Summary Plan Description

HEALTH AND WELFARE BENEFITS
RETIREES

BeWell4Life
Your Guide to Health & Wealth

Johnson Controls

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INTRODUCTION

The Retiree Program has been designed to include medical, prescription drug and life insurance benefits for eligible employees of Johnson Controls, Inc and certain affiliated employers after they retire. Just as with the program that covers you while you are an active employee, the Retiree Program is designed to provide comprehensive coverage. This is your Summary Plan Description (SPD) for the Retiree Program. It describes in easy-to-understand language the plans that make up the program.

In addition, the Benefits-at-a-Glance is also intended to supplement the Summary Plan Description. The Benefits-at-a-Glance describes in more detail the benefits that are described in the Summary Plan Description.

If you have questions on the information provided in this booklet, please contact the Johnson Controls Benefits Service Center at 866-496-1999.

The benefits described in this Summary Plan Description are applicable for employees who retired on or after March 1, 1994 and eligible York International retirees regardless of the date of retirement.

WHO IS ELIGIBLE TO PARTICIPATE

The following groups are eligible for the Retiree Program:

- Generally, all Johnson Controls, Inc. (and certain other affiliated employers) full-time or part-time, regular salaried employees hired before January 1, 2006 by Automotive, Power Solutions, Corporate, Building Efficiency including Global Workplace Solutions* (GWS North America)
- Power Solutions non-union hourly employees hired before January 1, 2006 at designated locations;(Contact the Benefits Service Center for more information regarding eligible locations.)
- Automotive Experience salaried employees at the Holland MI location who were active employees as of January 1, 2006
- Technotrim employees hired before January 1, 2006 who retired on or after January 1, 2005
- Building Efficiency O&M employees assigned to work on a contract entered into by the Company before April 1, 2001
- Employees who transferred from Johnson Controls or any of its affiliates to Johnson Controls Federal Systems or any of its affiliates who were covered under this program as of the date of transfer and were actively employed on or after December 31, 2012
- Security Systems, LLC employees who were employed as of October 2, 2001 by Scientech Inc. when Johnson Controls, Inc. acquired that company
- USI employees who were employed as of December 31, 2005 who transferred to Johnson Controls, Inc. on January 1, 2006
- Sagem, Inc. employees who retired on or after August 1, 2002 or who were enrolled in the Sagem Inc. retiree benefits program as of July 31, 2002
- Effective January 1, 2007, active and retired employees covered by the York International Retiree Benefits Program; eligibility for the Johnson Controls Retiree Program will be extended to York salaried and certain non-union hourly employees who meet the following requirements as defined under the York Retiree Program (refer to the summary plan description for the York Retiree Program for specific details):
  - hired by York International before January 1, 1993
  - meet the age and service requirements
  - belonged to certain designated groups of employees
  - if applicable, covered by a bargaining agreement that called for participation

Refer to the Participation section described later in this SPD for additional requirements.

*See exceptions to covered GWS employees as noted under "Excluded Employees" later in this section.

Excluded Employees

You are not eligible for the Retiree Program if you are covered by other company – or affiliate – sponsored plans or if you are represented by a collective bargaining agreement and your agreement does not call for your participation.

In addition, the following groups of employees are excluded from the Retiree Program:

- Employees in the eligible groups hired, rehired or transferred to the eligible group on or after January 1, 2006 (except as noted under Who Is Eligible To Participate section of this Summary Plan Description)
- GWS North America Account Level employees (other than those employees designated as GWS Customer Business Directors or Managers, Headquarters employees, or part of the Projects or Real Estate line of business) or employees covered under the Account Level Benefits Program
- O&M employees assigned to work on a contract entered into by the Company after April 1, 2001
- Non-union and union hourly employees of Johnson Controls or any of its affiliated employers (except for those eligible groups of employees as described under the Who Is Eligible To Participate section of this Summary Plan Description)
- Employees who transfer to the U.S. from a non-U.S. location to work under an expatriate assignment
- York International Corp. salaried and non-union hourly employees who were hired, transferred to the eligible group or acquired by York International Corp. on or after January 1, 1993 as defined under the prior York International Retiree Benefits Program

YOUR PARTICIPATION

To qualify for retiree benefits when you retire, you must meet the following conditions:

- You must retire from active employment at age 55 or older with 10 or more years of vesting service (as defined by the pension plan or under the York International Retiree Benefits Program) and receive pension benefits from the pension plan on the first of the month coincident with or following the date you leave the Company.
- Disabled employees are eligible to participate provided they have completed 10 years of vesting service prior to the date they became disabled and retire due to disability after reaching age 55.

COVERAGE

Medical, Dental and Vision Plans

Medical coverage is available to you, your spouse or domestic partner and your eligible dependent children who are covered under a company-sponsored medical plan immediately prior to your retirement.

As you or your spouse or domestic partner reach age 65, you or your spouse or domestic partner will automatically be enrolled in the Retiree Major Medical Supplement Plan. Your eligible dependent children will continue coverage under the pre-65 medical plan.

Dental and vision coverage end at retirement for you and your dependents. You may continue coverage under COBRA (if applicable), as described in the Summary Plan Description for active employees.

Life Insurance

Your Basic and Optional Life and AD&D, Optional Employee and Dependent AD&D and Dependent Life insurance end at retirement. You may be able to convert/port your insurance within 31 days following your date of retirement. You will be notified by the Benefits Service Center about the options available to you. Information about converting

and porting your active coverages can be found in your Summary Plan Description that covers your active life insurance benefits. Contact the Benefits Service Center if you have questions.

You may be eligible for Retiree Life Insurance. Refer to the Retiree Benefits-At-A Glance document included in your retiree enrollment kit to determine your eligibility for this benefit. Refer to the Life Insurance section of this Summary Plan Description for more information.

ENROLLMENT

You will receive enrollment information from the Benefits Service Center prior to your retirement. An enrollment worksheet is included and contains information about enrolling, the coverage available, the costs for continuing coverage, and payment options. To enroll for coverage or to elect having your premium payments deducted from your checking or savings account (direct debit), you can go to the Your Benefits Resources website at resources.hewitt.com/jci or contact the Benefits Service Center at 1-866-496-1999 for assistance.

MEDICAL

To be covered by retiree medical coverage (including prescription drugs), you must enroll yourself (and your eligible dependents, if applicable) within 31 days of your retirement. If you do not enroll within 31 days, you will not have medical coverage. In the event you waive retiree medical, you will not be eligible for retiree medical (including prescription drugs) at a later date. When you apply for retirement you will be provided with a retiree enrollment kit. If you have questions or do not receive this kit contact the Benefits Service Center at 1-866-496-1999.

LIFE INSURANCE

If you qualify, you are automatically covered under the Retiree Life Insurance Plan. The Benefits-at-a-Glance included in your enrollment kit will indicate if you are eligible for retiree life insurance and will describe the amount of coverage available. York International employees who retired and enrolled in retiree life insurance before December 31, 2006 will continue the retiree life insurance coverage they are enrolled in as long as they continue to pay any required premiums (if applicable).

COST

Pre-65 Coverage for Retirees.

Retirees pay a percentage of the total cost depending on years of benefit service (as defined by the pension plan) at retirement. The Company pays the remainder of the premium, subject to a monthly "cap." Retirees pay 100 percent of the premium amount above the cap. Please refer to the Benefits-at-a Glance for the table showing the cost-sharing arrangement.

Post-65 Coverage for Retirees.

The Company pays 100 percent of the total cost for the Retiree Major Medical Supplement Plan up to a monthly capped amount. The cap is $420 per month for couple coverage or $210 per month for single coverage. Retirees pay 100 percent of the premium above the cap amount.

Life Insurance

If you are eligible for Retiree Life Insurance coverage, generally the Company pays the full cost of coverage. (In some cases, monthly premiums are charged for coverage under prior plan rules. Refer to your monthly billing for the amount due.) Contact the Benefits Service Center for further information.

MONTHLY PAYMENTS

Once you enroll for coverage, you will be billed monthly. Your bill will include instructions on how to remit your monthly payments and the date payments are due.

You also have the option of electing to have your premium payments deducted from your checking or savings account (direct debit). You can elect direct debit when you enroll for coverage or at any time thereafter by logging on to the Your Benefits Resources website at resources.hewitt.com/jci or contacting the Benefits Service Center at 1-866-496-1999.

If payments are not received in a timely fashion then coverage will be cancelled and a notice of cancellation will be mailed.

SITUATIONS AFFECTING YOUR RETIREE BENEFITS

DEATH

If you die while your spouse or domestic partner and dependent children are covered under the Retiree Medical Plan, your spouse or domestic partner and dependent children can continue coverage as described below.

Your spouse's or domestic partner's retiree medical coverage may be continued under the same medical plan he or she is enrolled in at your death by paying any required contributions until the earlier of the date your spouse or domestic partner:

- Remarries or enters into a new domestic partner relationship, or
- Becomes eligible to enroll in coverage under another group medical plan.

If your spouse or domestic partner is under age 65, at the time of your death, coverage continues in the pre-65 medical plan until he or she reaches 65. Upon reaching age 65, your spouse or domestic partner will automatically be enrolled into the Retiree Major Medical Supplement Plan (if your spouse or domestic partner had continuous coverage in the Company pre-65 Retiree Medical Plan)

If your spouse or domestic partner is age 65 or older at your death, his or her coverage will continue under the Retiree Major Medical Supplement Plan by paying any required contributions. Claims incurred by your spouse or domestic partner after your death (including prescription drug claims) will need to be filed under his or her Social Security number.

Your eligible dependent children may continue the same medical coverage they are enrolled in at your death while they are considered dependents, are not eligible for another group medical plan and as long as the required contributions are paid.

In the event of your death, the Benefits Service Center will notify your eligible dependents about the new premiums. If your surviving spouse or surviving domestic partner or your eligible dependent children do not continue to pay the required contributions upon eligibility, coverage will cease and cannot later be reinstated.

As an alternative, if you die while your spouse and dependent children are covered under a retiree medical plan , your spouse and your children (but not your domestic partner or your domestic partner's children) can continue coverage under COBRA instead of the Retiree Program (see Administrative Information section for more information).

TRANSFERS

If you transfer out of the eligible group of employees at any time in the future, you will not be eligible for the Retiree Program even if you retire from active employment under a company pension plan and have the required age and service at the time you retire.

STATUS CHANGES

A qualifying family status change allows you to drop your dependents from coverage under the health plan. Status changes can only be made under certain circumstances. Also, the change must be requested within 31 days after the date of the event in order for the change to be effective retroactive to the date of the event. The company does not refund premiums you paid for coverage that ceased prior to the date you make an election change.

The following events allow you to drop dependents from medical coverage:

- Annulment of retiree's marriage
- Retiree's divorce
- Retiree's legal separation
- Termination of domestic partnership
- Death of a spouse, domestic partner or dependent child
- Your spouse, domestic partner or dependent child becomes eligible for other coverage
- Your dependent child no longer meets the definition of a dependent under the terms of the company plan. You may cancel your or your dependents enrollment at any time without a qualifying family status change, but if you do so, you and/or your dependents may not re-enroll in the Retiree Program at a later date. The Company does not refund premiums you or your dependents paid for coverage that was in effect prior to the date you make an election change.

If you have questions about how your benefits may change if one of these events occurs, contact the Benefits Service Center at 1-866-496-1999.

MEDICAL PLANS

ELIGIBILITY

If you and your eligible dependents are covered under a company-sponsored medical plan (including prescription drugs) at the time you retire, you may elect to continue medical coverage for yourself and your eligible dependents under this plan or, instead you may choose to exercise your rights under COBRA. If you elect to continue coverage under COBRA, please refer to your Summary Plan Description for active employees for more information about COBRA coverage. (Contact the Johnson Controls Benefits Service Center at 1-866-496-1999 to obtain a copy of the SPD.) This Summary Plan Description describes the retiree medical coverage only.

DEPENDENTS

You may cover your eligible dependents under some of the plans as described below:

Medical

- **Your spouse** – the person to whom you are legally married under federal law including your common law spouse, if applicable in your state.
- **Your domestic partner** – same-sex domestic partners are considered eligible dependents in all states; if you reside in California, certain opposite-sex domestic partners are eligible dependents. You and your partner are considered domestic partners, if for at least six months before you add your partner as a dependent, you and your partner are:
  - Are at least age 18
  - Are not legally married to another person or part of another domestic partner relationship
  - Intend to remain each other's sole domestic partner indefinitely
  - Reside together in the same principal residence and intend to do so indefinitely

- Are emotionally committed to one another and share joint responsibilities for your common welfare and financial obligations
- Are not related by blood closer than would prohibit marriage in the state in which you live
- Are mentally competent to enter into contracts

- If the above definition does not apply and you live in California, you and your partner are domestic partners if you:
  - Filed the applicable declaration or statement of domestic partnership with your state, county or city registry; and
  - Have not filed a notice of termination of the domestic partnership.

  Please note: Domestic partner medical coverage became available to employees who retired on or after February 1, 2011 and whose domestic partner was an insured dependent under the company-sponsored medical plan at the time the employee retired.
- **Your children** until the earlier of (1) the child's turning age 26; or (2) the child's eligibility for medical coverage through his/her employer; or age 26 or older, if your child is considered mentally or physically disabled, but only if the disability began prior to age 19 and has continuously existed since then.

  To qualify as mentally or physically disabled, a dependent child must be unable to earn a living and must depend on you for support.

  To continue coverage beyond age 26, you must provide proof that the child became mentally or physically disabled prior to attaining age 19 and has been continuously mentally or physically disabled since that time. Such proof must be provided within 31 days of the child attaining age 26. Failure to provide this proof of disability will result in coverage automatically terminating on the child's 26th birthday. Your dependent will no longer be eligible for coverage if and when the disability ceases. You must notify the Company when your child is no longer considered mentally or physically disabled as defined earlier in this section. You may be required periodically to provide proof of continued disability. Please call the Benefits Service Center at 1-866-496-1999 for additional information about providing proof of your child's disability.
  Children include your:
  - Natural children
  - Legally adopted children or children placed with you for adoption. A child is considered to have been placed for adoption on the date you assume legal obligation for full or partial support of the child(ren) in anticipation of the formal adoption
  - Foster children
  - Stepchildren or domestic partner children
  - Children for whom you are a court appointed permanent guardian provided the:
    - Child's parents are not living, cannot be located or refuse to support the child; and
    - Child is dependent on you for more than 50 percent of their support

Dependents acquired after you retire are not eligible for retiree medical coverage; also, you may not change to family coverage at a later date if you elected single coverage at retirement.

Please note: Dependent children who were covered dependents as of January 1, 2011 are subject to the eligibility rules described in this summary plan description. Dependent children who were no longer covered dependents as of January 1, 2011 are subject to the rules in effect prior to this date.

LIFE INSURANCE

You may be eligible for Retiree Life Insurance. Refer to the retiree Benefits-At-A Glance document included in your retiree enrollment

kit to determine your eligibility for this benefit. Your active life insurance ends at your retirement. You may be eligible to convert/port coverage within 31 days following your date of retirement. Refer to the Life Insurance section of this Summary Plan Description for more information.

TYPES OF MEDICAL COVERAGE

If you elect retiree medical coverage you are not eligible for duplicate coverage under COBRA. If you are in a plan that is not available as a retiree, you can continue coverage under COBRA but you are not eligible for retiree medical coverage at a later date. Highlights of the available medical plans for retiree coverage are shown on the Benefits-at-a-Glance.

PRE-65 COVERAGE (BETWEEN AGES 55 AND 65)

You and your insured dependents may continue pre-65 retiree medical (includes prescription drugs) coverage in the plan offered at the time you retire. (Refer to the Benefits-at-a-Glance document for the plan available.) Coverage is available for you and your spouse or domestic partner until you each attain age 65, and for your eligible dependent children until they no longer qualify as a dependent.

As you and your spouse reach age 65, you will automatically be enrolled in the Retiree Major Medical Supplement Plan, which is intended to supplement Medicare. Contact the Social Security Administration to enroll in Medicare Part A and B. Your eligible dependent children may continue coverage under the pre-65 Retiree Medical Plan in which you were previously enrolled.

RETIREE MAJOR MEDICAL SUPPLEMENT PLAN (AGE 65 OR AFTER)

Coverage is available under the Retiree Major Medical Supplement Plan for you and your spouse or domestic partner if you or your spouse or domestic partner are 65 or older at your retirement. Your eligible dependent children may continue coverage under the Retiree Medical Plan option available for pre-65 coverage. This coverage also replaces the pre-65 Retiree Medical Plan when you or your spouse or domestic partner turn age 65 (as long as you or your spouse or domestic partner were insured under pre-65 coverage at the time either of you become age 65).

The Retiree Major Medical Supplement Plan extends similar coverage and provisions outlined under the pre-65 coverage (except precertification by Utilization Management).

This plan will pay covered expenses at 80 percent after a $100 annual deductible is applied separately for you and your spouse or domestic partner. A lifetime maximum of $50,000 per person begins to accumulate after you are eligible for the plan (age 65). Prescription drugs are included in the lifetime maximum. The lifetime maximum can not be reinstated.

MEDICARE PART A AND B

ENROLLMENT

Because coverage for retirees and spouses or domestic partners, age 65 and over, is a supplement to Medicare, enrollment in Medicare is required to ensure you receive the maximum benefits allowed under both Medicare and the Supplement Plan. Enrollment in Medicare Part A and B should be completed prior to turning age 65. You and your spouse or domestic partner must contact the Social Security Administration 90 days in advance of retirement, or prior to age 65 if you will turn age 65 after you retire, to enroll in Medicare Part A and B.

Claim Coordination

Since Medicare is your primary medical coverage, all expenses incurred should first be submitted to Medicare and then to the

Supplement Plan's claims administrator. Once you have received the Medicare statement, either you or your provider should submit the itemized medical bill, with a copy of the Medicare statement, directly to the Retiree Medical Plan's claims administrator. The calculation for payment is based on the amount Medicare has not paid less:

- The plan deductible,
- Any items excluded by the medical plan, and
- Any expenses paid under other group coverage.

Example

Assume you incur covered expenses of $10,000 in a year. Medicare pays $8,000 toward the total. The amount paid by the Supplement Plan is computed as follows:

	Covered Expenses	$10,000
Less:	Medicare Payment	- 8,000
	Remaining Expenses	$2,000
Less:	Your Deductible	- 100
		$1,900
Less:	Your coinsurance (20%)	- 380
	Supplement Plan Payment	$1,520

MEDICARE ENROLLMENT PART D (OPTIONAL)

Enrollment in Medicare Part D prescription drug coverage is optional. If you are age 65 or over and you enroll in Medicare Part D, you and your covered spouse or domestic partner will no longer be eligible for medical and prescription drug coverage from the Company's Retiree Major Medical Supplement Plan. You may choose to enroll in Medicare Part D, or retain your Company retiree plan, but not both. If however, the reason you enroll in Medicare Part D is because you have exhausted your $50,000 lifetime maximum, your spouse or domestic partner may continue coverage until the earlier of the date they have exhausted their lifetime maximum or they enroll in Medicare Part D.

MEDICAL SERVICES THAT ARE COVERED

Most preventive care, hospital care, surgical procedures and emergency services are covered medical services. Some medical services may require Utilization Management. See "Utilization Management" later in this section for additional information.

If you question whether a treatment, service or supply is covered, you should call your claims administrator at the number listed on your medical ID card.

The following is a list of the types of services that are generally covered by the medical plans: (However certain restrictions and limitations may apply. Please see "Medical Services That Are Not Covered" for more information.)

PREVENTIVE CARE

- Adult preventive care, age 19 and older, including routine care such as physical exams and Pap smears
- Well-baby and well-child care for children age 18 and younger, including office visits, immunizations, lab and diagnostic tests

OTHER COVERED SERVICES

- Hospital care, including room and board at the hospital's semi-private room rate (or prevailing rate if no semi-private rooms are available) and hospital services
- Hospital care for a mother and newborn child for at least 48 hours following a vaginal delivery and 96 hours after a C-section (Caesarean delivery)
- Hospital services for mental health or chemical dependency treatment
- Surgical services; assistant surgeon's charges limited to 20 percent of surgeon's fee
- Physician's fees for inpatient hospital services, consultations and maternity care
- Office visits to physicians and specialists

- Outpatient mental health or chemical dependency treatment
- Diagnostic X-ray and lab services
- Outpatient facility charges and associated surgical, radiology, pathology and anesthesiology fees
- Maternity care (for employee or employee's covered spouse or domestic partner)
- Physician's fees for outpatient surgery
- Emergency care
- Ambulance service, including paramedic services; covered only if necessary to treat severe, life-threatening emergency conditions
- Outpatient rehabilitative therapy (speech, occupational and physical) when performed by a licensed therapist for therapeutic purposes; maintenance therapy not covered
- Chiropractic care from a licensed provider for therapeutic (not maintenance) purposes except for children under 2 years of age
- Acupuncture instead of anesthesia
- Allergy shots and treatment
- Cardiac rehabilitation within six months of the patient's hospitalization for a heart condition
- Chemotherapy
- Home health care, including temporary or part-time non-custodial care by or supervised by a Registered Nurse (RN); temporary or part-time care by a home health aide; physical, speech or occupational therapy
- Dialysis
- Durable medical equipment, rental up to purchase price or purchase of equipment that is appropriate for home use and generally not useful in the absence of an illness or injury
- Artificial limbs and prosthetic devices (pace-makers, hip joints), when approved by the Food and Drug Administration; no replacement except when medically necessary
- Skilled nursing facility care (must be precertified)
- Hearing care, for diagnosis only; exams and hearing aids not covered
- Hospice care (inpatient and outpatient), for patients with a life expectancy of six months or fewer (as certified by a physician); services include part-time nursing care (by an RN); physical, occupational and speech therapy; part-time services of a home health aide; medical supplies; lab services; physician's services; bereavement counseling sessions to surviving members of the immediate family
- Podiatry care, including treatment needed due to severe systemic diseases (removal of nail roots and treatment of metabolic or peripheral vascular disease); routine foot care is not covered
- Private duty nursing by RNs or Licensed Practical Nurses (LPNs) if precertified; custodial care is not covered
- Reconstructive cosmetic surgery, if it results from a birth defect, accident or surgery to correct conditions that impair bodily functions; reconstructive surgery of the breast on which a mastectomy was performed or on the other breast to produce a symmetrical appearance; including prostheses and complications of mastectomies and lymphedemas
- Voluntary sterilization (tubal ligation and vasectomy); reversal is not covered
- Second surgical opinions
- Eligible charges to establish a diagnosis of infertility

MEDICAL SERVICES THAT ARE NOT COVERED

If a medical service, treatment or supply isn't specifically listed as being covered or excluded, call your claims administrator at the number listed on your medical ID card for more information. Final determination of excluded services lies solely with your claims

administrator in its discretion. There may be exclusions not listed below.

The medical plans generally exclude:

- Hospital, surgical or medical expenses that exceed the reasonable and customary rate
- Treatment, services or supplies that are not ordered by a licensed provider
- Treatment services or supplies that are not medically necessary
- Charges that exceed the amount determined to be medically necessary
- Treatment, services or supplies that don't meet accepted health care standards
- Charges that are submitted for payment later than the end of the calendar year following the year in which they were incurred
- Experimental/investigational medical procedures, medications, treatments or services
- Charges for third party examinations and treatments, such as those requested for employment or purchase of insurance
- Any charges you are not required to pay or that you would have no legal obligation to pay without this coverage
- Non-medical fees such as postage, handling or late charges
- Charges for an injury or illness that is covered by workers' compensation or similar law or for an injury or illness that occurred at work
- Charges resulting from an injury that occurs during a war or act of war, while you are in the armed forces or during your commission of a felony
- Charges for services that are provided by the government (unless you are legally required to pay) or charges that are covered by a government program
- Charges for travel or transportation except covered ambulance services that are medically necessary
- Maternity care for dependents including newborn care for children of dependents
- Elective abortions
- Prosthetic devices, appliances or implants used for cosmetic purposes or for your convenience that are not medically necessary, except for breast reconstruction following a mastectomy
- Services or supplies billed twice due to duplicate coverage
- Marriage counseling or family therapy
- Educational classes and supplies for childbirth, smoking cessation, weight loss and other behavior modification programs
- Prenatal amniocentesis and ultrasound, except as medically necessary
- Orthomolecular medicine, cytotoxin testing in conjunction with allergy or hair analysis
- Training, supplies, medication or rehabilitation programs for dietary counseling
- Cosmetic surgery, unless otherwise specified as covered
- Routine foot care and treatment for flat feet and subluxations and related supportive devices, including orthotics
- Vocational rehabilitation
- Work hardening programs unrelated to job performance
- Hearing exams (other than for diagnosis only) and hearing aids
- Routine physical exams, unless otherwise specified as covered
- Immunizations, unless otherwise specified as covered
- Maintenance therapy (including chiropractic, occupational, physical and speech)
- Health care services and supplies from an employer, union or similar group's clinic
- Charges for missing an appointment, phone consultation, or not filling out a claim form or return to work or school form
- Special equipment, such as braces, splints, appliances, batteries or ambulatory apparatuses
- Blood derivatives not covered as drugs

- Eyeglasses, contact lenses or cataract lenses and related exams, unless otherwise specified
- Services provided by a member of your immediate family
- Hypnotherapy
- Charges for custodial care or maintenance (aside from hospice services), unless specified as covered
- Acupuncture or acupressure treatment
- Human growth hormonal treatment, except as medically necessary
- Prescription drugs (drugs are covered through a separate program)
- Drugs and related supplies, including dietary supplements such as food, vitamins and herbs, that can be purchased without a prescription
- Tutoring and education services
- Expenses that exceed the annual maximum
- Donor organ transplant expenses if the recipient is not covered by a company-sponsored health plan
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as diapers, air conditioners, purifiers, filters, humidifiers, whirlpools, saunas, spas, swimming pools, water beds, electric beds, lift chairs, home elevators, physical fitness equipment, televisions and telephones
- Radial keratotomy, except as medically necessary
- Treatment of infertility or fertility enhancements, including in vitro and invivo fertilization, artificial insemination, GIFT, ZIFT or any other artificial means of conception, unless specified as covered
- Treatment, services and supplies for, or leading to, sexual transformation and sex hormones related to such treatment; or treatment, services and supplies of sexual dysfunction not related to organic disease
- Treatment, services (including surgical services) and supplies in connection with obesity, weight reduction or dietary control, whether or not prescribed by a physician or associated with an illness
- Motor vehicles; vehicle lifts for wheelchairs and scooters; and stair lifts
- Assessments for Attention-Deficit Disorder
- Fraudulent charges
- Expenses for complications arising from an excluded treatment, service or supply
- Stem cell storage
- Service, supplies or equipment furnished:
  - Before the covered employee's or covered dependent's effective date of coverage; or
  - After the date the covered employee's or covered dependent's coverage ends.
- Chiropractic care for children two years of age and under

UTILIZATION MANAGEMENT (PRE-65 COVERAGE ONLY)

WHEN TO CALL

Generally, you are required to call your utilization review administrator for precertification prior to incurring charges for:

- Inpatient hospital stays
- Elective hospital stays
- Maternity stays *
- Emergency admissions (call must be made within 2 days after admission to the emergency room)
- Skilled nursing facilities
- Coordinated home care
- Extended care facilities
- Inpatient mental health and substance abuse
- Private duty nursing

* Group health plans, such as the retiree health plans and health insurance companies, generally may not under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48

hours following a normal vaginal delivery or less than 96 hours following a Cesarean section. The health plans also may not require the provider to obtain approval for lengths of stay that do not exceed the periods stated above.

NOTE: Precertification is not a guarantee of benefits. Refer to the specific sections of this book that list the medical services that are covered and not covered. If a service is not specifically listed as being covered or excluded, call the claims administrator for more information. Final determination regarding excluded services lies solely with the plan administrator in its discretion. Check with your medical plan for the requirements regarding approval for precertification for certain medical services and to verify if a particular medical service requires precertification (even if that service is not listed above).

WHO TO CALL

You, your physician, a family member or other designated person can call your utilization review administrator to confirm precertification before incurring charges for the above listed treatments. The phone number for the utilization review administrator will be listed on the back of your medical ID card. However, as a retiree of the Company you are ultimately responsible for the call to be made for precertification.

PENALTY FOR NO PRECERTIFICATION

Your benefits may be reduced if you do not obtain approval for precertification from the utilization review administrator. For more information about requirements for precertification, check the Benefits-at-a-Glance and/or with your claims administrator.

EMERGENCY

If a minor injury or accident occurs, call your physician first. In many cases, your physician can provide the same treatment given in a hospital emergency room. However, if the situation is critical, you should go directly to a hospital. You (or a family member or physician) must notify your utilization review administrator within 2 days of the visit that you have received emergency room treatment.

Your benefits may be reduced if a timely call is not made to your utilization review administrator.

Please note: Utilization Management is not required for the Retiree Major Medical Supplement Plan.

PRESCRIPTION DRUG PLAN

Each medical plan option automatically includes the prescription drug plan. The prescription drug plan provides prescription drug coverage through a Prescription Benefit Manager (PBM) to participants who are covered by retiree medical coverage. Refer to the Benefits-at-a-Glance for details. Here are a few features of the Prescription Drug Plan:

- The Prescription Drug Plan includes a retail pharmacy and mail order service benefit
- Prescriptions are subject to coinsurance
- The plan does not cover drugs that do not require a prescription, such as aspirin, even though a doctor may write an order for such a drug on a prescription form

NOTE: If you have a question about whether or not a drug is covered, check with your PBM directly. The PBM's contact information is included in the "Administrative Information" section of this SPD or can be found on your Prescription Plan ID card.

PREFERRED DRUG LIST

A Preferred drug List includes brand-name drugs for the prescription drug plan. A Preferred Drug List is a list of commonly prescribed brand-name medications meant to be presented to your physician. By asking your physician to prescribe brand-name drugs on the Preferred Drug List, you pay less while maintaining high quality care. The Preferred Drug List is available from the PBM.

PRENATAL VITAMINS

Prenatal vitamins that can be obtained only with a prescription because of the concentrated content will be covered during the term of the pregnancy only. Other dietary supplements are excluded.

PRESCRIPTION DRUGS NOT COVERED

If a prescription drug is not specifically listed as being covered or excluded, call the PBM for more information. Final determination regarding excluded drugs lies with the Plan Administrator in its discretion. There may be exclusions not listed below. The following is a list of some of the drugs that are not covered by the plan:

- Drugs obtainable without a prescription (other than insulin or prenatal vitamins)
- Growth hormones
- Retin-A for people older than age 36, and other prescription products to reduce wrinkles of the skin
- Smoking cessation aides and weight loss drugs
- Drugs used for cosmetic purposes
- Infertility drugs exceeding the lifetime maximum
- Therapeutic devices or appliances
- Sexual dysfunction and other lifestyle drugs

This is not a complete list of drugs not covered. Contact the PBM (by phone or on their website) to find out whether a particular drug is covered or excluded by the plan.

ADDITION OF NEW DRUGS

If determined by the Plan Administrator, new drugs may become covered under the plan.

HOW IT WORKS

Retail Pharmacy

This service is designed to meet short-term and immediate prescription drug needs up to a 30-day supply plus any refills or you can request up to a 90 day supply if you take any maintenance drugs. Participants are encouraged to ask the doctor to prescribe a generic substitute, if available, or to prescribe a drug from the Preferred Drug List.

Prescription drugs can be obtained through an in-network pharmacy or reimbursed through an out-of-network pharmacy.

If you obtain your prescriptions through an in-network pharmacy:

- There are no claims to file and no waiting for reimbursement
- Your share of the cost will generally be less because the pharmacies in-network have agreed to charge discounted prices for the prescriptions

If you obtain your prescriptions through an out-of-network pharmacy:

- You must pay the full cost of your prescription when it is filled
- You must file a claim form with the PBM to get reimbursed
- Participants who use out-of-network pharmacies will be reimbursed a percentage of the network cost of the prescription
- You will have to pay any amounts higher than the network cost for your prescription

Mail Prescription Service

The mail prescription service offers the convenience of home delivery for those who need up to a 90-day supply of maintenance drugs. To receive medications by mail, mail your doctor's prescription form, order form and appropriate coinsurance per prescription to the PBM. Your doctor may allow refills for up to one year. The mail order service fills prescriptions with generic drugs, when available. For more information about the mail prescription service, contact the PBM.

NOTE: If a generic drug is available and you receive a brand name drug, you must pay the generic coinsurance plus the difference in cost between the generic and brand name drug.

LIFE INSURANCE

ELIGIBILITY

If you are eligible for Retiree Life insurance when you retire, your enrollment worksheet will reflect your entitlement. Your Basic Life and AD&D, Optional Life and AD&D Dependent Life, Optional Employee and Dependent AD&D and Business Travel and Accident insurance end at retirement. You may be able to convert/port some or all of your active insurance. Refer to the Conversion & Portability Options found later in this section for more information.

NOTE: Eligibility for retiree life insurance is based on the benefits available to you when you retired from the Company. Please refer to the Benefits-at-a-Glance for specific information about eligibility for this benefit, if applicable.

BENEFICIARIES (RETIREES COVERED BY LIFE INSURANCE ONLY)

NAMING YOUR BENEFICIARY

Your beneficiary is the person you choose to receive the proceeds of your life insurance if you die.

To designate a beneficiary or change your current beneficiary designations, log on to the Your Benefits Resources website at resources.hewitt.com/jci or call the Benefits Service Center at 1-866-496-1999.

A beneficiary can be one or more people, an organization, including non-profits, or a trust. If you name two or more people, they will share the benefits equally. You can also name a secondary beneficiary to receive your benefit if your primary beneficiary is no longer alive at the time of your death.

If there is no beneficiary at the time of your death benefits due are payable to one or more of the following persons (in order as listed) who are related to you and who survive you:

- Spouse
- Child
- Parent
- Brother and sister

However, the plan may instead pay all or part of that amount to your estate. The insurance carrier is responsible for making all final decisions in regard to who is an eligible beneficiary.

CHANGING YOUR BENEFICIARY

To change your beneficiary, log on to the Your Benefits Resources website at resources.hewitt.com/jci or call the Benefits Service Center at 1-866-496-1999. Remember to protect the privacy of your personal ID and password so that unauthorized individuals cannot access your information. Neither the Company nor the Plan are responsible for any changes that are made online without your consent.

It is important to keep track of your beneficiary choices. You may want to change beneficiaries if:

- You get married
- The number of your dependents changes
- You are divorced or legally separated or your domestic partnership ends
- Your beneficiary predeceases you

Also, it's a good idea to let people know you have designated them as beneficiaries.

Beneficiaries for life insurance apply to retirees covered by life insurance only.

APPLYING FOR BENEFITS

For information on filing a life insurance claim, contact the Benefits Service Center at 1-866-496-1999.

CLAIM FILING DEADLINE

It's important to file claims as soon as possible. Be sure to submit your claims within one year of the date of death. Claims that are older than one year will not be considered for payment. If you disagree with a decision on a claim, you can appeal it. See the "Administrative Information" section of this SPD for additional information.

PAYMENT OF BENEFITS

Life insurance benefits are payable when the insurance company receives proof of your death. Benefits are usually paid in a lump sum, but beneficiaries can elect an optional form of payment if the insurance company offers one.

Because the Life Insurance Plan is provided through an insurance company, there may be other restrictions and conditions not described in this SPD that apply. If you have any questions, please contact the Benefit Service Center at 1-866-496-1999.

CONVERSION & PORTABILITY OPTIONS

When you retire, your active life insurance coverages terminate. You may have the right to convert your Basic Life, Optional Life, Optional Employee and Dependent AD&D, and/or Dependent Life Insurance to an individual policy or port your Optional Life and AD&D, and/or Dependent Life Insurance to a term life policy.

To exercise either or both of these options (conversion and/or portability), you must contact the insurer listed in the "Administrative Information" section within 31 days of the date of your termination of employment. If death occurs during the one month application period, whether or not you have applied for an individual policy, you may be eligible for benefit payments from your active life and/or optional employee and dependent AD&D insurance. Your rights to convert or port your life insurance applies to the coverages in effect prior to your termination of employment. Please refer to your Health and Welfare Summary Plan Description for active employees for more information about life insurance conversion and portability. (Contact the Johnson Controls Benefits Service Center at 1-866-496-1999 to obtain a copy of the SPD.) This Summary Plan Description describes the retiree life insurance coverage only.

ADMINISTRATIVE INFORMATION

GENERAL ADMINISTRATIVE INFORMATION

Plan Sponsor	Johnson Controls, Inc. or Technotrim, Inc.
ERISA Plan Administrator	Employee Benefits Policy Committee
ERISA Plan Administrator Address	Employee Benefits Policy Committee Johnson Controls, Inc. 5757 North Green Bay Avenue P.O. Box 591 Milwaukee, WI 53201 Administration of the plans is performed by the Plan Administrator, and through certain contract administrators and insurers.
Plan Sponsor Identification Number	39-0380010 Johnson Controls, Inc. or 38-2710245 Technotrim, Inc.
Agent For Service Of Legal Process	Secretary of the Company Johnson Controls, Inc. 5757 North Green Bay Avenue P.O. Box 591 Milwaukee, WI 53201 (414) 524-1200 Service of legal process may also be made on the Plan Administrator.
Plan Funding	The Johnson Controls Union and Non-Union Retiree Welfare Plans are funded through Company contributions and after-tax contributions by participants paid into a trust. The Technotrim, Inc. Retiree Welfare Plan is funded through Company contributions and after-tax contributions by participants. Life insurance is insured and provided through an insurance contract. Medical and prescription drug coverage is self insured.
Plan Year	Plans are maintained on a calendar-year basis, beginning on January 1 and ending on December 31.
Plan Trustee	For Johnson Controls Inc. Union and Non-Union Retiree Welfare Plans only: U.S. Bank 777 East Wisconsin Avenue Milwaukee, WI 1-414-765-5114

Formal Plan Name	Type of Plan	Plan Number*	Source of Payment	Claims Administrator or Insurer
Johnson Controls, Inc. Non-Union Retiree Welfare Plan (JCI) **Johnson Controls, Inc. Union Retiree Welfare Plan (JCI-U)** **Technotrim, Inc. Retiree Welfare Plan (TET)**	Medical (including Prescription Drug) (Welfare)	569 (JCI) 570 (JCI-U) 509 (TET)	Employee and Employer Self-insured Trust (Johnson Controls Plans only)	**Medical Plan:** Blue Cross Blue Shield 300 E. Randolph St. Chicago, IL 60609 1-888-541-7927 **Prescription Drugs:** Prime Therapeutics 1305 Corporate Center Drive Eagan, MN 55121 1-855-457-0005
	Life Insurance (Welfare)	569 (JCI) 570 (JCI-U) 509 (TET)	Employer and Employee Insured Trust (Johnson Controls Plans only)	MetLife Group Life Claims P.O. Box 6122 Utica, NY 13504-6122 1-800-638-6420

*Please note that the plan number is assigned only to plans governed by ERISA and is used for Department of Labor purposes only and is not the policy or group number. Please use your medical and prescription ID cards for the group number.

INFORMATION SPECIFIC TO MEDICAL PLANS

Medical plans are subject to rules that do not apply to other types of coverage in this program. These special rules are reviewed below.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that group medical plans provide participants and their enrolled dependents with certification of coverage when medical coverage is terminated for any reason.

PRE-EXISTING CONDITION EXCLUSIONS

The Company's retiree medical plans do not have a provision limiting or excluding coverage because of a pre-existing medical condition.

COORDINATION OF BENEFITS

When you are covered by another group medical plan in addition to the coverage under the Company retiree plan, coordination of benefits rules will be applied. This means that your benefits under other plans will be taken into consideration when a claim is being processed under the Company's retiree plans. Other plans that the program coordinates benefits with include:

- No-fault automobile insurance
- Government plans provided or required by law
- Other group health care plans, including student coverage provided by a school

The retiree plan will pay only up to the limits specified by the plan for covered services when it is the primary plan. When the Company retiree plan is secondary, after application of any deductible and/or copayment, the amount or value of the benefits or services provided by all other plans will reduce the benefit provided by the retiree plan. The total reimbursement for covered expenses from both plans will be no more than 100 percent of the allowable benefit under the retiree plan.

To determine which plan is primary and which is secondary (which plan pays first and which pays second), the following rules apply:

- If you are employed by another company or covered by other group coverage through your spouse, this coverage will be primary. Your Company plan will be secondary.
- If a child is covered by both parents' plans, the primary plan is determined by the "birthday rule," a standard method used by the insurance industry. This means that the plan of the parent whose birthday falls earlier in the year is primary. For example, if your spouse's birthday is Sept. 1 and yours is Jan. 10, your plan will pay benefits first for your children. If the other insurance company does not use the birthday rule, the father's plan will be primary.
- If you are divorced or separated, the plan of the parent whom the court decrees to have financial responsibility for the health care expenses of your child is the primary plan with respect to your child. If the court decrees to give joint financial responsibility to both parents for health care expenses of your child, the plan determines the primary plan. Without a court decree, the plan of the parent with custody is primary.
- If a child's parents are divorced and you are the step-parent married to the parent with custody, the plan of the parent with custody would pay first, then the Company retiree plan would pay.
- When a determination cannot be made, the plan that has covered the patient longer is primary.

You should first submit your claim to the plan that is primary. After that plan has paid benefits, you may then submit any remaining unpaid expense to the plan that is secondary.

Example

You incur medical charges that are covered at 80 percent under the Company retiree plan. If the Company retiree plan is primary, the plan will pay 80 percent of the usual, customary or reasonable charges (after you meet your deductible). But if the Company retiree plan is the secondary plan and the other plan pays 70 percent of the charge, then the Company retiree plan will pay 10 percent – the difference between the amount the other plan pays and what the Company retiree plan would have paid.

NOTE: In the event that you are covered by two plans, you must always submit to the primary plan first.

COORDINATION WITH MEDICARE BENEFITS

If you are eligible for or covered by Medicare in addition to your Company retiree coverage, Medicare will be the primary payor.

NOTE: Failure to enroll in Medicare Parts A and B when you or your dependents are eligible may result in reduced benefits under the retiree medical plans.

USUAL OR REASONABLE AND CUSTOMARY CHARGES

The usual, customary or reasonable (UCR) charge may either be the prevailing fee charged by providers which may vary by geographic location or may be based on 100% of the Medicare allowed amount.

The plans offered by the Company will not pay more than the UCR charge for any covered expense you incur for out-of-network medical expenses (in-network medical expenses are reimbursed based on pre-negotiated rates).

If your provider charges more than the UCR charge, you will be responsible for the difference. Also, any amount you pay over the UCR charge will not apply toward your yearly deductible and out-of-pocket limit.

PAYMENT OF CLAIMS

Benefits payable under the medical plan may be made directly to the provider or may be made directly to you, in which case it is your responsibility to reimburse the provider. Any benefits payable after your death will be paid to the provider or your estate.

You do not have a right to request that a claims administrator not pay a claim submitted by a medical service provider, and neither the Company nor the claims administrator is liable for failing to honor such a request.

RELATIONSHIP WITH YOUR PROVIDER

You have the right to select any medical service provider, although your choice of a provider may affect the eligibility for, and amount of, benefits payable under the medical plan. The use of words in this document such as "participating provider" or "approved provider" or "network provider" should not be considered a recommendation by the Company or claims administrator of such health care providers, or any indication of their degree of skill or quality.

You and your selected provider must decide what is the best course of treatment for your condition. Neither the Company nor any claims administrator is responsible for your health care decisions, nor for any act or omission of your health care provider, including the failure or refusal of a health care provider to provide services to you or your dependents.

INFORMATION ABOUT YOUR MEDICAL RECORDS

The Company and the claims administrator will make every effort to keep your medical information confidential in accordance with federal and state law, and will disclose it only as necessary for the plans' administration, or as authorized by you or permitted by law. It is your responsibility, however, to make sure the claims administrator and the Company have all pertinent information they need to process your claims and appeals and administer the

plans, such as information and records relating to your claim or appeal, medical history that may be pertinent to the claims administrator's decisions about covered treatment, eligibility for Medicare, termination of Medicare, and your rights to reimbursement for benefits from other sources.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If you become subject to or are awarded a court-ordered Qualified Medical Child Support Order (QMCSO) or other legal change of custody, you may make a corresponding change to your enrollment in the medical plan to comply with this order or judgment, even if you were not enrolled in any Company plan. In addition, if a court order requires your ex-spouse's health insurance to provide medical insurance for your child, you may make an election to cancel your child's coverage under the Company's health plans. If you become subject to an order, you and each child will be notified about further procedures to validate and implement the order. You may obtain a copy of the plan's procedures for QMCSOs, free of charge, by contacting the Benefits Service Center at 1-866-496-1999. You must submit your QMCSO to the Benefits Service Center for approval.

CERTIFICATE OF COVERAGE

Under HIPAA (Health Insurance Portability and Accountability Act), you can request that a subsequent medical plan or insurer reduce a pre-existing condition limitation waiting period by the amount of time you were covered under a Company medical plan, provided you do not have a 63-day break in coverage.

You will automatically be sent a certificate of coverage when coverage ends, even if you choose to continue your coverage through COBRA (if available). You will also be sent a certificate of coverage when your COBRA coverage ends. You can request a certificate of coverage at any time during the 24-month period after your medical coverage ends by contacting the Benefits Service Center at 1-866-496-1999.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans, such as the company-sponsored plans and health insurance generally may not under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The health plans also may not require the provider to obtain approval for lengths of stay that do not exceed the periods stated above.

BENEFITS RELATED TO MASTECTOMIES

Consistent with the Women's Health and Cancer Rights Act, the plan provides the following benefits in connection with a plan-covered mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes)

The manner in which the above services will be performed will be determined after consultation with the physician and patient. Coverage for the above services will be subject to deductibles, copayments and other limitations as described in the materials provided by the medical plan.

CONTINUING BENEFITS UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, is federal legislation that allows

your dependents to continue health care coverage after certain qualifying events, as described below. This section on COBRA only describes the COBRA rights of dependents who are covered under the retiree medical plan. If a retiree chooses COBRA coverage instead of retiree medical at the time of retirement, the retiree should refer to the Summary Plan Description for active employees for information on COBRA.

HOW COBRA WORKS

Under COBRA, your COBRA-eligible dependents who would otherwise lose retiree medical coverage under certain circumstances may choose to continue retiree medical coverage at their own expense. An individual who is eligible to elect continuation of coverage under COBRA, is called a qualified beneficiary.

If you are the spouse or dependent child of a retiree and you are covered under the retiree health care plan, you will become a qualified beneficiary if you lose coverage because of any of the following qualifying events:

- Death of the retiree
- You become divorced or legally separated from the retiree or your marriage is annulled
- You are no longer considered an eligible dependent (i.e. dependent child reaches the age limit, or surviving spouse remarries) as defined in the plan

If you are a qualified beneficiary, you may elect COBRA if you are covered under the medical plan on the day prior to a qualifying event and you would otherwise lose coverage as a result of that event.

If you are the spouse or dependent child of the retiree and the retiree drops your coverage in anticipation of a divorce, legal separation or annulment before the divorce, or legal separation or annulment is final, you may still be entitled to elect COBRA following the divorce, legal separation or annulment even though you were not covered on the day prior to the qualifying event. For this exception to apply, the Benefits Service Center must determine that the retiree dropped your coverage in anticipation of a divorce, legal separation or annulment. In this case, COBRA coverage would be offered only from the date of the divorce, legal separation or annulment. COBRA coverage would not be available from the date coverage was dropped to the date of the divorce, legal separation or annulment.

Domestic partners and children of domestic partners (who have not been legally adopted by the retiree) are generally not considered qualified beneficiaries. Contact the Benefits Service Center at 1-866-496-1999 for details.

For certain qualifying events, you must provide written notice of the event in order to be eligible to elect COBRA continuation coverage (see "Notice Procedures" later in this section).

LENGTH OF COBRA CONTINUATION COVERAGE

If properly elected, COBRA continuation coverage will generally last for a maximum of 36 months (as shown in the following chart) from the date of the qualifying event.

QUALIFYING EVENT	**MAXIMUM COVERAGE PERIOD** (from date of qualifying event)
Retiree's death	36 months
Retiree's divorce, legal separation or annulment of marriage	36 months
Dependent loses eligibility (for example, by reaching the age limit	36 months

NOTICE PROCEDURES

In order to be eligible for COBRA continuation coverage, you must follow the notice procedures described in this section. Failure to comply with the notice requirements below will result in loss of your right to elect or extend COBRA continuation coverage, as applicable.

Notice of Qualifying Event

When the qualifying event is divorce, legal separation or annulment of marriage from the retiree, or a dependent child of the retiree losing status as a dependent, at least one qualified beneficiary must notify the Benefits Service Center at 1-866-496-1999 of the qualifying event within 60 days after the later of: (i) the date of the qualifying event, or (ii) the date coverage is (or would otherwise be) lost.

ELECTING COBRA CONTINUATION COVERAGE

Upon receipt of notice of the qualifying event, the Benefits Service Center will provide each qualified beneficiary with a COBRA election notice. Your eligible dependent(s) have 60 days after the date coverage is lost or the date the election notice is sent, if later, to elect COBRA by calling the Benefits Service Center at 1-866-496-1999 or by logging onto the Your Benefits Resources webstie at http://resources.hewitt.com/jci. Failure to contact the Benefits Service Center in a timely manner to enroll in COBRA will result in loss of your family's rights to COBRA continuation coverage.

The election notice will include:

- An explanation of your COBRA rights
- COBRA election information
- An estimate of the monthly cost for COBRA coverage

Notice to you or your spouse is also notice to all other COBRA-eligible dependents living at your or your spouse's address. Each qualified beneficiary has the right to separately elect COBRA continuation coverage. When enrolling in COBRA, you must identify eligible COBRA dependents.

COBRA coverage will last no later than the end of the maximum coverage period as described earlier in this booklet. If the Company changes or terminates coverage under the plan, continuation coverage may be changed or terminated.

PAYMENT FOR COBRA COVERAGE

Here is how payment for COBRA coverage works:

- Your dependents are required to pay for continuation coverage
- Your dependents will be notified of the amount of the payments (which may include the entire cost of coverage plus a 2 percent administrative charge as permitted by law)
- Your dependents' first premium must be sent no later than 45 days after the date your dependents enroll for coverage (either on line or by contacting the Benefits Service Center). If you and/or your dependents fail to make the first premium payment within the 45-day period, your dependents' COBRA coverage will not become effective and all rights to COBRA continuation will be lost. The first premium payment generally must cover all monthly premiums due to such date
- After the first premium is paid, all premium payments are due monthly; they will be billed monthly; your covered dependents who apply for COBRA will be informed when monthly premiums are due and about whether a direct debit payment option is available; payment must be made in full for each month before their coverage will show as active for that month

TERMINATION OF COBRA COVERAGE

COBRA continuation coverage will be terminated prior to the end of the 36-month maximum period if:

- Your dependents fail to make a premium payment on time.
- Your dependents first become covered after the date of the election under another group health care plan that does not apply any exclusion or limitation for a pre-existing condition to your dependents; if the plan does apply an exclusion or limitation for a pre-existing condition, your dependents COBRA continuation coverage will terminate at the end of the pre-existing condition exclusion or limitation period.

- Your dependent(s) first become enrolled in Medicare (Part A or Part B) after the date of your dependent's election.
- The coverages offered under the plan are terminated.
- Coverage is terminated for cause (such as for the submission of a fraudulent claim to the plan).

COORDINATION BETWEEN COBRA AND MEDICARE

If your dependents are eligible for both COBRA and Medicare, then they should keep in mind that in most cases Medicare will pay the health care expenses as the primary payor, and COBRA coverage will pay secondary to Medicare.

If your dependents would like to have both Medicare and COBRA medical, then they should make sure to enroll in Medicare Part A and Medicare Part B as soon as possible in order to reduce the amount they will have to pay out-of-pocket. If they are eligible for Medicare, when the COBRA medical plan calculates their benefits, it assumes that they are enrolled in Medicare Part A and Part B, even if they are not. In other words, the COBRA medical plan calculates and pays benefits on a secondary basis regardless of whether your dependents actually enrolled. So, if they do not enroll in Medicare Part A and Part B, they will be responsible for paying the portion of their health care expense that would have been paid by Medicare. This out-of-pocket amount will not count towards the COBRA medical plan's deductible or out-of-pocket maximums. So, to keep the out-of-pocket costs as low as possible, it is generally advisable to enroll in Medicare Part A and Part B if your dependent also intends to elect COBRA.

Of course, the discussion above may not apply to every person's situation, and you have to consider what is the right course of action for you.

Also remember that if your dependents enroll in Medicare after the date of the COBRA election, then COBRA coverage will terminate. Your dependents must notify the Benefits Service Center immediately to cancel their COBRA coverage.

MISCELLANEOUS COBRA INFORMATION

If You Have Questions

Questions concerning your plan or your dependents COBRA continuation coverage rights should be addressed to the Benefits Service Center at 1-866-496-1999.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you or your dependents should keep the Benefits Service Center informed of any changes in the addresses of family members. You or your dependents should also keep a copy, for their records, of any notices they submitted to the Benefits Service Center.

BENEFIT CLAIMS AND APPEAL INFORMATION

The following information will help you to better understand how to file claims, as well as the claim review and appeal process.

FILING INITIAL CLAIMS FOR MEDICAL AND LIFE BENEFITS

All initial claims for benefits must be filed with the claims administrator/insurer or the Company, as indicated in the "General Administrative Information" chart(s). Whether you file a claim or someone else (such as a preferred provider or another authorized representative, such as an attorney) files a claim on your behalf, it is your responsibility to make sure the claim is filed in writing with the appropriate claims administrator/insurer and is filed before the deadline for each of the plans. Claims not filed in writing or filed after the applicable

deadline will not be paid. The claims administrator/insurer or the Company has the right to require that you provide proof of appointment of your personal representative.

Claim Filing Deadlines

Almost all of the plans have a claim-filing deadline. In cases where health care and other providers file claims on your behalf, it is still your responsibility to ensure that claims are filed before the applicable deadline. Claims filed or postmarked after the deadline will not be paid. Here are the deadlines:

- Company-sponsored Retiree Medical Plan: No later than the end of the calendar year following the calendar year in which the charges were incurred
- Life Insurance Plan: No later than one year from date of death

Evidence of Claims

The claims administrator/insurer reserves the right to require verification of any claim for benefits. For example, the claims administrator/insurer may require submission of medical summaries, discharge reports, X-rays or other appropriate materials. Benefits may be reduced or not paid if verification cannot be made. Your benefit claim may be approved or denied, in whole or in part, by the claims administrator/insurer.

RESPONSE TO YOUR INITIAL BENEFIT CLAIM

If a claim is timely filed, the claims administrator/insurer (or Company, where applicable) will determine whether a claim should be approved or denied generally in the following timeframes:

Type Of Claim	Regular Response Time	Extension Of Response Time
Medical – Urgent Care	Up to 72 hours	Up to 48 hours after receipt of additional information**
Medical – Pre-service (i.e., preauthorizations)	No later than 15 days	Up to an additional 15 days
Medical – Post-service	No later than 30 days	Up to an additional 15 days
Medical – Concurrent Care (i.e., approved course of treatments)	If the benefits will be terminated before end of scheduled course of treatments, reasonable notice prior to termination* If the request is made for extended course of treatment, the response time will generally depend on whether the request is for urgent, pre-service or post-service treatment, as described above.	None See above, as applicable
Life Insurance	No later than 90 days	Up to an additional 90 days
Participation/Enrollment	No later than 90 days	Up to an additional 90 days

* Notice is not required to be given if the course of treatments will end at the regularly scheduled time.

** The plan must notify you within 24 hours if more information is needed to decide your claim. You will have at least 48 hours to respond and provide the information. The plan must then decide your claim within 48 hours of receiving the needed information.

NOTE: The above timeframes relate only to when a decision to approve or deny a claim will be made. Payment of an approved claim may be made at a later date.

As indicated above under the "Extension of Response Time" portion of the chart, the claims administrator/insurer may extend the time period needed to make a determination for circumstances beyond its control, such as the need for you to submit additional information. In such case, you will be notified that additional information is needed. If you do not timely respond, the claims administrator/insurer will make a determination on the benefit claim based on the information in its possession at such time.

DENIAL OF INITIAL BENEFIT CLAIM

Your benefit claim may be approved or denied, in whole or in part, by the claims administrator/insurer (or Company, where applicable).

If your claim is denied by the claims administrator/insurer (or Company, where applicable), you will receive written notification of the denial. (In the case of a denial of an urgent care claim, the denial may be provided over the phone as long as a written denial of your urgent care claim is furnished to you within 72 hours after the oral notification.)

The oral or written denial notice will include all information as required by law.

APPEALING BENEFIT CLAIM DENIAL OR DENIAL OF PARTICIPATION / ENROLLMENT

If your initial claim for benefits is denied, or if you or a dependent are denied participation in a plan or your or your dependent's coverage is terminated, and you disagree with that decision, you have the right to appeal that decision. You may authorize another person to file the appeal on your behalf, such as an attorney. The claims administrator/insurer or the Company has the right to require that you provide proof of appointment of your personal representative. Your appeal must be filed before the following deadlines:

- Medical 180 days from the date you receive the initial claim denial
- Life insurance, 60 days from the date you receive the initial claim denial
- Plan participation/enrollment, 60 days from the date you receive the initial denial

Appeals for benefit claim denials should be filed with the individual/entity listed in your claim denial notice in accordance with the procedures specified in the denial notice.

Appeals relating to participation should be filed with:

Appeals Manager, x-62
Johnson Controls, Inc.
5757 North Green Bay Avenue
P.O. Box 591
Milwaukee, WI 53201-0591
Fax: 877-734-9278

For all appeals (except urgent care claim appeals), your appeal must be made in writing. As part of your appeal, you may:

- Submit written comments, documents, records and other information relating to the claim for benefits that you believe is pertinent;
- Upon written request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- If applicable, upon written request and free of charge, receive the identification of medical or vocational experts whose advice was obtained in connection with the claim denial, even if the advice was not relied upon.

RESPONSE TO YOUR APPEAL

The claims administrator/insurer (or Company, where applicable) will determine whether an appeal should be approved or denied, generally in the following timeframes:

Type Of Claim	Regular Response Time	Extension Of Response Time
Medical – Urgent Care	Up to 72 hours*	None
Medical – Pre-service (i.e., preauthorizations)	No later than 30 days*	None
Medical – Post-service	No later than 60 days	None
Medical – Concurrent Care (i.e., approved course of treatments)	The response time will generally depend on whether the request is for urgent, pre-service or post-service treatment, as described above.	None
Life Insurance	No later than 60 days	Up to an additional 60 days
Participation/Enrollment	No later than 60 days	Up to an additional 60 days

*Please note that certain appeals reviewers or insurance companies may require two levels of appeal. If that is the case, you will be notified that two levels of appeal are required and where to file the second level of appeal. Each appeal will be decided within ½ of the timeframe described above.

NOTE: The above timeframes relate only to when a decision to approve or deny an appeal will be made. Payment of an approved appeal may be made at a later date.

As indicated above under the "Extension of Response Time" portion of the chart, the claims administrator/insurer may extend the time period needed to make a determination for circumstances beyond its control, such as the need for you to submit additional information. In such case, you will be notified that additional information is needed. If you do not respond timely, the claims administrator/insurer will make a determination on the benefit appeal based on the information in its possession at such time.

The appeal reviewer will take into account your comments and all of the information that you provide, regardless of whether such information was submitted or considered in the initial benefit determination. If your appeal is for an urgent claim, you may submit your appeal either in writing (as described above) or by telephone. The phone number for each claims administrator/insurer can be found in the "General Administrative Information" chart(s).

RESPONDING TO APPEALS

Upon appeal, the appeals reviewer will either approve your appeal or uphold the denial. If your appeal is denied, you will receive a written response containing the information required by law.

VOLUNTARY APPEALS

If your appeal is denied at all of the required appeal levels (either one or two, depending on the specific rules of the appeal reviewer), you may:

- Bring a suit for benefits or to clarify your rights to participation under ERISA (see "Final Suit in Court" below for more information); or
- For the self-insured plans only, voluntarily appeal the denial to the Policy Committee*; or
- For the medical plan only, and only with respect to adverse appeal decisions involving medical judgment or rescissions of coverage, request a review of the denial by an external independent review organization.

* **NOTE**: A voluntary appeal to the Policy Committee is not available if your appeal has been reviewed and decided by an external independent review organization.

Please note that the appeal to the external independent review organization and the Policy Committee is not required. There are no voluntary appeals allowed for insured plans except as otherwise permitted by the insurance carrier.

Voluntary Appeal to Policy Committee (Self-Insured Medical Plan)

To appeal a denial of a self-insured plan claim to the Policy Committee, the claimant should submit a written appeal to the address indicated in the "General Administrative Information" chart(s) within 180 days of receipt of the notice of the final mandatory appeal denial. In some cases, the Policy Committee may refer the claimant's appeal to an outside agency, such as a panel of doctors, for determination. When writing your appeal, the claimant should read the legal plan documents and send written comments supporting his or her position.

The Policy Committee (or its agent) will write to the claimant within 60 days after receiving your request (120 days under special circumstances). The notice will either change the earlier decision and provide for payment of the claim or deny the appeal. If the claim is once again denied, the notice also will include the specific reason for the denial and specific references to applicable plan provisions.

Voluntary Appeal to External Independent Review Organization (Self-Insured Medical Plan Only)

You may file a request for independent external review if your adverse appeal decision involves medical judgment (except claims which only involve interpretation of a contract or law without any use of medical

judgment) or a rescission of coverage (as described below in "Rescission of Coverage"). Examples of adverse appeal decisions involving medical judgment include, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. An example of adverse appeal decisions involving rescission includes, but is not limited to, a retroactive termination of coverage for someone you enrolled as your domestic partner but who did not qualify as your domestic partner under the terms of the plan.

During the period of January 1, 2011 through September 19, 2011, additional adverse appeal decisions may have been eligible for external review. Check with the claims administrator if you think this may affect you.

To file a request for review by an external independent review organization (IRO), the claimant must make a written request within four months from the claimant's receipt of notice of the plan's final adverse mandatory appeal decision. If there is no corresponding date four months after the date of receipt of such notice, then the request for external review must be filed by the first day of the 5th month following receipt of such notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. The notice of the final adverse appeal decision will provide information about where to file a request for an independent external review. If a claimant does not timely file a request for an independent external review by the deadline, the only recourse will be to file a lawsuit under ERISA.

Upon receipt of the request for external review, the claims administrator will conduct a preliminary review within five days to confirm that:

- The claimant was covered under the plan at the time the item or service was requested, or in the case of a retrospective review, was covered under the plan at the time the item or service was provided.
- The medical benefit denial does not relate to the claimant's failure to meet the plan's eligibility requirements.
- The claimant has exhausted the plan's mandatory internal appeals process (unless it is an expedited review, which is described in more detail below); and
- The claimant has provided all information necessary to process the external review.

Within one business day after the completion of the preliminary review, the claims administrator will notify the claimant of one of the following:

- That the request is complete, but not eligible for consideration by an external IRO because not all of the requirements described above were satisfied. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.
- That the request is incomplete, but may still be eligible for consideration by an external IRO. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (1) the last day of the four-month filing period or (2) 48-hours after receipt of the notice.
- That the request is complete and eligible for consideration by an external IRO.

If the request is complete and eligible for consideration by an external IRO, then the claim, along with all documentation, will be referred to an accredited external IRO. The external IRO will determine if the claim relates to medical judgment or a rescission of coverage. If the external IRO determines that the claim does not meet these requirements, the external IRO will not review the claim.

If the external IRO will review the claim, the plan will provide the assigned IRO with the documents and any information considered

in making the final internal adverse benefit determination. The claimant may submit additional information to the IRO conducting the review within ten business days following the claimant's receipt of the notice from the claims administrator that the request has been assigned to external review. Upon receipt of the claim, the IRO will review all relevant documentation. The IRO is not bound by the plan's original decision when making its review.

Within 45 days after the IRO receives the external review request, it will provide written notice of the final review decision to the claimant and the plan. If the IRO determines that the claim should be denied, then the claimant may file a lawsuit under ERISA for benefits.

A claimant may qualify for an expedited external review if (1) the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize his or her life or health, or (2) if the final adverse appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not been discharged from a facility. The external review process is the same for expedited reviews except that:

- The claims administrator must conduct the preliminary review immediately, instead of taking five days for the review;
- If eligible, the claim is immediately referred to an IRO; and
- The IRO will review the claim and communicate its decision no later than 72 hours after receipt of the external review documentation.

FINAL SUIT IN COURT

As explained in "Statement of ERISA Rights" later in this section, a claimant has the right to file a suit for benefits or to clarify his or her rights to participate in a plan in a court of competent jurisdiction. However, a claimant may file suit only after the claimant has completely exhausted all of the mandatory claims and appeals procedures described above. In addition, a claimant may not file suit in any event after 180 days after a final decision has been rendered or should have been rendered. Please note that a shorter or longer time frame to file suit may be required by an insurance company—please refer to the booklets for the insured plans for more information.

STATEMENT OF ERISA RIGHTS

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive information about your plan and benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as your local Human Resources office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under a group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- If you leave employment with the Company, and if you have creditable coverage from this plan, you may be eligible for a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your new employer's group health plan, you should be provided a certificate of creditable coverage, free of charge, from this plan or health insurance issuer when:
  - You lose coverage under the plan
  - You become entitled to elect continuation coverage
  - Your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage
- Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new employer's coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a pension or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the plan's claim procedures as described in this Summary Plan Description. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact

the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS INFORMATION

The following is information that pertains to all of the plans and to you as a participant.

HOME ADDRESS CHANGES

Active employees should advise their Human Resources Department when they have an address change. Retirees and surviving dependents who are eligible to receive benefits should notify the Benefits Service Center of their current address to ensure proper receipt of benefits information.

ASSIGNMENT OF BENEFITS

Your rights under the Plan or ERISA may not be assigned or transferred in any manner except as permitted under the terms of a plan or by law. Without limitation, a plan participant cannot assign their right to bring an appeal or to file suit for benefits to any third party, including a health care provider.

SOURCE OF PAYMENTS

The various medical and life insurance plans are funded with employer and employee contributions which are paid into a trust. Benefit payments are either insured or self-insured. If an insurance company is listed next to a plan that is self-insured, the insurance company is providing only administrative services and is not insuring the benefits. Benefit payments are made through a trust or by an insurance company.

MISTAKES AND RECOVERY OF OVERPAYMENTS

The plans have the right to recover from you, your dependents, or beneficiaries, as applicable, or any third party to whom payment has been made on such person's behalf, such as a health care provider, the amount of any overpayment. Some examples of when an overpayment may occur include if:

- A benefit is inadvertently paid twice
- The amount of a benefit is larger than it should be
- You are paid benefits for which a subsequent retroactive award is made which may offset the prior benefits paid to you
- You or a dependent is no longer eligible for coverage and the plan continues to pay benefits in error after you or your dependent is no longer eligible (even if you continue to pay the premiums for the coverage)
- A benefit payment is not permitted by or conflicts with plan documents

The plans may recover the full amount of the overpayment through any of the following means:

- Require the individual to repay the overpayment to the plan in one lump sum
- Stop current benefit payments until the full overpayment is repaid
- Reduce future benefit payments until the overpayment is repaid

SUBROGATION AND REIMBURSEMENT

All payments made under the medical plans are conditioned on the understanding that the plans will be reimbursed for the benefits paid if the benefits relate to an illness, injury or serious health condition for which the covered person has, may have or asserts any claim or right to recovery against a third party or parties. If a covered person receives money from a third party or parties in connection with an illness, injury or serious health condition for which the covered person

is also receiving benefits under the plans, then the covered person should contact the claims administrator. The covered person will be considered to hold these amounts in constructive trust for the benefit of the plans. If the claims administrator determines that a plan has made payments for which a covered person has been reimbursed by another party or parties, the covered person may be required to repay some or all of the benefits paid to him or her. The plans have the right to be reimbursed in full before any amounts (including attorneys' fees) are deducted from any policy, proceeds, judgment or settlement.

The plans will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under the plans arising out of the illness, injury or health condition that is the basis for any claim the covered person may have or assert. The plans will also be subrogated for attorneys' fees incurred in enforcing its rights under this paragraph.

A covered person may not take any action that could prejudice the plans' rights to reimbursement or subrogation. A covered person must cooperate fully with the plans in asserting their rights. A covered person may be requested to sign a subrogation or reimbursement agreement. If a covered person fails to cooperate, his or her benefits may be terminated.

If a covered person receives benefits under the medical plans that relate to an illness, injury or serious health condition for which the covered person has, may have or assert any claim or right to recovery against a third party or parties, the covered person should contact the claims administrator.

The Plan's right to subrogation or reimbursement takes preference over any other claims against the recovery, and the Plan's right exists and is enforceable regardless of how settlement proceeds are characterized or whether the recovery makes the covered person whole.

TERMINATION OF BENEFITS FOR CAUSE

The Plan Administrator reserves the right to terminate your participation (or that of your covered dependents) in any or all of the welfare benefit plans for cause. Cause may include, but is not limited to, any of the following: providing false information; making misrepresentations in connection with a claim for benefits; permitting a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtaining or attempting to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; failure to make any copayment, supplemental charge or other amount due with respect to a benefit; failure to cooperate with the Plan, Plan Administrator or claims administrator/insurer; or threatening the life or well-being of personnel administering the plan or of a provider of services or benefits. Each insurer may also have a specific definition of cause that may apply to the insured benefits provided under the retiree program.

RESCISSION OF COVERAGE

It is very important that all statements and representations you make in connection with your coverage under the welfare benefit plans are truthful. The Plan Administrator may retroactively discontinue or cancel your coverage under a plan if it is determined that you (or a person seeking coverage on your behalf) engaged in fraud or made an intentional misrepresentation of material fact. You will be considered to have engaged in fraud or intentional misrepresentation of a material fact if the Plan Administrator determines that you engaged in a deception with knowledge that the act or omission could result in an unauthorized benefit under the Plan for yourself or some other person.

For example, if you have been provided with this SPD – which contains a detailed explanation of the dependent eligibility requirements (see "Who Is Eligible To Participate" in the "Introduction" section of this SPD) – but you enroll someone in the medical plan who does not meet the requirements to be considered your eligible dependent, the Plan Administrator may retroactively terminate coverage for the ineligible individual. This means that you may be financially responsible for paying all of the claims that the medical plan had paid from the date you enrolled the ineligible individual until the date the Plan Administrator rescinds coverage.

For rescissions of medical plan coverage, you will be provided at least 30 days advance written notice before the coverage is rescinded. You may appeal the Plan Administrator's decision to rescind the coverage. See "Benefit Claims and Appeal Information" earlier in this "Administrative Information" section for more information.

CONFLICT WITH PLAN DOCUMENTS

This Summary Plan Description (SPD) describes the benefit plans that are offered to eligible Johnson Controls employees, and certain affiliated employers, and their eligible dependents. The plans are governed by the text of the official plan documents and insurance policies that provide the benefit plans under the program. If there is any conflict between this SPD and the text of the plan documents and insurance policies, the plan documents and insurance policies will govern.

PLAN AMENDMENT OR TERMINATION

The Company reserves the right to amend or terminate the benefits program or any portion of it at any time. The Company may amend or terminate the benefits program by action of the Policy Committee or Board of Directors. The benefits program operates on a calendar year basis. Although the Company intends to continue the benefits program indefinitely, the Company does reserve the right to amend a plan or discontinue any plan. The Policy Committee's right to amend the program includes, but is not limited to, changing the amounts required to be contributed by the Company and/or the employee for the purchase of benefits, level of benefits provided and the class or classes of employees eligible to participate. If the program is discontinued, benefits, if any, will be paid for all charges incurred for covered expenses prior to that date.

NOT A CONTRACT OF EMPLOYMENT

No provision of this SPD, the plan documents or insurance policies are to be considered a contract of employment between you and the Company. The Company's rights with regard to the disciplinary action and termination of any employee, if necessary, are in no manner changed by any provision of the program.

RULES OF ADMINISTRATION AND PLAN RECORDS

The Company, Policy Committee or insurance company has adopted rules for administration of the plans. The Company, Policy Committee or insurance company reserves the right, in its discretion, to adopt new rules, correct defects, supply omissions and correct inconsistencies to the extent required to carry out the plans, and such action will be definitive and binding on participants.

Records of administration will be kept for a minimum of three years, and participants and their beneficiaries may examine records pertaining directly to themselves.

ABOUT THIS PUBLICATION

This publication and any materials that accompany it provide highlights of the plans in the Retiree Benefits Program. This publication and any materials that accompany it are not intended to include all details about the plans. If there is a discrepancy between this publication and official plan documents or insurance contracts for the plans in the Retiree Benefits Program, the official plan documents or insurance contracts will govern. Nothing in this publication or any materials that accompany it implies automatic participation in the plan or is a guarantee of continued employment with the Company. The Company has the right to change or end the plan at any time for any reason and to require additional contributions from participants in the benefits program.

Revised Date: 01/2014
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