

Your 2009 Enrollment Guide

***Square D Company Coordinated
Bargaining Employees' Group Life and
Health Plan***

2009 Open Enrollment:

*Monday, November 3
through Friday, November 21, 2008
(until 11:59 p.m. Central Time)*

**Enroll for your 2009 benefits via
*Direct ACTION***

Open Enrollment 2009 Is Here!

It's time to enroll for 2009 benefits. This enrollment guide describes your benefit options and details your decisions for 2009.

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Resources for 2009 Open Enrollment

Your resources include:

- **This enrollment guide** — Read this guide for an overview of the Coordinated Bargaining Employees' Group Life and Health Plan, including your enrollment decisions.
- **Direct INFO** — Go on-line to read more information about your benefit options.
- **Direct ACTION** — Enroll for your benefit elections for 2009. Directions to access the open enrollment tool on *Direct ACTION* can be found on page 4 of this guide.
- Print your on-line personalized enrollment worksheet, which shows your personal benefit options and price tags. Turn to page 4 for directions to access your personalized enrollment worksheet through *Direct ACTION*.
- **Employee Direct** — Contact for answers to your questions about benefits and the enrollment process Monday through Friday, 7 a.m. to 5 p.m. Central Time. You can:
 - Call **1-800-993-7638** or **1-847-925-7010**, or
 - E-mail **employee.direct@us.schneider-electric.com**.

Employee *Direct* will have a limited staff available until midnight Central Time on November 21.

Important!

The 2009 open enrollment period is Monday, November 3 through Friday, November 21, 2008 (until 11:59 p.m. Central Time).

- After you enroll or change your benefit elections for 2009 through *Direct ACTION*, **print the confirmation page that shows your elections**. You will not receive a separate confirmation statement in the mail.
- After November 21, you will not be able to make changes to your benefits until the 2010 open enrollment period, unless you have an eligible change in status or experience another event under which benefit changes are allowed. See page 5 for information about what qualifies as an eligible change in status.

WEB TIPS!

Review 2009 Plan Information Using Direct INFO

You can use *Direct* INFO to research your 2009 medical options. You can even compare options — overall or by specific services. See page 18 for specific instructions.

Print Your Confirmation Statement!

After you enroll via *Direct* ACTION, print a confirmation statement to verify your 2009 benefit elections.

2009 Open Enrollment Schedule

Here is the calendar of events for the upcoming open enrollment:

Event	Timing	What to Expect
Enrollment period	Monday, November 3 through Friday, November 21 (until 11:59 p.m. Central Time)	<p>This is the enrollment period for the Coordinated Bargaining Employees' Group Life and Health Plan effective January 1, 2009 through December 31, 2009. Please see "Who Needs to Enroll for 2009?" on page 3 to learn if you need to enroll. You will enroll for your benefits via <i>Direct</i> ACTION by logging into the:</p> <ul style="list-style-type: none"> ▪ Internet at www.squared.com/employeedirect; or ▪ Intranet and accessing the Employee <i>Direct</i> home page, then clicking "Login to <i>Direct</i> ACTION." <p>You can enroll 24 hours a day, seven days a week from Monday, November 3 through Friday, November 21, 2008 (until 11:59 p.m. Central Time).</p>
New medical ID cards	Late December	All employees and their dependents who are covered under a medical option for 2008 (except for the Bluegrass Family Health HMO) will receive a new medical ID card. You will receive an ID card even if you did not make any changes to your benefits for 2009. NOTE: Your prescription drug program information will be printed on your BCBSIL ID card.
Flexible Spending Account debit card	Early January 2009	If you elect to open a Health Care Flexible Spending Account (FSA) and you did not have an FSA in 2008, you will receive a debit card from PayFlex. See page 13 for more information. If you have an FSA in 2008 and elect to open an FSA in 2009, you will not receive a new debit card. Please note that you cannot use the debit card for Dependent Care FSA expenses.

Summary of Material Modifications (SMM)

The "What Is Changing for 2009?" section of this enrollment guide constitutes a Summary of Material Modifications (SMM) to the Summary Plan Descriptions (SPD) with respect to the change in medical and prescription drug claims administrators; elimination of the UnitedHealthcare EPO (HMO), UnitedHealthcare of the River Valley EPO (HMO), and Humana EPO (HMO) medical options; change in in-network deductible and in-network office visit co-payments for the Optional PPO Plan; change in brand name prescription drug co-payments and lifetime out-of-pocket maximum benefit under the Comprehensive Plan and the Optional PPO Plan; change in annual out-of-pocket maximum for a physical under the Comprehensive Plan and the Optional PPO Plan; pre-certification requirement changes; and change in vision claims administrator, benefits and network.

Who Needs to Enroll for 2009?

You need to enroll for 2009 benefits if:

▪ **Your current medical option will not be offered in 2009. This includes:**

- UnitedHealthcare EPO (HMO)
- UnitedHealthcare of the River Valley EPO (HMO)
- Humana EPO (HMO)

You need to select a new medical option during open enrollment. If you do not select a new medical option, you will automatically be enrolled in the Comprehensive Plan under your 2008 coverage category.

▪ **You've moved and as a result your current medical option is no longer available.**

▪ **Your home address has been added to or deleted from a network area.**

NOTE: If you enrolled in a medical option as an exception for 2008, that option may not be listed on your on-line personalized enrollment work sheet. However, you may be able to re-elect the same option as an exception for 2009. (Please see the seventh bullet for more information.)

▪ **You want to participate in the Health Care and/or the Dependent (Day) Care Flexible Spending Accounts (FSA) for 2009.** Your FSA election does not roll over from year to year. You *must* re-enroll if you want to participate in the Health Care FSA or Dependent (Day) Care FSA for 2009 — even if you currently participate and want to contribute the same amount in 2009.

▪ **You want to make changes to your current elections.** After the open enrollment period ends on November 21, you will *not* be able to make changes to your benefit elections until the 2010 open enrollment period — unless you have an eligible change in status or experience another event under which election changes are allowed (see page 5 for more information). Please carefully consider if your 2008 elections will meet your needs in 2009 before you decide not to make any changes.

▪ **You want to update your dependent information.** If you need to add a dependent to, or drop a dependent from your benefits (for example, as a result of the birth of a child) for 2009, you must login to *Direct ACTION* to initiate your change and revise your coverage. Please note that if you experience a qualified change in status during open enrollment and change your coverage category, that change will not carry over for 2009. You will need to participate in 2009 open enrollment to change your 2009 coverage.

▪ **You enrolled in a medical option as an exception for 2008.** If you continue to be eligible for an option as an exception in 2009, there is a message on the “Medical” screen on *Direct ACTION*. If you want to re-enroll in an option as an exception for 2009, you must:

- Complete a medical waiver form and submit it to Employee *Direct* to make this option available to you; and
- Re-elect the option through *Direct ACTION* to complete your enrollment.

▪ **You recently became benefit eligible.** You will need to make elections for 2008 and possibly for 2009 (if you wish to have different 2009 coverage) using *Direct ACTION*. Special enrollment instructions are included with this guide.

IMPORTANT!

If your current medical option will not be offered in 2009, you need to enroll in a different medical option during the open enrollment period or you will automatically be enrolled in the Comprehensive Plan under your 2008 coverage category.

DON'T FORGET!

Open Enrollment is Monday, November 3 through Friday, November 21, 2008.

Enroll Anytime!

You can enroll any time beginning Monday, November 3 through Friday, November 21 (11:59 p.m. Central Time).

Elections Stay in Effect for 2009

Your 2009 benefit elections are in effect throughout 2009 — you can only change certain elections if you have an eligible change in status or experience another event under which election changes are allowed (see “Making Mid-Year Changes to Your Benefits” on page 5 for more information).

Steps to Enroll

Step 1

Review this enrollment guide and your on-line personalized enrollment work sheet. Your on-line personalized enrollment work sheet can be found by clicking on the “Enrollment Work Sheet” link in the left navigation bar under “My Benefits” on *Direct ACTION*.

Step 2

Decide if you want to make changes. You must enroll if you want to change any benefits for 2009 or update your dependent information. However, you must also enroll if you want to participate in a flexible spending account for 2009. Plus, if an option you are enrolled in for 2008 is not available in 2009, you must select another option, or you will be enrolled in the default coverage (see page 3).

Step 3

Enroll for benefits. You may enroll for your benefits via *Direct ACTION* by logging in to the:

- **Internet** at www.squared.com/employeedirect; or
- **Intranet**, where you should access the Employee *Direct* home page and click “Login to *Direct ACTION*.”

To access *Direct ACTION*, you will need your Employee ID along with your password. Contact Employee *Direct* if you need assistance with your Employee ID or password.

Have your on-line personalized enrollment work sheet ready. You can enroll **any time** beginning on *Monday, November 3 through Friday, November 21 (11:59 p.m. Central Time)*.

Step 4

Review and confirm your elections. Your elections will not be saved unless you click the “Confirm” button on the “Review Your Elections” page.

Step 5

Print a confirmation statement. Once your elections are saved you may print a confirmation statement. **Make sure you receive your confirmation number before exiting *Direct ACTION* or your elections will not be saved.** Carefully review and save your confirmation statement. If you need to make changes, you must do so by November 21, 2008 (by 11:59 p.m. Central Time).

Step 6

Check your deductions on your first 2009 paycheck by comparing them to the deductions shown on your confirmation statement you print from *Direct ACTION*. If the deductions do not match, contact Employee *Direct* immediately to report the discrepancy.

If You Don't Enroll

If you do not enroll by **November 21** (by 11:59 p.m. Central Time), in most cases, you will remain covered under the same options you are enrolled in for 2008. However, your medical option provider network may be different. In addition, you will not be able to participate in the Health Care or Dependent (Day) Care FSAs.

If you enrolled in an option as an exception or if your 2008 medical option is no longer available and you do not enroll, you will be automatically enrolled in the Comprehensive Plan under your 2008 coverage category.

In addition, you will not be able to make changes to your benefits until the 2010 open enrollment period — unless you have an eligible change in status or experience another event under which election changes are allowed (see “Making Mid-Year Changes to Your Benefits” below for more information).

Making Mid-Year Changes to Your Benefits

According to Internal Revenue Service (IRS) rules, the benefit coverage you elect remains in effect for the entire calendar year. However, you may be able to change your benefits during the year under certain circumstances, as described below.

- **If you have an eligible change in status** such as marriage, divorce, birth or adoption of a dependent child, or death of a spouse or dependent.
- **If you have a significant change in cost or coverage.** If your coverage level or cost for coverage dramatically changes during the year, you may be able to change your coverage or increase your contributions to reflect the change, or choose another option providing similar coverage.
- **If you qualify for a special enrollment** because you, your spouse or your dependent experiences an employment change that affects benefit eligibility.

If you have a change in status or another event under which benefit changes are allowed, you must login to *Direct ACTION* within 31 days of the event to complete your change in status and make any necessary benefit changes. The date the change in status occurs is considered day one of the 31-day period.

For more information on making mid-year changes to your benefits, please refer to the “General Information” section of your Summary Plan Description.

Review Your Life Insurance Beneficiary Designations On-line

Keeping your beneficiary information up to date ensures that your benefit will be distributed as you intended in the event of your death. If you have not confirmed your designations on-line through *Direct ACTION* or if you need to update your designations, click the “Life Insurance Beneficiary” link under “My Benefits” on *Direct ACTION*.

Change in Status Reminder

If you experience an eligible change in status between the close of the enrollment period and the end of the year, you will need to login in to *Direct ACTION* within 31 days and complete a 2008 status change to update your benefit selections.

For example, if you get married on November 27, 2008 and want medical coverage for you and your spouse for the remainder of 2008 and 2009, you must make your change on *Direct ACTION* within 31 days of the event so you can have coverage for you and your spouse through the end of 2008. In addition, you will need to update your 2009 benefit elections by contacting Employee *Direct*.

NOTE: If you initiate a status change on *Direct ACTION* after 7 p.m. Central Time on December 17, 2008, you must notify Employee *Direct* to ensure the coverage for 2008 and 2009 is updated.

What Is Changing for 2009?

The following changes will be effective beginning January 1, 2009.

Medical Changes

New Medical Claims Administrator

The medical options that will be administered by Blue Cross and Blue Shield of Illinois (BCBSIL) are as follows:

- Comprehensive Plan
- Optional PPO Plan
- EPO (HMO)

If you are currently enrolled in the Comprehensive Plan or Optional PPO Plan, you do not need to take special action if you do not plan to change your benefit elections for 2009. If you do not take action during the 2009 open enrollment period, you automatically will be re-enrolled in your current medical option under your current coverage category.

You will find that many of the doctors and hospitals that are in the UnitedHealthcare, UnitedHealthcare of the River Valley and Humana networks are also in the BCBSIL network. However, you will want to check that your provider is part of the BCBSIL PPO network. You can view a complete listing of BCBSIL providers at www.bcbsil.com/sena/provider_finder.

If your current provider is in the BCBSIL PPO network, you do not have to choose a new provider. If your current provider is **not** in the BCBSIL PPO network you have two options:

- Choose a provider who is in the BCBSIL PPO network to receive in-network benefits, or
- Continue seeing your current provider. If you are enrolled in the PPO or EPO, and you will be responsible for higher out-of-pocket expenses.

Medical Options No Longer Available in 2009

The UnitedHealthcare EPO (HMO), UnitedHealthcare of the River Valley EPO (HMO) and Humana EPO (HMO) options will not be offered for 2009. If you are enrolled in one of these options, you will need to select a new medical option during the 2009 open enrollment period. If you do not enroll in a new medical option for 2009, you will be enrolled in the default medical option for 2009 — the Comprehensive Plan under your current coverage category.

Optional PPO Plan Changes

The following plan provisions are changing for 2009:

- In-network deductible will change to \$250 per person and \$500 per family
- Doctor's office visit co-payments will change to \$20 for primary care physician and \$35 for specialist

Comprehensive Plan and Optional PPO Plan Changes

The following plan provisions are changing for 2009:

- Annual maximum for a physical is \$500
- Lifetime maximum benefit is \$3,000,000
- The prescription drug co-payments are as follows:

Prescription Drug Costs for the Comprehensive and Optional PPO Medical Options		
Drug Type	Generic	Brand
Retail (For up to a 30-day supply of a short-term drug)	\$10	\$30
Home Delivery (For up to a 90-day supply of a long-term drug)	\$20	\$60

Pre-certification Requirement Changes

Employees and their covered dependents must pre-certify one business day prior to elective hospital admissions, skilled nursing facilities/extended care facilities and coordinated home health care, and within two business days following an emergency hospital admission and maternity admission. In addition, pre-certification is no longer required for outpatient surgery (Optional PPO Plan only), assistant surgeon's services and outpatient pre-admission testing.

Medical Option Price Tags

As negotiated, your 2009 price tags for the Comprehensive Plan and the Optional PPO Plan medical options will remain the same as 2008. Your price tags for the medical options are listed on your personalized enrollment worksheet available on-line through *Direct ACTION*. Remember, these contributions are deducted from your weekly paycheck on a before-tax basis.

New Prescription Drug Claims Administrator

Express Scripts will be the prescription drug claims administrator for the Comprehensive Plan, Optional PPO Plan and BCBSIL EPO (HMO) in 2009. If you and/or your covered dependent have mail order prescription refills available at the end of the year:

- Prescription refills with Caremark and Medco (UnitedHealthcare EPO) will transfer to Express Scripts, and will be available based on your refill schedule beginning January 1, 2009. Prescriptions with expired refills or no refills on file will not transfer to Express Scripts. Prescriptions for compound drugs and controlled substances will **not** transfer to Express Scripts. If you require these types of medications, **you will need to obtain a new prescription from your provider.**
- Prescription refills with *RightSourceRx*, the Humana prescription drug provider, and WellPoint NextRx, the UnitedHealthcare of the River Valley EPO (HMO) prescription drug provider, will not transfer to Express Scripts. You will be required to get a new prescription from your doctor. Any open refills will not be transferred to Express Scripts.

To check that your prescription drugs are considered generic, preferred brand or brand, please visit www.member.express-scripts.com/preview/schneiderelectric2009.

Vision Changes

Change in Provider and Benefit Coverage

Vision care coverage for employees enrolled in the Comprehensive Plan, Optional PPO Plan and BCBSIL EPO (HMO) medical options will be provided by OptumHealth Vision. Vision care will remain part of your medical option coverage, so you do not need to make a separate election to have coverage. However, there will be a difference in in-network versus out-of-network benefits coverage. See the chart below for more information.

Vision Care Program Summary of Schedule of Benefits*		
Eligible Service	In-Network Benefit	Out-of-Network Benefit / Reimbursement
Eye exam	\$15 co-payment; 100%	Up to \$60
Eyeglass frames**	\$30 co-payment <ul style="list-style-type: none"> ▪ Designer frames — employee pays cost over \$130 retail frame allowance, generally between \$25 – \$50 	Up to \$70
Eyeglass lenses**	\$30 co-payment (includes single lenses, bifocal lenses, trifocal lenses and lenticular lenses)	Up to \$50 – \$90 (depending on lens type)
Eyeglass lens options***	<ul style="list-style-type: none"> ▪ Polycarbonate coating: covered in full ▪ Standard scratch resistant coating: covered in full ▪ Anti-reflective coating: \$40 ▪ Ultraviolet protection: \$16 	Employee pays full cost
Contact lenses	<ul style="list-style-type: none"> ▪ Disposable contacts: \$30 co-payment for up to six boxes (depending on prescription), plus Fitting Fee and Evaluation covered at 100% ▪ Necessary: \$30 co-payment; 100% ▪ All other elective contacts: \$175 allowance toward the contact lenses, and Fitting Fee and Evaluation 	Up to \$175 – \$210 (depending on lens type)

* Benefits are available any time during your first year of coverage, and every 12 months after that, based on last date of service.

** The \$30 co-payment for eyeglasses is for the combined hardware (frames and lenses). Additional costs may apply depending on additional lens options.

*** Additional eyeglass lens options are available.

NOTE: You are covered to receive eyeglasses (frames and lenses) OR contact lenses once every 12 months based on last day of service.

Making Your Benefit Decisions

Medical

The medical option helps you and your family with the cost of maintaining good health and treating illness or injury. You can choose a medical option that best fits the needs of you and your family. Your on-line personalized enrollment work sheet and the *Direct ACTION* enrollment tool list your options, along with each option's price tag per pay period. Your eligibility to participate in a specific option is based on your home zip code. Depending on where you live, you can choose from the following medical options:

Your Options	Coverage Categories
<ul style="list-style-type: none"> ▪ Comprehensive Plan ▪ Optional PPO Plan (where available) ▪ BCBSIL EPO (HMO) (where available) ▪ Bluegrass Family Health HMO (where available) ▪ PPO Exception* ▪ HMO Exception* ▪ No coverage 	<ul style="list-style-type: none"> ▪ Employee Only ▪ Employee plus One ▪ Employee plus Two or More

* If you are eligible for the PPO or an HMO option as an exception, there is a message on the "Medical" screen on *Direct ACTION*.

Exception Options

The PPO and HMO Exception options are *only* for employees whose home zip code is *outside* the PPO network area or the Bluegrass Family Health HMO network areas. These options provide a way for those who live outside a network area to take advantage of in-network benefits by traveling to a network area. If either of these options applies to you, there is a message on the "Medical" screen on the *Direct ACTION* enrollment tool indicating you are eligible.

To elect one of these options, you must complete a waiver form and fax it to Employee *Direct* to make the PPO or an HMO option available to you. Completing the waiver form does not finalize your enrollment in the selected option. Once the option is made available to you by Employee *Direct*, you must then access *Direct ACTION* to enroll in the option for 2009.

NOTE: If you are eligible to enroll in the PPO or an HMO option as an exception, you can print the waiver form from the "Forms" page on *Direct ACTION*.

Confirm Your Provider is a Member of the Network

Before you confirm your medical election for 2009, call your health care organization's toll-free number or visit its Web site to confirm that your provider is included in the network. See the "Finding a Provider and Plan Contact Information" chart on page 19 for contact information, or link to an organization's Web site through *Direct INFO*.

Medical Option Comparison Chart

The following chart provides a summary of your medical options to help you compare plans. Your choice will affect how much of your health care expenses you will have to pay and how much the medical option will pay. More detailed plan information can be found on *Direct INFO* and in your Summary Plan Description. Please check these sources before making your enrollment decisions.

Medical Option Comparison Chart				
	Comprehensive Plan	Optional PPO Plan		HMO Plan*
		<i>In-Network</i>	<i>Out-of-Network</i>	
Deductible (Individual/Family)	\$250/\$500	\$250/\$500	\$750/\$1,500	None
Annual Out-of-Pocket Maximum (Individual/Family)	\$1,000/\$3,000	\$1,000/\$3,000	\$2,000/\$6,000	\$1,000/\$1,000
Office Visit Co-Payments/ Co-Insurance **	20%	<ul style="list-style-type: none"> ▪ \$20 for primary care physician ▪ \$35 for specialist 	30%	<ul style="list-style-type: none"> ▪ \$25 for primary care physician ▪ \$40 for specialist ▪ 10% hospital co-insurance
Your Co-Insurance	20%	20%	30%	10%

* Benefits are different for the Bluegrass Family Health HMO (Lexington area). Refer to *Direct INFO* for more information.

** Some benefits are paid at other levels. Refer to "Eligible Services" in the Summary Plan Description.

Reconstructive Surgery Reminder

All of the Company's medical options cover the following procedures when done in connection with a mastectomy in a manner determined in consultation with the attending physician and patient:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgical reconstruction of the other breast for symmetrical appearance; and
- Protheses and treatment of other physical complications at any stage of the mastectomy, including lymphedemas.

This coverage is subject to the plan's pre-certification requirements for inpatient hospitalization and to the same annual deductibles, co-insurance and lifetime maximums that apply to any other covered medical or surgical procedures under the medical option.

Prescription Drug Coverage

Express Scripts will be the prescription drug claims administrator for the Comprehensive, Optional PPO and BCBSIL EPO (HMO) medical options.

Your prescription drug coverage is part of your medical option. This coverage provides you with retail pharmacy and home delivery prescription drug benefits — offering you cost savings and convenience. Your co-payments for prescription drugs depend on the option you enroll in, as described in the charts below. Any co-payments for prescription drugs do not count toward your out-of-pocket maximum for the medical option.

NOTE: Express Scripts refers to its mail order program as a home delivery program.

Comprehensive and Optional PPO Options

Your prescription drug coverage is detailed in the chart below. Visit Express Scripts' Web site (see page 19 for Web address) to find out whether a drug is considered generic or brand and/or short-term or long-term.

NOTE: Long-term drugs must be purchased through the home delivery program.

Prescription Drug Costs for the Comprehensive and Optional PPO Medical Options		
Co-Payment	Generic	Brand
Retail (For up to a 30-day supply of a short-term drug)	\$10	\$30
Home Delivery (For up to a 90-day supply of a long-term drug)	\$20	\$60

HMO Options

For HMO options, your prescription drug coverage is detailed in the chart below. You may contact your HMO prescription drug claims administrator by calling the Customer Service phone number listed in the "Finding a Provider and Plan Contact Information" chart beginning on page 19 or by visiting the provider's Web site to find out whether a drug is considered generic, preferred brand (listed on the primary drug list) or brand and/or short-term or long-term.

Prescription Drug Chart for HMO Options			
Co-Payment	Generic	Preferred Brand	Brand
Retail (For up to a 30-day supply of a short-term drug)	\$10	\$20	\$35
Home Delivery (For up to a 90-day supply of a long-term drug)	\$20	\$40	\$70

WEB TIP!

Learn How to Save Money on Prescription Drugs

Prescription drugs are one of the main drivers of increasing health care costs. Using your prescription drug program effectively by requesting generic drugs will help both you and the Company manage health care expenses. Learn more about generic drugs by logging in to your prescription drug program's Web site (see page 19 for Web address), or accessing the Web site through *Direct INFO*.

What's Covered

- **Preventive services** include exams and cleanings.
- **Basic services** include fillings and X-rays.
- **Major services** include restorative work and dentures.

Reminder: Check if Your Dentist Is in the Network

To see if your provider is a Delta Dental participating dentist, contact Delta Dental or review the on-line provider directories. See page 19 for details.

Dental

The dental option helps you and your family with the cost of maintaining good dental health. You automatically receive dental coverage. You just need to decide which coverage category you would like to elect.

Coverage Categories

- Employee Only
- Employee plus One
- Employee plus Two or More

Dental Coverage

The chart below provides a summary of the Union Basic Dental plan.

Union Basic Dental Option Summary				
Type of Service	Deductible (Individual/Family)	Plan Coverage Amount	Annual Plan Maximum	Your Co-Insurance
Preventive	None	100% or 80%	\$2,000 per person	0% or 20%
Basic Services		80%		20%
Special Oral Surgery		100%		0%
Major Services		50%		50%

Using Delta Dental Network Providers

The dental option allows you to go to any general or specialty dentist for treatment within two Delta Dental networks — DeltaPreferred and DeltaPremier.

When you call your dentist's office to make an appointment, ask if your dentist participates in either of Delta's networks. Your out-of-pocket costs will vary depending on the network your dentist participates in or whether your dentist is out-of-network. You will maximize your benefits by receiving care from a DeltaPreferred network dentist. Average discounts range from 15% to 35% for the Preferred network and 5% to 10% for the Premier network.

Here's an example of how the type of network provider you receive services from affects your out-of-pocket expenses. If you need a crown, assume the DeltaPreferred fee allowance is \$500, the Maximum Plan Allowance (MPA)* is \$600 and your dentist normally charges \$700. Since the Union Basic Dental option covers crowns at 50%, your out-of-pocket cost (excluding deductible) would be:

- **DeltaPreferred Dentist — \$250** (50% of the \$500 fee allowance)
- **DeltaPremier Dentist — \$300** (50% of the \$600 MPA)
- **Out-of-Network Dentist — \$400** (50% of the \$600 MPA *plus* \$100 difference between the MPA and the dentist's billed charge)

* The Maximum Plan Allowance (MPA) is an amount determined by Delta Dental from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. Delta Dental's term, "Maximum Plan Allowance (MPA)," replaces the term, "usual and customary (U&C)" or "reasonable and customary," which other medical and dental claims administrators use to describe the same type of charges.

Health Care Flexible Spending Account

With the Health Care Flexible Spending Account (FSA), you elect to have money deducted from your paycheck, before taxes are taken out, to pay for eligible health care expenses not covered by the medical and dental options. This can help you save on out-of-pocket expenses such as deductibles, co-payments and co-insurance.

The annual maximum contribution to the Health Care FSA is \$3,000. This means you can contribute from \$50 to \$3,000 to the Health Care FSA in 2009. Use the “Health Care Flexible Spending Account Work Sheet” on page 15 to help you decide how much to contribute in 2009.

Your Options	Your Contribution Amounts
▪ Health Care FSA	▪ From \$50 to \$3,000 per year
▪ No account	▪ No contribution

Use Your FSA For Over-the-Counter Medications

Remember, *you can purchase certain non-prescription medications on a before-tax basis*. Products such as antacids, aspirin, pain relievers, cough medicine, allergy medications and other over-the-counter medications used to treat an illness or injury that are purchased without a prescription can be reimbursed through your Health Care FSA. Go to www.mypayflex.com for a comprehensive list of covered items.

PayFlex Debit Card

To pay for eligible health care expenses with your FSA, you will be able to use the PayFlex debit card. This card allows you to access money directly from your account to pay for eligible expenses. Use it at the pharmacy or your physician’s office to pay for eligible expenses such as co-payments, short-term or home delivery prescriptions, and over-the-counter (OTC) medications. When ordering home delivery prescriptions, you may provide your debit card information to your prescription provider to have the expense automatically taken from your FSA. By using the card, you can pay for eligible expenses at the point of service. In addition, it:

- Provides immediate access to your FSA funds — you avoid paying with cash or check;
- Reduces paperwork — you avoid filling out a claim form; and
- Provides immediate payment of the expense — you avoid waiting for reimbursement.

PayFlex monitors the use of the debit card to ensure that only eligible expenses are reimbursed. Be sure to save your receipts that reflect health care expenses you paid for with your FSA (either by using your debit card or mailing a claim form). PayFlex may request documentation for your expenses. Your itemized receipts should list the merchant name, name of the item/product, date and amount. If requested documentation is not received in a timely manner, your PayFlex debit card will be deactivated.

If you newly enroll in the Health Care FSA, you will receive your debit card in mid-January. If you re-enroll in the Health Care FSA for 2009, you will continue to use your current PayFlex debit card. You will not receive a new card. **You also cannot be reimbursed through your debit card in 2009 for claims from 2008. You will need to submit the claim on-line or submit a paper claim form. You cannot use the debit card to pay for Dependent Care FSA expenses.**

Paper Claim Form Available

If you do not use your debit card, you can mail or fax your FSA claims to PayFlex, and your claims will be processed on a daily basis. PayFlex also has an e-mail alert system, called e-Notify, that will e-mail you when your paper claim has been processed. Express claims can also be submitted on-line.

The Health Care Flexible Spending Account: An Example

Suppose you earn \$30,000 a year and incur \$1,500 in eligible Health Care FSA expenses during 2009. By using the Health Care FSA, you would have \$340 more in take-home pay because you would pay less in taxes!

	<i>With the Health Care FSA</i>	<i>Without the Health Care FSA</i>
Your Pay	\$30,000	\$30,000
Before-tax contributions to the Health Care FSA, used for eligible health care bills	- \$1,500	- \$0
Taxable Pay	\$28,500	\$30,000
Federal Income Tax	- \$3,874	- \$4,099
FICA (Social Security) Tax	- \$2,180	- \$2,295
Health Care Bills, Paid After Taxes	- \$0	- \$1,500
Take-Home Pay	\$22,446	\$22,106
Annual Tax Savings	\$340	\$0

NOTE: This example uses 2008 tax rates and assumes that you are single, with no dependents. It considers only federal income taxes and FICA taxes; you could save even more in state taxes.

How Can I Learn More about Eligible Expenses for the Health Care FSA?

For a list of eligible health care expenses, contact:

- The IRS by calling **1-800-829-3676** or visiting **www.irs.gov/formspubs** and selecting “Forms and Publications” and downloading *Publication 502*; or
- PayFlex Info Line by calling **1-800-284-4885** (or 1-402-345-0666) or by visiting **www.mypayflex.com**.

You may also login to *Direct* INFO for a list of eligible expenses.

You Must Enroll to Participate in the FSA

If you want to contribute to the Health Care FSA for 2009, you must login to *Direct* ACTION to confirm your 2009 election. Otherwise, any account you may have had for 2008 will close effective December 31, 2008.

Health Care Flexible Spending Account Work Sheet

Use this work sheet to help you decide how much to contribute to your Health Care FSA in 2009.

Health Care FSA Work Sheet		
Eligible Expenses	Actual Expenses in 2008	Estimated Expenses for 2009
Medical Expenses		
▪ Deductibles	\$	\$
▪ Co-insurance	\$	\$
▪ Co-payments	\$	\$
▪ Amounts above Plan limits	\$	\$
▪ Routine care above Plan limits	\$	\$
▪ Expenses not reimbursed by your medical option	\$	\$
▪ Eligible over-the-counter medications	\$	\$
Total Medical Expenses	\$	\$
Other Health Care Expenses		
▪ Dental expenses not reimbursed by the Union Basic Dental Plan (i.e., orthodontia)	\$	\$
▪ Vision care, glasses and contact lenses above Plan limits, including corrective eye surgery (i.e., LASIK)	\$	\$
▪ Hearing care above Plan limits	\$	\$
▪ Other health care expenses not listed above	\$	\$
Total Other Health Care Expenses	\$	\$
Line A: Total Estimated Health Care Expenses (Add the two total expenses from above. This is the estimated amount you can expect to pay in 2009 for health care expenses not covered by the Plan. This is also the approximate total annual contribution you might consider making to your Health Care FSA.)		\$
Line B: Your Contribution Each Pay Period (Divide Line A by 52. This is the amount that would be deducted from each paycheck for your Health Care FSA contributions.)		\$

Dependent (Day) Care Flexible Spending Account

With the Dependent (Day) Care Flexible Spending Account (FSA), you elect to have money deducted from your paycheck, before taxes are taken out, to help pay for eligible dependent care expenses. This can help you save on the cost of caring for your eligible dependents while you **and** your spouse work or attend school full-time. You may use the account to pay for care for:

- Your dependent child(ren) under the age of 13;
- Your physically or mentally handicapped child(ren) of any age who is incapable of caring for himself or herself; and/or
- Your physically or mentally handicapped parent, spouse or other relative who is not capable of caring for himself or herself, is totally dependent on you for support and spends at least eight hours a day in your home.

You may contribute from \$50 to \$5,000 to the Dependent (Day) Care FSA for 2009. Use the “Dependent (Day) Care Flexible Spending Account Work Sheet” on the next page to help you decide how much to contribute in 2009.

NOTE: The Dependent (Day) Care FSA cannot be used to pay for dependent health care expenses. Also, you cannot use the account to pay for expenses incurred solely for your personal enjoyment, convenience or ease.

Your Options	Your Contribution Amounts
▪ Dependent (Day) Care FSA	▪ From \$50 to \$5,000 per year*
▪ No account	▪ No contribution

** If you are married and file a separate income tax return, you may only contribute up to \$2,500 a year. If you are married and file jointly, and your spouse's employer offers a dependent care FSA, then you can contribute a combined total of \$5,000.*

Plan Your Contributions Carefully

The Internal Revenue Service (IRS) requires that you use all the money in your Health Care FSA and Dependent (Day) Care FSA during the year. Any amount remaining at the end of the year cannot be carried over and is forfeited, so estimate your expenses carefully. Keep in mind, however, that the benefits of an FSA may outweigh this risk.

Keep In Mind

When you file your federal income tax return, you will be required to supply the name, address and Social Security or tax identification number of the individual or organization providing dependent care. If you are unable to supply this information, you should not use the Dependent (Day) Care FSA to pay for these dependent care services.

You Must Enroll to Participate in the FSA

If you want to contribute to the Dependent (Day) Care FSA for 2009, you must login to *Direct ACTION* to confirm your election.

Dependent (Day) Care Flexible Spending Account Work Sheet

Use this work sheet to help you decide how much to contribute to your Dependent (Day) Care FSA in 2009.

Dependent (Day) Care FSA Work Sheet		
Eligible Expenses	Actual Expenses in 2008	Estimated Expenses for 2009
▪ Babysitter	\$	\$
▪ Day care center	\$	\$
▪ Nursery school	\$	\$
▪ After school care	\$	\$
▪ Care for eligible adult	\$	\$
▪ Other eligible dependent care expenses not listed above	\$	\$
Total Expenses	\$	\$
Total Estimated Dependent Care Expenses (This is the amount you expect to pay in 2009 for eligible dependent care expenses.)		\$
Your Contribution Each Pay Period (Divide total estimated dependent care expenses by 52. This is the amount that would be deducted from each paycheck for Dependent [Day] Care FSA contributions.)		\$

Choosing a Health Care Option That's Right for You

COVERAGE

- What kind of health care coverage do you need (e.g., basic benefits, preventive care, maternity coverage)?
- Are there any specific health care treatments or surgeries you or a family member anticipate in 2009?

COST

- What were your total health care expenses in 2008?
- Do you participate in the Health Care or Dependent (Day) Care Flexible Spending Accounts (FSAs) to save money on out-of-pocket expenses?
- How would you prefer to pay for your health care services? Would you rather pay more through price tags and less through out-of-pocket costs, or less in price tags and more through out-of-pocket costs?

CHOICE

- Is it important for you to visit any provider you wish, regardless if he or she is an in-network or out-of-network provider?
- Would you like to stay with your current provider?

CONVENIENCE

- Are network doctors and hospitals located near your home or work?
- Do they take appointments at times that fit into your schedule?

Use Direct INFO to View Your 2009 Benefit Options

Now that you have considered the questions above, use *Direct INFO* to view your 2009 benefit options.

- Login to *Direct INFO* (Employee ID and password required). If you forget your ID card or password, contact Employee *Direct* for assistance.
- Click on "Open Enrollment" in the left navigation bar.
- Click on the second "Open Enrollment" in the left navigation bar to go to the Open Enrollment home page.
- Under "Topics you will find on this page" click on the green text with the name of the benefit you are interested in reviewing, or scroll down the page to review all benefits.
- Click on the green text under the "More" link in each section to review current and next year's plans.
- The "More" link in the medical plans allows you to create a plan comparison table by following step-by-step on-line instructions. You can compare your current options to your eligible options for in 2009.

Finding a Provider and Plan Contact Information

It's important that you have up-to-date information on health care providers. Because this information is frequently updated, we encourage you to contact the health care organizations directly via their Web sites or toll-free phone numbers. The following table lists how to find this information. You can also link directly to these Web sites through *Direct ACTION* — by clicking on the “Service Providers” link in the left navigation bar and selecting your carrier from the list in the pop-up window.

Finding a Provider and Plan Contact Information		
Health Care Providers	Customer Service Numbers	Web Sites
Blue Cross and Blue Shield of Illinois	General: 1-877-557-3417	To locate BCBSIL providers: <ul style="list-style-type: none"> ▪ Visit www.bcbsil.com/sena/provider_finder ▪ Search by name or provider type
Bluegrass Family Health HMO	General: 1-800-787-2680	www.bgfh.com <ul style="list-style-type: none"> ▪ Click “Provider Directory” ▪ Enter applicable criteria, then click “Search”
Delta Dental	General: 1-800-323-1743	www.deltadentalil.com <ul style="list-style-type: none"> ▪ Click “Dentist Search” ▪ Enter applicable criteria, then click “Search for a Dentist”
Express Scripts	Customer Service: 1-888-772-5181 (phone number will be available in late December)	www.member.express-scripts.com/preview/schneiderelectric2009
OptumHealth Vision	General: 1-800-638-3120 Provider Locator: 1-800-839-3242	www.myoptumhealthvision.com
PayFlex	General: 1-800-284-4885	www.mypayflex.com

Important Notice from Schneider Electric About Your Prescription Drug Coverage and Medicare

The purpose of this notice is to advise that the prescription drug coverage provided under the Square D Company plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2009. This is known as “Creditable Coverage.”

Why this is important — if you or your covered dependent(s) are covered under prescription drug coverage under a Company medical plan during 2009 and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage from Schneider Electric and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Option or join a Medicare Advantage Option (like an HMO or PPO) that offers prescription drug coverage. This coverage sometimes is called “Medicare Part D.” All Medicare prescription drug options provide at least a standard level of coverage set by Medicare. Some options may also offer more coverage for a higher monthly premium.

Schneider Electric has determined that the prescription drug coverage offered by Schneider Electric is, on average for all option participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage with Schneider Electric is, on average, at least as good as standard Medicare prescription drug coverage, you can keep your Schneider Electric coverage and not pay a penalty or higher premium to Medicare if you later decide to join a Medicare prescription drug plan.

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15 through December 31. However, if you lose creditable prescription drug coverage, through no fault of your own, you also will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you decide to join a Medicare prescription drug option, your Square D/Schneider Electric prescription drug coverage will end. However, you will still be eligible to receive your Square D/Schneider Electric medical coverage. You will not be able to get back your Square D/Schneider Electric prescription drug coverage.

You should also know that if you drop or lose your coverage with Schneider Electric and do not join a Medicare prescription drug option within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later.

If you go longer than 63 continuous days without creditable prescription drug coverage, your monthly Medicare Part D premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than what many other people pay. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage, contact Schneider Electric by calling Employee *Direct* at 1-800-993-7638. NOTE: You will receive this notice annually and at other times in the future such as before the next Medicare prescription drug enrollment period and if this coverage through Schneider Electric changes. You also may request a copy at any time.

More detailed information about Medicare options that offer prescription drug coverage is in the “Medicare & You” handbook. You will receive a copy of the handbook from Medicare in the mail every year if you are Medicare eligible. You may also be contacted directly by the insurance companies offering Medicare prescription drug options. For more information about Medicare prescription drug options:

- **Visit www.medicare.gov,**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for the contact information) for personalized help, or
- Call 1-800-MEDICARE at **1-800-633-4227** (TTY: 1-877-486-2048).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1-800-772-1213** (TTY: 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher Medicare Part D premium (a penalty).

October 2008
Nancy D. Lau
Health and Welfare Benefits Manager
Square D Company/Schneider Electric
1415 South Roselle Road
Palatine, IL 60067

These materials have been prepared to help you understand what benefits you may be entitled to under benefit plans sponsored by the Company. The complete provisions of the Company benefits plans are found in the plan documents, which rule in the case of any differences between them and informal materials like these. While the Company expects to continue its benefits programs, it reserves the right, subject to the terms of any applicable collective bargaining agreement or obligation, to terminate, suspend, withdraw, amend or modify all or any part of the Plans at any time without notice. Subject to the terms of any such collective bargaining obligation, any such change or termination of the Plans will be based solely on the decision of the Plan Sponsor and/or the Plan Administrator and may apply to any or all groups of employees, including active or disabled employees and current and future retirees and their dependents as determined under the Plan. No supervisor, manager, or any other representative of the Company has any authority to enter into any oral or written agreement contrary to the foregoing or contrary to the terms of any Summary Plan Description or applicable plan document.

