.

However, if You submit a claim for reimbursement which is approved, but only a portion of that claim is reimbursement up to the remaining balance in Your RHRA, the remainder of that claim will be reimbursed after the next Plan Year's RHRA amount has been credited to Your account. For example, if You have a balance of $400 in Your RHRA for 2016 and You submit a claim for $500, which is approved, You will be reimbursed the $400 balance in 2016. When the 2017 RHRA amount is credited to Your account on January 1, 2017, the remainder of the 2016 claim ($100) will be reimbursed to You.

How to Receive Reimbursement Under the Plan

Aon Hewitt's *Your Spending Account™* (YSA) is the Claims Administrator. Reimbursements are issued from a YSA bank account. If Your account is a Joint Account, You can request and receive reimbursements for You and Your Dependent's Eligible Medical Expenses up to Your current RHRA account balance. Your Dependent must also be eligible for and enrolled in the Plan.

Auto-Reimbursement of Premiums

If You enroll in a supplemental Medicare health care policy that offers premium Auto-Reimbursement, once You pay Your monthly premium to the insurance carrier of the policy for which You enrolled, confirmation of Your premium payment will be automatically sent to the Claims Administrator. Your premium will automatically be reimbursed to You from Your RHRA Account—up to Your current balance. You will not need to submit a claim form. You will receive a paper check mailed to Your home address, unless You elect to have it electronically deposited to Your bank account.

Note: Many individual supplemental Medicare health care policies offered through the Aon Retiree Health Exchange offer the Auto-Reimbursement option. If You enroll in a policy issued by an insurance carrier that does not offer this option, You will be responsible for submitting claims for reimbursement of Your premiums to the Claims Administrator. Please contact the Aon Retiree Health Exchange for information as to whether the policy You select is eligible for Auto-Reimbursement.

If You do not want the Auto-Reimbursement feature when You enroll in an individual supplemental Medicare health care policy through the Aon Retiree Health Exchange, or You want to decline it in the future, let the Aon Retiree Health Exchange know. If You decline the

Auto-Reimbursement feature, You will have to submit a manual claim form in order to be reimbursed for Your health care premiums. You can elect to stop the auto-reimbursement at any time. Contact the Claims Administrator at **855.819.0011**, Option 1.

If Your insurance policy has an Auto-Reimbursement feature in effect and the premium payment amount changes, Your insurance carrier will notify Aon, and Your reimbursement amount will be adjusted accordingly. No action is needed from You unless there is a need to have the adjustment made sooner. In that case, contact the Claims Administrator at **855.819.0011,** Option 1 and request a Premium Auto-Reimbursement Claim Form.

Filing a Form for Reimbursement

Eligible Medical Expenses under the Plan that are not reimbursed through the Auto-Reimbursement process can be reimbursed by completing and submitting a paper claim form to the Claims Administrator. Visit www.retiree.aon.com/ameren to print and complete the *Your Spending Account™* Claim form, or contact the Aon Hewitt's *Your Spending Account* at **855.819.0011**, Option 1. Each claim form contains a bar code that is specific to Your account information. You should only use claim forms that contain the bar code with Your information. Requests for reimbursement are processed daily. Keep a copy of the claim form and supporting documentation for Your records in the event of an IRS audit.

If You enroll in an additional medical or a prescription drug policy outside of the Aon Retiree Health Exchange, You will need to submit a manual claim form for that policy's premium reimbursement each month. However, remember that You must be enrolled in either a medical or a prescription drug policy through the Aon Retiree Health Exchange or both to be eligible for the **Ameren Retiree Health Reimbursement Account Plan**.

How to submit Your request for reimbursement

- Fax Your completed claim form and copies of receipts to the dedicated fax number, **888.211.9900**. A cover letter or cover sheet is not needed. OR;
- Mail Your completed claim form and copies of receipts to the address below (also listed on the claim form).

  Your Spending Account™
  P.O. Box 785040
  Orlando, FL 32878-5040

  OR:

- Upload Your claims on www.retiree.aon.com/ameren.

How You will receive Your reimbursement

There are two options in which to receive the reimbursement for Your claims:

- Paper check mailed to Your home mailing address on file, OR;
- Electronically deposited to Your bank account. With electronic reimbursement, funds are available to You more quickly. You can sign up for direct deposit by contacting the

Claims Administrator at **855.819.0011**, Option 1, or, visit www.retiree.aon.com/ameren and click on Your Profile. You will be required to enter Your bank account information, which can be found on Your personal checks.

Note: Banking laws do not permit electronic deposit (direct deposit) to international bank accounts. (This does not apply to U.S. territories such as Puerto Rico.)

Information required for reimbursement

To file a claim for reimbursement from Your RHRA, complete the *Your Spending Account* Claim form. You must sign and date the form verifying the expenses have not been reimbursed by another policy or plan. You need to include supporting documentation with Your claim form, showing the following:

Premium amount(s) paid:

- Coverage period start date; typically the first day of the month; and
- Proof of payment.

Common supporting documents may include:

- Bank statements;
- Copies of mailed checks; and
- Statements provided by Your insurance carrier.

When submitting a claim for reimbursement of Your out of pocket medical expenses, Your supporting documentation should include the following:

- Type of service;
- Date of service;
- Service provider;
- Who service is for; and
- Requested reimbursement amount;

Submit Your claims directly to the Claims Administrator:

Your Spending Account™
P.O. Box 785040
Orlando, FL 32878-5040

Notes:

- Prescription drug out-of-pocket expenses are not eligible for reimbursement, except as described under the "Catastrophic RHRA" section (see CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).
- Verbal or handwritten information for general merchandise, illegible receipts, credit card receipts, and statements with a forwarding balance will not be accepted as supporting documentation.

Recurring Claim Reimbursement

The Recurring Claim Reimbursement feature allows You to receive a monthly reimbursement without having to submit a new claim every month if You wish to be reimbursed in the following situations:

- If You are eligible for and enrolled in a Medicare Part D policy other than through the Aon Retiree Health Exchange; or
- Your monthly premiums for Your Medicare Part D and/or Medicare Part B coverage are deducted from Your monthly Social Security payment.

You can set up a Recurring Claim Reimbursement by contacting the Claims Administrator to obtain a Recurring Claim Reimbursement form. Then submit it along with documentation that shows the amount of the monthly premium You are paying and either the applicable insurance carrier, or a statement that it is being deducted from Your Social Security monthly payment. You will not need to submit another Recurring Claim form unless the premium amount changes. With the recurring claim form, the Claims Administrator will reimburse you each month for that same amount until you tell them to stop, or change the dollar amount.

You are responsible to notify *Your Spending Account*™ if Your premium amount changes, You discontinue payment of the premiums for which You are being reimbursed, or You dis-enroll from a policy from which You are being reimbursed. Contact Aon Hewitt's *Your Spending Account*™ at **855.819.0011**, Option 1.

Remaining RHRA Balance

If You do not use all the credit in Your RHRA during the year for reimbursement of Eligible Medical Expenses, any unused remaining balance is automatically rolled into Your next year's RHRA, as long as You continue to be eligible for and enrolled in the Plan. Any Ameren credit You receive for the following Plan Year will be added to Your remaining RHRA balance, if any.

Reimbursement Deadline Under the Plan

You have six (6) months to file a request for reimbursement after You are no longer eligible for the Plan. For example, if Your coverage under the Plan terminates because You are no longer enrolled in an individual supplemental Medicare policy through the Aon Retiree Health Exchange, You have six (6) months from the date Your Plan coverage ends to file a claim for reimbursement for Eligible Medical Expenses Incurred while You were covered under the Plan. Otherwise there is no deadline for requesting reimbursement as long as You continue to be eligible for and enrolled in the Plan and Your account remains active.

RHRA Statements

You will receive an RHRA Balance Reminder after January 1 of each year to confirm the annual credit that has been made to Your account for the new year. You also will receive an RHRA statement in the fourth quarter of each year showing Your available balance and amounts paid to date. Your available balance and any credit or reimbursement history can be obtained at any

time on the Aon Hewitt's *Your Spending Account* web site www.retiree.aon.com/ameren or by calling **855.819.0011**, Option 1.

Forfeiting Your RHRA Account Balance

The amount credited to Your RHRA will be forfeited in the situations described below. Any credits that are forfeited are not available to You, Your Spouse, Your Dependents, or Your estate.

- If You have an RHRA, and as of the date of Your death, You do not have a surviving Spouse who was Medicare eligible based on age 65 or older before the date of Your death and enrolled in the Plan, any balance remaining in the RHRA as of the date of Your death is forfeited. Your estate will have six (6) months from the date of Your death to file claims for reimbursement for any Eligible Medical Expenses You Incurred prior to the date of Your death.
- If Your coverage under the Plan ends, (e.g., You terminate coverage under Your individual supplemental Medicare medical and/or prescription drug policy purchased through the Aon Retiree Health Exchange), the credited amount remaining in Your RHRA after any Eligible Medical Expenses are reimbursed will be forfeited. Only Eligible Medical Expenses Incurred prior to Your termination of Plan coverage can be reimbursed from Your RHRA. You have six (6) months to file requests for reimbursement after You are no longer eligible for the RHRA.

Reimbursement After Your Death

If You die while a Participant in the **Ameren Retiree Health Reimbursement Account Plan**, reimbursement from Your RHRA is not available for expenses Incurred after Your death. However, Your estate may request reimbursement of Eligible Healthcare Expenses Incurred before Your death (up to Your remaining RHRA balance) and while You were participating in the RHRA, as long as a request for reimbursement is filed within six (6) months following the date of Your death. Requests for reimbursement filed after the six-month (6) period will be denied.

The balance of the Joint RHRA will pass to the surviving Covered Spouse at the Retiree's (or Spouse's) death. If there is no surviving Spouse, the balance of the RHRA will be forfeited.

What Happens if there is an Overpayment or a Reimbursement is Made in Error

If it is later determined that You and/or Your eligible Dependent received an overpayment, or a payment was made in error (e.g., You were reimbursed from Your RHRA Account for an expense that is later paid by another medical plan), You or Your eligible Dependent will be required to refund the overpayment or erroneous reimbursement.

If You do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to You from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan

Administrator may treat the overpayment as a bad debt, which may have tax implications for You.

Catastrophic Retiree Health Reimbursement Account

Most Medicare Part D prescription drug plans currently have a limit on what they cover for prescription drugs. This limit creates a "Coverage Gap" (or "Donut Hole"). This means that after You and Your prescription drug policy have spent a certain amount of money ($3,310 for 2016) on covered prescriptions drugs in a Calendar Year (January 1 through December 31), You enter the Coverage Gap. While in the Coverage Gap, You will pay for Your prescription drug cost out of Your own pocket. Your prescription drug insurance policy will not share in the cost. However, while in the Coverage Gap, You will only pay a certain percentage of brand-named and generic drugs (see chart below). Since all Medicare prescription drug insurance policies are different, You should contact Your Aon Retiree Health Exchange Benefits Advisor, or the prescription drug insurance policy You are enrolled in about how the Coverage Gap works for You. The chart below shows what You pay for covered prescription drugs while in the Coverage Gap.

Year	You'll pay this percentage for brand-name drugs in the coverage gap	You'll pay this percentage for generic drugs in the coverage gap
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

Over the next several years, You pay a decreased percentage of your prescription drug cost while in the Coverage Gap until it's closed in 2020. By 2020, You'll pay only 25% for covered brand-name and generic drugs during the Coverage Gap—the same percentage You pay from the time You meet the deductible (if Your supplemental Medical policy has one) until You reach the out-of-pocket spending limit (up to $4,850 in 2016).

If Your out of pocket prescription drug expenses exceed the outer limit of the Coverage Gap ($4,850 in 2016), You move into the Catastrophic level of coverage and pay five percent (5%) of the cost of Your medication for the remainder of the Calendar Year. Each month that You fill a prescription, Your prescription drug insurance policy will send You an Explanation of Benefits (EOB) notice, which tells You how much You have spent on covered prescription drugs, and if You have reached and/or exceeded the Coverage Gap.

Because there is no limit on how much You could pay for prescription drugs, once You reach the Catastrophic level of coverage, the Company currently offers a special Catastrophic RHRA to assist You.

The Catastrophic RHRA is a separate RHRA that the Company establishes in Your name. It is intended to subsidize the cost of covered prescription drug expenses once You reach the Catastrophic level of coverage of Your Medicare Part D policy. The Catastrophic RHRA is based on each individual Participant's prescription drug expenses – it is not based on Your plus Your Dependents' prescription drug expenses.

You are only eligible for the Catastrophic RHRA if You are eligible for the regular RHRA. There was no limit on the amount You can request for reimbursement for qualified prescription drug costs under the Catastrophic RHRA for 2015. However, limits do apply beginning January 1, 2016. See the chart on the next page.

In order for You to request reimbursement from a Catastrophic RHRA, You must first submit the Explanation of Benefits (EOB) statement along with the prescription drug claim form to Aon Hewitt's *Your Spending Account*™ (YSA), indicating that You have entered the prescription Catastrophic coverage level under Your Medicare prescription drug policy. Once the EOB and claim for reimbursement have been received, YSA will create the Catastrophic RHRA and process the claim for reimbursement.

You do not have to use all the credit in Your regular RHRA before You can receive reimbursement for prescription drug expenses from the Catastrophic RHRA.

The chart below outlines the various cost steps in Medicare Part D prescription drug policies.

Yearly Deductible	What You pay for Your covered prescription drugs each Calendar Year before Your prescription drug policy begins to share in the cost of Your covered prescription drugs for that year.
Copayment or Coinsurance	After the deductible, this is the amount You pay for Your covered prescriptions drugs. Your Medicare Part D insurance policy pays the remainder of the cost of the covered prescriptions.
Coverage Gap ("Doughnut Hole")	After You and Your prescription drug policy have spent a certain amount of money for Your covered prescription drugs since the start of the Calendar Year, You enter the Coverage Gap. For 2016, when You and Your prescription drug insurance policy have paid $3,310 in covered prescription drug costs, You enter the Coverage Gap. While in the Coverage Gap, You may pay more out of Your pocket for the cost of Your prescription drugs – up to a limit. What counts toward the limit while in the Coverage Gap? • Your Yearly Deductible • Your Copayments or Coinsurance • What You pay while in the Coverage Gap What does not count toward the limit while in the Coverage Gap? • The monthly premium You pay for Your prescription drug insurance policy. • The amount Your prescription drug insurance policy paid for Your prescription drugs prior to reaching the Coverage Gap. • Cost of prescription drugs that are not on Your insurance policy's formulary (drug list).
Catastrophic Coverage	For 2016, when You have paid $4,850 out of Your own pocket for Your covered prescription drugs for the Calendar Year, You reach the Catastrophic Coverage level. Once You reach this level of coverage, You will be required to pay five percent (5%) of the cost of Your covered prescriptions for the remainder of the Calendar Year. When You have reached this level, Ameren will have a special Catastrophic RHRA established to assist You. For 2015, this special Catastrophic RHRA reimbursed You 100% of Your out-of-pocket covered prescription drug costs beyond this limit. However, <u>You will have a gradually increasing deductible over the next several years</u>. Effective January 1, <u>2016, the Plan will exclude Your first $250 of Catastrophic Coverage expenses</u>. It will be $500 in 2017, $750 in 2018, and $1,000 in 2019. Beginning 2020, the Catastrophic RHRA will no longer be available, which coincides with the closure of the Coverage Gap.

Below is a general example of how the Catastrophic RHRA works:

$ 320	Mary's yearly deductible under the prescription drug policy. Mary pays this amount ($320) out of her own pocket before her prescription drug policy shares in the cost of her covered prescriptions.
$2,990	The total amount of Mary's Copayment or Coinsurance share for her covered prescription drug costs, plus the share her prescription drug policy pays for her, prior to reaching the Coverage Gap. This amount ($2,990) does not include her yearly deductible.
$3,310	Mary has reached the Coverage Gap for 2016 once her prescription drug costs have reached this amount. The Coverage Gap starts when Mary's total covered prescription drug costs reach $3,310. This includes what she (her prescription drug policy deductible plus copayments or coinsurance) and her insurance policy have paid for her for covered prescription drugs since the start of the Calendar Year.
$ 4,850	Mary has reached the Catastrophic level once her out-of-pocket expenses for prescription drug costs have reached this amount. For 2016, $4,850 is the amount Mary must pay out of her own pocket before reaching the Catastrophic level of coverage. This amount includes her yearly deductible and the Copayments or Coinsurance she had paid since the beginning of the Calendar Year. It does <u>not</u> include the share her prescription drug policy has paid.
The greater of 5% Coinsurance; or $2.95 for covered generic drugs and $7.40 for covered brand-name drugs.	Mary has now reached the Catastrophic level of coverage because she has paid $4,850 out of her own pocket for prescription drugs. This is the amount she is required to pay for her covered prescription drugs for the remainder of the Calendar Year. After Mary has paid the first $250 in covered catastrophic expenses, Mary can be reimbursed for this additional amount for her covered prescription drugs (the greater of 5% Coinsurance or $2.95 for covered generic drugs and $7.40 for covered brand-name drugs) from a special Catastrophic RHRA that the Company will establish, upon request, in her name for the remainder of 2016. This special Catastrophic RHRA will reimburse Mary 100% of her out-of-pocket covered prescription drugs costs for the remainder of 2016 <u>after</u> she has reached the Catastrophic level and paid $4,850 out of her own pocket for prescription drugs, <u>in addition to</u> the first $250 in covered catastrophic expenses.

Accessing Your Retiree Health Reimbursement Account

You can access Your RHRA on the YSA website by visiting www.retiree.aon.com/ameren. There You can find information related to Your RHRA such as:

- Your RHRA account balance;
- Your recent RHRA activity;
- Status of Your reimbursements;
- Submit claims and documentation;
- Eligible Medical Expenses; and
- Add or update Your direct-deposit address.

Eligible Medical Expenses

Eligible Medical Expenses are expenses Incurred for the Participant's medical care, as that term is defined in Internal Revenue Code Section 213(d) (e.g. medical, dental and vision premiums) that are not reimbursed through any other source. Under the **Ameren Retiree Health Reimbursement Account Plan**, a wide variety of health care services, equipment and supplies are eligible for reimbursement.

Eligible Medical Expenses do not include items that are merely beneficial for Your general health (i.e., vitamins, dietary supplements), toiletries and items used for cosmetic purposes (i.e., Propecia, Rogaine, moisturizers, teeth whiteners, etc.), and over-the-counter drugs or medicines (other than insulin).

Additionally, Eligible Medical Expenses do not include copays and coinsurance for prescription drugs. Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (see CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).

Only Eligible Medical Expenses Incurred while You are a Participant in the Plan may be reimbursed from Your RHRA Account. Eligible Medical Expenses are "Incurred" when the medical care is provided, not when You are billed, charged or pay for the expense. Thus, an expense that has been paid but not Incurred (e.g.: pre-payment to a physician) will not be reimbursed until the services or treatment has been provided. Below is a chart summarizing Eligible Medical Expenses and Ineligible Medical Expenses. You may also view this listing of Eligible Medical Expenses, by visiting the www.retiree.aon.com/ameren website. From the Home page of the website, select "**Check Eligible Expenses**" from the "**Take Action**" menu on the right side of the webpage.

For a complete list of expenses allowed by the IRS and any special requirements for a service or supply (including those in the list above) to be reimbursable under the RHRA, refer to Internal Revenue Service ("IRS") Publication 502. This publication is available by calling 1-800-TAX-FORM (829-3676). You can also access IRS Publication 502 by logging on to the IRS web site at http://www.IRS.gov.

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Abortion	Eligible	
Acne products - specifically marketed for and used to treat acne	Potentially Eligible	Must provide prescription from a licensed health care professional.
Acne products - used for general hygiene, such as facial wash, cleaners, toner, and medicated makeup	Ineligible	
Acupuncture – treatment for a medical condition	Eligible	
Advance payments – nonrefundable advance payments to a private institution for lifetime care, treatment, and training of a physically or mentally impaired dependent after the death or disability of a legal guardian	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional documenting the disability or mental impairment.
Alcohol or drug addiction – payments to a treatment center including meals and lodging	Eligible	
Allergy prevention products – products to alleviate allergies, such as a pillow, mattress, or vacuum	Potentially Eligible	Must provide a statement of medical necessity from a licensed health care professional documenting the diagnosed allergy and that the product will help alleviate the allergy symptoms.
Allergy testing and shots	Eligible	
Ambulance service	Eligible	
Arch support – supportive foot products prescribed by a doctor to treat a medical condition	Eligible	
Artificial limbs	Eligible	
Automobile insurance premiums	Ineligible	
Automobile modifications – modifications of special equipment installed in an automobile for disabled Participant	Potentially Eligible	Must provide a statement of medical necessity from a licensed health care professional documenting the disability.
Birth control pills - (prescribed)	Potentially Eligible	Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (See CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses.

In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.

EXPENSE	COVERED?	MORE DETAILS
Birth control products – over-the-counter items such as gels and foams	Potentially Eligible	Must provide a prescription from a licensed health care professional. Products for general health purposes are not eligible.
Birth control products – over-the-counter items such as home pregnancy tests, condoms, and ovulation monitors	Eligible	
Birth control products – prescribed devices such as diaphragms, IUDs, and Norplant	Eligible	
Blood donation – costs associated with blood donation, including self-administered blood donations, stoat fees, and processing fees	Eligible	
Blood pressure monitors - expenses include electronic monitors and replacement blood pressure cuffs	Eligible	
Body scans	Eligible	
Bottled water	Ineligible	
Braille books and magazines – expenses limited to those that exceed regular printed copies	Potentially Eligible	Must provide receipt or advertisement with the cost of the regular printed version, and receipt for the Braille version.
Breast augmentation – elective procedures that do not promote proper functioning of the body or prevent or treat an illness or disease	Ineligible	
Breast feeding classes	Ineligible	
Breast pumps - prescribed by a doctor for medical reasons	Eligible	
Chelation therapy – to treat a medical condition such as lead poisoning	Eligible	
Childbirth classes – classes necessary to reduce pain during labor and delivery	Eligible	Expenses related to parenting techniques, infant CPR, and breast feeding are not eligible.
Chiropractor – treatment for a medical condition	Eligible	

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses.

In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.

EXPENSE	COVERED?	MORE DETAILS
Christian science practitioner – expenses paid to a practitioner for medical care	Eligible	
COBRA premiums – premiums paid on after-tax basis for continuation of group medical, dental or vision coverage	Eligible	
Contact lenses – including cases and enzyme cleaners	Eligible	
Cosmetic services and products – non-medically necessary (i.e. liposuction, hair transplants, electrolysis, laser treatments, face-lifts)	Ineligible	
Cosmetic services and products – necessary to improve a deformity related to a congenital abnormality or an injury resulting from an accident, trauma, or disfiguring disease (i.e. post-mastectomy reconstructive surgery)	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting the deformity, disfigurement, or injury. Service or product must promote the proper functioning of the body or prevent/treat an illness, injury or disease.
Counseling – marriage or family counseling	Ineligible	Other types of counseling such as mental health and psychiatric services are eligible.
Crutches	Eligible	
Dental coinsurance – out of pocket expenses not covered by another dental plan	Eligible	
Dental copayments	Eligible	
Dental deductibles	Eligible	
Dental expenses – i.e. fees for x-rays, fillings, braces, extractions, crowns and orthodontia	Eligible	
Dental implants – insertion of artificial teeth, bone drafting and follow-up care	Eligible	
Dental reasonable/customary – amounts not paid by a dental plan that exceed reasonable and customary limits	Eligible	
Dentures – includes dental fees, cleaning products and adhesives	Eligible	

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Diabetic supplies – i.e. insulin, needles, test strips	Eligible	
Diaper service	Ineligible	
Diapers (adult) – medically necessary as a result of a medical condition	Eligible	
Diapers (child)	Ineligible	
Dietician services – fees paid to a dietician when referred by a doctor for treatment of a medical condition	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional describing the medical condition, service prescribed and length of treatment.
Disability construction costs – i.e. construction entrance/exit ramps, adding handrails, modifying stairways at personal resident for a disabled participant	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional documenting the disability.
Disability equipment – installed equipment in home/car due to disability	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional documenting the disability.
DNA testing – for paternal responsibility	Ineligible	
Ear wax removal materials – kits and ear drops as prescribed by a doctor	Potentially Eligible	Must provide prescription from licensed health care professional for a medical condition.
Earplugs – prescribed by a doctor	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, product prescribed and length of treatment.
Erectile dysfunction – nonprescription medication, herbal remedies and nutritional supplements	Potentially Eligible	Must provide a prescription from licensed health care professional.
Erectile dysfunction – prescription medication to treat a medical condition	Potentially Eligible	Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (See CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).
Exercise equipment –prescribed by doctor for treatment of a medical condition	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, such as cardiac condition.

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Exercise equipment – for general health purposes or prevention of an undiagnosed disease	Ineligible	
Eye examinations	Eligible	
Eye surgery – to correct defective vision	Eligible	
Eyeglass tinting and coating	Eligible	
Eyeglasses - prescription glasses and nonprescription reading glasses	Eligible	
Flu shots	Eligible	
Fluoride treatment – installation and monthly rental charges of home fluoride water kit	Eligible	Must be recommended by a dentist.
Food (prescribed) – prescribed by a doctor to treat a medical condition (i.e. specialty baby formula and lactose-free foods). Cost limited to those that exceed common version of the product.	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, receipt or advertisement with the price of the commonly available version of the food item, and receipt for the prescribed food.
Funeral and burial expenses	Ineligible	
Future payments – down payments or payments for services that have not been rendered or products not received	Potentially Eligible	Lump-sum payments for future orthodontia services are an eligible exception. Once service is rendered, an itemized bill indicating the service date is required.
Hair regrowth treatment – prescription and nonprescription for cosmetic purposes	Ineligible	
Hair regrowth treatment – prescription and nonprescription to improve a deformity related to a congenital abnormality or injury resulting from an accident, trauma or disfiguring disease	Potentially Eligible	Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (See CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT). Must provide prescription from a licensed health care professional for over-the-counter medications.
Health care supplies – i.e. band aids, gauze, elastic wraps and bandages, braces, and supports	Eligible	

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Health club or YMCA dues – individual membership and personal trainer fees when prescribed by a doctor to treat a specific medical condition	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, the service or product prescribed and length of treatment.
Health club or YMCA dues – for general health, not related to a specific medical condition	Ineligible	
Hearing Aids	Eligible	
Hearing coinsurance - out of pocket expenses not covered by another hearing plan	Eligible	
Hearing copayments	Eligible	
Hearing deductible	Eligible	
Earing expenses – examinations and hearing aid batteries	Eligible	
Hearing reasonable/customary – amounts not paid by a hearing plan that exceed reasonable and customary limits	Eligible	
Hearing-impaired phone tools – telephone equipment that allows hearing-impaired Participant to communicate over a regular telephone	Eligible	
Hearing-impaired TV equipment – equipment that displays the audio part of TV programs as subtitles for a hearing-impaired Participant	Eligible	
Herbal remedies – prescribed by a doctor for a medical condition	Potentially Eligible	Must provide a prescription from licensed health care professional.
Hospital care – inpatient care including private room	Eligible	Personal convenience items such as television, telephone and concierge services are not eligible.
Household help	Ineligible	
Human guide – to assist a physically, mentally, visually, or hearing-impaired Participant	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting the disability.

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Humidifiers – portable units prescribed by doctor for treatment of a medical condition	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, the service or product prescribed and length of treatment.
Hypnosis – prescribed by a doctor for medical reasons	Eligible	
Illegal medical treatment – including surgery	Ineligible	
Immunizations	Eligible	
Infertility – treatments including artificial insemination, in-vivo or in-vitro fertilization, embryo placement, egg and sperm storage, and ovulation monitors	Eligible	
Laboratory and X-ray fees	Eligible	
Laetrile – anti-cancer drug	Ineligible	
Language training – training for a child with dyslexia or other learning disabilities	Eligible	
LASIK surgery	Eligible	
Lead-based paint removal – costs for residences with children who have or had lead poisoning	Eligible	
Legal fees – paid to authorize treatment for mental illness	Eligible	Does not include guardianship or estate management fees
Lens replacement insurance – to replace eyeglass or contact lenses	Ineligible	
Life and accidental death and dismemberment insurance premiums	Ineligible	
Lodging –cost of lodging not provided in a hospital or similar institution while away from home when primarily for and essential to medical care	Potentially Eligible	Limited to $50 per person per night and only applicable to the Participant and caregiver ($100 maximum per night). Must provide statement of medical necessity from a licensed health care professional documenting the medical condition.
Long-term care facility fees – room and board at a long-term care facility	Ineligible	
Long-term care premiums	Eligible	

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EXPENSE	**COVERED?**	**MORE DETAILS**
Massage therapy – prescribed by a doctor to treat an injury or trauma	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, the service or product prescribed and length of treatment.
Massage therapy – general health purposes	Ineligible	
Mastectomy-related products – i.e. breast prosthesis and specialty bras	Eligible	
Maternity care – service and supplies from doctors, midwives, clinics, hospitals, and laboratories	Eligible	3D and 4D ultrasounds are not eligible.
Maternity clothes	Ineligible	
Mattresses prescribed by a doctor to treat a medical condition	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting that the mattress is necessary to treat a medical condition, injury, or illness.
Medic alert identifications – prescribed by a doctor in connection with treatment of a medical condition	Eligible	
Medical alert programs – expenses include installation of equipment and monthly monitoring fees	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting that the medical alert program is necessary to treat a medical condition, injury, or illness.
Medical coinsurance	Eligible	
Medical conference – admission and transportation costs	Eligible	
Medical contract fees – fees for exclusive provider care (i.e. concierge services, boutique fees, and retainer fees)	Potentially Eligible	Once service is rendered, the expense is eligible. Must provide an itemized bill indicating the Participant's name, date of service, and description of the service provided. Fees for future service are not eligible.
Medical copayments	Eligible	
Medical deductibles	Eligible	

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Medical equipment – costs to buy or rent durable equipment prescribed by a medical practitioner to alleviate or treat a medical condition.	Eligible	
Medical information – costs to a medical information plan for storage and retrieval of medical information	Eligible	
Medical reasonable/customary – amount not paid by a medical plan that exceed reasonable and customary limits	Eligible	
Medical services – provided by doctors, surgeons, specialists, or other medical practitioners	Eligible	
Medical supplies – over-the-counter items such as bandages, thermometers, and heating pads	Eligible	
Medicare Part B Premiums	Eligible	
Medicare Part D Premiums	Eligible	
Mental health – psychoanalysis or amounts paid to a psychiatrist, psychologist, hospital, clinic or mental health facility for medical care	Eligible	
Mentally handicapped home – cost of a special home as recommended by a psychiatrist to help Participant adjust from mental hospital to community living	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting that the special home/facility is necessary.
Nursing or retirement home fee – for custodial services – i.e. room and board	Ineligible	
Nursing or retirement home fee – for medical services	Eligible	
Nursing services for newborns – services by healthcare professional to care for normal and healthy newborn at a hospital or at home	Ineligible	

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EXPENSE	**COVERED?**	**MORE DETAILS**
Nursing services – wages and other cost for nursing services for Participant at home or in a facility such as a nursing home or rehabilitation center	Eligible	Home health care and private duty nursing are eligible. Fees for personal and households services are not eligible.
Nutritional supplements – prescribed by a doctor to treat a diagnosed medical condition	Potentially Eligible	Must provide a prescription from a licensed health care professional.
Nutritional supplements – for general health purposes.	Ineligible	
Occupational therapy	Eligible	
Organ donor – surgical, hospital, laboratory, and transportation expenses for an organ donor, if Participant paid the donor's expenses	Eligible	
Orthodontic fees	Eligible	
Orthopedic shoes and inserts – shoes and inserts prescribed by a doctor for a medical condition. Costs limited to those that exceed the cost of regular footwear	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, and a receipt or advertisement with the price of the commonly available version of the item.
Over-the-counter medicine – for general health purposes	Ineligible	
Over-the-counter medicine – to relieve pain, colds, and medical conditions	Potentially Eligible	Must provide prescription from a licensed health care professional.
Oxygen or oxygen equipment – for rental or purchased equipment to relieve breathing problems caused by a medical condition	Eligible	
Pain relievers	Potentially Eligible	Must provide prescription from a licensed health care professional.
Personal-use items – includes toiletries and cosmetics	Ineligible	

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EXPENSE	**COVERED?**	**MORE DETAILS**
Personal-use items – to prevent or ease a physical or mental defect of illness. Cost limited to those that exceed common version of the product	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional describing the medical condition, and a receipt or advertisement with the price of the commonly available version of the item.
Physical examinations – routine physical exams and related charges	Eligible	
Physical therapy	Eligible	
Premiums for medical insurance	Eligible	Must be premiums paid on an after-tax basis.
Prenatal vitamins - prescribed by a doctor for use during pregnancy	Eligible	
Prescription drugs	Potentially Eligible	Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (See CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).
Prosthetics	Eligible	
Psychiatric care	Eligible	
Psychiatric expenses – psychoanalysis or amounts paid to a psychologist for medical care	Eligible	
Reading glasses – nonprescription reading glasses	Eligible	
Sales taxes - sales and service taxes on eligible medical care or products	Eligible	
Saline solution – for eyes, ears, and nose	Eligible	
School (alternative)	Ineligible	
School payments for disabled	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting that the school is necessary to relieve the learning disability of the Dependent Child who is also a Participant of the Plan.

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Service animals – Costs of obtaining and training a guide dog or other animal to provide assistance to a Participant with a disability	Potentially Eligible	Must provide statement of medical necessity from licensed health care professional documenting the disability.
Shipping – charges to ship an eligible medical product	Potentially Eligible	Must be related to an eligible product. May be required to provide statement of medical necessity from a licensed health care professional describing the medical condition, the product prescribed, and length of treatment.
Social activities	Ineligible	
Speech therapy – when prescribed as treatment for a specific medical condition	Eligible	
Sterilization – cost of sterilization and reversal of sterilization operations	Eligible	
Stop-smoking program – over-the-counter products to stop smoking	Potentially Eligible	Must provide a prescription from a licensed health care professional.
Stop-smoking program – prescription drugs and medical services to stop smoking	Potentially Eligible	Prescription drugs are only eligible under the Catastrophic Retiree HRA account. (See CATASTROPHIC RETIREE HEALTH REIMBURSEMENT ACCOUNT).
Sunglasses – nonprescription sunglasses prescribed by eye doctor for light sensitivity	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional describing the medical condition, the product prescribed, and length of treatment.
Support hose - prescribed by a doctor for a medical condition.	Potentially Eligible	Must be primarily manufactured and marketed for relief of a medical condition, and provide statement of medical necessity from a licensed health care professional describing the medical condition, the product prescribed, and length of treatment.
Taxes – Social Security and Medicare taxes paid for a nurse, attendant, or other person who provides medical care	Eligible	
Teeth whitening or bonding	Ineligible	
Toothbrush	Ineligible	
Transgender services	Ineligible	

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EXPENSE	**COVERED?**	**MORE DETAILS**
Transportation expenses – costs to receive medical care, including airfare, parking, tolls, taxis, rental cars, buses, gas for car, or mileage	Potentially Eligible	Must provide statement of medically necessity from doctor documenting medical condition for any expense over $100 if no diagnosis has been previously submitted.
Tutoring – recommended by a doctor for a Dependent Child who is covered under this Plan and has severe learning disabilities caused by a mental or physical impairment, including nervous system disorders	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional documenting the medical condition.
Umbilical cord storage – costs to collect, freeze, and store umbilical cord blood only when a medical condition is present	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional documenting the medical condition.
Uniforms	Ineligible	
UVR treatments – recommended by a doctor for a medical condition	Eligible	
Vacation or travel	Ineligible	
Vaccinations	Eligible	
Varicose vein surgery – prescribed by a doctor for treatment of a medical condition	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional describing the medical condition, the service or product prescribed, and length of treatment.
Veneers – if covered by an insurance plan or recommended by a dentist as the only course of treatment	Potentially Eligible	Must provide statement from a dentist indicating that veneers are the only suitable course of treatment and are not for cosmetic or general health purposes.
Vision coinsurance	Eligible	
Vision copayments	Eligible	
Vision deductibles	Eligible	
Vision expense – cost not covered by a vision plan	Eligible	
Vision reasonable/customary – amounts not paid by a vision plan that exceed reasonable and customary limits	Eligible	

This chart is a summary of Eligible Medical Expenses and Ineligible Medical Expenses. **In all cases, the reimbursement of an Eligible Medical Expense must be for a Participant or Dependent who is eligible for and enrolled in the Ameren Health Reimbursement Account.**		
EXPENSE	**COVERED?**	**MORE DETAILS**
Vitamins – prescribed by a doctor to treat a diagnosed medical condition.	Potentially Eligible	Must provide a prescription from a licensed health care professional.
Vitamins – for general health purposes.	Ineligible	
Walking aids – i.e. canes, walkers, and crutches	Eligible	
Warranties – for health-related equipment	Ineligible	
Weight loss – programs for general health	Ineligible	
Weight loss – prescribed by doctor to treat a diagnosed medical condition	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional describing the medical condition, the service or product prescribed, and length of treatment. Examples of what could be eligible include medical costs and program fees for support groups and non-medically supervised programs such as Weight Watchers, NutriSystem, and Medifast. Fees associated with food cost are not eligible.
Wheelchair	Eligible	
Wigs – doctor's recommendation for the mental health of a Participant who has lost all of his/her hair from disease	Potentially Eligible	Must provide statement of medical necessity from a licensed health care professional describing the medical condition, the product prescribed, and length of treatment.
Work transportation expenses	Ineligible	
Work-related medical expenses – cost for accident/illness not covered by worker's compensation or another medical plan	Eligible	

Claim and Appeal Procedures

If You file a claim for reimbursement and one or more of Your expenses are not reimbursed, You or a person You have designated as Your authorized representative may file a claim using the following procedures. If You file a claim regarding RHRA eligibility, You may also file a claim using the following procedures. In this SPD, a claim for reimbursement from Your RHRA Account for Eligible Medical Expenses received by either You, Your Spouse, or by one of Your eligible Dependents is referred to as "Your claim." A "claim" is a written request for benefits.

A casual inquiry (even if it is in writing) regarding RHRA 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 to the Plan Administrator and appeals to the Appeal Reviewer. If You file a claim or appeal, You must do so in writing by U.S. mail or by email.

All claims related to request for reimbursement must be submitted to:

Your Spending Account
PO Box 785040
Orlando, FL 32878-5040
Fax: 888.211.9900

All claims related to RHRA eligibility must be submitted to:

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

All appeals must be submitted to:

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

Responding to Your RHRA Claim

If the Claims Administrator needs information to process Your claim, the Claims Administrator will notify You, in writing, within thirty (30) days after receiving Your claim of the specific information required and the date when You can expect a determination. This date will be not later than forty-five (45) days after the date You filed Your initial claim. If the extension is necessary because You failed to provide sufficient information to allow the claim to be decided, You will be notified and You will have forty-five (45) days to provide the additional information. The determination period to respond to Your claim will be suspended as of the date the Claims Administrator sends the notice and will resume again once You have provided the additional information.

If You do not provide the requested information within the specified timeframe, the Claims Administrator will decide the claim without the requested information.

If the Claims 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 Claims Administrator will notify You within the initial thirty (30)-day period after its initial receipt of Your claim that an extension of up to an additional fifteen (15) days will be required. The new due date will not be later than forty-five (45) days after the date You filed Your initial claim.

Once You have filed a claim, the Claims Administrator will notify You of its decision as soon as practical, but no later than thirty (30) days (ninety (90) days for eligibility claims) after receipt of Your claim. If You do not follow the required procedures for filing a claim, the Claims Administrator will notify You and explain the proper procedures to follow in filing Your claim.

If Your Claim Is Denied

If Your claim is denied, in whole or in part, the Claims Administrator will send You a written notice of its decision within thirty (30) days (ninety (90) days for eligibility claims) after the claim is received including:

- The specific reason(s) for the denial of the claim;
- Reference to the specific RHRA 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 RHRA's appeal procedures and the time limits under those procedures, including Your right to bring a civil action under Section 502(a) of ERISA if the appeal of Your claim is denied;
- If applicable, a copy of the internal rule, guideline, or protocol that was relied upon to make the determination for Your claim; and
- If the claim is denied based upon a medical necessity or experimental treatment or similar exclusion limitation, an explanation of the scientific or clinical judgment relied upon.

Appealing Your Claim

If Your claim under the Plan is denied in whole or in part, and You do not agree with the decision of the Claims Administrator, You will have 180 days (sixty (60) days for eligibility claims) following the receipt of the denial notice to file a written appeal with the Appeals Reviewer. The following procedures will apply in considering Your appeal.

Contact the Claims Administrator to obtain an appeal form.

- 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 Appeals Reviewer's documents, records, and other information relevant to Your claim.
- The review of Your appeal will consider all comments, documents, records, and other information You submit on the appeal and will not afford deference to the initial denial of Your claim.
- The review of Your appeal will not be conducted by the same person (or his or her subordinate) who originally denied Your claim.
- If the review of Your appeal involves a determination that is based, in whole or in part, on a medical judgment (including determinations based upon a medical necessity, experimental treatment or similar exclusion limitation), the Appeals Reviewer will consult with a health care professional who has appropriate training and experience in the field of health care involved.
- Any health care or vocational experts whose advice was obtained in connection with Your claim will be identified. Any health care expert who is consulted in the appeal process will not be the same person (or his or her subordinate) who was consulted in connection with the initial denial of Your claim.

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

If Your 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;
- Reference to the specific RHRA provision on which the denial is based;
- If applicable, a copy of the internal rule, guideline, or protocol that was relied upon to make the claim determination; and
- If the claim is denied based upon a medical necessity or experimental treatment or similar exclusion limitation, an explanation of the scientific or clinical judgment relied upon.

Upon request to the Appeals Reviewer, You will also be provided (free of charge) copies of all of the 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 Appeal Reviewer, 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.

Termination of Benefits

Retirees

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

- Date You cease to be an eligible Retire for any reason;
- Date You are no longer enrolled in an insurance policy through the Aon Retiree Health Exchange (including termination for failure to pay the required premium);
- Date You cease to be eligible for Medicare;
- Date of Your death;
- Date of termination of the **Ameren Retiree Health Reimbursement Plan**;
- Date the Company amends the **Ameren Retiree Health Reimbursement Plan** to eliminate coverage for the class of eligible individuals to which You are a member;
- Date You become covered under another Group Plan sponsored by Ameren (for example, You are covered under another active health plan of a company which has been purchased by Ameren, while also covered as a Retiree under this Plan); or
- Date You or a Covered Dependent participates in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent.

Dependents

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

- Date You cease to be an eligible Retiree for any reason;
- Date Your coverage under the Plan ends except by reason of Your death (See CONTINUATION OF BENEFITS FOR SURVIVING DEPENDENTS OF DECEASED RETIREES);
- Date Your Covered Dependent is no longer enrolled in an insurance policy through the Aon Retiree Health Exchange (including termination for failure to pay required premiums);
- Date Your Covered Dependent ceases to be eligible for Medicare;
- Date Your Dependent ceases to satisfy the eligibility requirements (See ELIGIBILITY);

- Date Your Covered Spouse re-marries, following Your death;
- In the case of a Covered Spouse, the date of divorce of You and Your Spouse;
- In the case of a Covered Spouse, the date of legal separation of You and Your Spouse;
- Date of the death of the Covered Dependent;
- Date Your Dependent no longer meets the Plan's eligibility requirements;
- Date the Company amends the **Ameren Retiree Health Reimbursement Plan** to eliminate coverage for the class of eligible individuals to which Your Dependent is a member;
- Date You or Your Covered Dependent becomes covered under another Group Plan sponsored by Ameren (for example, You are covered under another active health plan of a company which has been purchased by Ameren, while also covered as a Retiree under this Plan); or
- Date You or a Covered Dependent participates in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent.

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

Continuation of Benefits for Surviving Dependents of Deceased Retirees

In the event of Your death, Your eligible Dependents may continue as Participants in the **Ameren Retiree Health Reimbursement Account Plan**, or elect the continuation benefits available under federal law (COBRA). If Your eligible Dependents elect a temporary extension of their coverage in the **Ameren Retiree Health Reimbursement Account Plan** under COBRA, they will not be allowed to re-enroll in the Plan at any time in the future. The following paragraph and the COBRA continuation section below include information about the difference between the two types of benefits.

Upon Your death, Your eligible Dependents may continue their coverage under the Plan as long as they continue to meet the eligibility requirements of the Plan, provided Your Covered Dependents have not elected to terminate the coverage. If Your Covered Dependents chose to continue their participation in the **Ameren Retiree Health Reimbursement Account Plan**, the coverage will end on the earliest of the following dates:

- Date in which Your surviving Spouse remarries (coverage ends only for the surviving Spouse);
- Date Your surviving Dependent becomes covered under any other group medical care plan (coverage ends only for the surviving Dependent with the other coverage);

- Date in which Your surviving age 65 or older Dependent Children no longer meet the eligibility requirements for Dependent Children (coverage ends only for the ineligible Dependent);
- Date in which Your surviving Dependent is no longer enrolled in an insurance policy through the Aon Retiree Health Exchange (including termination for failure to pay the required premium);
- Date of Your surviving Dependent's death (coverage ends only for the deceased Dependent).
- Date of termination of the Plan; and
- Date the Plan is amended to eliminate continuation coverage for surviving Dependents.

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

This section contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. Depending on the type of qualifying event, You, Your Covered Spouse and Covered Dependent Children may be qualified beneficiaries. Newly-adopted children age 65 or over and alternate recipients under a Qualified Medical Child Support Order age 65 or over may also be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

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

Ameren has partnered with Xerox as the COBRA Administrator. Participants enrolled in COBRA benefits can obtain information regarding their COBRA benefits through **www.myAmeren.com** or by accessing it directly at www.benefitsweb.com/ameren.html. 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).

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.
- 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 Dependent Child ceases to satisfy the Plan Sponsor's eligibility rules for Dependent status.
- Filing of bankruptcy by Ameren Corporation.

Alternate Recipients under Qualified Medical Child Support Orders

An age 65 or older 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; or

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

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 or commencement of a proceeding in bankruptcy, You are not

required to notify the Plan Administrator. However, each Participant has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing Dependent status under the Plan within sixty (60) days of the qualifying event. Notice must be provided through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). Failure to provide this notification within sixty (60) days will result in the loss of continuation coverage rights and may result in retroactive cancellation of coverage.

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

Address Changes

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

Additionally, You contact the insurance carrier of the supplemental Medicare insurance policy in which You enrolled of any address charge.

You should also keep a copy, for Your records, of any notices You send to the Plan Administrator and the insurance carrier

If You Have Questions

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

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

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

Privacy Practices

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

Most of the comprehensive requirements are outlined in the "Notice of Privacy Practices" You have received from the Plan. This notice can also be found on **www.myAmeren.com** by selecting "Healthcare and Life Benefits", then "Healthcare and Life", then "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 request for reimbursement 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.

Miscellaneous Provisions

Plan Administration

The Plan Administrator has delegated authority to administer the Plan on a day-to-day basis to the Administrative Committee. The Administrative Committee has discretionary authority to construe and interpret the Plan, grant or deny benefits, construe any ambiguous provision of the Plans, correct any defect, supply any omission or reconcile any inconsistency in such manner and to such extent as the 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. Benefits under the Plan will only be paid if the Administrative Committee decides in its discretion that the applicant is entitled to them.

The Administrative Committee may delegate its authority under the Plan. To the extent such authority is delegated, references in this document to the Administrative Committee will include such delegates. 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.

Plan Amendment or Termination

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

Applicability

Except as otherwise indicated, the provisions of this document shall apply equally to the Covered Retiree and eligible 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 Participant is entitled to receive RHRA coverage or other benefits to be furnished by the Plan. Such right to RHRA 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 Participant to enforce any provision of this document shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this document shall not be deemed or construed to be a waiver of such default.

Lost Distributees

If any person to whom a check is issued in payment of a benefit under this Plan cannot be located or does not present the check for payment, the amount of the check may be applied to other Plan purposes; provided, if any such person subsequently appears and makes demand for such payment, the Plan Administrator shall direct that such payment be made in full as soon as practical.

Recovery of Excess Payments

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

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.

Your Rights Under ERISA

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

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

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

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a

Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

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

Administrative Information About the Plan

Plan Name:	Ameren Retiree Health Reimbursement Account Plan, a component of the Ameren Retiree Medical Plan
Type of Plan:	A welfare benefit plan providing reimbursement for Eligible Medical Expenses for retirees and their eligible Dependents age 65 and over.
Plan Year:	January 1 through December 31
Plan Number:	511
Funding Medium and Type of Plan Administration:	The Plan is funded by contributions made by the Plan Sponsor. With the exception of certain key Retirees, all contributions are paid by trusts established for the purpose of providing benefits under the Plan. Plan Sponsor has a contract with Aon Hewitt's *Your Spending Account™* (YSA) ("ARHE YSA") ("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.

Trustee:	To the extent permitted under applicable law, reimbursements for Eligible Health Expenses are paid out of trust funds held by The Bank of New York Mellon, located at 135 Santilli Highway, Everett, Massachusetts, 02149. If the trusts are terminated, the remaining assets will be distributed in accordance with the provisions of the trust agreements.
Plan Sponsor:	Ameren Corporation 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Plan Sponsor's Employer Identification Number:	43-1723446
Plan Administrator:	Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)
Claims Administrator:	Aon Hewitt *Your Spending Account*™ Service Center P. O. Box 785040 Orlando, FL 32878-5040 Phone number: 1-855-819-0011 Fax number: 1-888-211-9900
Appeals Reviewer	Ameren Services P.O. Box 66149 MC533 St. Louis, MO 63166-6149 Email: EBenefits@ameren.com
COBRA Administrator:	Ameren Benefits Center PO Box 199434 Dallas, TX 75219-9434 1.877.769.2637 www.myameren.com
Named Fiduciary for Plan:	Ameren Services Company 1901 Chouteau Avenue, Mail Code 533 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)

Agent for Service of Legal Process:	General Counsel Ameren Services Company 1901 Chouteau Avenue, Mail Code 1300 Post Office Box 66149 St. Louis, MO 63166-6149 877.7my.Ameren (877.769.2637)Service of Legal Process also may be made upon the Plan Administrator.

Appendix - How the Maximum Amount of Retiree Health Reimbursement Account Credits are Determined

This Appendix does not apply to You if You are eligible to participate in the **Ameren Retiree Health Reimbursement Account Plan** as described in the Eligibility section of this document, and:

- You were enrolled in the Ameren Retiree Medical Plan (CILCO) prior to enrollment in this Plan; or,
- You are not a Participant subject to the Retiree Medical Cap as defined in the chart under the "Retiree Medical Caps" section below.

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

If You are listed in the chart under the "Retiree Medical Caps" section below, the Maximum Amount to be credited is also subject to the applicable Retiree Medical Cap as described in this Appendix. The Maximum Amount the Company will credit to Your RHRA for 2016 is the lessor of $2,652 for You, $1,734 for Your Dependent (the annual credit amounts), or the annualized amount of Your Retiree Medical Cap.

Retiree Medical Caps

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

Eligible Group	Retirement Date
Management employees who are not participants in the Voluntary Retirement Program (VRP) and their surviving dependents.	Retired on or after October 1, 2002
AmerenCILCO IBEW Local 51 and their surviving dependents.	Retired on or after January 1, 2008
AmerenEnergy Resources Generating Company IBEW Local 51 (formerly NCF&O Local 8) and their surviving dependents.	Retired on or after January 1, 2007
UEC (Ameren Missouri) Callaway Energy Center, Unit 1 and UGSOA Local Union 11 and their surviving dependents.	Retired on or after July 2, 2012
All other contract employees who are not participants in the Voluntary Retirement Program (VRP), and who have previously been participants in a union in which the contract in effect on their retirement date has expired.	Retired on or after October 1, 2002

Note: The reference to "eligible surviving dependents" above includes both the eligible surviving dependents of retirees and those of deceased active employees as described in the Eligibility section of this document.

The Retiree Medical Cap is based on Your age and Years of Service at retirement. As described above, the Maximum Amount the Company will credit to Your **Ameren Retiree Health Reimbursement Account** for You and Your eligible Dependent is the lessor of the applicable annual credit amounts for You and Your Spouse and Your Retiree Medical Cap.

Note: For survivors of Retirees, the Retiree Medical Cap is based on the age and Years of Service of the Retiree at the time of his/her retirement. For survivors of an active Employee, the Retiree Medical Cap is based on the age and Years of Service of the Employee at the time of his/her death. If a Retiree does not have the minimum Years of Service as reflected in the chart below, but is otherwise eligible to participate in the Plan, the minimum number of Years of Service (10) along with the appropriate age at retirement is applied in determining the Company's maximum Retiree Health Reimbursement Account credit.

In all cases, if You or Your eligible Dependent is age 65 or older and enrolled in the **Ameren Retiree Health Reimbursement Account Plan**, and the other eligible Participant is under age 65 and enrolled in the **Ameren Retiree Medical Plan**, the Maximum Amount to be credited to the applicable Participant's Retiree Health Reimbursement Account taking into account the Retiree Medical Cap based on the age and Years of Service of the Retiree at the time of his/her retirement, will be applied first. If there is any amount remaining, it will then be applied to the monthly premium for the under age 65 eligible Participant. When one of the eligible Participants is under age 65 and enrolled in the **Ameren Retiree Medical Plan**, that Participant is subject to the remaining amount available under the Retiree Medical Cap and is responsible for paying the greater of:

a. The Minimum Retiree Premium; OR,

b. The amount of the premium that exceeds the remaining amount of the Retiree Medical Cap listed in the applicable table below.

(See the EXAMPLES included in this Appendix).

Retiree Medical Cap for Retirees Under Age 65

The following chart shows the monthly Retiree Medical Cap. Ameren will contribute the monthly Maximum Amount towards both Your eligible Dependent's Retiree Health Reimbursement Account and then Your retiree medical premiums if:

- You are under age 65; AND
- You were not a participant in the Voluntary Retirement Program (VRP); AND
- You are enrolled in the **Ameren Retiree Medical Plan**; AND
- Your eligible Dependent is age 65 or older and enrolled in the **Ameren Retiree Health Reimbursement Account Plan**.

Notes:

- Each Plan year, the Company will determine the Maximum Amount to be credited to the **Retiree Health Reimbursement Account Plan** for each eligible Participant. This amount may be less than the maximum Retiree Medical Cap amount shown below.
- Age and Years of Service are rounded down to the nearest year.

	Age at Retirement (rounded down to the nearest year)							
Years of Service	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62 or older**
10	$387	$396	$405	$414	$423	$432	$441	$450
11	426	436	446	455	465	475	485	495
12	464	475	486	497	508	518	529	540
13	503	515	527	538	550	562	573	585
14	542	554	567	580	592	605	617	630
15	581	594	608	621	635	648	662	675
16	619	634	648	662	677	691	706	720
17	658	673	689	704	719	734	750	765
18	697	713	729	745	761	778	794	810
19	735	752	770	787	804	821	838	855
20	774	792	810	828	846	864	882	900
21	813	832	851	869	888	907	926	945
22	851	871	891	911	931	950	970	990
23	890	911	932	952	973	994	1014	1035
24	929	950	972	994	1015	1037	1058	1080
25	968	990	1013	1035	1058	1080	1103	1125
26	1006	1030	1053	1076	1100	1123	1147	1170
27	1045	1069	1094	1118	1142	1166	1191	1215
28	1084	1109	1134	1159	1184	1210	1235	1260
29	1122	1148	1175	1201	1227	1253	1279	1305
30	1161	1188	1215	1242	1269	1296	1323	1350

Retiree Medical Cap for VRP Participants Under Age 65

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

Retiree Medical Cap for Retirees Age 65 and Older

- The following chart shows the monthly Retiree Medical Cap Ameren will contribute the Maximum Amount towards both Your Retiree Health Reimbursement Account and Your eligible Dependent's retiree medical coverage if: You are age 65 or older; AND
- You were not a participant in the Voluntary Retirement Program (VRP); AND
- You are enrolled in the **Ameren Retiree Health Reimbursement Account Plan**; AND
- Your eligible Dependent is under age 65 and enrolled in the **Ameren Retiree Medical Plan**, or age 65 or older and also enrolled in the **Ameren Retiree Health Reimbursement Account Plan**.

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

	Age at Retirement (rounded down to the nearest year)							
Years of Service	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62 or older**
10	$172	$176	$180	$184	$188	$192	$196	$200
11	189	194	198	202	207	211	216	220
12	206	211	216	221	226	230	235	240
13	224	229	234	239	244	250	255	260
14	241	246	252	258	263	269	274	280
15	258	264	270	276	282	288	294	300
16	275	282	288	294	301	307	314	320
17	292	299	306	313	320	326	333	340
18	310	317	324	331	338	346	353	360
19	327	334	342	350	357	365	372	380
20	344	352	360	368	376	384	392	400
21	361	370	378	386	395	403	412	420
22	378	387	396	405	414	422	431	440
23	396	405	414	423	432	442	451	460
24	413	422	432	442	451	461	470	480
25	430	440	450	460	470	480	490	500
26	447	458	468	478	489	499	510	520
27	464	475	486	497	508	518	529	540
28	482	493	504	515	526	538	549	560
29	499	510	522	534	545	557	568	580
30	516	528	540	552	564	576	588	600

Retiree Medical Cap for VRP Participants Age 65 and Older

If You retired under the Voluntary Retirement Program and You are age 65 or older, the **Retiree Medical Cap for Retirees Age 65 and Older** chart above does not apply to You. Your actual

age and Years of Service at the time of retirement are not used to calculate Your Retiree Medical Cap and Your Dependent's Retiree Health Reimbursement Account credit amount, or their retiree medical premium. Your maximum Retiree Medical Cap is $700 per month. This is the Maximum Amount the Company will contribute towards Your retiree medical coverage under the **Retiree Health Reimbursement Account Plan** and Your Dependent's retiree medical coverage under the **Retiree Health Reimbursement Account Plan** or the **Ameren Retiree Medical Plan**, whichever is applicable based on their age.

Important Notes

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

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

Examples

It may be helpful to look at some EXAMPLES of how to estimate what You might pay for medical coverage once You retire:

Example 1

Let's assume that:

- Bill retires on January 1 at age 55 with 25 years of service; AND
- Bill's Retiree Medical Cap is $968 per month; AND
- The total monthly premium for Bill's coverage under the **Ameren Retiree Medical Plan** is $800; AND
- His spouse is age 66 and eligible for the **Ameren Retiree Health Reimbursement Account Plan (RHRA)**; AND
- The 2016 annual credit amount for a spouse's RHRA is $1,734.
- Bill's Minimum Retiree Premium is $175

In this example, the amount credited to the RHRA is the Maximum Amount of $1,734 (the lesser of $1,734 and $11,616, the annualized Retiree Medical Cap). After applying the **Ameren Retiree Reimbursement Health Account Plan** credit to Bill's spouse under the **Ameren Retiree Reimbursement Health Account Plan**, to cover **himself** under the **Ameren Retiree Medical Plan**, Bill pays the greater of:

Bill's annualized Retiree Medical Cap ($968 x 12)	$11,616	
Annual RHRA credit amount for Bill's spouse	$1,734	
Bill's remaining annualized Retiree Medical Cap	$9,882	
Bill's remaining Retiree Medical Cap per month ($9,882 ÷ 12)	$824	
Bill's Minimum Retiree Premium (25% of $800)	$ 200	⇐ **Greater**
OR		
Total Monthly Premium ($800 for Bill)	$800	
Less the remaining Retiree Medical Cap (age 55 with 25 Years of Service)	$ 824	
(Amount that exceeds the cap)	**$ - 24**	

In this example, Bill pays $200 per month to cover himself under the **Ameren Retiree Medical Plan** since his Minimum Retiree Premium ($200) is *greater than* the amount that exceeds his Retiree Medical Cap ($-24).

Example 2

Now, let's assume that:

- Bill retires on January 1 at age 65 with 25 years of service; AND
- Bill's Retiree Medical Cap is $500 per month; AND
- The 2016 annual credit amount for Bill's RHRA is $2,652.
- His spouse is age 63 and eligible for the **Ameren Retiree Medical Plan**; AND
- The total monthly premium for Bill's spouse's coverage under the **Ameren Retiree Medical Plan** is $800; AND
- The spouse's Minimum Retiree Premium is $350

In this example, the amount credited to the RHRA is the Maximum Amount of $2,652 (the lesser of $2,652 and $6,000, the annualized Retiree Medical Cap). After applying the Ameren **Retiree Reimbursement Health Account Plan** credit to Bill's Ameren Retiree Reimbursement Health Account to cover his spouse under the **Ameren Retiree Medical Plan**, Bill pays the greater of:

Bill's annualized Retiree Medical Cap ($500 x 12)	$6,000	
Annual RHRA credit amount for Bill	$2,652	
Bill's remaining annualized Retiree Medical Cap	$3,348	
Bill's remaining Retiree Medical Cap per month ($3,348 ÷ 12)	$279	
Bill's Spouse's Minimum Retiree Premium (50% of $800)	$ 400	
OR		
Total Monthly Premium ($800 for Bill's spouse)	$800	
Less the remaining Retiree Medical Cap (age 55 with 25 Years of Service)	$ 279	
(Amount that exceeds the cap)	**$ 521**	⇐ **Greater**

In this example, Bill pays $521 per month to cover his Spouse under the **Ameren Retiree Medical Plan** because this amount is *greater than* the Minimum Retiree Premium ($400).

Example 3

Now, let's assume that:

- Bill retired under the Voluntary Retirement Program and is age 65; AND
- Bill's Retiree Medical Cap is $700 per month; AND
- The 2016 annual credit amount for Bill's RHRA is $2,652.
- His spouse is age 63 and eligible for the **Ameren Retiree Medical Plan**; AND
- The total monthly premium for Bill's spouse's coverage under the **Ameren Retiree Medical Plan** is $800; AND
- The spouse's Minimum Retiree Premium is $350

In this example, the amount credited to the RHRA is the Maximum Amount of $2,652 (the lesser of $2,652 and $8,400, the annualized Retiree Medical Cap). After applying the Ameren **Retiree Reimbursement Health Account Plan** credit to Bill's Ameren Retiree Reimbursement Health Account to cover his spouse under the **Ameren Retiree Medical Plan**, Bill pays the greater of:

Bill's annualized Retiree Medical Cap ($700 x 12)	$8,400	
Annual RHRA credit amount for Bill	$2,652	
Bill's remaining annualized Retiree Medical Cap	$5,748	
Bill's remaining Retiree Medical Cap per month ($5,748 ÷ 12)	$479	
Bill's Spouse's Minimum Retiree Premium (50% of $800)	$ 400	⇐ **Greater**
OR		
Total Monthly Premium ($800 for Bill's spouse)	$800	
Less the remaining Retiree Medical Cap (age 55 with 25 Years of Service)	$ 479	
(Amount that exceeds the cap)	**$ 321**	

In this example, Bill pays $400 per month to cover his Spouse under the **Ameren Retiree Medical Plan** because this amount is *greater than* the Minimum Retiree Premium ($321).