

Your 2010 Enrollment Guide

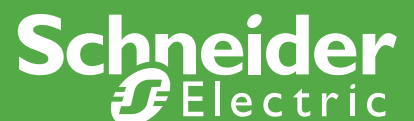
Schneider Electric Benefit Program for U.S. Employees



2010 Open Enrollment

Wednesday, November 4 through Wednesday, November 18, 2009
(until 5:00 p.m. Pacific Time)

Enroll for your 2010 benefits by logging on to www.workterra.net



Welcome to Open Enrollment 2010

Schneider Electric is proud to provide valuable, comprehensive benefits to its eligible employees and their families. A project was created to converge multiple plans into a single, unified U.S. benefits program. This creates consistency across all Schneider Electric entities, and strategically and competitively positions the Company for success.

Open enrollment is your annual opportunity to review your Schneider Electric benefits and choose coverage options that work best for yourself and your family. Review this guide and other communications you have received to learn about your benefits for 2010. Also attend a meeting at your location if one is offered to learn more and ask questions.

Important

Open enrollment is Wednesday, November 4 through Wednesday, November 18, 2009 (until 5:00 p.m. Pacific Time).

After you enroll or change your benefit elections for 2010, review the Confirmation Statement screen for accuracy and print a copy for your records. Click the “Finish” button to complete your enrollment process. Any elections or changes will be saved and changed even if you have not gone through the entire open enrollment process and clicked on the “Finish” button.

After the open enrollment period closes, you will not be able to make changes to your benefits until the 2011 open enrollment period unless you have an eligible change in status or experience another event under which benefit changes are allowed. See page 8 for information about what qualifies as an eligible change in status.

Resources for 2010 Open Enrollment

Pre-enrollment newsletter	Learn about the U.S. benefits convergence and how it affects your employee benefits.
This enrollment guide	Read this guide for an overview of your benefit options, as well as your enrollment decisions.
Employee meetings	Attend a meeting to learn more about your benefit options and ask questions.
Workterra	Access Workterra, your single link to all your benefit plan information with 24-hour access to view current elections, link to carrier Web sites, directories, toll-free numbers, and plan comparisons. Go to www.workterra.net .
This internet-based enrollment system	Accessible from any Internet-enabled computer. Please note that Workterra may only be accessed through the following browsers: <ul style="list-style-type: none"> • Microsoft® Internet Explorer® 5.5 SP1 or later • Netscape® Navigator 7.1 or later • Mozilla 1.3 or later • AOL® 7.0 or later
Employee Benefit Specialists (EBS)	For questions or assistance during the enrollment process: <ul style="list-style-type: none"> • 1-888-327-2770 (phone) • custserv@ebsbenefits.com (email)

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Important Dates

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

Event	Timing	What to expect
Enrollment period	Wednesday, November 4 through Wednesday, November 18, 2009 (until 5:00 p.m. Pacific Time)	<ul style="list-style-type: none"> This is the enrollment period for the Schneider Electric Benefit Program for U.S. employees effective January 1, 2010 through December 31, 2010 You may enroll for your benefits 24 hours a day, seven days a week through www.workterra.net
Health Savings Account materials	Mid-December	<ul style="list-style-type: none"> If you enroll in the High Deductible Health Plan (HDHP) medical option through Blue Cross and Blue Shield of Illinois (BCBSIL), the HSA terms and conditions and debit card will be mailed to your home
New medical ID cards	Late December	<ul style="list-style-type: none"> If there is change in your medical or dental coverage from 2009, you will receive new medical and dental cards based on the option(s) you elect for 2010 <p>Note: Your prescription drug program information will be printed on your BCBSIL ID card</p>
Benefits become effective	January 1, 2010	
Flexible Spending Account debit card	Early January 2010	<ul style="list-style-type: none"> If you elect to open a Health Care FSA for 2010, you will receive a new debit card
Vision ID cards	January 2010	<ul style="list-style-type: none"> If you enroll in vision coverage for 2010, you will receive a vision ID card

Save money on health care expenses

Use the Health Care FSA and save before-tax dollars to help pay for out-of-pocket health care costs, such as copayments, coinsurance and eligible over-the-counter medications. The Company will match your Health Care FSA contributions with 50 cents for every dollar you contribute each pay check, up to a maximum match of \$1,000! See page 20 for more details.

The HDHP medical option offers an HSA. The Company and you can contribute to the account to pay for eligible expenses now and in the future. See page 15 for more details. If you enroll in the HDHP medical option, you may participate in the Limited-use Health Care FSA with no Company match. See page 20 for more details.

Eligibility

You are eligible to participate in Schneider Electric benefits if you are a:

- Salaried or hourly full-time employee, or
- Regular part-time employee, scheduled to work at least 17.5 hours per week.

This excludes temporary workers, contracted or leased employees.

If you are eligible for benefits, you may cover your spouse or domestic partner, and your eligible dependent children up to age 19. Definitions for these dependents are as follows:

- **Spouse:** A person of the opposite sex to whom you are legally married, including common law spouses in states where it is recognized.
- **Domestic partner definition for BCBSIL, Dental and Vision plans:** Same- or opposite-sex partner (no age limit) whether a tax dependent of the employee or not, with whom the employee is involved in an ongoing and committed relationship and who has been residing with the employee for the last six consecutive months. In addition, for purposes of these plans, same sex spouses will be recognized as domestic partners.
- **Domestic partner definition for Anthem Blue Cross HMO and Kaiser:** Same- or opposite-sex partner (no age limit) whether a tax dependent of the employee or not, with whom the employee is involved in an ongoing and committed relationship and who has been residing with the employee.
- **Domestic partners are not recognized by the Health Advantage HMO in Arkansas.**
- **Eligible dependent children** (up to age 19) include:
 - » Natural children
 - » Adopted children
 - » Step-children, foster children and children for whom the employee is the court appointed legal guardian, if they live in the employee's home
 - » Unmarried children age 19 - but less than age 25 - who are full-time students
 - » Children entitled to coverage under a qualified medical child support order
 - » Disabled children over age 19
 - » Children of domestic partners covered under BCBSIL, Dental, Vision and all regional HMO's except Health Advantage HMO in Arkansas

Coordination of Benefits Provision

The Coordination of Benefits provision under the Schneider Electric plans administered by BCBSIL and Delta Dental is known as “non-duplication of benefits.” This means if you or a dependent are covered under both Schneider Electric’s health plan and another health plan, Schneider Electric will pay benefits based on the amount allowed from your plan less any benefits already paid by another plan.

This provision does not have an impact on your benefits when Schneider Electric provides the primary coverage. However, when the Schneider Electric plan is secondary, the amount Schneider Electric pays depends on the amount the primary plan pays first:

- If coverage under the primary plan is equal to or greater than coverage under the Schneider Electric plan, no benefits are payable from the Schneider Electric plan.
- If coverage under the primary plan provides lower coverage than the Schneider Electric plan, Schneider Electric will pay benefits on the difference. For example, if the primary plan provides 70% coverage and the Schneider Electric plan provides 80% coverage, the Schneider Electric plan would provide the additional 10% of coverage.

Special Tax Considerations for Domestic Partners and their Children

Please be aware of special tax considerations that apply if you cover a domestic partner and/or the dependents of your domestic partner under your benefits. According to IRS regulations, medical and dental benefits for domestic partners and their dependent children may not be provided on a tax-free basis for federal income tax purposes, unless these individuals are your qualified tax dependents as defined by the IRS. This means your contributions for covering these individuals will be made on an after-tax basis. In addition, the value of the company's contribution to cover these individuals will be added to your income with each pay check you receive and will be reported on your W-2 at year end.

Taxation For Non-Tax Dependents

Under Internal Revenue Service rules, only individuals who qualify as your tax dependents may be provided tax-favored medical, dental and vision benefits.

If you cover a domestic partner or a domestic partner's child who does not meet IRS criteria for tax-favored benefits, you will be taxed on the value of the benefits provided by Schneider Electric to these dependents. In addition, your contributions for their benefits must be paid on an after-tax basis. The total amount of medical and/or dental premiums paid by the company for your domestic partner and domestic partner's children is considered "imputed income" and must be added to your compensation. It appears on your W-2 statement and is taxable at your regular income tax rate.

When you enroll a domestic partner and/or domestic partner's child, you will be asked to provide a written "Declaration of Domestic Partnership" to Schneider Electric. You will also be asked to provide a "Certification Of Tax Dependency" to indicate if your domestic partner and/or domestic partner's child is your tax dependent under federal guidelines. If you do not provide the "Certification of Tax Dependency," it will be assumed your domestic partner and/or domestic partner's child do not qualify as your tax dependents. Please refer to the domestic partnership documents for examples of how the imputed income for these benefits are determined.

Proof of Dependent Eligibility

Schneider Electric and its health plan providers may ask you to show proof of dependent eligibility at enrollment and other times. For example, you may be asked to provide a marriage license, birth certificate verification of full-time student status, court-ordered support papers, or adoption papers.

Enrolling ineligible dependents or continuing them on your benefits coverage is fraud and grounds for disciplinary action, up to and including termination of employment. In addition, you will be financially liable for any benefits paid for ineligible dependents.

You Must Enroll for 2010 Benefits

Health care cost sharing

You and the Company share in the cost of benefits. For example, Schneider Electric pays about 80% of the cost of coverage for employees who enroll in the Core PPO. Employees pay the remaining 20% through payroll deductions on a tax-free basis. Depending on which medical plan you choose and whether you cover dependents, the exact percentage you pay may be slightly higher or lower.

Open enrollment is your annual opportunity to review your Schneider Electric benefits and make benefit choices for the year ahead. For 2010, all Schneider Electric employees must enroll for benefits.

If you do not enroll for your 2010 benefits, you will be automatically enrolled in the elections listed below. Keep in mind that your benefits will be in effect from January 1, 2010 until December 31, 2010. If you do not enroll, you will not be able to make changes to your benefits until the next open enrollment period in the fall of 2010 — unless you have an eligible change in status or experience another event under which election changes are allowed. See page 8 for more information.

If you do not enroll by Wednesday, November 18, 2009 at 5:00 p.m. Pacific Time, you will be enrolled in benefits as shown in the chart below.

If you do not enroll during the 2010 open enrollment period:	Effective January 1, 2010, your coverage will default to:
Medical (if you have coverage in 2009)	The Core PPO option, with your 2009 coverage level
Medical (if you waived coverage in 2009)	No coverage
Dental	No coverage
Vision	No coverage
Health Care FSA	No participation
Dependent (Day) Care FSA	No participation

It is important for you to enroll to select the plan and coverage level you want, or select “no coverage” if you wish to receive no coverage in 2010.

How to Enroll

Making Benefit Elections and Changes Through Workterra

The open enrollment period is Wednesday, November 4 through Wednesday, November 18, 2009 (until 5:00 p.m. Pacific Time). Access www.workterra.net and make changes to your benefit elections as many times as you wish during this period. Your last benefit elections on file on Wednesday, November 18, 2009 (at 5:00 p.m. Pacific Time) are the ones that will be effective for 2010.

How to Enroll (Cont.)

Step 1: Log on to www.workterra.net

The login page is located at: www.workterra.net. On this page, you will be asked to enter your user name and password as follows:

- **User name:** Your user name is the first six letters of your last name (or your entire last name if it is less than 6 letters) followed by the first letter of your first name and the first four digits of your Social Security number. The first letter of your first and last name must be capitalized.

Example #1

Jack Johnson SSN 123456789:
JohnsoJ1234 (Note: Case sensitive)

Example #2

Mary Post SSN 111223333:
PostM1112 (Note: Case sensitive)

- **Password:** The first time you log on to Workterra, your password will be the same as your user name. The Workterra system is a secured site and all of your information is protected. Therefore, for security reasons, upon your first log on you will be asked to change your password. If you forget your password you can call Human Resources to have it reset. For your protection, the Human Resources Representative does not have access to your password. Once reset, upon your next log on with your new password, you will be required to change it again.
- **Company name:** Enter "CST" (Required for Workterra employee access).
- **Please note:** Each year during Open Enrollment, all user names and passwords will be changed and reset as defined above.

Step 2: Make Your Benefit Elections/Changes

After you log on to Workterra, follow the prompts to add dependents, make benefit elections, or changes to your coverage. Once you have begun your elections, you will have the ability to leave the Web site at any time. Any elections

or changes you have made on the Web site up to that point will automatically be stored and submitted at the close of Open Enrollment. You can log back on and resume or change your enrollment elections anytime until the Open Enrollment period is closed.

NOTE: If you enroll a domestic partner and/or domestic partner's child(ren), you must complete a "Declaration of Domestic Partnership" and "Certification of Tax Dependency" form and return them to Employee Benefit Specialists by November 20, 2009.

Step 3: Confirm and Finalize Your Elections/Changes

Once you are certain that your elections are correct, the final steps for completing the enrollment process are as follows:

- **Review** the Confirmation Statement screen for accuracy.
- **NOTE:** If you have chosen to enroll for Supplemental Life Insurance or increase your coverage amount, your confirmation statement will indicate the coverage as pending insurance carrier review and approval. The insurance carrier, upon receipt of your completed and signed Evidence of Insurability form, will review your additional coverage application and notify the Company. If approved, your payroll deductions will be increased to cover the approved coverage.
- **Print** a copy of the Confirmation Statement for your records.
- **IMPORTANT:** You must click the Finish button to complete your enrollment process.

Step 4: Check Your Deductions

Check your deductions on your first 2010 paycheck by comparing them to the deductions shown on your confirmation statement you print from www.workterra.net.

If the deductions do not match, contact EBS immediately to report the discrepancy.

Helpful prompts during the Open Enrollment process

By following the prompts through the Workterra Open Enrollment process, you may:

- Add your spouse and/or child information.
- Elect or waive benefit coverage.
- Enter complete beneficiary information.
- Complete an EOI form if enrolling in Supplemental Life coverage over the Guarantee Issue amount (the amount of coverage you may elect without providing proof of good health).

Questions?

If you have any questions or require assistance during the enrollment process, please contact Employee Benefit Specialists (EBS) directly at the number/ email below.

- 1-888-327-2770 (phone)
- custserv@ebsbenefits.com (email)

Eligible Status Changes

Allowable Mid-Year Benefit Election Changes

Status Event Change

You may make changes to or discontinue your benefit coverage(s) during the plan year only if you experience a status event. You must make changes to your coverage within 31 calendar days from the date of the status event. Otherwise, your next opportunity to enroll new dependents or make other benefits changes is the next annual Open Enrollment period or the date you have another status event, whichever occurs first.

Deadlines Apply!

You have 31 days from the date of the status event to make your changes. You must also provide proof of the status event (e.g., marriage license, birth certificate, employment letter, insurance documents) to EBS.

Any change you make to your benefit elections must be due to and consistent with the status event. For example, if your dependent child reaches the maximum age limit, you must drop your dependent from coverage, but you will not be allowed to switch medical plans. Please see your Summary Plan Description (SPD) or Evidence of Coverage (EOC) for more details.

Examples of eligible status event changes include:

- Marriage
- Divorce, legal separation, or annulment
- Establishment or termination of a domestic partnership
- Gaining of a child through birth, legal guardianship, adoption, or placement for adoption
- Beginning or ending care of a foster child
- Death of your spouse, domestic partner, or dependent child
- Change in your dependent child's eligibility for coverage (gaining or losing coverage) due to age, student status or similar circumstances

- Change in employment status for you, your spouse, your domestic partner, or your eligible dependent(s) resulting in a gain or loss of eligibility for coverage, such as:
 - » Beginning or terminating employment
 - » Starting or returning from an unpaid leave of absence during which your benefits eligibility would be affected
 - » Changing from part-time to full-time employment status (or vice versa for which your benefits eligibility would be affected)
- Change in residence or worksite for you, your spouse/domestic partner, or your dependent child resulting in a gain or loss of eligibility for coverage

Other Election Changes

There are other types of events that allow you to make mid-year benefit changes. Examples of these events include:

- CST coverage is significantly reduced or ends. Note that if the significant reduction does not result in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, but you may not drop coverage all together. If the significant reduction results in a loss of coverage, you may revoke coverage under that option and elect coverage under a similar option, or if no similar option is available, drop coverage.*
- A similar benefit option is added, significantly improved, or eliminated.*
- There is a significant cost increase in a benefit option, in which case you can elect to pay the increased cost for your current option, select a new benefit option, or cancel your coverage if there is no similar option. You will not, however, be allowed to change your Dependent Care FSA coverage level on account of a significant cost increase where the dependent care provider is your relative.*
- There is a significant cost decrease in a Company benefit option, in which case you can select that option.*

Eligible Status Changes (Cont.)

- You, your spouse/domestic partner, or a dependent child loses or gains Medicare or Medicaid entitlement.
- There are changes pursuant to a judgment, decree, or court order, including a qualified medical child support order (“QMCSO”). Note, you may cancel coverage for a child pursuant to a judgment, decree, or order to enroll a child in another employer’s plan only if the child is actually enrolled in the other plan.
- There are changes under your spouse’s plan due to a mid-year election change that satisfies the Section 125 regulations or a change during an Open Enrollment period where your spouse’s plan has a different plan year.*

With respect to your Dependent (Day) Care FSA and the first four events above, you may adjust your account contribution if:

- You change your daycare provider.
- The number of hours of daycare changes.
- Your non-relative daycare provider significantly increases your cost for childcare.

* You will not be allowed to change your Health Care FSA participation on account of these changes.

Making your Enrollment Decisions

Terms to know

Annual deductible:

Amount paid out of pocket before a medical plan begins paying benefits

Copayment:

Flat dollar amount paid for some health care services

Coinsurance:

Amount paid for some health care services, calculated as a percentage of the total cost of that service

Out-of-pocket maximum:

The most you will pay out of pocket for eligible health care expenses in one year

Employee contribution:

Amount deducted from your paycheck for medical coverage

Primary Care Physician (PCP):

Health care practitioner who coordinates the overall medical care of a patient, including referrals for specialists and hospital care. PCPs are generally internists, general practitioners, family practitioners and, for children, pediatricians

Medical

The medical plan helps you and your family with the costs of maintaining good health and treating illness or injury. You have the opportunity to choose a medical option that best fits your family's needs.

Price tag information for each of the available plans can be found on page 13.

Your online enrollment statement lists the options available to you, along with each option's price tag per pay period.

Your options	Coverage categories
<p>Four medical options are administered by Blue Cross and Blue Shield of Illinois (BCBSIL) and three HMO options are administered by regional HMO's.</p> <ul style="list-style-type: none"> • Core PPO • Buy-up PPO • EPO (HMO) • High Deductible Health Plan (HDHP)* • Anthem Blue Cross HMO (California only) • Health Advantage HMO (Arkansas only) • Kaiser Permanente HMO (California only) • No coverage 	<ul style="list-style-type: none"> • Employee only – coverage for yourself only • Employee + spouse/domestic partner – coverage for yourself and your spouse or domestic partner • Employee + child(ren)/domestic partner child(ren) – coverage for yourself and one or more dependent children. This does not include coverage for a spouse or domestic partner • Employee + family – coverage for yourself, and your spouse or domestic partner, and your dependent children

* If you elect the High Deductible Health Plan medical option, you have an additional decision to make. You must decide if you would like to contribute to a Health Savings Account (HSA) through before-tax payroll contributions. The amount you are eligible to contribute depends on the coverage category you select. See page 15 for more information.

Paying for Your Coverage

You and Schneider Electric share the cost of your medical plan. You pay your share through payroll deductions. The amount you pay depends on the plan you choose and the coverage category you elect. See page 13 for medical plan price tags.

You may waive medical coverage, if you wish. However, you will not receive an opt-out credit in your paycheck.

More about Your Medical Options

Choosing a medical plan is an important decision for you and your family. Several different medical options are available so you can select the one that fits you best. Please read about all medical options to learn about the features of each. Refer to the "Terms to Know" section to help you understand each description better.

For more details on each medical plan option, see the medical plan comparison charts on pages 12 and 13 of this guide. Remember, medical plan comparison tables are available on Workterra.

Visit www.bcbsil.com/sena/provider_finder to see if your doctor participates in the BCBSIL PPO network. Each of the medical options administered by BCBSIL utilizes the PPO network of providers. Visit www.anthem.com/ca to see if your doctor participates in the Anthem Blue Cross HMO network.

Two PPO Options

A Preferred Provider Organization, or PPO, is a managed care medical plan that features a network of providers. You have coverage for in-network and out-of-network care, but in-network care costs you less. You do not need a primary care physician (PCP) to coordinate your care. The plan features an annual deductible, copayments, coinsurance, and an out-of-pocket maximum.

You have two PPO options for 2010.

- The Core PPO has lower per-paycheck contributions and higher out-of-pocket costs when you use care, and
- The Buy-up PPO has higher per-paycheck contributions and lower out-of-pocket costs when you use care.

EPO (HMO)

An Exclusive Provider Organization, or EPO, is a different kind of managed care medical plan that features a network of providers. Unlike the PPO, the EPO has no coverage for out-of-network care, except in a medical emergency. You do not need a PCP to coordinate your care. The plan features copayments, not coinsurance. There is no annual deductible to meet and no out-of-pocket maximum.

HDHP

A High Deductible Health Plan, or HDHP, is a newer kind of managed care medical plan. It features a higher deductible, as defined by the IRS. You have coverage for in-network and out-of-network care, but in-network care costs you less. You do not need a PCP to coordinate your care. In this plan, in-network preventive care services are covered at 100% without having to meet the plan's deductible. That means you can receive eligible preventive care services throughout the year at no cost to you.

This plan has a higher annual deductible than your other medical options. It features coinsurance instead of copayments, and has an out-of-pocket maximum. Your family deductible is met when all of the family's eligible expenses, added together, reach the amount of the family deductible. In other words, once the family deductible is met, either by one individual or by combining each of the family member's eligible expenses, the plan moves to coinsurance.

Employee contributions are lower for this type of plan.

When you enroll in an HDHP, a Health Savings Account, or HSA, is set up in your name. This is a key feature of the HDHP medical option. Schneider Electric makes a contribution to your HSA to help you meet the plan's higher deductible, so the HSA is a very valuable piece of the HDHP.

HMO

A Health Maintenance Organization, or HMO, is usually limited to a certain geographical area. It features a network of providers and there is no coverage for out-of-network care, except in a medical emergency. This is the only medical plan where you must select a PCP to coordinate your care. The plan features copayments, not coinsurance. There is no annual deductible to meet and no out-of-pocket maximum.

- **Anthem Blue Cross HMO (California only)**
 - The Anthem Blue Cross HMO provides all of your medical care using CaliforniaCare network physicians, medical groups, and hospitals. You must use network providers in order to receive benefits, except in approved emergencies.

Each member of your family chooses their own primary care physician (PCP) to coordinate all medical care, including specialist referrals and hospital stays. You and your family members must live or work within 30 miles of your PCP. You may change your PCP during the year. Women may see an OB/GYN within their medical group without a referral from their PCP.

Making your Enrollment Decisions (Cont.)

- Health Advantage HMO (Arkansas only)**
 - The Health Advantage HMO provides all of your medical care using Health Advantage network physicians, medical groups, and hospitals. You must use network providers in order to receive benefits, except in approved emergencies.
- Kaiser Permanente HMO (California only)**
 - The Kaiser Permanente HMO provides all of your medical care using Kaiser network doctors at their facilities. Kaiser does not require you to select a primary care physician (PCP); however, you must use Kaiser doctors and hospitals, except in approved emergencies.

Each member of your family chooses their own primary care physician (PCP) to coordinate all medical care, including specialist referrals and hospital stays. You may change your PCP during the year. Women may see an OB/GYN within their medical group without a referral from their PCP.

Medical Plan Comparison Chart

The following chart provides a summary of your medical options to help you compare out-of-pocket costs. Your choice will affect how much of your health care expenses you will have to pay and how much the medical plan will pay.

Plan provision	EPO	PPO (Core)		PPO (Buy-up)		HDHP with HSA	
	In-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible							
Single	N/A	\$350	\$700	\$200	\$400	\$1,400	\$2,800
Family	N/A	\$700	\$1,400	\$400	\$800	\$2,800	\$5,600
Health Savings Account (Company contribution)							
Single			N/A			\$500	
Family			N/A			\$1,000	
Out-of-pocket maximum							
Single	N/A	\$2,000	\$4,000	\$1,250	\$2,500	\$3,000	\$6,000
Family	N/A	\$4,000	\$8,000	\$2,500	\$5,000	\$6,000	\$12,000
Coinsurance	N/A	20%	40%	10%	30%	20%	40%
Office visit							
Preventive care	100%; no copayment	100%; no copayment	N/A	100%; no copayment	N/A	100%; no deductible	N/A
Primary doctor	\$20 copayment	\$20 copayment	Subject to deductible and coinsurance	\$10 copayment	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Specialist	\$30 copayment	\$30 copayment	Subject to deductible and coinsurance	\$15 copayment	Subject to deductible and coinsurance	Subject to deductible and coinsurance	
Emergency room	\$75 copayment	\$75 copayment		\$75 copayment		Subject to deductible and coinsurance	
Hospital admission	\$250 copayment	Subject to deductible and coinsurance					

Plan provision	Anthem Blue Cross HMO (California) In-network	Health Advantage HMO (Arkansas) In-network	Kaiser Permanente HMO (California) In-network
Deductible			
Single	N/A	N/A	N/A
Family	N/A	N/A	N/A
Out-of-Pocket Maximum (in addition to deductible)			
Single	\$1,500/person	\$600/person	\$1,500/person
Family	\$4,500/family	\$1,200/family	\$3,000/family
Coinsurance	N/A	N/A	N/A
Office visit			
Preventive care	\$20 copayment	\$20 copayment	\$20 copayment
Primary doctor	\$20 copayment	\$20 copayment	\$20 copayment
Specialist	\$20 copayment	\$25 copayment	\$20 copayment
Emergency room*	\$100 copayment	\$100 copayment	\$100 copayment
Hospital admission	\$250 copayment	\$300 copayment	\$250 copayment

Medical Plan Price Tags – 2010 Bi-weekly Costs

	EE only	EE + spouse/ domestic partner	EE + child(ren)	EE + family
Core PPO	\$34.02	\$71.44	\$64.64	\$107.16
Buy-up PPO	\$48.42	\$101.68	\$92.00	\$152.52
EPO (HMO)	\$44.60	\$93.66	\$84.73	\$140.48
High Deductible Health Plan (HDHP)	\$10.99	\$23.09	\$20.89	\$34.63
Anthem Blue Cross HMO	\$50.82	\$125.43	\$77.89	\$150.78
Health Advantage HMO	\$39.72	\$70.93	\$106.39	\$124.13
Kaiser Permanente HMO	\$42.06	\$106.12	\$62.09	\$123.56

Making Your Enrollment Decisions (Cont.)

Choose generics when possible

Requesting generic drugs can help you manage your health care expenses. Learn more about generic drugs through BCBSIL by visiting the Express Script's Web site at www.member.express-scripts.com/preview/SchneiderElectric2010

Save money with mail order

If you use long-term or maintenance medication, the mail order pharmacy is a safe and convenient way to fill your prescriptions. You can order your prescriptions easily and have them delivered to your home. When you use the mail order pharmacy, you get a 90-day supply of medication for the price of two 30-day prescriptions at the retail pharmacy. If you wish to use the mail order pharmacy, ask your doctor to write your prescription for a 90-day supply, instead of a 30-day supply.

Prescription Drug Coverage

When you enroll in a medical option for 2010, you will automatically have prescription drug coverage based on the medical option you elect. For BCBSIL, your prescription drug coverage is through Express Scripts. This coverage provides you with retail pharmacy and mail order (home delivery) prescription drug benefits. The prescription drug plan features a formulary or preferred drug list with three categories of drugs:

- Generic drugs are always your lowest cost option. A generic drug is a prescription drug sold under its chemical name, rather than a brand name. Generic drugs are required by law to include the same or similar levels of active ingredients as their brand-name equivalents. The decision to use a generic versus a brand-name medication is between you and your doctor, and you are encouraged to discuss generic alternatives with your doctor each time a medication is prescribed for you.
- Preferred brand drugs are preferred by Express Scripts because they cost less and provide the same quality medication, when compared with other brand-name drugs intended for the same purpose. If you need a prescription and no generic alternative is available, purchasing a preferred drug instead of a brand drug will still save you money.
- Generally, brand drugs have a generic or preferred alternative available. Choosing a brand drug will always cost you the most money.

BCBSIL enrollees can visit the Express Scripts Web site at www.member.express-scripts.com/preview/schneiderelectric2010 to find out whether a drug is considered generic, preferred brand or brand. Anthem Blue Cross HMO enrollees can visit www.anthem.com/ca, Health Advantage HMO enrollees can visit www.healthadvantage-hmo.com and Kaiser enrollees can visit www.kaiserpermanente-org.

Paying for Your Prescriptions

Your coverage for prescription drugs depends on the medical option you elect. If you enroll in one of the PPO options or the EPO, you pay a flat dollar amount for your prescription drugs, depending on the category of the drug and whether you use a retail pharmacy or the mail order (home delivery) service. Copayments toward prescription drugs do not count toward your annual out-of-pocket maximum for the medical plan. If you enroll in the HDHP with HSA, you pay for prescription drugs the same way you pay for all other medical services — through coinsurance after you meet the plan's deductible. There are no copayments for prescription drugs under the HDHP medical option.

Your BCBSIL prescription drug coverage features a network of participating pharmacies. If you use an out-of-network pharmacy, you will need to pay the full price of your prescription when you purchase it. Then, you will need to submit a paper claim for reimbursement. To see if your local pharmacy is in the Express Scripts network, visit www.member.express-scripts.com/preview/schneiderelectric2010.

If you use a local retail pharmacy, be sure to show your medical ID card when you pick up your prescriptions.

NOTE: BCBSIL Long-term drugs must be purchased through mail order. For contact information about the home delivery program, refer to page 32.

Prescription Drug Costs			
	EPO, PPO (Core) and PPO (Buy-up)	HDHP with HSA	
		In-network	Out-of-network
Retail pharmacy (30-day supply)			
Generic	\$10 copayment	20% (after you meet the annual deductible)	40% (after you meet the annual deductible)
Preferred brand (formulary)	\$25 copayment		
Brand (non-formulary)	\$50 copayment		
Mail order (90-day supply)			
Generic	\$20 copayment	20% (after you meet the annual deductible)	40% (after you meet the annual deductible)
Preferred brand (formulary)	\$50 copayment		
Brand (non-formulary)	\$100 copayment		

Prescription drugs through the HDHP

You must satisfy your annual deductible before the plan will begin to pay for a portion of your prescription drugs. Once you have met your deductible, the plan will pay 80% of the full cost of the prescription for an in-network pharmacy or 60% for an out-of-network pharmacy.

However, before you meet the deductible, you will pay the full cost of any prescription drugs.

Plan provision	Anthem Blue Cross HMO	Health Advantage HMO	Kaiser Permanente HMO
Retail pharmacy (30-day supply / 34-day supply for Health Advantage)			
Generic	\$10 copayment	\$10 copayment	\$10 copayment
Preferred brand (formulary)	\$20 copayment	\$20 copayment	\$20 copayment
Brand (non-formulary)	\$35 copayment	\$30 copayment	N/A
Mail order (100-day supply / 90-day supply for Anthem Blue Cross. For Health Advantage, medications are eligible for the mail order program if listed on the Maintenance Drug List.)			
Generic	\$20 copayment	\$20 copayment	\$20 copayment
Preferred brand (formulary)	\$40 copayment	\$40 copayment	\$40 copayment
Brand (non-formulary)	\$70 copayment	\$60 copayment	N/A

HMO Prescription Drug Coverage

To find out whether a drug is considered generic, preferred brand or brand, contact your HMO prescription drug claims administrator by calling the customer service phone number on page 32 or by visiting the provider's Web site.

Health Savings Account

If you enroll in the HDHP medical option for 2010, your HSA is funded by contributions made by the Company and optional before-tax payroll deductions made by you. If you enroll in single coverage, Schneider Electric will contribute \$500 to your HSA; for family coverage, \$1,000. Similar to FSAs, an HSA helps you save money on eligible health care expenses.

Making Contributions to Your HSA

The IRS defines the maximum amounts you can contribute to an HSA in a year. For 2010, the total contribution maximum is:

- \$3,050 for individual coverage, or
- \$6,150 for family coverage.

The total contribution maximum includes your contributions and all contributions Schneider Electric makes on your behalf. (The annual Schneider Electric contribution for individual coverage is \$500. All other levels of coverage will receive an annual contribution of \$1,000.)

Funds in your HSA are Yours to Keep

Unlike the FSAs, the money in your HSA rolls over from year to year. You can save the money in your HSA to use in the future, even after you retire. You decide whether and when to use your HSA dollars to pay for eligible health care expenses or pay out of your own pocket and save your HSA dollars for future expenses.

The HSA is only available when you enroll in the HDHP medical option.

Making Your Enrollment Decisions (Cont.)

Catch-up contributions

If you will reach age 55 by December 31, 2010, you may make additional catch-up contributions of \$1,000 to your HSA.

FSA and HSA participation

Because of IRS regulations, you may not contribute to a Health Care FSA and an HSA in the same year. However, if you enroll in the HDHP, you may contribute to a Limited-use Health Care FSA. See page 20 for more information. Keep this in mind in case you experience an eligible status change during the year.

The HSA is portable, which means you can continue to use the money if you change jobs or retire. The money in your HSA can grow with interest. In addition, if you have at least \$1,000 in your account, you can invest the additional money in a variety of available fund options.

If you enroll in the HDHP for 2010, you will receive the terms and conditions associated with the HSA in mid-December. You will need to elect your per-paycheck contribution amount during open enrollment if you choose to make HSA contributions.

HSA Eligibility Requirements

To be eligible for an HSA:

- You must be enrolled in a HDHP medical option;
- You cannot have medical or prescription drug coverage under any other medical plan, including another employer's plan (some exceptions may apply, such as coverage for a specific disease or illness; a fixed payment for a period of hospitalization; or coverage for accidents, vision, disability, dental care or long term care);
- You cannot be eligible to be claimed as a dependent on another person's tax return;
- You cannot be enrolled in Medicare, either because you are age 65 or disabled.

Investment Options

Through the HSA, you have three investment options:

- **Interest bearing option** – This option, also known as the HSA Deposit Account, is FDIC insured to the extent provided by law. If you have more money in your HSA Deposit Account than what is needed to pay for qualified medical expenses, you have a few options that may allow you to earn higher yields on your HSA funds. One of these options is the money market sweep option.
- **Money market sweep option** – This option automatically “sweeps” funds in excess of \$1,000 in your HSA Deposit Account into a money market mutual fund account on a daily basis. If charges posted to the HSA Deposit Account cause its balance to dip below \$1,000, your money market mutual fund investment will be automatically liquidated, and the funds will be transferred to your HSA Deposit Account to maintain a \$1,000 balance.
- **Brokerage option** – This option allows you to open an account directly through UMB Financial Services, Inc. This gives you broader investment options than the money market sweep option and is designed to provide you with other long-term investment options for your HSA funds. This is a self-directed investment account, which means that you select the investments from those offered. If you want to move funds from this option to be available to pay for qualified medical expenses, you must place a sell order with UMB Financial Services, Inc.

NOTE: If you choose the money market sweep option or the brokerage option, be aware that those investments:

- Are not deposits or obligations of, and are not guaranteed by UMB;
- Are not insured by the FDIC or any other government agency; and
- Involve investment risks, including the possible loss of principal.

Dental

The dental plan covers dental care for yourself and your covered dependents. It includes coverage for preventive care like exams and cleanings. It also covers basic and major restorative care as well as special oral surgery services.

Our dental plan provider for 2010 is Delta Dental of Illinois. You have two dental options — Core and Buy-up — with different price tags. Both cover the same services, but the Buy-up option has a higher annual maximum amount, as well as orthodontia coverage for dependent children (see below).

Check if your dentist is in the network

Visit www.deltadentalil.com to see if your dentist is in the Delta Dental network.

Your options	Coverage categories
Both dental plan options are administered by Delta Dental of Illinois. <ul style="list-style-type: none"> • Core • Buy-up • No coverage 	<ul style="list-style-type: none"> • Employee only – coverage for yourself only • Employee + spouse/domestic partner – coverage for yourself and your spouse or domestic partner • Employee + child(ren)/domestic partner child(ren) – coverage for yourself and one or more dependent children. This does not include coverage for a spouse or domestic partner • Employee + family – coverage for yourself, and your spouse or domestic partner, and your dependent children

If you enroll in dental coverage, you will receive an ID card for 2010.

The dental plan allows you to go to any general or specialty dentist for treatment. For 2010, you will have access to two Delta Dental networks — Delta Dental PPO and Delta Dental Premier. When you call your dentist's office to make an appointment, ask if your dentist participates in either of these 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 Delta Dental PPO network dentist. Average discounts range from 15% to 35% for the Delta Dental PPO network and 5% to 10% for the Delta Dental Premier network.

Plan provision	Core	Buy-up
	In-network and out-of-network	In-network and out-of-network
Calendar year maximum		
Excludes orthodontia	\$1,500	\$2,000
Annual deductible		
Individual	\$50 per person	\$50 per person
Family	\$150 per family	\$150 per family
Orthodontia		
Lifetime maximum (limited to dependent children to age 19 regardless of full-time student status)	No benefit	50%; \$2,000 per child

Making Your Enrollment Decisions (Cont.)

Dental Plan Coverage

The following chart provides a summary of your dental coverage.

Plan provision	In-network		Out-of-network*
	Delta Dental PPO	Delta Dental Premier	
Preventive and diagnostic care			
Exams, cleanings, x-rays, etc.	100% of reduced fees	100% of MPA	100% of MPA
Basic restorative care			
Fillings, endodontics, periodontics, etc.	80% of reduced fees	80% of MPA	80% of MPA
Major restorative care			
Oral surgery, crown, bridge, denture, implant, etc.	50% of reduced fees	50% of MPA	50% of MPA

* An out-of-network dentist may bill you for any difference between the maximum plan allowance (MPA) and the dentist's submitted charge. You are responsible to pay fees that exceed the MPA.

About the Maximum Plan Allowance (MPA)

Both dental options cover care from any dentist, but you pay less if you use a dentist who participates in Delta's network. When a claim is submitted for services rendered by a Delta Dental Premier or out-of-network dentist, the maximum eligible expense is limited to a MPA. MPA amounts are based on average prices of what dentists charge in a certain geographic area. The coinsurance you pay for dental care is based on the MPA. If the charge exceeds the amount, claims will be paid based on the MPA amount only. A Premier dentist is under contract to accept the MPA as full payment for covered services; however an out-of-network dentist may bill you for any difference between the MPA and the submitted charge.

Here is an example of how your out-of-pocket dental expenses can vary based on your decision to use an in-network or out-of-network dentist. This example is for major restorative care services. The plan pays 50% coinsurance for this type of service, and you pay the remaining 50%.

	Delta Dental PPO dentist	Delta Dental Premier dentist	Out-of-network dentist
Actual price of service	\$700	\$700	\$700
Fee allowance	\$500	N/A	N/A
MPA	N/A	\$600	\$600
Coinsurance you pay	50% of \$500 = \$250	50% of \$600 (MPA) = \$300	50% of \$600 (MPA) = \$300
Difference between MPA and price of service	N/A	N/A	\$100
Your total cost	\$250 (50% of fee allowance)	\$300 (50% of MPA)	\$400 (50% of MPA plus \$100 difference between MPA and actual price)

Dental Plan Price Tags – 2010 Bi-weekly Costs

	Core	Buy-up
Employee only	\$2.80	\$4.99
Employee + spouse/domestic partner	\$5.87	\$10.49
Employee + child(ren)	\$5.31	\$9.49
Employee + family	\$8.81	\$15.74

Vision

The vision plan is entirely voluntary, and employees pay 100% of the cost of coverage. The plan provides coverage for an annual vision exam, as well as corrective lenses and frames. The vision plan features a network of participating providers, and you pay less when you use an in-network vision care provider.

If you enroll in a Blue Cross and Blue Shield of Illinois medical plan or one of the regional HMO plans, you will have vision care discounts available to you through the medical plan. Think about your vision care needs carefully to determine if it's more cost effective for you to elect the vision plan or to use the discounts available with your medical plan.

Your options	Coverage categories
<p>The vision plan is administered by OptumHealth Vision (formerly called Spectera)</p> <ul style="list-style-type: none"> • Vision coverage • No coverage 	<ul style="list-style-type: none"> • Employee only – coverage for yourself only • Employee + spouse/domestic partner – coverage for yourself and your spouse or domestic partner • Employee + child(ren)/domestic partner child(ren) – coverage for yourself and one or more dependent children. This does not include coverage for a spouse or domestic partner • Employee + family – coverage for yourself, and your spouse or domestic partner, and your dependent children

The following chart provides a summary of your vision plan. Coverage allows for one pair of eyeglasses or contacts each year.

Plan provision	In-network benefits	Out-of-network benefits
Frequency of coverage	Exam, lenses, and frames once every calendar year (resetting in January of every year)	
Exams	\$10 copayment	Up to \$60 allowance
Lenses	\$25 copayment	\$50 to \$90 allowance
Frames	\$130 allowance	Up to \$70 allowance
Contacts	\$25 copayment; \$175 allowance (in lieu of lenses and frames)	Up to \$175 allowance

Vision Plan Price Tags – 2010 Bi-weekly Costs

Employee only	\$2.70
Employee + spouse/domestic partner	\$5.62
Employee + child(ren)	\$5.09
Employee + family	\$7.50

NOTE: Vision benefits under the HDHP qualify as “other insurance.” This means your vision expenses are not qualified medical expenses and cannot be reimbursed through your HSA. However, expenses not covered under the vision plan can be paid from a Limited-use Health Care FSA.

Making Your Enrollment Decisions (Cont.)

Schneider Electric will match your Health Care FSA contributions with 50 cents for every dollar you contribute to the account, up to a maximum match of \$1,000.

This match not only allows you to save money, but it also provides a way to customize your health care plan to fit your needs.

Flexible Spending Accounts

Flexible spending accounts allow you to set aside before-tax dollars to pay for eligible expenses, as defined by the IRS. There are three spending account options with different purposes and features.

- Health Care Flexible Spending Account (FSA),
- Dependent (Day) Care Flexible Spending Account (FSA), and
- Limited-use Health Care Flexible Spending Account (FSA).

You contribute to a FSA through payroll deductions before taxes are taken out.

Visit www.irs.gov for more detail about eligible expenses.

- View Publication 502 for eligible health care expenses
- View Publication 503 for eligible dependent day care expenses

More about the Health Care and Dependent (Day) Care FSAs

These accounts let you set aside before-tax dollars to pay for eligible health care or dependent day care expenses for you and your eligible dependents. You will not pay taxes on money in your FSA(s) as long as you use it for qualified expenses. Visit www.mytakecareplan.com for more information about FSAs.

It is important to plan carefully when you decide how much you want to contribute to your FSA(s). Because they offer substantial tax savings, the IRS places restrictions on these types of accounts:

- You must use all of the money in your account for expenses incurred through March 15, 2011 or any remaining balance in your account will be forfeited as of March 31, 2011.
- You cannot use funds in your Health Care FSA to reimburse yourself for dependent day care expenses or vice versa.

- You may only be reimbursed for eligible health care or dependent day care expenses, as determined by IRS rules.

If you elect to contribute to a FSA in 2010, you will be allowed to incur expenses through March 15, 2011 and you must file reimbursement requests by March 31, 2011. You forfeit all funds remaining in the account after March 31, 2011.

Health Care FSA

You may elect to contribute up to \$4,000 per calendar year, on a before-tax basis, to help pay for eligible health care (medical, dental and vision care) expenses for you and your family. Eligible expenses include (but are not limited to) deductibles, copayments, coinsurance, expenses in excess of your benefit plan coverage and other out-of-pocket health care expenses that are deductible for federal income tax purposes. You may also submit for reimbursement the cost of certain over-the-counter medications, such as antacids, allergy medications, pain relievers and cold medicines purchased without a prescription.

The annual maximum contribution to the Health Care FSA is \$5,000, including the Company match. Use the "Health Care Flexible Spending Account Work Sheet" in this guide to help you decide how much to contribute to the account in 2010.

About the Limited-use Health Care FSA

You may contribute to a Limited-use Health Care FSA only if you enroll in the HDHP and open an HSA.

Similar to other FSA options:

- You contribute from your pay before taxes are taken out
- You don't pay taxes on the money when you use it for qualified expenses
- You forfeit any unused money

You may use money for eligible dental and vision care expenses, over-the-counter medications and any medical expense incurred after you meet your annual medical deductible.

You will receive an FSA debit card to pay for your eligible expenses. You may use your debit card if your provider accepts VISA credit cards. When you use the FSA debit card for eligible expenses, your FSA debit card will deduct the amount from your account (if you do not use the card, you will need to pay for the expense first, and file a claim for reimbursement). Keep your Explanation of Benefits (EOB) that you receive from the health care provider as proof of the expense.

If you do not use your FSA debit card to pay for your eligible expenses, you will need to file a claim for reimbursement to EBS, the claims administrator. Attach receipts for all eligible expenses. You can download a form to request automatic deposit into a checking account at www.ebsbenefits.com.

Employee Benefits Specialists - VISA Debit Card

When you elect to contribute to a Health Care FSA during open enrollment, you will receive a debit card. This card allows you to access money directly from your FSA to pay for eligible expenses. Use it at the pharmacy or your physician's office to pay for eligible expenses such as copayments, short-term or mail order prescriptions, and over-the-counter (OTC) medications. When ordering mail order 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.

Your FSA administrator, EBS monitors the use of the debit card to ensure that only eligible expenses are reimbursed. So 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 paper claim form). EBS 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 debit card will be deactivated.

Paper Claim Form Available

If you do not use your debit card, you can mail or fax your FSA claims to EBS, and your claims will be processed on a daily basis..

Receiving your card

If you elect to contribute to a Health Care FSA you will receive your debit card in mid-January. Check with your Dependent (Day) care facility to determine whether or not you can use your debit card to pay for your **Dependent (Day) Care FSA expenses**.

Making Your Enrollment Decisions (Cont.)

Health Care Flexible Spending Account Worksheet		
Eligible expenses	Actual expenses in 2009	Estimated expenses for 2010
Medical expenses		
Deductibles	\$	\$
Co-insurance	\$	\$
Copayments	\$	\$
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 dental plan	\$	\$
Vision care, glasses and contact lenses above plan limits	\$	\$
Hearing care above plan limits	\$	\$
Other health care expenses not listed above	\$	\$
Total other health care expenses	\$	\$
Line A: total estimated unreimbursed health care expenses (this is the amount you expect to pay in 2010 for health care expenses not covered by the plan.)		\$
Line B: your contribution toward unreimbursed health care expenses (multiply Line A by 0.667. This is the approximate total annual contribution you might consider making to your Health Care FSA.) \$50 Minimum per year/\$4,000 maximum per year.		\$
Line C: the company's contribution toward unreimbursed health care expenses (multiply Line B by 0.50. This is the total annual contribution the Company would contribute to your Health Care FSA — up to \$1,000 — if you contribute the amount shown on Line B .)		\$
Line D: your contribution each pay period (divide Line B by 26. This is the amount that would be deducted from each paycheck for Health Care FSA contributions.)		\$

Dependent (Day) Care FSA

The Dependent (Day) Care FSA can help you save money 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 help pay for care for your:

- Dependent child(ren) under the age of 13;
- Physically or mentally handicapped child(ren) of any age who is/are incapable of caring for himself or herself; and/or
- 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.

Dependent care expenses typically not reimbursable through the reimbursement account include housekeeping, food, clothing, transportation, overnight camps, educational

programs and education for children in kindergarten or higher. For a complete list of eligible expenses, contact the IRS at www.irs.gov or 800-829-3676 and request Publication 503.

You may contribute a minimum of \$50 per year up to \$5,000 to the Dependent (Day) Care FSA for 2010. 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 (Day) Care FSA, then you can contribute a combined total of \$5,000.

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 services.

The Dependent (Day) Care FSA cannot be used to pay for dependent health care expenses

In addition, there is no Company match on your contributions, and you cannot use the account to pay for expenses incurred solely for your personal enjoyment, convenience or ease.

Dependent (Day) Care Flexible Spending Account Worksheet		
Eligible expenses	Actual expenses in 2009	Estimated expenses for 2010
Babysitter	\$	\$
Day care center	\$	\$
Nursery school	\$	\$
After school care	\$	\$
Care for eligible adult	\$	\$
Other eligible dependent day care expenses not listed above	\$	\$
Total expenses	\$	\$
Total estimated unreimbursed dependent day care expenses (this is the amount you expect to pay in 2010 for eligible dependent day care expenses.)		\$
Your contribution each pay period (divide total estimated unreimbursed dependent day care expenses by 26. This is the amount that would be deducted from each paycheck for Dependent (Day) Care FSA contributions.) \$50 minimum per year/\$5,000 maximum per year		\$

Making Your Enrollment Decisions (Cont.)

Life Insurance

Terms to know

Annual Earnings:

Annual Earnings is defined as your base salary as of October 1 of the prior year (before any reduction for your 401(k) contributions, before-tax dollars paid for benefits, or non-qualified deferred compensation plan contributions) plus eligible commissions and incentive bonuses paid by the Company, or other controlled group member for employees transferring to the plan, during the 12-month period before that October 1. Annual Earnings do not include overtime pay, gain sharing or any long-term incentive, executive, or stock-based award.

Financial security for your family

An Overview of Coverage

Life, Accidental Death & Dismemberment (AD&D), and Business Travel Accident (BTA) Insurance are designed to provide a degree of financial protection in the event of death or accidental injury. CST offers several coverage options that can help you plan an appropriate level of protection.

Basic Life, AD&D and BTA

CST pays the full cost of Basic Life, AD&D, and BTA Insurance for employees. Your Basic Life and AD&D Insurance coverage is equal to one times your Annual Earnings, not to exceed \$1,000,000. Proof of good health is required for life insurance amounts over \$750,000. All coverage amounts reduce after you turn age 65.

CST also provides BTA coverage when you travel on business for the Company. Your BTA coverage is AD&D-style insurance and is equal to five times your Annual Earnings, not to exceed \$1,500,000. AD&D and BTA Insurance also pay benefits to you if you sustain certain covered losses, such as loss of limb or eyesight.

Supplemental Life and Voluntary AD&D Insurance

If you buy Supplemental Life and AD&D coverage for yourself, you also have the option to buy coverage for your dependents. Please note that if you do not purchase Supplemental Employee or Dependent Life Insurance coverage when you are first eligible, you will be required to provide proof of good health for any amount of coverage, except for Voluntary AD&D Insurance.

Supplemental Life Coverage for You: You may buy 1, 2, 3, 4, or 5 times your Annual Earnings, not to exceed \$500,000. Proof of good health is required for life insurance amounts that exceed 3 times your Annual Earnings or \$250,000, whichever is less.

Supplemental Dependent Life Coverage for Your Spouse: You may buy 50% of your Supplemental Life coverage, not to exceed \$100,000. Proof of good health is required for spouse life insurance amounts over \$25,000.

Supplemental Dependent Life Coverage for Your Child(ren): You may buy \$10,000 or \$25,000. Proof of good health is required for child life insurance amounts over \$10,000.

Voluntary AD&D Coverage for You and Your Spouse: You may buy 1, 2, 3, 4, or 5 times your Annual Earnings, not to exceed \$500,000. Your spouse may be covered for 50% of your Voluntary AD&D amount.

Voluntary AD&D Coverage for Your Child(ren): To select this coverage, you must elect Voluntary AD&D for yourself. Your child(ren) may be covered for 15% of your Voluntary AD&D amount if you have no spouse, 10% of your Voluntary AD&D amount if you have a spouse. Life and accident insurance provides you with financial protection in the event of a death or accident.

Choosing a Beneficiary

When you enroll for benefits, be sure to choose a beneficiary for your life and AD&D insurance on Workterra. If you choose coverage for your family, you will be the beneficiary.

During Open Enrollment

During Open Enrollment each year, you can elect Supplemental Life and Voluntary AD&D Insurance or request to increase your current coverage amount. You will be required to submit proof of good health if:

- You elect to increase your coverage by any amount,
- Your 2010 Annual Earnings increases your coverage over 3 times your Annual Earnings or \$250,000,
- Your 2010 Annual Earnings increases your spouse coverage over \$25,000,

- You increase your Dependent Life Coverage for your children from \$10,000 to \$25,000, or
- If you did not elect coverage during your initial enrollment period and are now electing coverage for 2010.

If you previously went through proof of good health in 2009 and were approved, you will not need to resubmit proof of good health for 2010 coverage as long as you do not increase your election amount.

Your Monthly Cost for Supplemental Life Insurance

Employee/ Spouse Age	Employee Rate per \$1,000		Spouse Rate per \$1,000	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 25	\$.04	\$.05	\$.04	\$.04
25-29	\$.04	\$.06	\$.04	\$.04
30-34	\$.06	\$.08	\$.06	\$.07
35-39	\$.07	\$.09	\$.07	\$.08
40-44	\$.09	\$.11	\$.07	\$.09
45-49	\$.14	\$.17	\$.11	\$.13
50-54	\$.21	\$.25	\$.18	\$.21
55-59	\$.40	\$.48	\$.31	\$.37
60-64	\$.57	\$.69	\$.52	\$.63
65-69	\$1.08	\$1.30	\$1.02	\$1.22
70+	\$1.75	\$2.10	\$1.80	\$2.02

Employee and spouse age is determined as of January 1. When your age or your spouse's age moves to a higher rate tier, your contribution will be adjusted in the January after that birthday.

Child(ren) Optional Dependent Life Rate	\$.131 per \$1,000
Employee Voluntary AD&D Rate	\$.024 per \$1,000
Family, Spouse, and/or Child AD&D Rate	\$.033 per \$1,000

Features of Supplemental Employee Life Insurance

Please note that the following features are subject to plan guidelines. Please see your plan booklet for details.

- **Portability:** If you leave CST, you can keep your coverage.
- **Accelerated Benefit:** You may receive up to 80% of your Supplemental Life Insurance (not to exceed \$500,000) if you are diagnosed with a terminal illness.
- **Waiver of Premium:** If you become disabled and are unable to work, your employee life insurance premium payments may be waived.

Calculating your cost for Supplemental Life Insurance

- Supplemental Life Insurance rates are based on your tobacco use in the past 12-month period. For example, assume an employee age 35 earns \$50,000 annually and does not use tobacco. The employee elects two times salary for a total of \$100,000 of Supplemental Life coverage.

$$\begin{aligned} \$100,000 \div \$1,000 &= 100 \\ 100 \times \$0.07 &= \$7.00 \text{ monthly} \\ \$7.00 \times 12 \div 26 &= \$3.23 \text{ bi-weekly} \end{aligned}$$

Terms to know

Proof of Good Health:

Proof of good health (also referred to as Evidence of Insurability) is required for certain employee and dependent life insurance amounts. Benefit amounts requiring proof of good health are subject to approval by the insurance company (MetLife). You must complete an evidence of insurability application and take any requested medical exams and lab tests. All requests for medical exams, lab tests, and requests for medical documents are at MetLife's expense.

Imputed Income:

The value of Company-paid life insurance coverage over \$50,000 is considered taxable income under federal tax law. This "imputed income" will be included in your bi-weekly gross income reported on your W-2 form.

Making Your Enrollment Decisions (Cont.)

Why do I need disability coverage?

Statistics show that one in five Americans age 35 will experience a disability that lasts three months or longer before age 65. In fact, workers are more likely to become disabled for 90 days or longer than they are to die.

Top five reasons to visit the EAP website:

Online tools that allow you to take a health risk assessment, create a living will, and plan for retirement.

Coach's Corner, which offers personalized coaching, tools, and resources to help you meet your diet and exercise goals.

Financial and legal resources and calculators for general finance, college planning, real estate issues, and more.

Articles about coping with family issues, improving your health through diet and exercise, and communicating effectively.

Interactive self-help programs for stress, smoking cessation, alcohol/drug issues, and depression.

Disability Benefits

Income while you are disabled and unable to work

Short-Term Disability Coverage

CST provides Short-Term Disability (STD) coverage at no cost to you. STD coverage provides benefits if you are unable to work for a limited period of time due to pregnancy or a non-occupational illness or injury.

Benefit amount: 66 2/3 of your Annual Earnings divided by 52 up to a weekly maximum benefit of \$3,500. STD benefits will be reduced by other income replacement benefits you may be eligible to receive under a state disability benefit or Social Security, if applicable. Because STD coverage is Company-paid, any benefits paid to you will be taxable.

When benefits begin: STD benefit payments begin after you have been disabled for a waiting period of seven calendar days.

How long benefits are paid: Following the waiting period, STD benefit payments continue while you are disabled, for up to 26 weeks.

Long-Term Disability Coverage

For disabilities that last longer than 180 days, CST provides Long-Term Disability (LTD) coverage, at no cost to you. Certain limitations and exclusions apply; please refer to your LTD plan booklet for details.

Benefit amount: 60% of your Annual Earnings divided by 12 up to a monthly maximum of \$10,000. LTD benefits are reduced by any other disability benefits and income-related benefits you may be eligible to receive. Because LTD coverage is Company-paid, any benefits paid to you will be taxable.

When benefits begin: LTD benefit payments begin after you have been disabled for more than 180 continuous days and after your STD benefits end.

How long benefits are paid: The maximum amount of time that LTD benefits are paid depends on your age at the time of disability and how long you continue to be disabled. Other conditions may apply.

Employee Assistance Program

Confidential support when you need it

An Overview of Your EAP

The Employee Assistance Program (EAP) gives you access to services designed to enhance your personal well-being. The EAP is available to all eligible employees and their dependents – even if they are not enrolled in a CST medical plan.

You and each of your eligible dependents receive up to eight free face-to-face counseling sessions for assessment and evaluation per issue per year. The EAP is administered by Managed Health Network (MHN). All services are confidential and no personal information is ever shared with CST.

In addition, you can receive unlimited referrals and information on a variety of matters to help you balance your work/life needs.

The EAP can assist you with:

- Emotional well-being
- Work issues
- Financial and legal issues
- Child care resources for adoption, daycare facilities, sick-child care, and summer camps
- Parenting and educational resources
- Marital, relationship, and custody issues
- Addiction and recovery
- Adult and elder support issues
- Retirement planning

Call the EAP 24/7 at 1-800-695-9355 or access online resources and information at www.members.mhn.com (Access code: cst)

Claims and Appeals

Generally, claims for benefits under the medical, dental, life, and disability plans will be administered by the appropriate claims administrator (see “Contact Information” on the back cover).

If your claim is denied, you will receive a written explanation of the denial from the appropriate claims administrator.

Claims regarding eligibility for all plans, as well as claims for benefits under the Flexible Spending Account (FSA) and 401(k) Plans, will be reviewed by the Plan Administrator (the Company). If you request a review of your eligibility claim or a claim under the FSA or 401(k) Plan, and it is denied, you will generally be notified within 60 days of the date the request is received. However, in special situations, the Plan Administrator may need an extension to respond to your request. If an extension is necessary, you will be notified of the need for an extension and the date by which the Plan Administrator expects to make a decision on your claim. For more information, please see the specific plan’s Summary Plan Description.

How to Appeal if Your Claim Is Denied

Appeals for benefits under the medical, dental, life, and disability plans will also be administered by the appropriate claims administrator as outlined in the Summary Plan Description or Evidence of Coverage (EOC).

If you submit a claim for benefits with the Company (for eligibility, FSA, or 401(k) benefits) and your claim is denied, you may file a written appeal with the Appeals Committee.

The Company has delegated an Appeals Committee to review all appeals filed with the Committee where the authority to decide appeals is not delegated to the insurance companies.

All appeals must be in writing and should indicate any related issues, comments, and reasons why you think your claim should not be denied. The review of the appeal will take into account any information you submit, even if it was not submitted or considered as part of the initial determination. To prepare your appeal, you can obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim.

The Appeals Committee meets at least quarterly. Normally, the Appeals Committee will make its final decision on behalf of the Plan Administrator no later than the date of its next meeting following the date the Plan Administrator receives your request for a review. However, if your request is filed within 30 days before the next meeting, a final decision normally will be made no later than the date of the second meeting following the date the Plan Administrator receives your request for a review.

Important Legal Information

HIPAA Privacy Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan, whether received in writing, in an electronic medium, or as an oral communication. The HIPAA privacy rules impact the Medical Plan, Dental Plan, Health Care FSA and the Limited-use Health Care FSA.

The Plan is required by law to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured Plan option, you will receive a notice directly from the insurer. It's important to note that these rules apply to the Plan, not Schneider Electric as an employer – that's the way the HIPAA rules work. Different policies may apply to other Schneider Electric programs or to data unrelated to the health Plan.

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

The Plan, or its health insurer, may disclose your health information without your written authorization to Schneider Electric for Plan administration purposes. Schneider Electric agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Employee Benefits personnel are the only Schneider Electric employees who will have access to your health information for Plan administration functions, including obtaining contribution bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan.

Use and disclosure of your health information other than as authorized under HIPAA will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. You received a copy of the HIPAA Privacy Notice in April 2008 or when you became covered under the Plan, if later.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Employee Benefit Specialists at 1-888-327-2770.

The Women's Health and Cancer Rights Act

All Schneider Electric'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
- Prosthesis 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, coinsurance and lifetime maximums that apply to any other covered medical or surgical procedures under the Medical Plan.

Special Note on Maternity and Newborn Infant Coverage

Federal law requires us to tell you that Schneider Electric medical plans can't restrict or require you to obtain certification for any length of stay in a hospital in connection with childbirth, for mother or newborn, that is 48 hours or less following a standard delivery or 96 hours following a cesarean delivery.

Also, don't forget to add your newborn to your medical coverage within 31 days unless a greater enrollment period is applicable in your state.

Important Information About Michelle's Law for Students

Effective January 1, 2010, if your child loses his or her status as a full-time student because he or she must take a leave of absence from school or change to part-time student status due to a serious illness or injury, your child will be eligible for continued group health plan coverage for up to one year from the date your child loses full-time status, unless your child's eligibility would end earlier for another reason (such as exceeding the plan's age limit). The child's physician must certify in writing that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Qualified Medical Child Support Orders (QMCSOs)

Schneider Electric will honor a qualified medical child support order (QMCSO) relating to provisions for child support, alimony payments, or marital property rights that may require you to provide medical coverage to an eligible child. If Schneider Electric receives such an order, you will be notified of how it will be handled with respect to your benefits.

Children's Health Insurance Program (CHIP) Notice

You will be allowed a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or coverage under the Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

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

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.

The purpose of this notice is to advise that the prescription drug coverage provided under the Schneider Electric plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2010. 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 2010 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.

Important Legal Information (Cont.)

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 with 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.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. 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 plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Schneider Electric has determined that the prescription drug coverage offered by Schneider Electric is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. **Because your existing coverage from Schneider Electric is Creditable 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 plan, your Schneider Electric prescription drug coverage will end. However, you will still be eligible to receive your Schneider Electric medical coverage. You will not be able to get back your 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 plan (if you are eligible for Medicare) 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 Benefit Specialists at 1-888-327-2770

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 plans 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 plans.

For more information about Medicare prescription drug plans:

- 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).

Janet A. Gallert
 Director, North America Total Rewards
 Administration
 Schneider Electric
 1415 South Roselle Road
 Palatine, IL 60067

The chart below shows the 2010 COBRA rates for each of the medical, dental and vision options. These rates include the 2% administrative fee.

	COBRA rates (2% administrative fee included)			
	EE only	EE + spouse	EE + child(ren)	EE + family
Core PPO	\$375.82	\$789.23	\$714.06	\$1,183.84
Buy-up PPO	\$407.64	\$856.06	\$774.53	\$1,284.08
EPO (HMO)	\$399.20	\$838.32	\$758.48	\$1,257.48
High Deductible Health Plan (HDHP)	\$324.93	\$682.36	\$617.38	\$1,023.54
Kaiser HMO (California only)	\$393.58	\$865.86	\$708.43	\$1,220.07
Anthem Blue Cross HMO (California only)	\$412.95	\$908.54	\$743.37	\$1,280.23
Health Advantage HMO (Arkansas only)	\$438.91	\$783.77	\$1,175.65	\$1,371.60
Core Dental	\$30.90	\$64.89	\$58.71	\$97.34
Buy-up Dental	\$35.76	\$75.10	\$67.94	\$112.65
Vision	\$5.97	\$12.41	\$11.24	\$16.59

Contact Information

Benefit	Carrier	Phone	Web address
Medical	Blue Cross and Blue Shield of Illinois (BCBSIL)	1-877-557-3417	www.bcbsil.com To find a provider: www.bcbsil.com/sena/provider_finder
Medical and Prescription Drug	Anthem Blue Cross HMO (California only) (Group # 165203)	1-800-227-3613	www.anthem.com/ca
	Health Advantage HMO (Arkansas only) (Group # 150004)	1-800-843-1329	www.healthadvantage-hmo.com
	Kaiser Permanente HMO (California only) (Group # 25814-N. CA, 107543-S. CA)	1-800-464-4000	www.kaiserpermanente.org
Prescription drug (for medical options administered by BCBSIL)	Express Scripts	1-888-772-5181	www.member.express-scripts.com/preview/schneiderelectric2010
Dental	Delta Dental of Illinois	1-800-323-1743	www.deltadentalil.com
Vision	OptumHealth Vision	General: 1-800-638-3120 Provider locator: 1-800-839-3242	www.myoptumhealthvision.com
Flexible Spending Accounts	Employee Benefit Specialists	Debit card hotline: 1-800-327-3539 Customer service: 1-888-327-2770 Fax: 1-925-460-3929	www.mytakecareplan.com (FSA debit card) www.ebsbenefits.com (account balance) custserv@ebsbenefits.com (email)
Life/AD&D (Group # 123365)	MetLife	1-800-638-6420	www.metlife.com
Business Travel Accident	Chubb	N/A	N/A
Managed Health Network	EAP	1-800-695-9355	www.members.mhn.com Access code: cst (lower case)
Health Savings Account	PayFlex (UMB Bank, n.a.)	1-866-520-4472	www.mypayflex.com



This guide has been prepared to help you understand what benefits you may be entitled to under benefit plans sponsored by the Company. Please keep this guide with your other Plan materials to be sure you have all of your benefit information at hand. The official Plan documents will control in the case of any differences between them and the information provided here. While the Company expects to continue its benefit programs, it reserves the right to terminate, suspend, withdraw, amend or modify all or any part of these Plans at any time without notice. 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 or future retirees and their dependents as determined under the Plans. No supervisor, manager or any other representative of the Company has any authority to enter into any oral agreement contrary to the foregoing or contrary to the terms of any Summary Plan Description (SPD) or applicable Plan document.

Schneider Electric

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