A Plan Designed to Provide
Security for Employees of

Ameren Vision Plan

for

Employees Represented by a Collective Bargaining Agreement with AmerenIP

Administered by:
Vision Service Plan Insurance Company

As Amended and Restated January 1, 2011

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 Vision Plan** (the "Plan") to provide vision benefits to eligible Employees, their lawful Spouses, Domestic Partners, 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, 2011. It replaces and supersedes all prior summary plan descriptions for the Plan.

The **Ameren Vision Plan** has been established on a noninsured basis. All liability for payment of benefits is assumed by Ameren. While Vision Service Plan ("VSP") administers the payment of claims, VSP has no liability for the funding of the Plan.

While one of the functions of VSP 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 Plan Administrator. The Plan Administrator has complete discretion to construe or interpret all Plan provisions, to determine eligibility for 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 vision benefit claims and appeals to VSP.

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.

DURATION OF THE PLAN. Ameren Corporation hopes and expects to continue the **Ameren Vision 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.

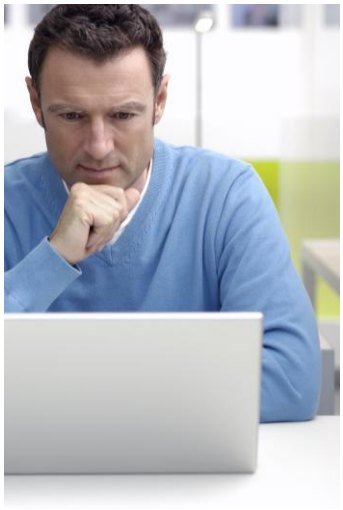
PLEASE READ THIS BOOKLET CAREFULLY. We suggest that You start with a review of the terms listed in the DEFINITIONS Section. The meanings of these terms will help You understand the provisions of Your Plan. Terms defined in the DEFINITIONS section of this booklet are capitalized in this document.

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



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

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

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Eligibility

Employees

You are eligible for coverage under this Plan if You:

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

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

- a temporary Employee 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 vision 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. Eligible Dependents are limited to:

- Your Spouse;
- Your Domestic Partner; provided You are not married to someone else under statutory or common law;
- Your Dependent Children who have not reached age 26;
- 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 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 in the next paragraph, a Spouse, Domestic Partner or Dependent Child who is eligible for coverage under an Ameren sponsored vision or dental/vision Plan as an Employee, cannot be covered as Your Dependent under this Plan. 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 vision or dental/vision plan at the same time.

If You and Your Spouse or Domestic Partner are both eligible for coverage under an Ameren sponsored vision 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 vision 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 Vision 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, Domestic Partner and/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 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.
- A Spouse or Domestic Partner who is covered as an Employee under the Plan.
- A parent or other relative of You or Your Spouse/Domestic Partner.

Enrolling Provisions

Employees

In order to elect or waive coverage in the **Ameren Vision 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 31 days from the date of Your Enrollment Worksheet.

Unless You waive coverage during this initial 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 vision coverage for Yourself and Your family. You won't have another opportunity to choose or change Your vision benefits until the next Annual Enrollment period, 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, Domestic Partner 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, legally separated or terminate Your domestic partnership;
- You gain a Dependent through birth, adoption, placement for adoption or marriage, or upon entering a domestic partnership;

- You, Your Spouse, Your Domestic Partner or Your Dependent becomes employed or loses a job;
- Your Spouse, Domestic Partner or child dies;
- You, Your Spouse, Domestic Partner or Dependent changes from full-time to part-time work or vice;
- You, Your Spouse or Domestic Partner commence or versa return from an unpaid leave of absence;
- Your Spouse, Domestic Partner or Dependent experiences a significant change in vision coverage or cost under another employer's health plan;
- Your Dependent Child satisfies or ceases to satisfy the eligibility requirements;
- You, Your Spouse, Domestic Partner or Dependent's experience a change in coverage eligibility due to a relocation of residence or workplace.

If the change in status occurs with respect to Your Domestic Partner, any coverage change is generally limited to Your Domestic Partner's coverage.

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 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 31 days after the event, You and/or the Dependent must wait until the next Annual Enrollment Period to enroll for coverage.

If You have a status change and want to drop coverage for Yourself, or drop a Dependent from Your coverage, 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 31 days of the change in family status. In the event of the death of a dependent, divorce, legal separation, or termination of a domestic partnership, 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 vision plan (including COBRA continuation coverage) or had other vision 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 Domestic Partner, divorce, termination of domestic partnership, 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 31 days after loss of coverage. Coverage will be effective as of the date coverage was lost.

If You acquire an eligible Dependent through marriage, domestic partnership, 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 31 days of the date of marriage, birth, adoption, placement for adoption, or within 31 days of meeting the eligibility rules for a Domestic Partner. In the case of a birth, adoption or placement for adoption of a child, Your Spouse or Domestic Partner 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 or the date You are eligible to add Your Domestic Partner (see ELIGIBILITY).

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

Annual Enrollment

You may add or drop coverage for You and/or Your Dependents during Annual Enrollment which is normally held each November. Changes in coverage made during Annual Enrollment 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

You pay the full cost of coverage for You and Your Dependent(s) 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. However, Your other benefits based on pay are generally not affected.

Your cost for this coverage is subject to change.

Is Your Domestic Partner Eligible for Federal Tax-Free Health Benefits?

In order for the coverage for Your same sex Domestic Partner to be tax-free, You must be able to claim Your Domestic Partner as a dependent for federal income tax purposes OR he or she must meet all of the following requirements:

1. Lives with You for the entire calendar year.
2. Is a member of Your household for the entire calendar year.
3. Receives more than half of his/her support from You for the calendar year.
4. Cannot be claimed as anyone else's qualifying child dependent.
5. Is a U.S. resident, U.S. citizen, U.S. national or a resident of Canada or Mexico.

In order for Your Domestic Partner to be a member of Your household, You must both maintain and occupy the same household and the relationship between You and Your Domestic Partner must not violate local law.

If Your Domestic Partner **DOES** meet the necessary requirements outlined above and therefore coverage under the Plan qualifies for tax-favorable treatment, You must inform the **Ameren Benefits Center** of the qualified tax-free status by calling 877.7my.Ameren (**877.769.2637**). If You do not notify the **Ameren Benefits Center** of the tax dependent status of Your Domestic Partner, premiums deducted for coverage for Your Domestic Partner will be subject to imputed income, which means that You will be required to pay income tax withholding and employment taxes.

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

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.

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 Domestic Partner means a same sex Domestic Partner 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 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, Domestic Partner or Dependent Child, if that Spouse, Domestic Partner or child is not in the active service 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 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 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.

Domestic Partner means an individual who meets the following requirements:

- is the same sex as the Employee;

- is at least 18 years of age and not related to the Employee by blood;
- is not married to another person under statutory or common law;
- is not in another domestic partnership;
- has been in an exclusive, committed relationship with the Employee for at least twelve (12) consecutive months;
- has shared the same principal residence as the Employee for at least twelve (12) consecutive months; and
- is jointly responsible with the Employee for financial obligations and for each other's common welfare.

Employee means any person who is employed on other than a temporary basis.

Member means a Covered Employee or Covered Dependent.

Network Provider/In-Network Provider means a doctor (optometrist or ophthalmologist), or other provider who has agreed to participate in the VSP network.

Non-Network/Out-of-Network Provider means a doctor (optometrist or ophthalmologist) or other provider who does not participate in the VSP network.

Non-Specialty Contacts are soft, spherical single-vision lenses and do not include toric, multifocal, monovision, aphakic or other specialty lenses.

Plan means **Ameren Vision Plan**.

Plan Administrator means Ameren Services Company.

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 of the opposite sex to whom You are currently married by a marriage procedure which was solemnized by a person authorized by law to solemnize marriages. Spouse does not include common-law spouses (even if Your state recognizes common-law marriage), ex-spouses, Domestic Partners, boyfriends, girlfriends or anyone else to whom You are not currently married.

Visually Necessary or Appropriate means services and materials medically or Visually Necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

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 a Covered Employee.

Schedule of Benefits

The **Ameren Vision Plan** allows You to go to any doctor. However, You get the best value from Your VSP benefit when You visit a VSP network doctor. There are several advantages of using a VSP network doctor:

- Lowers Your out-of-pocket costs;
- You can change Your doctor at any time;
- You can go to a specialist of Your choice;
- You can select different doctors for each member of Your family;
- The networks are national;
- The doctor will file Your claim for You and/or Your Dependent.

The following chart shows how benefits are paid:

Plan Features	In-Network	Out-of-Network
Eye exam (once every Plan Year)	$10 co-pay	$10 co-pay, then You are reimbursed up to $45
Pair of Eyeglass Lenses (once every Plan Year)[1]		
– Single Vision	$10 co-pay	$10 co-pay, then reimbursed up to $45
– Lined Bifocal	$10 co-pay	$10 co-pay, then reimbursed up to $65
– Lined Trifocal	$10 co-pay	$10 co-pay, then reimbursed up to $85
– Lenticular	$10 co-pay	$10 co-pay, then reimbursed up to $125
– Most tinted and photochromic lenses	Plan pays 100%	Reimbursed up to $5
Frames (once every Plan year) [2]	Frame of Your choice covered up to $130	Frame of Your choice covered up to $47
Contact Lenses (once every Plan Year)[1]		
– Necessary	Plan pays 100% (after $10 co-pay)	Plan pays 100% up to $210
– Elective	Plan pays 100% up to $130	Plan pays 100% up to $130

1. [1]Once per Plan Year, You may receive benefits for eyeglasses or contact lenses, but not both.
2. 2 If You have had laser vision surgery (PRK, LASIK, or Custom LASIK) You can use Your frame allowance to buy non-prescription sunglasses.

Diabetic Eyecare Program (DEP)

Additional services are available through the Diabetic Eyecare Program (DEP) for participants who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions. This program allows Your VSP doctor to provide services not available under the regular schedule of benefits shown above.

Plan Features	In-Network	Benefit Frequency	Out-of-Network
Ophthalmological Services and Office Visits	Covered in full, less $20 co-payment	Once every 12 months	Contact VSP Customer Service at 800.877.7195 before obtaining services from non-VSP providers.
Gonioscopy	Covered in full	Once every 12 months	
Extended Ophthalmological	Covered in full	Once every 6 months	
Fundus Photography	Covered in full	Once every 6 months	

Frames

Your VSP frame benefit offers You the freedom to choose a frame that complements Your lifestyle.

If You choose a frame that exceeds the $130 Plan allowance, You will be responsible for paying the difference at the time of Your doctor's visit. Note: You may be eligible for a 20% discount on the amount over the Plan's frame allowance.

The Plan covers the cost of frames once every calendar year.

Contact Lenses

When You choose contact lenses instead of glasses, Your $130 allowance applies to the cost of Your contacts and the contact lens exam. This exam, which ensures proper fit of the contacts, is in addition to Your vision exam.

You receive a 15% discount on the cost of contact lens professional services from Your VSP network doctor.

Why is the contact lens exam not covered as part of my routine eye exam?

The contact lens exam is a special exam which ensures the proper fit of Your contact lenses and evaluates Your vision with the contacts. Depending on Your needs, a doctor will provide training and education based on the type of services and eyewear provided. You should discuss the services that Your doctor provides to better understand the value of their contact lens exam, as well as the extent of the services necessary for Your individual eye health.

Visually Necessary Contact Lenses

The Plan pays 100% of the professional fees and materials (after $10 co-pay) for Visually Necessary contact lenses obtained from a VSP network doctor, subject to prior authorization. When Visually Necessary contact lenses are obtained from a non-participating provider, the Plan covers up to $210 (after $10 co-pay).

Note: You can receive benefits for eye glasses or contact lenses, but not both.

Contact Lens Care Program

The Contact Lens Care Program is designed for participants who wear soft contact lenses. If You qualify for the Contact Lens Care Program, when You visit a VSP network doctor, Your contact lens fitting and evaluation will be covered in full (after $10 co-pay). Your initial six month supply* of Non-Specialty Contact lenses will be covered at 100% up to $130, as indicated in the Schedule of Benefits above. For Your initial six-month supply of Non-Specialty Contact replacement lenses, You can choose from a variety of wear schedules, including:

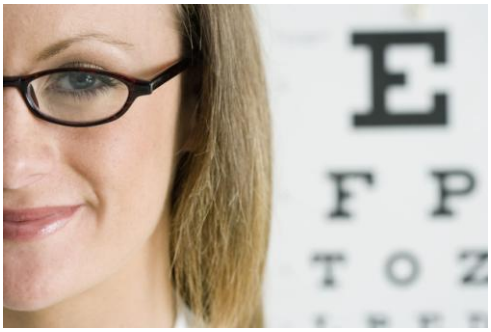
- Conventional
- One to two week disposable
- Extended Wear
- Planned Replacement

To participate in this program, You must already wear soft contact lenses from VSP's list of the most popular brands available. For a current list of soft contact lens brands available through this program, check www.vsp.com or call **800.877.7195**.

*The initial supply averages six months, but varies based on the manufacturer and brand of contact lenses.

Note: Contact lens wearers with complex prescriptions, more than a minor change in prescription or eye health problems, as determined by Your VSP network doctor require greater evaluation and fall outside of this program.

Extra Discounts Available From VSP Network Providers



When You purchase eyeglasses from a VSP Network Provider, You can receive an average of 35% - 40% off all non-covered lens extras. Examples of lens extras are:

- Scratch-resistant coating
- Anti-reflective coating
- Ultraviolet (UV) protection
- Progressive lenses

- Blended bifocal lenses

When purchasing eyeglasses from a VSP Network Provider for Your Dependent Children, the Plan covers 100% of the cost of polycarbonate lenses.

Receive 30% off unlimited additional pairs of prescription glasses and sunglasses if You purchase them from the same VSP doctor who performs Your eye exam and on the same day Your eye exam is performed.

Receive 20% off additional prescription glasses, prescription sunglasses and non-prescription sunglasses if You purchase from any VSP doctor within the last 12 months of an eye exam by a VSP doctor.

Receive 15% off the cost of the contact lens exam (fitting and evaluation) if You purchase from any VSP doctor within the last 12 months of an eye exam by a VSP doctor.

Discounts for laser vision correction surgery (LASIK, custom LASIK, PRK) are also available from VSP doctors and laser centers. After surgery, You can use Your frame allowance for sunglasses from any VSP doctor.

Low Vision Benefit

If You or Your Covered Dependent has severe visual problems that are not correctable with regular lenses, subject to prior approval by VSP Consultants, the following additional benefits may be available:

- Supplementary Testing (complete low vision analysis/diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated). These services are covered in full if provided by a VSP network doctor. If these services are provided by a non-participating doctor, they are covered up to $125.
- Supplemental low vision care aids, as Visually Necessary and Appropriate. The Plan will pay 75% of the cost and You pay 25% of the cost for such supplemental care aids if provided by a VSP network doctor. If supplemental low vision care aids are received from a non-participating doctor, the Plan will pay an amount not to exceed what VSP would pay a member doctor in similar circumstances.

Benefit Maximum

The maximum low vision benefit available is $1,000 per covered individual (excluding co-pay) every two years.

How to Receive Vision Benefits

Simply call the doctor's office and make an appointment. If You select a VSP network doctor, tell him or her that You are a VSP member. Your doctor and VSP will handle the rest.

How to Verify Participation in VSP Network

In order to verify if Your doctor is a participant in the VSP network, You can:

- Simply ask Your doctor if he/she is a VSP network doctor; or
- Visit VSP's website at www.vsp.com and search the directory for a VSP doctor; or
- Call VSP's customer service department at **800.877.7195.**

You do not need to notify VSP when You choose or change Your VSP network doctor. When You are ready, simply make an appointment with a VSP doctor.

VSP Savings Statement

Each time the Plan pays a claim for You, a VSP Savings Statement will be generated and will be available for You to access online at www.vsp.com. The Savings Statement will show You what the Plan paid on Your behalf and what the services would have cost You if there had been no Plan coverage.

Covered Expenses

The amount the Plan pays depends on the type of services provided (See SCHEDULE OF BENEFITS). The following are covered expenses under the Plan:

1. Annual eye examinations - complete vision analysis which includes an Appropriate examination of visual functions, including the prescription of corrective eyewear where indicated;
2. Vision Care Materials, including single vision, bifocal, trifocal, lenticular, photochromic and tinted lenses. These materials are available once per Plan Year, beginning on January 1;
3. Frames – once per Plan Year, beginning on January 1;
4. The following professional services as are necessary for lenses and frames:
   a. Prescribing and ordering proper lenses;
   b. Assisting in selection of frames;
   c. Verifying the accuracy of the finished lenses;
   d. Proper fitting and adjustment of frames;
   e. Subsequent adjustments to frames to maintain comfort and efficiency;
   f. Progress or follow-up work as necessary.

5. Contact lenses – Available once per Plan Year, beginning on January 1, in lieu of all other lens and frame benefits. You will be eligible for lenses and frames during the next Plan Year unless You opt again to receive contact lenses;
6. Low Vision Supplementary Testing and Supplemental Care Aids, subject to prior approval by VSP Consultants;
7. Additional diagnostic services for covered individuals who have been diagnosed with Type 1 diabetes and specific ophthalmological conditions, following routine eye examination by a VSP doctor.

Expenses Not Covered

The Plan is designed to cover visual needs, rather than cosmetic materials. If You or Your Covered Dependent select any of the following options, the Plan pays the basic cost of the allowed lenses, and You or Your Covered Dependent pay the additional costs:

1. Optional cosmetic processes
2. Anti-reflective coating
3. Color coating
4. Mirror coating
5. Scratch coating
6. Blended lenses
7. Cosmetic lenses
8. Laminated lenses
9. Oversize lenses
10. Polycarbonate lenses, except those for Dependent Children
11. Progressive multifocal lenses
12. UV (ultraviolet) protected lenses
13. Certain limitations on low vision care
14. A frame that costs more than the Plan allowance
15. Contact lenses (except as noted under the SCHEDULE OF BENEFITS).

In addition, the Plan will not pay benefits for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ±.5 diopter power); or two pair of glasses in lieu of bifocals;
2. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
3. Medical or surgical treatment of the eyes;
4. Corrective vision treatment of an experimental nature;
5. Costs for services and/or materials above Plan benefit allowances;

6. Services and/or materials not indicated on this Schedule as covered Plan benefits;
7. Laser Vision Correction.

Important Note: VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of You or Your Covered Dependent.

Coordination of Benefits

If a patient is covered by more than one vision plan (whether it be another carrier or another VSP plan), and therefore has duplicate coverage, he/she may:

- Receive two separate sets of service; OR
- Choose to have both plans pay for one set of services. In this case, the patient is "coordinating benefits".

Determine Primary and Secondary Plan

When a patient has duplicate coverage and wants to coordinate benefits, VSP must determine the order of assignment. The plan that covers the patient as an Employee is "primary". The plan that covers the patient as a dependent is "secondary".

If the patient is a dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Primary Plan

The primary plan must pay or provide its benefits as if the secondary plan or plans do not exist.

Secondary Plan

If a VSP plan is the secondary plan, the patient will receive allowances (exam, lenses and frame) that will be used to pay up to, but not more than the billed amount. Only services used on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service or product of the primary plan. Well vision benefits may only be coordinated with services provided for well vision care.

Payment of Benefits

If You receive services from a doctor who participates in the VSP network, payment of benefits will be made directly to the doctor. When services are received from an Out-Of-Network Provider, You will be required to pay the provider in full at the time of Your appointment and submit a claim to VSP for a partial reimbursement. If You decide to see a provider not in the VSP network, we suggest You first call VSP at **800.877.7195** to discuss the benefits of using In-Network Providers versus Out-of-Network Providers.

If You, a provider or other person has been paid benefits under that 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 VSP 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. However, the Plan Sponsor is ultimately responsible for providing Plan benefits.

You do not need to file a claim if You use a VSP network doctor.

If You use a non-VSP provider, You will need to send a claim to the applicable address:

VSP
Attn: Out-of-Network Claims
P. O. Box 997105
Sacramento, CA 95899-7105
800.877.7195

Claims for vision 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 service 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 vision claim should be directed to VSP at 800.877.7195.

All claims for vision benefits must be received by VSP within 180 days from which date the expense is incurred.

VSP 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:

- End of the month of Your termination of employment.
- The last day of the month prior to Your retirement date.
- Date of Your death.
- End of the month in which You no longer satisfy the eligibility requirements as specified in the ELIGIBILITY section of this booklet.
- End of the month in which You last paid the required payroll deduction for coverage if You do not make the next required contribution when due.
- 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 AMD MEDICAL LEAVE ACT OF 1993 (FMLA));
- Date of transfer to an Employee group not covered by the Plan;
- The date the Plan terminates.
- Date the Company amends the Plan to eliminate coverage for the class of eligible individuals to which You are a member.
- The date of expiration of the Labor Agreement.
- 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 Your vision 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 vision plan option is discontinued.

Dependents

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

- The date Your coverage ends.
- Except for divorce, the end of the month in which Your Dependent(s) is no longer eligible (See ELIGIBILITY).

- In the case of a Covered Spouse, the date of divorce;
- In the case of a Covered Domestic Partner, the cessation of the Domestic Partnership.
- End of the month in which You last paid the required payroll deduction for Dependent coverage.
- Date of death of the Dependent.
- The date the Plan terminates.
- The date the Dependent's coverage part of the Plan stops.
- The date Your Dependent handicapped child who is over the age of 26 is no longer handicapped according to the Plan definition or You fail to provide proof of Your child's handicap.

You and Your Covered Dependents may be eligible for temporary healthcare continuation benefits as required by federal law. (See 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 ACS 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.

Domestic Partners

A Covered Domestic Partner of a Covered Employee does not meet the guidelines of a qualified beneficiary under COBRA. However, if coverage is lost under the Plan because of any of the following events, Ameren will offer continuation coverage to the Covered Domestic Partner for the same length of time as a Covered Spouse would be offered coverage under COBRA:

- 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.
- Termination of the domestic partnership with the Covered Employee.

Dependent Children

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

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

Newborn or Adopted Children

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

when the child is enrolled in the Plan and it lasts until the continuation coverage for other family members ceases. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements.

If You want to add a new Dependent child, You must complete the appropriate enrollment process within 31 days 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.

Note: Newborn or adopted children of a Covered Domestic Partner are not considered to be a qualified beneficiary under COBRA. However, under the circumstances listed above, the Plan will offer continuation coverage for the same length of time as a newborn or adopted child of a Covered Employee would be offered under COBRA.

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.

Note: Domestic Partners receiving continuation coverage will also be allowed to enroll eligible family members in the Plan under the special enrollment rules set forth in this document, as if they were a qualified beneficiary.

Alternate Recipients under Qualified Medical Child Support Orders

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

Length of Coverage

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

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

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

  The eighteen (18) month period of continuation coverage may be extended for up to an additional eleven (11) months if a qualified beneficiary is determined by the

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

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

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

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

  (1) the Covered Employee's death;
  (2) the Covered Employee's divorce or legal separation; or
  (3) a Dependent Child's ceasing to satisfy rules for Dependent status.

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

- If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, a Covered Spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the Covered Spouse and any Dependent children receiving continuation coverage if the Covered Employee or former Covered

Employee dies 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.

Note: A Covered Domestic Partner will be allowed to continue coverage for the same period of time as outlined above for Covered Dependents who are considered qualified beneficiaries under COBRA.

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.

Note: The notification requirements outlined above also apply to a Domestic Partner who is eligible to continue coverage under the Plan.

If You Have Questions

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

Address Changes

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

Continuation of Coverage Under the Trade Act of 1974

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

Tax Credit Under the Trade Act of 2002

Individuals who are eligible for "trade adjustment assistance" as a result of termination of reduction of hours may qualify for a tax credit created under the Trade Act of 2002. Under the tax provisions, an eligible individual can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. If You qualify or may qualify for the tax credit under the Trade Act of 2002, contact the Plan Administrator for additional information. If You have questions about these tax provisions, You may call the Health Care Tax Credit Customer Contact Center toll-free at 866.628.4282. TTD/TTY callers may call toll-free at 866.626.4282.

Extension Of Coverage

Leaves Of Absence

Depending on the circumstances, Your vision coverage may be continued when You are not at work.

- ***Sickness or accidental injury***. If You stop active work because of sickness or accidental injury but are not totally disabled, the program may continue coverage as long as all required contributions are paid.
- ***Long-term disability***. If You are receiving monthly disability (LTD) benefits, coverage may continue up to age 65 as long as required contributions are paid.

Note: Coverage may continue past age 65 depending on age at time of disability.

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

In compliance with the provisions of the Family Medical Leave Act (FMLA), coverage under the Plan for a Covered Employee and his/her Covered Dependents may be continued during a period of leave under the FMLA just as if the Covered Employee were actively employed. In the case of a paid FMLA leave, any required contributions for coverage during the leave period will continue to be deducted from the Covered Employee's pay. If the FMLA leave is unpaid, the Plan Administrator will provide the Covered Employee with one or more of the following methods to pay any required contributions: (1) pay the

contribution amounts that will be due during the leave period before the commencement of the FMLA leave; (2) make regular periodic payments during the period of FMLA leave; or (3) upon return from the leave, pay the amounts advanced by the Company for the cost of any coverage maintained during the leave. The Plan Administrator will also make available any payment methods available to individuals on non-FMLA leaves of absence.

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

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

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

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

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

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

A Covered Employee may be required to pay a portion of the cost of his/her benefits. If Your military service is less than thirty-one (31) consecutive days, Your healthcare

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

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

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

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

If You Have Questions

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

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

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 Vision 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 vision 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 addresses:

Vision Service Plan
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

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 final discretionary authority for adjudicating claims to a claims administrator or other entity, the Administrative Committee has discretionary authority to 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

Ameren Corporation hopes and expects to continue the **Ameren Vision 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.

Applicability

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

Nontransferable Benefits

No person other than the Covered Employee and Covered Dependent is entitled to receive vision coverage or other benefits to be furnished by the Plan. Such right to vision 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 Ameren Illinois. 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 healthcare 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 or Your Dependents 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.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under Your group health plan, if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a pre-existing condition limitation for 12 months (18 months for late enrollees) after the date You enrolled in Your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties on those who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, 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 have the 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 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 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 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 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 Vision Plan
Type of Plan:	A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA), providing vision benefits.
Plan Year:	January 1 through December 31
Plan Number:	510

Plan Funding:	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 Vision Service Plan ("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, vision 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:	Vision Service Plan Insurance Company Attention: Claims Department P. O. Box 997105 Sacramento, CA 95899-7105 800.877.7195

COBRA Administrator:	Ameren Benefits Center COBRA Services 150 Clove Rd. Little Falls, NJ 07424 1.877.769.2637 www.myameren.com
Named Fiduciary:	Ameren Services 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 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.