A Plan Designed to Provide
Security for Employees of

Ameren Dental Plan
for
Employees Represented by a Collective Bargaining Agreement
with AmerenIP

Administered by:
Delta Dental of Missouri

Amended and Restated January 1, 2016

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

Purpose

Ameren Corporation ("the Plan Sponsor") maintains the **Ameren Dental Plan** (the "Plan") to provide dental benefits to its eligible Employees, their Spouses, and other eligible Dependents.

This booklet (including any subsequent supplements) constitutes the Summary Plan Description (SPD) for and outlines the provisions and benefits afforded under the Plan as of January 1, 2016. It replaces and supersedes all prior summary plan descriptions for the Plan.

The **Ameren Dental Plan** has been established on a noninsured basis; all liability for payment of benefits is assumed by Ameren. While Delta Dental of Missouri ("Delta Dental") administers the payment of claims, Delta Dental has no liability for the funding of the Plan.

While one of the functions of Delta Dental is to process claims according to the Plan provisions, all claims under the Plan are paid by Ameren and Ameren owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by Ameren Services.

Ameren Services Company (the "Company") serves as the Plan Administrator. 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. The Plan Administrator has also delegated discretionary authority for the administration of dental benefit claims and appeals to Delta Dental.

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

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. This SPD contains a brief description of the principal features of the Plan and is not meant to interpret, extend or change the provisions of the Plan in any way. A copy of the Plan document is on file with the Plan Administrator and is available to You, upon request and free of charge, at any time. The Plan document shall govern if there is a discrepancy between this SPD and the actual provisions of the Plan.

DURATION OF THE PLAN. Ameren Corporation hopes and expects to continue the **Ameren Dental Plan** in the years ahead but cannot guarantee to do so. The Company reserves the right to amend, modify, or terminate the Plan, and/or any benefits provided under the Plan at any time, with respect to all individuals.

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. Terms defined in the DEFINITIONS section of this booklet are capitalized in this document.

Ameren Benefits Center

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

www.myAmeren.com

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

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

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

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Ameren Dental Plan

Eligibility

Employees

You are eligible to participate in this Plan if You are:

- an Employee represented by a collective bargaining agreement with AmerenIP who works at least 20 hours a week; or
- a temporary employee represented by a collective bargaining agreement with AmerenIP who is regularly scheduled to work at least 20 hours a week.

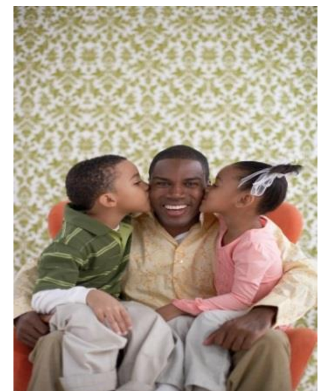
You are **not** eligible to participate if You are:

- A temporary employee represented by a collective bargaining agreement with AmerenIP who is regularly scheduled to work less than 20 hours per week;
- A leased employee;
- A person employed on a per diem, part-time or seasonal basis;
- Designated, compensated or otherwise classified or treated by Your employer as an independent contractor, leased employee or other non-common law employee;
- Covered under another Ameren-sponsored dental plan.

You may complete the appropriate enrollment process, either by enrolling on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

Dependents

If You enroll in the Plan, Your Dependents are also eligible for coverage, provided that You enroll them according to the appropriate procedures. You must be enrolled in the **Ameren Dental Plan** in order for Your eligible Dependent to be enrolled. Eligible Dependents are limited to:



1) Your Spouse;
2) Your Dependent Children who have not reached age 26. A child and/or spouse of any Dependent Children are not eligible for coverage under the Plan;
3) Your unmarried Dependent Children who are not capable of self-sustaining employment due to a disability and are therefore dependent upon You for support, are eligible to continue their coverage under the Plan beyond age 26. Proof of the disability must be furnished to the Plan Administrator no later than thirty-one (31) days after the date of the child's 26th

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

Disabled Dependent children who were not covered under the Plan upon attainment of age 26 are not eligible for coverage.

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

Important Note: Except as noted paragraphs below, a Spouse or a Dependent Child who is eligible for coverage under an Ameren sponsored Dental or Dental/Vision Plan as an Employee, cannot be covered as Your Dependent under this Plan, whether or not they chose to enroll in the Plan for which they are eligible.

A Dependent Child under the age of 26 who is also an Ameren Employee and eligible for coverage under an **Ameren Dental Plan** as an Employee, can be covered as an Employee, or can be covered as the Dependent Child of another Ameren Employee, but cannot be covered as both an Employee and a Covered Dependent.

Additionally, no person can be covered as a Dependent of more than one Employee**.** No person can be covered under more than one Ameren sponsored dental or dental/vision plan at the same time.

If You and Your Spouse are both eligible for coverage under an Ameren sponsored dental or dental/vision plan as Employees, and at least one of You are represented by a collective bargaining agreement between AmerenIP and one of the following unions:

- AmerenIP and IBEW Local 51 (IP); or
- AmerenIP and IBEW Local 309 (IP); or
- AmerenIP and IBEW Local 702 (IP); or
- AmerenIP and Laborers Local12 Counties(IP); or
- AmerenIP and Pipefitters Local 101(IP); or
- AmerenIP and Pipefitter Local 360 (IP); or
- AmerenIP and Laborers Local 459(IP); or
- AmerenIP and IBEW 51 MDF(IP); or
- AmerenIP and Laborers Local 100(IP)

You may each be covered as an Employee under the Ameren dental or dental/vision plan for which You are each eligible, or, one of You may be covered as an Employee and the other as a Dependent, but only under this Plan – **Ameren Dental Plan for Employees Represented by a Collective Bargaining Agreement with AmerenIP.**

The Plan may require at any time that an Employee furnish proof of continued eligibility or continued eligibility of any Spouse or and Dependent Child(ren). If false or misleading information is provided, it may result in any or all of the following actions: a) You will

reimburse Ameren for all expenses; b) immediate termination of all coverage under the Plan; c) termination of employment with Ameren; and d) other legal action may be taken against You.

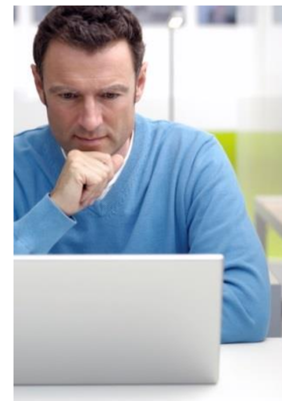
The term *dependent* does not include:

- A child who is eligible for coverage as an Employee under the Plan, and enrolled as an Employee under another Ameren sponsored dental or dental/vision plan.
- A Spouse who is covered as an Employee under the Plan.
- A parent or other relative of You or Your Spouse.

Enrollment Provisions

Employees

In order to elect or waive coverage in the **Ameren Dental Plan**, You must complete the appropriate enrollment or waiver process, either on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). You must choose one of these coverage categories:



- Waive coverage
- You Only
- You + Family

Whether You become eligible for this Plan because You are a new Employee or because You have had a change in Your employment status (such as an increase in Your scheduled hours or a transfer from another union), You must elect a coverage category or waive coverage no later than thirty-one (31) days from the date of Your Enrollment Worksheet.

Unless You waive coverage during this initial thirty-one (31)-day enrollment period, Your coverage will be effective on Your eligibility date. If You do not make a coverage election, You will be considered to have waived dental coverage for Yourself and Your family. You won't have another opportunity to choose or change Your dental benefits until the next Annual Enrollment Period for dental benefits under this Plan, unless You qualify for a special enrollment period (see below) or You experience a change in status (see below).

Dependents

Coverage for Your eligible Dependents will generally begin on the same date as Your coverage begins if You enroll them at the time You enroll Yourself in the Plan. If You choose not to cover Your Spouse or child immediately, You can add that Dependent only during the Annual Enrollment Period, unless You qualify for a special enrollment right or You experience a change in status (see COVERAGE CHANGES).

Coverage Changes

Change In Status

Aside from the Special Enrollment Period, You may not change Your coverage in any way during the Plan Year unless there is a change in status that results in a gain or loss of eligibility for coverage. The change in coverage must be on account of and consistent with Your change in status. Qualifying changes in status as defined by the IRS include, but are not limited to:

- You get married, divorced, or legally separated;
- You gain a Dependent through birth, adoption, placement for adoption or marriage;
- You, Your Spouse or Your Dependent Child becomes employed or loses a job;
- Your Spouse or Dependent Child dies;
- You, Your Spouse or Dependent Child changes from full-time to part-time work or vice versa;
- You or Your Spouse commence or return from an unpaid leave of absence;
- Your Spouse or Dependent Child experiences a significant change in dental coverage or cost under another employer's health plan;
- Your Dependent Child satisfies or ceases to satisfy the eligibility requirements.

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

If You have a status change and want to enroll Yourself, or add a new Dependent, You must complete the appropriate enrollment process by either enrolling on-line through "Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**) within thirty-one (31) days of the event in order for the change in coverage to be retroactive to the date of the event. If notification is received later than thirty-one (31) days after the event, You and/or the Dependent must wait until the next Annual Enrollment Period for this Plan to enroll for coverage.

If You have a status change and want to drop coverage for Yourself, or a Dependent, in most cases, the coverage will be terminated on the last day of the month in which the event occurred, provided You notify the **Ameren Benefits Center** within thirty-one (31) days of the change in family status. In the event of the death of a dependent, divorce or legal separation, coverage will be terminated on the date of the event.

All enrollment and coverage changes due to a change in status event are subject to the approval of the Plan Administrator. Documentation of a change in status may be necessary to make the change in coverage. The Plan Administrator has the discretionary authority to determine whether a change in status has occurred in accordance with the IRS rules and regulations permitting a change.

Special Enrollment Period

If coverage under the Plan was waived, You and/or Your eligible Dependents may enroll in the Plan only during the Annual Enrollment Period unless You and/or an eligible Dependent qualifies for a special enrollment period due to loss of coverage or the acquisition of a new Dependent.

If You and/or an eligible Dependent were covered under another group dental plan (including COBRA continuation coverage) or had other dental insurance coverage at the time enrollment was waived, and have lost or will lose coverage under the other plan as a result of:

a) loss of eligibility (due to such reasons as death of a Spouse or divorce, legal separation, termination of employment or reduction in the number of hours of employment), or

b) cessation of the employer's contributions towards the other coverage (regardless of whether You or an eligible Dependent lost eligibility for such coverage), or

c) exhaustion of COBRA continuation coverage,

You and/or an eligible Dependent must request enrollment within thirty-one (31) days after the loss of coverage. Coverage will be effective as of the date coverage was lost.

If You acquire an eligible Dependent through marriage, birth, adoption or placement for adoption while You are eligible for the Plan, You (if You waived coverage when You became eligible) and Your newly acquired eligible Dependent(s) may enroll within thirty-one (31) days of the date of marriage, birth, adoption, or placement for adoption. In the case of a birth, adoption or placement for adoption of a child, Your Spouse may also be enrolled as Your eligible Dependent if otherwise eligible for coverage. Coverage will be effective as of the date of marriage, birth, adoption, placement for adoption.

If You do not enroll Yourself or Your eligible Dependents during the thirty-one (31) -day special enrollment periods permitted above, enrollment is not permitted until the next Annual Enrollment Period.

Annual Enrollment Period

You may add or drop coverage for You or Your Dependents during the Annual Enrollment Period which, for dental coverage, is normally held every two (2) years in November. Changes in coverage made during this period will be effective January 1 of the following year.

Qualified Medical Child Support Orders

This Plan will also provide coverage to the extent required pursuant to a Qualified Medical Child Support Order (QMCSO), including National Medical Support Notices, as defined by ERISA § 609 (a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants can obtain, without charge, a copy of such procedures from the Plan Administrator.

Cost of Coverage

The Company currently pays a portion of the cost of this coverage for You and Your Covered Dependents. You pay the remainder of the cost for You and/or eligible Dependent coverage through pre-tax payroll deductions from Your earnings.

Paying on a pre-tax basis means that Your premiums are deducted from Your paycheck before federal income, Social Security, and (in most cases) state taxes are withheld. The premiums are not included on Your W-2 form as taxable wages, so You lower Your taxable income.

The cost of coverage for Members is subject to change. Additionally, at any time an overpayment or underpayment of premiums by You for coverage under this Plan becomes known to the Plan, a correction will be required. Unless otherwise subject to IRS Section 125 rules, in the case of an overpayment, the overpaid premium amount will be refunded to You, or in the case of an underpayment, the underpayment of premiums will need to be paid by You to Ameren.

Coverage of Certain Dependents May be Taxable

Dental coverage under the Plan for Your Spouse (including a same-sex Spouse) and eligible Dependent Children is generally not taxable for federal tax purposes.

Children

Your children, stepchildren and foster children may receive Ameren healthcare coverage on a tax-free basis for federal tax purposes until they reach age 26. Healthcare coverage provided to other children, such as a grandchild, a child for whom you have guardianship, may be provided on a tax-free basis for federal tax purposes only if the child meets the guidelines for being Your qualified tax dependent for healthcare purposes.

If you cover a Dependent Child under the Ameren Dental Plan, You are responsible for determining whether the child is eligible for tax-free coverage. It is recommended that You consult with Your tax advisor to determine if Your Covered Child is eligible for tax-free coverage. If You determine that one or more of Your Covered Children are not eligible for tax-free employer provided healthcare coverage, you must contact the **Ameren Benefits Center** at 877.my.Ameren (**877.769.2637**).

Identification Card

Once You are enrolled in the Plan, You will be issued identification cards which provide information about Your dental coverage. You should carry the cards with You at all times, and show them to Your provider when You go for any appointments.

Definitions

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

Ameren means Ameren Corporation and its subsidiaries.

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

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

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

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

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

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

Covered Expenses mean charges for the types of treatment or service listed under the Covered Expenses section to the extent the charges do not exceed the Maximum Plan Allowance.

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.

Deductible means a specified dollar amount of covered dental expenses that must be incurred by You or one of Your covered Dependents before benefits will be payable under the Plan for all or part of the remaining covered expenses during the calendar year.

Dependent means Your Spouse or Dependent Child, if that Spouse or Dependent Child is not in the active services of any Armed Forces of any country and is not covered under this Plan as an Employee.

Dependent Child means:

- Your natural or adopted child who depends on You for support and maintenance;
- A child for whom You have a legal support obligation for purposes of adoption. The child becomes an eligible Dependent on the later of the date of birth or the date You have legal obligation.
- A child who is primarily dependent upon You for support and lives with You in a permanent parent-child relationship, and who is Your stepchild, Your foster child, or a child for whom You or Your Spouse are a legal guardian;

- Your grandchild who is primarily dependent on You for support and lives with You in a permanent parent-child relationship.

In all cases, the child must depend on You for his or her main 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 depends on You for support and maintenance.

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.

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

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

Maximum Plan Allowance means the amount determined by the applicable Delta Dental plan as the allowed amount for a particular procedure, service or item for the particular dentist of service provider. The allowed amount for a particular dentist of service provider depends on its, his or her participation status (e.g., Delta Dental PPO Dentist, Delta Dental Premier Dentist or Non-Participating Dentist).

Member means a Covered Employee or Covered Dependent.

Network Provider/In-Network Provider/Participating Dentist means a dentist, or other provider who has agreed to participate in Delta Dental's Preferred Provider organization (PPO) or Premier network program.

Non-Network/Out-of-Network Provider/Non-Participating Dentist means a dentist or other service provider who does not have or participate under a participation agreement with a Delta Dental's PPO plan for rendering dental care and who has not agreed to accept payment based on the applicable Maximum Plan Allowance for a Delta Dental PPO dentist or a Delta Dental Premier dentist.

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

Participating Dentist means a dentist or service provider who has or participates under a participation agreement with a Delta Dental plan for rendering dental care and who has

agreed to accept payment based on the applicable Maximum Plan Allowance for a Delta Dental PPO dentist or a Delta Dental Premier dentist.

Plan means **Ameren Dental Plan**.

Plan Administrator means Ameren Services Company, or its delegate.

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

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

You/Your means an Employee who is eligible to participate in the Plan offered by the Company as set forth in this Summary Plan Description; however, in the context of receiving Plan benefits, You/Your is intended to refer to any Member.

Schedule of Benefits

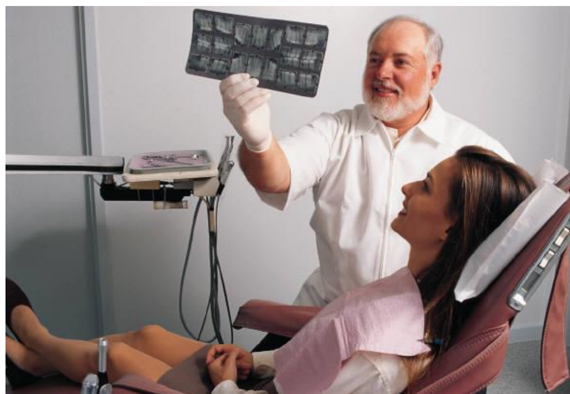
The Plan allows You to go to any dentist. However, Delta Dental offers access to large dentist networks – Delta Dental PPO and Delta Dental Premier.

Advantages of Selecting a Participating Dentist

All Participating Dentists (Delta Dental PPO and Delta Dental Premier) have the necessary forms needed to submit Your claim. Delta Dental Participating Dentists will usually file Your claims for You and Delta Dental will pay them directly for Covered Expenses. Visit our website at www.deltadentalmo.com to find out if Your dentist participates, or contact Delta Dental to receive, at no cost, a listing of Delta Dental PPO and Delta Dental Premier Participating Dentists in Your area. You are not responsible for paying the Participating Dentist any amount which exceeds the Delta Dental PPO or Delta Dental Premier Maximum Plan Allowance; whichever is applicable. You are only responsible for any non-Covered expenses, Deductible and Coinsurance amounts.

Selecting Your Dentist

You may visit the dentist of Your choice and select any dentist on a treatment by treatment basis. It is important to remember Your Out-of-Pocket Expense costs may vary depending on Your choice. You have three (3) options:



Delta Dental PPO Dentist

Delta Dental's PPO network consists of dentists who have agreed to accept payment

based on the applicable PPO Maximum Plan Allowance and to abide by Delta Dental policies. This network offers You cost control and claim filing benefits.

Delta Dental Premier Dentist

Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the applicable Premier Maximum Plan Allowance. This network also offers You cost control and claim filing benefits. However, Your Out-of-Pocket Expenses (Deductibles and Coinsurance amounts) may be higher with a Delta Dental Premier dentist based upon Your plan design.

Non-Participating Dentist

If You go to a Non-Participating Dentist (a dentist not contracted with a Delta Dental plan), Delta Dental will make payment directly to You based on the applicable Maximum Plan Allowance for the Non-Participating Dentist. It will be Your obligation to make full payment to the dentist and file Your own claim.

How The Program Works

The Dental Program is designed to:

- Encourage You and Your family to seek preventive dental care and possibly avoid major restorative treatment, and
- Provide coverage for dental services for You and Your family when dental problems occur.

The next few pages give You a closer look at what dental services the program covers and those services not covered. Covered Expenses generally include services and supplies that are ***dentally necessary*** and appropriate, and are ordered or prescribed by a dentist. These services and supplies must also be provided while the patient is covered by one of these options. An expense is incurred on the date of treatment, service, or purchase.

If You participate in the program, a customary charge for a Participating Dentist is the fee which is allowed by Delta Dental in the terms of the Participating Dentist agreement. You are responsible for verifying whether the dentist You select is a Participating Dentist.

The following charts show how benefits are paid under each schedule:

Plan Features	In-Network (PPO)	In-Network (Premier)	Out-of-Network
Provider Selection	**Delta Dental PPO Dentists**	**Delta Dental Premier Dentists**	**Non-Participating Dentists**
Deductible (once every Plan Year) – **Individual** – **Family**	$25 $75	$25 $75	$50 $150
Preventive care (such as regular exams, cleanings and X-rays)	100% No Deductible	100%* No Deductible	100%* No Deductible
Basic treatment services (such as fillings or root canal therapy)	80% (after Deductible)	80%* (after Deductible)	50%* (after Deductible)
Major dental work (such as bridges, crowns or dentures)	50% (after Deductible)	50%* (after Deductible)	50%* (after Deductible)
Annual maximum benefit	$1,000/person	$1,000/person	$1,000/person

*Subject to maximum allowed for the area, as determined by the Plan, or the Dentist's charge, whichever is less. The 'maximum allowed for the area' is the fee charged by the majority of the dentists in that area.

In addition, a reimbursement will never be more than 100% of the charge for a service.

How to Receive Dental Benefits

Simply call the dental office and make an appointment. If You select a Delta Dental Participating (PPO or Premier) Dentist, he or she is required to complete and submit a claim for You at no charge. Show them Your coverage identification card and they will handle the rest.

How to Verify Participation in Delta Dental Networks

In order to verify if Your dentist is a participant in the Delta Dental PPO or Delta Dental Premier network, You can:

- Simply ask Your dentist if he/she is a Delta Dental PPO or Premier Participating Dentist; or
- Visit Delta Dental's website at www.deltadentalmo.com/ameren and search the directory for a Delta Dental Participating Dentist; or
- Call Delta's customer service department at **800.335.8266**.

Explanation of Benefits

An Explanation of Benefits (EOB) is an itemized list of services provided, dates of service, amount paid to the dentist according to the terms of the Plan and the balance owed by the patient. You can access and print an EOB from Delta Dental's website at any time after a claim is processed. In addition, if there is a balance due after a claim is processed, You will

receive an EOB in the mail. If a Delta Dental PPO or Premier dentist bills You for an amount that is different from what the EOB indicates, contact Delta Dental customer service for assistance by calling **800.335.8266**, or e-mailing at service@deltadental.com.

Deductible Amounts

There is no Deductible required for preventive care. However, You must satisfy the Deductible specified by the Plan before basic and major restorative services will be paid. The Deductible amount for basic and major dental expenses each calendar year is $25/$50 per person or $75/$150 per family each calendar year depending on if You use an In-Network or Out-of-Network dentist (see chart above). The Plan will subtract the Deductible amount from Covered Expenses; then the Plan will pay for Covered Expenses as stated in this document.

Maximum Benefits

There is an annual limit on the amount of benefits each covered person may receive from the **Ameren Dental Plan**. The maximum annual benefit payable by this Plan is $1,000 per covered individual.

Covered Expenses

The amount the Plan pays depends on the type of service You receive. Services fall into three categories:

- Diagnostic and Preventive services.
- Basic services (including therapeutic and restorative services).
- Major services.

Diagnostic and Preventive Services

Preventive services include:

1) Routine oral exams and teeth cleaning — twice each calendar year, including periodontal cleaning, which are paid as Basic.
2) Routine bitewing X-rays — twice each calendar year.
3) Fluoride treatments for children under age nineteen (19) — twice each calendar year.
4) Full mouth X-rays — one set in a thirty-six (36) consecutive month period.
5) Space maintainers for missing primary teeth.
6) Diagnostic X-rays and laboratory procedures.
7) Sealants applied to the permanent molars of Your covered Dependent Child who is at least six but less than nineteen (19) years old — once every three (3) years.
8) Emergency oral exam.

Basic Services

Basic Services include:

1) Amalgam, silicate, acrylic and composite fillings.
2) Extractions, including surgical removal of partially and fully impacted wisdom teeth. However, when service for the removal of full-bony impacted wisdom teeth is paid by the **Ameren Employee Medical Plan**, it will not be covered under this Plan.
3) Endodontic treatment including root canal therapy.
4) Periodontal therapy including cleaning and occlusal adjustments.
5) Consulting with Your dentist or doctor when required, except when due to pre-orthodontic treatment.
6) Surgery to prepare dental ridges for prosthetic appliances.
7) Oral surgery performed inside the mouth.
8) General anesthesia for oral surgery except when due to pre-orthodontic treatment.
9) Emergency care and treatment of the jaw or sound natural teeth received within seventy-two (72) hours after the first visit.
10) Relining or rebasing of dentures more than six months from the date of placement (one of either in a thirty-six (36) consecutive month period).
11) Repair of crowns, dentures or bridgework.

Major Services

It is recommended that You or Your covered Dependent send the Claims Administrator a dentist's pretreatment estimate for the major treatment shown below. Based on the information You submit, You and Your dentist will be notified in writing of the estimated benefit the program will pay.

Major Services include:

1) Inlays, onlays, crowns and build-ups for crowns when the tooth cannot be restored with a filling or when needed as a support for a bridge.
2) First placement of bridges or partial or full dentures.
3) Replacement of a bridge or denture if:
    a) Five years have passed since the last placement and the bridge or denture is not serviceable.
    b) An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

Expenses Not Covered

Just because a dentist recommends a type of treatment does not necessarily mean it will be covered under the program. The Claims Administrator, in its sole discretion, decides whether a dental service is covered, is dentally necessary and appropriate. Contact Delta Dental for any questions about whether or not a procedure is covered.

No payment will be made for these expenses (this is not an exhaustive list):

1) Orthodontia.
2) Services which are paid by a government or given to You or Your covered Dependent without charge if You did not have coverage.
3) Hospital room and board and miscellaneous hospital expenses and any additional fees charged by the dentist for treatment in any such facility.
4) Accidental injury for which You or Your covered Dependent has or had a right to payment under a Workers' Compensation or similar law.
5) Accidental injury arising out of or in the course of work for pay, profit, or gain. Exception: The program pays benefits for a person who is not covered by Workers' Compensation and lawfully chose not to be.
6) Dental treatment for cosmetic reasons, except for reconstructive surgery or treatment required:
    a) Because of accidental injury which takes place while You or Your covered Dependent is covered for this benefit.
    b) For facings or crowns on molar teeth if needed as a result of an accidental injury.
    c) For a birth defect or sickness of a covered Dependent Child born to You, or Your Spouse while covered for Dependent's coverage.
7) Dental treatment for which You are not required to pay.
8) Dental checkups or dental screening by Your employer, a school, or a government.
9) Any experimental treatment.
10) Dietary planning, plaque control or oral hygiene instructions.
11) Missed appointments or completion of claim forms.
12) Services for restoring tooth structure lost from wear, erosion, or abrasion, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to: equilibration, periodontal splinting, and occlusal adjustment.
13) Replacement of a lost or stolen prosthetic device or any other device or appliance.
14) Any dentures, crowns, inlays, onlays, bridgework, or other appliances or services mainly for increasing vertical dimension.
15) Replacement of dentures or bridgework if less than five years from the last denture or bridgework placement. An exception is made if the bridge or denture cannot be made

satisfactory due to a change in supporting tissues or because too many teeth have been lost.

16) Sickness or accidental injury:

    a) Resulting from any armed conflict, whether declared as war or not, involving any country or government.

    b) While on military service for any country or government.

17) Fluoride treatments after reaching age nineteen (19).

18) Services for which the participant, absent this coverage, would normally incur no charge, such as care rendered by a dentist to a member of his/her Immediate Family or the Immediate Family of his/her Spouse;

19) Drugs and medicines for which a prescription is required if covered under the prescription drug benefit of the **Ameren Employee Medical Plan**.

Expenses are not covered by the Dental Program if they are:

1) Payable under any medical coverage provided by Ameren.

2) In excess of the maximum benefits provided by this program.

3) Charges for anesthesia, other than by a licensed dentist for administering general anesthesia in connection with covered oral surgery services.

4) Services performed by any person other than a dentist or auxiliary personnel legally authorized to perform services under the direct supervision of a dentist.

5) Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

6) Services with respect to any disturbance of the temporomandibular joint.

All decisions concerning exclusions and limitations under the Ameren Dental Plan are at the sole discretion of the Claims Administrator.

Coordination Of Benefits

You or a Covered Dependent may be entitled to dental benefits from another source. If this is the case, dental benefits from the **Ameren Dental Plan** are coordinated with benefits from the other source so that the total amount reimbursed may be less than but does not exceed 100% of allowed expenses, as outlined in the section titled SCHEDULE OF BENEFITS.

Another source of benefits means:

- Any group, blanket, or franchise health coverage.
- A group contractual prepayment or indemnity plan.
- A health maintenance organization (HMO), whether group practice or individual practice association.
- A labor-management trusteed plan or a union income protection plan.
- An employer or multi-employer plan or employee benefit plan.

- A government program.
- Coverage required or provided by statute.

The **Ameren Dental Plan** does not coordinate benefits with any individually purchased coverage or public assistance program. The **Ameren Dental Plan** does not coordinate benefits with the **Ameren Employee Medical Plan**.

Part of the *allowed expense* must be covered under at least one of the programs covering You or Your Covered Dependent. When the program covers an expense incurred for care provided by a Network Provider or an advanced procedure designated facility (see COVERED EXPENSES), the allowed expense is limited to the payment that the provider agreed to accept.

If the Dental Plan is primary, its benefits are determined before those of another plan. The benefits of the other plan are not considered. When this Plan is secondary, its benefits are determined after those of the other plan. Its benefits may be reduced because of the other plan's benefits.

If this Coordination of Benefits provision applies to benefits to which You or Your family members are entitled, the bills must first be filed with the primary carrier before being filed with the secondary carrier. A copy of the primary plan's explanation of benefits should be included with the secondary claim.

The Dental Plan determines its order of benefits by using the first of the following rules that applies:

- A plan that does not coordinate with other plans is always the primary plan.
- The plan that covers the person as an employee, member, or subscriber (other than a dependent) is the primary plan; the plan that covers the person as a dependent is the secondary plan.
- The primary plan is the plan that covers the person as an employee who is neither laid off nor retired (or as that employee's dependent). The secondary plan is the plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

In the case of a Dependent Child whose parents are not legally separated or divorced:

- The primary plan is the plan of the parent whose birthday (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year.
- If both parents have the same birthday, the benefits of the plan that covered the parent the longer is the primary plan; the plan that covered the parent the shorter time is the secondary plan.

- If the other plan has the male/female rule instead of the birthday rule and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
- If a dependent child whose parents are legally separated or divorced and who is covered by the plans of both parents has a claim, the primary payer is the plan covering the parent who is responsible for the child's health care under the terms of the court decree. In the absence of a court decree, the payment order is:

  — The plan of the natural parent with custody.

  — The plan of the spouse of the natural parent with custody.

  — The plan of the natural parent without custody.

If none of the above rules determine the order of benefits, the primary plan is the plan that covered an employee, member or subscriber longer. The secondary plan is the plan that covered that person the shorter time.

The Effect Of No-Fault Auto Insurance

First-party auto insurance coverage is considered primary. The benefits payable under the Plan are coordinated with the first-party benefits that automobile insurance pays or would pay without regard to fault for the same covered expenses. This also applies to the extent first-party auto insurance coverage is legally required but not in force.

Subrogation

The Plan does not cover expenses that are or should be paid by other parties. When another party (such as an issuer of an automobile or liability insurance policy) is, or may be, obligated to pay for some or all of Your expenses, or a court orders or You agree to a settlement with another party to pay for Your expenses, the Plan is subrogated in Your right to recover from these other parties. You will be requested to complete an agreement to reimburse the Plan if some or all of the expenses are recovered from a third party. If You collect from another party, You must reimburse the Plan for any benefits You received from the Plan that has been paid by another party. If You, Your Dependents or the representative of either You or a Dependent receives any form of recovery from a third party, that recovery is held in trust for the Plan.

Payment of Benefits

If You receive services from a dentist who participates in the Delta Dental network, payment of benefits will be made directly to the dentist. When services are received from an Out-of-Network Provider, reimbursement will be made directly to the Member by Delta Dental of Missouri for all Covered Expenses under the Plan.

If You, a provider or other person has been paid benefits under the Plan that are in excess of the benefits that should have been paid, or which should not have been paid under the provisions of the Plan, the Plan or the Claims Administrator may cause the deduction of the amount of the excess or improper payment from any present or future benefits payable to You, the provider or other person or to recover such amounts by any other appropriate method that the Plan or the Claims Administrator shall determine.

How to File a Claim

The Plan Sponsor has contracted with Delta Dental to serve as the Claims Administrator. The Claims Administrator is responsible for: (1) initial determination of the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be followed and the claim forms to be used by Participants, and (3) administration of claims appeals. However, the Plan Sponsor is ultimately responsible for providing Plan benefits.

Delta Dental Participating Dentists have agreed to file claims with Delta on Your behalf and benefits will be paid directly to them. You are only responsible for Your share of the bill. Delta Dental Participating Dentists can charge You only for Deductibles, Your Coinsurance, any amounts over Plan maximums, and any non-covered services.

Dentists who are not in a Delta Dental network do not promise to file a claim for You but may submit a standard ADA claim form and Delta Dental will make the benefit payment directly to You. Most dentists have the ADA form available; however, one can also be obtained by visiting www.deltadentalmo.com/ameren.

If You use a non-Delta Dental provider, You will need to send a claim to the address below:

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690
800.335.8266

Claims for dental Covered Expenses may be submitted in any amount for payment. You do not need a claim form in order to file a claim for reimbursement; You may submit Your itemized bill for services provided. The bill must show the following information:

- The patient's full name;
- The Employee's full name and Social Security Number, or the assigned privacy identification number;
- The provider's name, address and federal tax or Social Security Number;
- A description of each service or supply provided;
- The charge made for each Covered Expense or supply; and
- The date the service or supply was provided.

You must submit original bills. Photocopied bills will be accepted only when You have other coverage and this Plan is the secondary payer. Be sure to keep a copy for Your records.

Any questions about a dental claim should be directed to Delta Dental at 800.335.8266 or 314.656.3001.

All claims for dental benefits must be received by Delta Dental within one (1) year after the end of the year in which the expense is incurred. For example, all expenses incurred during

2016 must be received by Delta Dental by December 31, 2017. If a claim is denied due to a Delta Dental Participating Dentist's failure to make a timely submission, You will not be liable to such dentist for the amount which would have been payable by the Plan, provided You advised the dentist of Your eligibility for benefits at the time of treatment.

Delta Dental is primarily responsible for processing Your claims and for determining the benefits to be paid. If a claim for benefits under the Plan is denied, the reason for the denial will be stated in writing and delivered or mailed to the Member. The Plan will also provide a reasonable opportunity for a full and fair review of the decision denying the claim.

Termination of Benefits

Employees

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

1) End of the month of Your termination of employment;
2) The last day of the month prior to the date of Your retirement;
3) Date of Your death;
4) End of the month in which You no longer satisfy the eligibility requirements as specified in the ELIGIBILITY section of this booklet;
5) End of the month in which You last paid the required payroll deduction for coverage;
6) End of the month in which You commence an unpaid leave of absence (See CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT & RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA) for information on termination of coverage for Employees who are on an unpaid leave of absence due to military service, and CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA));
7) Date of transfer to an Employee group not covered by the Plan;
8) The date the Plan terminates;
9) Date the Company amends the Group Plan to eliminate coverage for the class of eligible individuals to which You are a member;
10) The date of expiration of the Labor Agreement providing for Your coverage under the Plan as stated in the ELIGIBILITY section of this document;
11) Date You or a Covered Dependent participate in fraud or misrepresentation of a material fact in enrolling or making claims for benefits under the Plan. Under those circumstances, the Plan will have the right to recover the full amount of benefits paid on behalf of You or a Covered Dependent.

In addition, Your coverage under this Dental Plan will end on the date You cease to be eligible for such coverage option (for example, change in employment from contract to management status) or the date the dental plan option is discontinued.

Dependents

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

> You and Your Covered Dependents may be eligible for temporary dental continuation benefits as required by federal law. See *COBRA*.

1) The date Your coverage stops. This does not apply if Your coverage stops because You received the maximum benefits under the Plan;
2) Except for divorce, the end of the month in which Your Dependent(s) is no longer eligible (see ELIGIBILITY);
3) In the case of a Covered Spouse, the date of divorce;
4) In the case of a Covered Spouse, the date of legal separation;
5) End of the month in which You last paid the required payroll deduction for Dependent coverage;
6) Date of death of the Dependent;
7) The date the Plan terminates;
8) The date the Dependent's coverage part of the Plan stops;
9) The date Your Dependent disabled child who is over the age of 26 is no longer disabled according to the Plan definition or You fail to provide proof of Your child's disability.

If a Member's coverage is terminated, all rights to receive benefits under the Plan will end as of the date of the Member's termination of coverage. However, the Member may be eligible for temporary healthcare continuation benefits as required by federal law. (See CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")).

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

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

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

to choose COBRA continuation coverage. COBRA continuation is provided, subject to the person's eligibility for coverage under the Plan.

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

Employees

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

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

Spouses

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

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

Dependent Children

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

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

Newborn or Adopted Children

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

family members ceases. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

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

Special Enrollment Rules for Qualified Beneficiaries

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

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

Alternate Recipients under Qualified Medical Child Support Orders

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

Length of Coverage

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

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

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

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

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

If, during the initial eighteen (18) month period, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the eleven (11) month extension does not apply. If the Social Security Administration determines that the qualified beneficiary is no longer disabled after the initial eighteen (18) month period, the period of continuation coverage ends the first (1st) day of the month that begins more than thirty (30) days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not exceed twenty-nine (29) months.

- Coverage for Dependents may be continued up to a maximum of thirty-six (36) months, if coverage is terminated due to:
  (1) the Covered Employee's death;
  (2) the Covered Employee's divorce or legal separation; or
  (3) a Dependent Child's ceasing to satisfy rules for Dependent status.

- If the qualifying event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Covered Employee lasts until thirty-six (36) months after the date of Medicare entitlement.
- If another qualifying event occurs while receiving eighteen (18) months of COBRA continuation coverage, a Covered Spouse and Dependent Children can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the Covered Spouse and any Dependent Children receiving continuation coverage if the Covered Employee or former Covered Employee dies or gets divorced or legally separated, or if the Covered Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Notification and Election Requirements

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

"Healthcare and Life Benefits" at **www.myAmeren.com** or by calling the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**). Failure to provide notification of a qualifying event to the Plan Administrator within sixty (60) days will result in the loss of continuation coverage rights.

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

If You Have Questions

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

Address Changes

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

Ameren Benefits Center
PO Box 199434
Dallas, TX 75219-9434

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

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

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

If the Covered Employee does not return to active employment with Ameren after his/her FMLA leave has expired or if the Plan Administrator is notified or otherwise determines that the Covered Employee is not returning to employment, coverage under the Plan may only be continued under COBRA (See COBRA CONTINUATION section of this booklet). The period of coverage during FMLA leave will not be counted toward the maximum number of months of coverage permitted under COBRA.

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

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

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

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

A Covered Employee may be required to pay a portion of the cost of his/her benefits. If Your military service is less than thirty-one (31) consecutive days, Your healthcare coverage continues as if You remained employed, and You will be required to pay only Your normal share of the premium for this period of coverage. If Your military service is thirty-one (31) days or more, Your healthcare coverage under the Plan will terminate on the last day of the month coincident with or next following thirty-one (31) days of military service. However, You may elect to continue healthcare coverage for Yourself and Your Covered Dependents by paying the required premiums. You will be required to pay up to one

hundred two percent (102%) of the full premium for Your own coverage. Dependents will be required to pay the normal Employee share of the premium for the first twelve (12) months of continuation. After the first twelve (12) months, Covered Dependents will also be required to pay up to one hundred two percent (102%) of the full premium for coverage.

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

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

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

If You Have Questions

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

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

Privacy

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

Most of the comprehensive requirements are outlined in the "Notice of Privacy Practices" You have received from the Plan. This notice can also be found on **www.myAmeren.com**

by selecting "Healthcare and Life Benefits", then "Healthcare and Life", then "Resource Materials", "Documents and Forms" and finally choosing "HIPAA Privacy Notice". In addition, You have the right to receive a paper copy of this notice by contacting the **Ameren Benefits Center** at 877.7my.Ameren (**877.769.2637**).

The Plan is permitted to use and disclose Your protected health information without Your consent or authorization, as necessary, to carry out Plan functions and duties. For example, the Plan may obtain health claims information and provide it to the Claims Administrator to perform claims adjudication and appeals. The Plan will comply with any law that requires a disclosure of Your protected health information, such as a court order. Please review the Notice of Privacy Practices for a more complete discussion about how the Plan may use Your protected health information and disclose it to third parties.

Claims Procedure and Appeals

As a participant in the **Ameren Dental Plan**, You are entitled to certain rights and protections as stated in the regulations issued by the Department of Labor, effective January 1, 2002, for all health and welfare claims governed by the Employee Retirement Income Security Act of 1974 (ERISA). However, a participant may not bring a cause of action hereunder in a court, or other governmental tribunal, unless and until all administrative remedies set forth in this document have first been exhausted.

Claim Determinations

Unless special circumstances require an extension of time for processing the claim, the time frame in which You will be provided with a written notice of the decision, will be determined by the type of claim as summarized below:

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

Notification of Denial

If a claim is denied in whole or in part, You will be notified of the denial in writing. The notice of denial will contain the following information: the specific reason(s) for the denial; a reference to the specific provision(s) in the Plan on which the denial is based; a description of additional material or information necessary to perfect the claim; an explanation of why the material or information is needed; and an explanation of the procedure to appeal the denial. If an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, the notice will include the rule, guideline, protocol or other criterion or state that You will be provided with a copy free of charge upon request. Notice of a denial based on medical necessity, experimental treatment or a

similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge. A Participant will also be informed of the Plan's appeal procedures and of Your right to bring a civil action under Section 502(a) of ERISA.

Right to Appeal

If Your claim for benefits under the Plan has been denied, in whole or in part, You or any person You authorize to represent You, may appeal the denial of dental benefits by submitting a written appeal setting forth the basis for Your claim to the Plan Administrator. You should include with Your request for review any comments, documents, records or other information You would like to have considered. Appeals may be sent to the following address:

Delta Dental of Missouri
Appeals Committee
12399 Gravois Road
St. Louis, MO 63127-1702

1. Deadline for Filing Appeal

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

2. Decision on Appeal

   A decision on the appeal will be made by the Plan Administrator within 60 days after receipt of Your written appeal.

   Appeals will be conducted by an appropriate qualified individual who was not involved with the initial claim decision or a subordinate to that original decision maker. No deference to the initial claims denial will be given by the reviewer.

3. Notification of Determination on Appeal

   If a claim is partially or wholly denied on Appeal, You will be advised of the determination in writing. The notice will give the specific reason for the denial and reference Plan provisions on which the denial is based. The notice will include statements as to the Participant's rights to obtain upon request, without charge, access to and copies of all documents, records and other information relevant to the claim, to bring a civil action under Section 502(a) of ERISA or to pursue other voluntary alternative dispute resolution options. The notice will also describe any voluntary appeal procedures under the Plan. If the Claims Administrator relied on a rule, guideline, protocol or similar criterion in denying the appeal, the notice will either

include a copy or state that it was relied on and will be provided upon request, without charge. The decision of the Plan Administrator on appeal shall be final and binding.

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

Miscellaneous

Plan Administration

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

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

No Contract of Employment

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

Plan Amendment or Termination

The Company hopes and expects to continue the **Ameren Dental 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 Services Company, or such officer's delegate may effect an amendment or termination of the Plan or a benefit provided under the Plan by written instruments describing the terms of such amendment or termination. Such amendment will be incorporated into this document The Plan Sponsor may also amend the Plan through the issuance of revised Benefit Program booklets, enrollment materials, brochures, or Certificates.

Verbal Statement May Not Alter Document

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or

benefits. The terms of the Plan may not be amended by oral statements by Ameren representatives, the Plan Administrator or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan's terms will control. It is Your responsibility to confirm the accuracy of statements made by Ameren or its designees, including the Plan Administrator, in accordance with the terms of this SPD and other Plan documents.

Applicability

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

Nontransferable Benefits

No person other than the Covered Employee and Covered Dependent is entitled to receive dental coverage or other benefits to be furnished by the Plan. Such right to dental care service coverage or other benefits is not transferable.

Severability

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

Waiver

The failure of Claims Administrator, the Plan Sponsor, or a 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.

Collective Bargaining Agreement

The Plan is maintained pursuant to a collective bargaining agreement with AmerenIP and one of the following unions:

- AmerenIP and IBEW Local 51 (IP); or
- AmerenIP and IBEW Local 309 (IP); or
- AmerenIP and IBEW Local 702 (IP); or
- AmerenIP and Laborers Local12 Counties(IP); or
- AmerenIP and Pipefitters Local 101(IP); or
- AmerenIP and Pipefitter Local 360 (IP); or
- AmerenIP and Laborers Local 459(IP); or
- AmerenIP and IBEW 51 MDF(IP); or
- AmerenIP and Laborers Local 100(IP)

A copy of the collective bargaining agreement is available for inspection from the Plan Administrator upon request.

Your Rights Under ERISA

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

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

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

If Your claim for a (welfare) benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim.

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

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

General Information About The Plan

Plan Name:	Ameren Dental Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA), providing dental benefits.
Plan Year:	January 1 through December 31
Plan Number:	510

Funding Medium and Type of Plan Administration:	The Plan is generally funded from contributions made in part by the Plan Sponsor and in part by Plan participants. All contributions are paid directly to a trust established for the purpose of providing benefits under the Plan. Plan Sponsor has a contract with Delta Dental of Missouri ("Claims Administrator") to process claims under the Plan, including claims administration. Benefits under the Plan are not guaranteed under a contract or insurance policy. The Plan Sponsor is ultimately responsible for providing the Plan benefits, and not the Claims Administrator.
Trustee:	To the extent permitted under applicable law, dental benefits are paid out of trust funds held by the Bank of New York Mellon, located at 135 Santilli Highway, Everett, Massachusetts, 02149. If the trusts are terminated, the remaining assets will be distributed in accordance with the provisions of the trust agreements.
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:	Delta Dental of Missouri P.O. Box 8690 St. Louis, MO 63126-0690 800.335.8266 www.deltadentalmo.com/ameren

COBRA Administrator:	Ameren Benefits Center PO Box 199434 Dallas, TX 75219-94341.877.769.2637 www.myameren.com
Named Fiduciary:	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, Missouri 63166-6149 877.7my.Ameren (877.769.2637) Service of legal process also may be made upon the Plan Administrator.
Membership ID Card:	Every Covered Employee receives membership ID card(s). Employees need to carry the Plan ID card(s) with them at all times, and present the ID card whenever the Employee or a Dependent receives dental services. If a dental plan ID card is missing, lost, or stolen, contact Delta Dental at 800.335.8266 to obtain a replacement.