Benefits-at-a-glance

Benefits effective 90 days after date of hire Amounts shown below are the <u>EMPLOYEE'S</u> responsibility

MEDICAL	HIGH DEDUCTIBLE BlueCross BlueShield (BCBS)		BASIC PPO BlueCross BlueShield (BCBS)		PPO PLUS BlueCross BlueShield (BCBS)		PPO 100* BlueCross BlueShield (BCBS)
Deductibles	**In-Network** •Individual = $1,400 annually •Family = $2,800 annually	**Out-of-Network** •Individual = $2,800 annually •Family = $5,600 annually	**In-Network** •Individual = $1,000 annually •Family = $2,000 annually	**Out-of-Network** •Individual = $2,000 annually •Family = $4,000 annually	**In-Network** •Individual = $600 annually •Family = $1,200 annually	**Out-of-Network** •Individual = $1,200 annually •Family = $2,400 annually	•Individual = $200 annually •Family = $400 annually
Coinsurance/Copays	**In-Network** •Deductible and 20% for all services including inpatient hospital stays, outpatient surgery center and ambulance •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	**Out-of-Network** •Deductible and 40% plus any amounts over UCR •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	**In-Network** •Deductible and 20% for all services including inpatient hospital stays, outpatient surgery center and ambulance •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	**Out-of-Network** •Deductible and 40% plus any amounts over UCR •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	**In-Network** •$30 office copay (copay is not applied to deductible) •Deductible and 20% for all services including hospital stays, outpatient surgery center and ambulance •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	**Out-of-Network** •Deductible and 30% plus any amounts over UCR •$100 emergency room/ trauma center copay (copay is not applied to deductible) and deductible	•Deductible and 0% for all services •$50 copay per day, 5 day maximum for inpatient hospital stay (semiprivate room and board) •$50 copay for outpatient surgery •Maternity prenatal and postnatal care, and delivery at birthing center covered at 100% •$50 copay per day, 5 day maximum for hospital delivery •$125 copay for emergency care at hospital or outpatient emergency facilities (waived if admitted) •$20 office copay (primary care) •$30 office copay (specialist)
Out-of-Pocket Maximum	**In-Network** •Individual = $5,000 •Family = $10,000	**Out-of-Network** No limit	**In-Network** •Individual = $3,000 •Family = $6,000	**Out-of-Network** No limit	**In-Network** •Individual = $2,000 •Family = $4,000	**Out-of-Network** No limit	No limit
Routine Preventive Care (subject to established guidelines)	**In-Network** •Covered at 100%	**Out-of-Network** No coverage	**In-Network** •Covered at 100%	**Out-of-Network** No coverage	**In-Network** •Covered at 100%	**Out-of-Network** No coverage	•Covered at 100%
Immunizations (Covered to Age 19)	**In-Network** Covered at 100%	**Out-of-Network** No coverage	**In-Network** Covered at 100%	**Out-of-Network** No coverage	**In-Network** $30 office copay	**Out-of-Network** No coverage	$20 office copay
Vision Exam (Under age 40 one exam every two years, age 40 and over one exam per year)	**In-Network** Deductible and 20%	**Out-of-Network** No coverage	**In-Network** Deductible and 20%	**Out-of-Network** No coverage	**In-Network** $30 office copay	**Out-of-Network** No coverage	$30 office copay
Utilization Management (Precertification)	Call Utilization Management to precertify all inpatient services including maternity stays, emergency admissions, skilled nursing, home health care, hospice, reconstructive procedures, and durable medical equipment in excess of $1,000. For a complete list of services call the phone number listed on your medical ID card.		Call Utilization Management to precertify all inpatient services including maternity stays, emergency admissions, skilled nursing, home health care, hospice, reconstructive procedures, and durable medical equipment in excess of $1,000. For a complete list of services call the phone number listed on your medical ID card.		Call Utilization Management to precertify all inpatient services including maternity stays, emergency admissions, skilled nursing, home health care, hospice, reconstructive procedures, and durable medical equipment in excess of $1,000. For a complete list of services call the phone number listed on your medical ID card.		
If you <u>do not call</u> for precertification	Deductible and 50% plus any amounts over UCR		Deductible and 50% plus any amounts over UCR		Deductible and 50% plus any amounts over UCR		
Mental Health/Substance Abuse Outpatient	**In-Network** Deductible and 20%	**Out-of-Network** Deductible and 40% plus any amounts over UCR	**In-Network** Deductible and 20%	**Out-of-Network** Deductible and 40% plus any amounts over UCR	**In-Network** $30 office copay	**Out-of-Network** Deductible and 30% plus any amounts over UCR	$30 office copay
Inpatient If precertified	**In-Network** Deductible and 20%	**Out-of-Network** Deductible and 40% plus any amounts over UCR	**In-Network** Deductible and 20%	**Out-of-Network** Deductible and 40% plus any amounts over UCR	**In-Network** Deductible and 20%	**Out-of-Network** Deductible and 30% plus any amounts over UCR	$50 copay per day; 5 day maximum
If not precertified	Deductible and 50% plus any amounts over UCR		Deductible and 50% plus any amounts over UCR		Deductible and 50% plus any amounts over UCR		
Prescription Drug **Retail** (30 day supply maximum; 34 day supply maximum for PPO 100) *Note: If you are prescribed a brand name drug you may be required to take a generic drug before the dispensing of the brand name drug can be approved. Your physician will be consulted before the generic drug is dispensed. If you have any questions, please contact Caremark at 1-866-273-8571.* *Note: If generic is available and employee receives brand name drug, employee pays difference in cost.*	**In-Network** <u>Generic</u> •20% of cost •$7.50 minimum; $100 maximum <u>Preferred Brand</u> •25% of cost •$20 minimum; $100 maximum <u>Non-Preferred Brand</u> •40% of cost •$35 minimum; $100 maximum *Note: After maintenance medication is filled two times at a retail pharmacy, employee will pay 50% of cost.*	**Out-of-Network** <u>Generic</u> Reimbursed at 80% of the network drug cost <u>Preferred Brand</u> Reimbursed at 75% of the network drug cost <u>Non-Preferred Brand</u> Reimbursed at 60% of the network drug cost *Note: All claims must be submitted by employee*	**In-Network** <u>Generic</u> •20% of cost •$7.50 minimum; $100 maximum <u>Preferred Brand</u> •25% of cost •$20 minimum; $100 maximum <u>Non-Preferred Brand</u> •40% of cost •$35 minimum; $100 maximum *Note: After maintenance medication is filled two times at a retail pharmacy, employee will pay 50% of cost.*	**Out-of-Network** <u>Generic</u> Reimbursed at 80% of the network drug cost <u>Preferred Brand</u> Reimbursed at 75% of the network drug cost <u>Non-Preferred Brand</u> Reimbursed at 60% of the network drug cost *Note: All claims must be submitted by employee*	**In-Network** <u>Generic</u> •20% of cost •$7.50 minimum; $100 maximum <u>Preferred Brand</u> •25% of cost •$20 minimum; $100 maximum <u>Non-Preferred Brand</u> •40% of cost •$35 minimum; $100 maximum *Note: After maintenance medication is filled two times at a retail pharmacy, employee will pay 50% of cost.*	**Out-of-Network** <u>Generic</u> Reimbursed at 80% of the network drug cost <u>Preferred Brand</u> Reimbursed at 75% of the network drug cost <u>Non-Preferred Brand</u> Reimbursed at 60% of the network drug cost *Note: All claims must be submitted by employee*	<u>Generic</u> $15 copay <u>Preferred Brand</u> $20 copay <u>Non-Preferred Brand</u> $35 copay
Mail Order (90 day supply maximum) *Note: If you are prescribed a brand name drug you may be required to take a generic drug before the dispensing of the brand name drug can be approved. Your physician will be consulted before the generic drug is dispensed. If you have any questions, please contact Caremark at 1-866-273-8571.* *Note: If generic is available and employee receives brand name drug, employee pays difference in cost.*	<u>Generic</u> •20% of cost •$15 minimum; $200 maximum <u>Preferred Brand</u> •25% of cost •$40 minimum; $200 maximum <u>Non-Preferred Brand</u> •40% of cost •$70 minimum; $200 maximum		<u>Generic</u> •20% of cost •$15 minimum; $200 maximum <u>Preferred Brand</u> •25% of cost •$40 minimum; $200 maximum <u>Non-Preferred Brand</u> •40% of cost •$70 minimum; $200 maximum		<u>Generic</u> •20% of cost •$15 minimum; $200 maximum <u>Preferred Brand</u> •25% of cost •$40 minimum; $200 maximum <u>Non-Preferred Brand</u> •40% of cost •$70 minimum; $200 maximum		<u>Generic</u> $20 copay <u>Preferred Brand</u> $40 copay <u>Non-Preferred Brand</u> $70 copay
Other Special Coverages	•TMJ: $1,000 annual maximum •Infertility: Up to $3,500 lifetime maximum (diagnosis only) •Chiropractic: 25 visits per year (therapeutic only) •Hospice, human organ transplants based on medical necessity		•TMJ: $1,000 annual maximum •Infertility: Up to $3,500 lifetime maximum (diagnosis only) •Chiropractic: 25 visits per year (therapeutic only) •Hospice, human organ transplants based on medical necessity		•TMJ: $1,000 annual maximum •Infertility: Up to $3,500 lifetime maximum (diagnosis only) •Chiropractic: 25 visits per year (therapeutic only) •Hospice, human organ transplants based on medical necessity		•Physical Therapy: $30 office copay; 20 visits per year •Occupational & Speech Therapy: $30 office copay; 20 visits per year •Chiropractic: $30 office copay; 25 visits per year (therapeutic only) • Periodic Hearing Exam: $30 office copay
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited

This document is effective January 1, 2012.

UCR = Usual, Customary & Reasonable

You may need to enroll for some benefits to take effect. See your Summary Plan Description for further details.
This document is a supplement to the Summary Plan Description.
Domestic Partners and their dependents are eligible for select benefits. For more information call 1-866-496-1999 or go to http://resources.hewitt.com/jci.
***Plan only available to employees hired or transferred to an eligible group before June 30, 2005.**

These group health plans (except for the PPO 100) believe that they meet the requirements to be considered "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the JCI Service Center at 1-866-496-1999. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

BeWell4Life
Your Guide to Health & Wealth

Benefits-at-a-glance

Amounts shown below are the EMPLOYEE'S responsibility

DENTAL – *Effective first of month following one year of employment*

	BASIC	FULL	MIDDLETOWN PLAN*
Deductible	• Individual = $50 annually • Family = $150 annually (3 or more individuals)	• Individual = $25 annually • Family = $50 annually (2 or more individuals)	None
Preventive	Covered at 100% up to R&C	Covered at 100% up to R&C	Covered at 100% up to R&C
Basic (Includes fillings, endodontics, periodontics and X-rays)	Employee pays deductible and 40% plus any amounts over R&C	Employee pays deductible and 20% plus any amounts over R&C	Covered at 85% up to R&C
Major (Includes crowns, bridges and dentures)	Employee pays deductible and 60% plus any amounts over R&C	Employee pays deductible and 50% plus any amounts over R&C	Covered at 50% up to R&C
Annual Maximum	$1000 per individual	$1250 per individual	$1375 per individual
Orthodontia (Covered to age 19)	No coverage	• Employee pays 50% plus any amounts over R&C • $1250 lifetime maximum	$50 deductible $1375 lifetime maximum

EMPLOYEE ASSISTANCE PROGRAM (EAP)

COMPANY PAYS FULL COST OF THIS BENEFIT

The program provides confidential and comprehensive assessments, information, and planning referrals for situations ranging from everyday issues to crisis counseling

FLEXIBLE SPENDING ACCOUNTS

- Participate in one or both Flexible Spending Accounts to pay for health care expenses and/or child/elder care expenses
- Contribute a minimum of $240 up to a maximum of $5,000 per year per account
- Contributions are made pre-tax
- You must re-enroll in these plans each year to participate

LIFE AND AD&D INSURANCE (EMPLOYEE ONLY)

BASIC LIFE
$27,000

BASIC AD&D
$54,000
COMPANY PAYS FULL COST OF THIS BENEFIT

OPTIONAL
- $5,000
- $10,000
- $20,000
- $25,000
- $75,000

DEPENDENT LIFE INSURANCE

CHILD(REN)
- $10,000

SPOUSE
- $10,000
- $20,000
- $50,000
- $100,000

BUSINESS TRAVEL & ACCIDENT INSURANCE

COMPANY PAYS FULL COST OF THIS BENEFIT

- 1.5 times annual base pay; rounded to the nearest $500
- Minimum = $100,000
- Maximum = $1 million

DISABILITY PLANS

COMPANY PAYS FULL COST OF THIS BENEFIT

SHORT-TERM DISABILITY (STD)*
$315 / Week

SHORT-TERM DISABILITY
$225 / Week

LONG-TERM DISABILITY (LTD)*
$305 / Week

LONG-TERM DISABILITY
$218 / Week

COMMON STOCK PURCHASE PLAN (CSPP)

- After-tax payroll deductions
- Invested in Johnson Controls, Inc., Common Stock
- The company pays broker's commissions for purchase of stock; the employee pays the broker's fees when shares are sold
- Call Wells Fargo at 1-877-602-7397 or online at www.wellsfargo.com/shareownerservices to enroll, change or suspend payroll contributions or inquire about account information

R&C = Reasonable & Customary

***Plan only available to employees hired or transferred to an eligible group before July 30, 2005**

Johnson Controls, Inc. medical plans as required by the Women's Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy. For more information, contact your medical administrator.