Michigan Electrical Employees' Health Plan
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www.meehp.com

IMPORTANT NOTICE ABOUT SIGNIFICANT PLAN IMPROVEMENTS

July 2011

To All Eligible Active Employees and Retirees Not Eligible for Medicare and Their Dependents:

This notice describes several improvements to your Health Plan effective September 1, 2011. These changes include coverage to age 26 for dependent children (enrollment form enclosed), changes in the Plan's lifetime limits and increased benefits for mental/nervous disorders and substance abuse. These changes are the result of the Patient Protection and Affordable Care Act and the Mental Health Parity and Addiction Equity Act of 2008. Please read this notice carefully and keep it with your Summary Plan Description (SPD) booklet for future reference.

AGE LIMIT FOR CHILDREN INCREASED

The Plan's definition of an eligible dependent child is changing as follows **effective September 1, 2011:**

- Your eligible children can remain covered through age 25 (until the end of the month in which their 26th birthday occurs).
- Eligible children are not required to be students in order to remain covered under the Plan.
- The residency, financial dependence and marital status of a child under age 26 will not affect eligibility.
- If your child is married and is an eligible dependent, his or her spouse is not an eligible dependent regardless of age.

To Enroll a Child - Children of eligible employees who lost coverage, or who were never covered due to their failure to satisfy the Plan's previous definition of a dependent child, and who would meet the new definition as of September 1, 2011, can enroll for coverage using the enclosed enrollment form. Plan coverage for a newly enrolled child will start on the day the child first meets the eligibility requirements but not before September 1, 2011. This special enrollment opportunity applies to:

- Dependents whose coverage under the Plan has already ended or who are receiving COBRA coverage;
- Dependents who were previously denied coverage under the Plan; or
- Dependents who were not previously eligible to enroll in the Plan

because eligibility for dependent coverage under prior Plan provisions ended before the dependent reached age 26.

Please return the enrollment form enclosed with this notice by August 26, 2011 to help prevent claim processing delays and to avoid the potential disallowance of claims for failure to enroll on a timely basis. Plan coverage for a newly enrolled child will start on the day the child first meets the eligibility requirements, but not before September 1, 2011. If the child has not been covered by the Plan in the past, you must submit proof that he or she meets the Plan's new definition of dependent (see the enclosed enrollment form for type of proof needed).

If the child has not been covered by the Plan in the past, you will be required to submit proof that he or she meets the Plan's new definition of a dependent.

New Definition of 'Dependent' - Because of the changes described above, the Plan's definition of "dependent" has been restated effective September 1, 2011 to read as follows:

DEPENDENT - An individual who is:

1. Your spouse, provided you are not divorced or legally separated under a decree of separate maintenance.
2. Your child until the last day of the month of his or her 26th birthday.
3. Your unmarried, disabled child who is age 26 or older and who: (a) is dependent on you for more than half of his or her annual financial support; (b) is incapable of self-support due to mental retardation, mental incapacity or physical handicap; (c) became disabled while covered under the Plan and while a dependent; (d) remains disabled; and (e) has the same principal residence as you for more than half the calendar year except for temporary absences under special circumstances such as educational reasons or, alternatively, is not considered to be a "qualifying child" of the employee or another taxpayer. If a child meets all of these conditions, he will be covered under the Plan as long as you remain eligible. If you or your spouse apply for Social Security benefits, you should request Medicare coverage for your disabled child. If approved, and after the applicable waiting period for Medicare coverage, this Plan's benefits for the child will be coordinated with Medicare until you become covered under the Supplement to Medicare. At that time, the child will also be covered under the Supplement to Medicare Benefit, subject to the eligibility rules that apply to the Supplement to Medicare. The child must be a citizen or national of the United States or a resident of the United States, Canada or Mexico. This provision does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as you, is a member of your household and you are a citizen or national of the United States.

For purposes of the Plan's definition of dependent, the term "child" includes your natural child, your legally adopted child or a child placed with you for adoption, and your stepchild.

The Plan will also cover your child for whom the Plan is required to provide benefits in accordance with a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice, or if you are required by a domestic relations order or other court order to provide primary health benefits for the child. If you would like a copy of the Plan's procedures for determining whether a support order will be recognized, please contact the Plan Office.

In their sole discretion, the Trustees may require an employee to submit acceptable proof that a child is a dependent before a claim for the child will be processed. Please contact the Plan Office within 30 days of the birth or adoption of the new child.

If an adult child has other coverage - If your adult child has other group coverage the following will determine the order in which the plans will pay:

A plan covering an employed child will be primary over a plan covering the child as a dependent. If the child is married, the plan covering the child as an employee will pay first, the plan covering the child as a spouse will pay second, and the plan covering him as a dependent child will pay third.

Note: When a plan pays first, it pays its full benefits. When a plan pays second, it reduces its benefits so that the total paid by both plans does not exceed 100% of the allowable expenses on the claim. A plan that pays third will only pay benefits if there are unpaid allowable expenses after the first and second plans have paid.

If your child works for a contributing employer and is eligible under the Plan as an employee, the child will not be considered a dependent.

BENEFIT IMPROVEMENTS

Effective September 1, 2011:

- **Lifetime Benefit Limit Removed -** The $5,000,000-per-lifetime overall maximum applicable to the medical plan is being removed. In its place there will be a $5,000,000 per-person limit applicable to all covered expenses incurred for essential benefits during a calendar year.

  Note: The $5,000,000 limit applies to all expenses a person incurs during a calendar year, even if there was an interruption in coverage or change in status, for example, from a dependent to an employee.

- **Transplant Limit Removed -** The $1,000,000-per-transplant limit for covered transplants is also being removed. Benefits for covered transplants will only be subject to the overall annual maximums described above and other applicable Plan provisions.

INCREASED BENEFITS FOR MENTAL/NERVOUS DISORDERS AND SUBSTANCE ABUSE

Covered expenses on and after September 1, 2011 for mental/nervous disorders and substance abuse will be paid the same as other covered medical expenses. The current limits on days and visits will no longer apply, nor will the dollar limit on outpatient treatment of substance abuse. In addition, your coinsurance amounts will count towards meeting the Plan's out-of-pocket limits and will be paid at 100% if the your out-of-pocket limit has been reached. However, costs for the treatment of mental/nervous disorders and substance abuse will be applied to the overall annual maximum dollar limit described in the previous section.

Covered expenses in excess of the calendar year deductible will be paid at the regular 80% PPO and 70% non-PPO payment percentages, or at 100% if the person's out-of-pocket limit has been reached. Remember: All percentages are based on the BCBS-approved amount.

Additionally:

- Pre-certification will apply to services for mental/nervous disorders and substance abuse only to the same extent that it does for medical/surgical services. Pre-certification is required for inpatient admissions, but not for outpatient treatment or office visits.
- The extension of major medical benefits described on page 40 of the Summary Plan Description booklet *will* apply to these conditions.
- "Substance abuse" is defined in the Plan as "alcoholism, alcohol abuse, drug addiction, drug abuse, or any other type of addiction to, abuse of, or dependency on any type of drug, narcotic or chemical, except nicotine."

NO PREEXISTING CONDITION LIMITATION FOR INDIVIDUALS UNDER AGE 19

The Plan's preexisting condition exclusion will not apply to individuals age 0-18 on or after September 1, 2011. (The preexisting condition exclusion only applies to non-bargaining unit employees and employees earning early eligibility.)

BREAST PUMPS COVERED UNDER SPECIAL FUND

Due to a recent IRS ruling, breast pumps and other lactation supplies will now be covered under the Special Fund program. This change is effective for claims incurred on or after January 1, 2010.

REQUIRED NOTICES

Notice Regarding Grandfathered Status

The Trustees of the Michigan Electrical Employees' Health Plan believe that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to cover preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Michigan Electrical Employees' Health Plan at 6011 W. St. Joseph, Suite 401, Lansing, MI 48917, telephone 1-517-323-9250. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice Regarding Removal of Lifetime Limit

The lifetime limit on the dollar value of benefits under the Michigan Electrical Employees' Health Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment. Coverage will begin effective as of September 1, 2011 and will not be retroactive to the date you originally lost coverage. If you or your dependent do not enroll within the 30-day period, you or your dependent will not later be able to enroll in the Plan unless there is a HIPAA special enrollment event. For more information contact the Plan Office at 6011 W. St. Joseph, Suite 401, Lansing, MI 48917, telephone 1-517-323-9250.

Prohibition of Retroactive Rescissions

Effective September 1, 2011, the Plan will not retroactively rescind the coverage of benefits provided under the medical and prescription drug components of the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or persons seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan, and in other instances that may be prescribed under guidance from the Internal Revenue Service. For example, failing to timely inform the Fund in the event of a divorce is an intentional misrepresentation of material fact. For purposes of the Plan, a rescission means a cancellation or discontinuance of Plan coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance is attributable to a delay in administrative recordkeeping if the employee does not pay any premiums for coverage after termination of employment. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contribution toward the cost of coverage. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage is effective retroactively to the date of divorce. The Plan is required to provide at least 30 days advance written notice to each Participant who is affected by a rescinding of coverage before the coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group. A rescission is also a type of adverse benefit determination of a health plan claim as defined under the U.S. Department of Labor Regulations.

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This Notice is a summary of material modifications which contains only highlights of recent Plan changes. If there is a discrepancy between this Notice and the Plan document, the terms of the Plan document will govern.

Please contact the Plan Office if you have any questions regarding your benefits.