WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUNDS

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NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION-WISCONSIN CHAPTER

December 10, 2010

Dear Participant:

This Summary of Material Modifications summarizes changes for the **Wisconsin Electrical Employees Heath and Welfare Plan** (the "Plan") that the Trustees have adopted, based on requirements of the Patient Protection and Affordable Care Act ("PPACA") (health care reform) and changes in the tax rules governing your (FLEX) Health Reimbursement Account ("HRA") under IRS Notice 2010-59. This Summary of Material Modifications also provides a clarification on the coverage of Specialty Drugs under the Plan. You should keep this notice, which is intended as a summary of material modifications, with your Summary Plan Description ("SPD") for future reference.

1. Eligibility for dependent children **after** the end of the calendar year in which the child reaches **age 19** has been amended effective January 1, 2011 to extend coverage for a natural child, adopted child or a child placed for adoption, through the month ending in which the child turns age 26.

2. Eligibility for dependent children **after** the end of the calendar year in which the child reaches **age 19** has been amended effective January 1, 2011, to extend coverage for Stepchildren, Foster Children or a child whose custody is court ordered, through the month ending in which the child turns age 26 provided the child continues to meet current support and residency requirements and has no other coverage available to them.

   *** (If you have a child who is **not already covered** on the Plan that meets the definition above under #1 or #2 and you would like to add the child on the Plan as your dependent **please complete and return the enclosed form no later than January 31, 2011 for coverage to take effect January 1, 2011**.)

3. The $2,000,000 aggregate lifetime limit on benefits has been eliminated effective January 1, 2011.

4. Effective January 1, 2011, the $500 Lifetime maximum on Diabetes Counseling and Education has been eliminated. Services for Diabetic Counseling and Education will be covered under the medical plan subject to In-Network and Out-of-Network Copayments and Deductibles.

5. Effective January 1, 2011, the current $35,000 per person lifetime dollar limit on Gastric Bypass Surgery has been amended to one procedure per lifetime. This benefit will continue to be subject to usual and customary, medical necessity and other plan conditions.

6. The $1,500 annual limit has been removed for Basic and Major Dental Services effective January 1, 2011 **only for eligible children through the end of the calendar year in which the child reaches age 19.**

7. The $300 annual limit for Vision Services has been removed effective January 1, 2011 **only for eligible children through the end of the calendar year in which the child reaches age 19**. Eligible children are entitled to one Vision exam and their choice of one set of Glasses, Standard Lenses and Frames (**OR**) one set of Non-Disposable Contact Lenses (**OR**) a one year supply of Disposable Contact Lenses, per calendar year.

8. Effective January 1, 2011, the $450 per person annual limit on Preventive Care Benefits has been eliminated only for services provided by **In-Network** Providers. (Note: the $450 per person annual limit for Preventive Care Benefits remains in effect for services provided by Out-of-Network Providers.)

9. Effective January 1, 2011, the $25,000 per 60-month period limit for Prosthetic Devices covered by the plan has been amended to a limit of one Device per limb, etc. per 60-month period plus any adjustments.

10. Effective January 1, 2011, the plan has been amended to remove pre-existing condition limitations for eligible individuals under age 19.

11. Effective January 1, 2011, the initial treatment for an accidental injury or life threatening medical emergency will be covered at the In-Network level when the diagnosis meets Medical Emergency guidelines. Medical Emergency is a condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. (Please Note: Follow-up care or routine care for minor medical problems such as headaches, colds, slight fever and back pain are not considered emergency care for these purposes, even if provided at an emergency room.)

12. The current limits of $1,400 under Plan 1 and $800 under Plan 2 (Catastrophic) per person per calendar year on outpatient treatment of Substance Abuse have been removed. Outpatient Substances Abuse Services will be paid as Medical Benefits subject to applicable deductibles and In-Network or Out-of-Network copayments effective January 1, 2011.

13. The current $7,000 per person annual limit for Inpatient Care for Substance Abuse has been removed. Inpatient Care for Substance Abuse Services will be paid as medical benefits subject to applicable deductibles and In-Network or Out-of-Network copayments effective January 1, 2011. (Please note: the annual 30-day inpatient limit and 60-day limit for partial hospitalization for Substance Abuse remains in effect.)

14. Effective January 1, 2011 the $10,000 per person annual limit on Prescription Drugs has been amended and improved to state that once the Plan has paid out $10,000 in a calendar year on a person for pharmacy benefits, future pharmacy costs will be shared equally between the Plan and the eligible person for the remainder of the calendar year. (Note: High Cost Injectible Drugs remain covered under the Medical Plan subject to the same 30% copayment)

15. **New Requirements for (FLEX) HRA Reimbursement of Over-The-Counter Medications On and After January 1, 2011.** The Internal Revenue Service ("IRS") recently revised the definition of medical expenses for employer-provided health plans (see IRS Notice 2010-59 for additional information). The change affects how the Plan may reimburse expenses under your HRA.

    The HRA **may only reimburse you** for expenses that you incur on or after January 1, 2011 for over-the-counter medications (e.g., aspirin, cough medicine) **if you have a prescription**. The new rule requiring a prescription for over-the-counter medications does

not apply to insulin. It also does not apply to items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. "Prescription" for over-the-counter medications means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state where the medical expense is incurred and is written by an individual who is legally authorized to issue a prescription in that state.

Expenses you incur for over-the-counter drugs without a prescription before January 1, 2011 may be reimbursed in accordance with the HRA claims procedures.

16. Coverage of **Specialty Drugs** dispensed after October 26, 2010. The Plan will cover specialty medications (as determined and pre-authorized by the Plan's pharmacy network provider, SavRx) only for uses or diagnoses for which the medication has been approved by the FDA (U.S. Food and Drug Administration). Coverage of these medications for non-FDA approved uses will be denied. The list of these medications may be revised from time to time. Contact the Plan Office if you have any questions concerning this provision.

If there is a discrepancy between the wording in this Summary of Material Modifications and the Plan document, the Plan document language will govern. The Trustees reserve the right to amend, modify, or discontinue all or part of the Plan at any time.

If you have any questions about this information please contact Bonnie or Art at the Plan Office at 608-276-9111 or 800-422-2128.

Sincerely,

Art Bishop

Art Bishop
Administrator