

## **American Standard Companies**

### **Plan Administration as of January 1, 2006**

This *Plan Administration* section of your summary plan description (SPD), along with the *Flexible Benefits Eligibility or Flexible Benefits Eligibility for TCS Americas Sales – District Offices*, the *Retirement Choice Eligibility* and the sections detailing the actual plan benefits, comprise your SPD for *Plan Administration*.

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## OVERVIEW

This section provides administrative details for the following benefit plans sponsored by American Standard:

- Medical
- Prescription drug
- Dental
- Vision
- Employee assistance program
- Life insurance
- Accidental death and dismemberment
- Business travel accident
- Disability
- Health care reimbursement account
- Dependent care reimbursement account
- Pension plan
- Savings plan
- Employee stock ownership plan (ESOP)

This summary plan description (SPD) does not guarantee that you are eligible to participate in every benefit plan described. Each benefit plan may have its own eligibility requirements, so be sure to review individual plan eligibility requirements carefully. Nothing in this SPD is intended to guarantee that benefit levels and costs will remain the same in future years.

This administrative section, along with the other sections of this SPD:

- Has been prepared to help you learn about and understand your benefits under the plans sponsored by American Standard.
- Is intended to comply with the documentation and disclosure requirements of the Employee Retirement Income Security Act (“ERISA”) and other applicable laws and regulations. This SPD, together with a booklet issued by an insurance company, or another governing document prepared by American Standard or a third party provider that administers the benefit, constitutes the written plan documentation required by ERISA Section 402 and the SPD required by ERISA Section 102 for all of the plans listed above. For the pension plan, savings plan and the employee stock ownership plan, there are separate plan documents that constitute the written plan documentation required by ERISA Section 402.
- Does not create a contract or guarantee of employment between American Standard and you. Your employment is always on an at-will basis. The company or you may terminate your employment relationship without notice at any time and for any reason.

Also, except as may be required by law, the benefits provided by the plans described in this SPD are not in any way subject to your or your dependents’ debts or other

obligations and may not be voluntarily or involuntarily sold, transferred, alienated or encumbered.

Although these plans have been summarized in everyday language, this SPD does not replace the legal plan documents. In the event there is a conflict between a provision in this SPD and a document specific to an individual benefit plan, such as an insurance contract or governing plan document, the terms of the insurance contract or governing plan document will govern with respect to the specific benefits provided, unless otherwise provided by any federal or state law.

## ADMINISTRATIVE INFORMATION

This section, as well as the Plan Funding and Administration chart, contains information on the administration of the American Standard benefit plans and your rights as a plan participant. Please read through this section. While you may not need this information for day-to-day participation in the American Standard benefit plans, it's important that you understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations.

### **Plan administrator and claims administrator**

The plan administrator administers your benefit plans. The plan administrator may appoint/employ the persons necessary to provide advice with respect to any responsibility of the plan administrator under the plans. Additionally, the plan administrator may delegate any responsibility under the plans to company employees or other persons.

Under several of the plans (for example, the insured plans), the plan administrator has delegated claims administration responsibility to a third party "claims administrator." To the extent the plan administrator has delegated such responsibility; the claims administrator has the discretionary authority and responsibility to make all factual determinations necessary to administer a plan's claims administration procedures. This includes claim denial reviews, determining the amount of benefits and interpreting the meaning and intention of the terms of the plans.

See the *Plan Funding and Administration Chart* at the end of this section for the plan administrator and claims administrator by benefit plan. Correspondence to the plan administrator/claims administrator should be sent to the addresses listed in the *Plan Funding and Administration Chart*.

The plan administrator and/or its duly authorized designee(s) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the plans—including this SPD, any trust agreements and any other plan documents. The administrator or designee(s) decides all matters (including factual matters) that arise in connection with the operation or administration of the plans and any trust agreements.

Without limiting the generality of the above described authority, the plan administrator and/or its duly authorized designee(s) has sole and absolute discretionary authority to:

- Take all actions and make all decisions (including factual decisions) about eligibility and the amount of benefits payable under the plans
- Formulate, interpret and apply rules, regulations and policies necessary to administer the plans according to the terms of the plans
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the plans
- Resolve and/or clarify any ambiguities, inconsistencies and omissions (including factual determinations) arising under the plans, including this summary, any trust agreements or other plan documents
- Process and approve or deny benefit claims
- Determine the standard of proof required in any legal case or claim

### **Agent for service of legal process**

The agent for service of legal process is CT Corporation System. Process may be served on the agent at 1633 Broadway, New York, NY 10019. Service of legal process also may be made on the plan administrator, claims administrator for insured benefits or plan trustees.

### **Plan funding and administration**

Refer to the *Plan Funding and Administration Chart* at the end of this section for this information.

### **Plan year**

The plan year for all benefit plans except the following ends on December 31 of each year. The plan year for the long-term disability, business travel accident and supplemental (voluntary) accident plans ends on August 31 of each year.

### **Contact information**

If you have questions about your benefits, contact the plan administrator or applicable claims administrator directly. Contact information, including telephone numbers and Web site addresses, can be found in the *Plan Funding and Administration Chart* at the end of this section.

## **PROVISIONS ABOUT YOUR HEALTH BENEFITS**

### **Coordination of benefits**

The American Standard health plan (medical, prescription drug, dental and vision) contains a provision called “coordination of benefits,” or COB. This feature is designed

to coordinate your American Standard health care coverage with other coverage and prevent a duplication of benefit payments. Under COB, the total benefits paid by all health care plans combined will not exceed what our plan would pay if it were the only plan. COB rules may be different for insured health care options. You should refer to an insured option's certificate of coverage for more information on applicable COB rules.

The COB feature applies when you or any of your covered dependents are eligible for health care benefits (in addition to those provided by American Standard) from another source such as:

- A group-sponsored insurance or prepayment plan (such as your spouse's group medical plan, another employer's group medical plan or a retiree group medical plan)
- A legal settlement that includes all or part of the cost of medical care
- A government-sponsored plan

COB rules apply to you and all of your covered eligible dependents. COB does **not** apply to any personal insurance policy except no-fault or other state-mandated automobile insurance.

The claims administrator requires information about other group health insurance coverage for you and any of your covered dependents. Our claims administrator may periodically request this information from you or the request may occur in connection with a submitted claim. If so, you'll be advised that the insurance information (including an explanation of benefits from the other insurance carrier) is required before your claim is processed for payment. If you don't respond within 90 days, your claim will be denied. If the claims administrator subsequently receives the requested information within the required time period for filing claims—generally 24 months from the date of service—your claim will be processed.

#### *Determining which plan pays first*

Our claims administrators follow standard rules to determine which plan is "primary" and which plan is "secondary." The primary plan pays benefits first. After the primary plan has processed your claim, you can then submit your claim to the secondary plan for consideration. The claims administrator determines which plan is primary and which plan is secondary as follows:

- When the other plan doesn't have a COB provision, that plan is considered primary, and our plan is secondary.
- When both plans have COB provisions, the primary plan is determined as follows:
  - The plan covering you as an employee is primary.
  - The plan covering you as a dependent is secondary.

### *How COB works*

If you are covered under one of the American Standard health plans and another health plan, always submit your claims to the primary plan first. Be sure to include any explanation of benefits from the primary plan and itemized bills when you submit your claim to the secondary plan.

When our plan is *primary*, it pays benefits as if there were no secondary plan. When our plan is secondary, it pays benefits *after* the primary plan has paid benefits.

As the *secondary* plan, our plan may pay all or part of the allowable expenses that are not paid by the primary plan. That is, our plan pays as if it was the primary plan, reduced by the allowable expenses paid by the primary plan. You will never receive more than 100% of your allowable expenses from the two plans combined, and our plan will not pay for a service or supply that it does not cover.

For claims incurred prior to April 1, 2006 for TCS Americas Sales—District Offices Medicare-primary retirees, our health care plan will adjust its benefits so that the total benefits paid under our plan and any other plan (e.g., Medicare) will not be greater than 100% of allowable expenses under our plan.

### *COB for eligible dependent children*

For covered dependent children, primary and secondary coverage is determined as follows:

- Except as described below, the plan covering the parent whose birthday comes first in the year (month and day) is the primary plan. The plan covering the other parent is secondary. This is called the birthday rule. Our plan uses this rule. If both parents have the same birthday, the primary plan is the plan that has covered the parent longer.
- If the other plan does not include the birthday rule, the rules of the other plan determine the order of benefit payments.

### *COB if parents are divorced or legally separated*

If you are divorced or legally separated, our claims administrator determines if there is a court decree or Qualified Medical Child Support Order (QMCSO) establishing one parent's financial responsibility for health care. You may obtain a copy of our procedures regarding QMCSO determinations, free of charge, by contacting the plan administrator.

Primary and secondary coverage is determined as follows:

- If a court decree or QMCSO exists, the plan covering the parent who has the medical support responsibility will be the primary plan.
- If there is no court decree or QMCSO, the plan covering the parent with custody will be the primary plan. The other parent's plan will be secondary.

- If there is no court decree or QMCSO and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary. The non-custodial parent's plan is third to pay benefits.

If payment responsibilities are still unresolved, the plan that has covered the child for the longest time is the primary plan. However, the plan of a laid-off or retired employee is secondary to the plan covering a person as an active employee or a dependent of an active employee. (If a plan does not have this provision, it does not apply.)

### *No-fault automobile insurance*

In states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident even if you have elected to make the no-fault plan secondary. You should always elect at least the minimum medical benefits required by state law under your no-fault automobile insurance as primary coverage. In no-fault states, all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The American Standard plan will pay covered expenses not payable under the no-fault automobile insurance according to the plan's COB rules.

### *Coordination with Medicare*

If you or your dependents are covered by Medicare and the American Standard health plan, the American Standard health plan is primary if:

- You are an eligible active employee age 65 or older and you are entitled to Medicare benefits.
- Your dependent spouse is age 65 or older, or under age 65 and disabled according to Social Security, and covered by an American Standard medical or prescription drug plan based on your active employment status.
- Eligibility for Medicare is due to having end-stage renal disease (ESRD) under the conditions and for the time periods specified by federal law. The American Standard health plan is primary during the first 30 months of Medicare due to ESRD.

If you are entitled to Medicare and want Medicare as your *primary* coverage, you must decline American Standard medical and prescription coverage. Medicare will be your only coverage. The company's medical plan will *not* provide any benefits.

If you or covered family members are enrolled for medical and prescription drug coverage through COBRA and then become covered by Medicare, your COBRA coverage will end.

The American Standard health plan is secondary to Medicare for you, your spouse or other covered dependents if you or your dependent are covered by Medicare and the American Standard health plan, and:

- You receive a determination from Social Security that you are totally and permanently disabled. Please see the *Flexibility Benefits Eligibility* and *Retirement Choice Eligibility* sections of the summary plan descriptions for more information about benefits that may be available for disabled individuals.
- You are a retired employee and covered under an American Standard health plan as a retired employee.

If you or a covered dependent is disabled, the disabled individual should apply for Social Security benefits, which generally can take up to five months for approval. After 24 months of being Social Security disabled, disabled individuals are eligible for Medicare. At this time, the plan will assume that the disabled individual has applied for full Medicare Part A and B coverage, and Medicare becomes the primary plan and the American Standard plan becomes the secondary plan. As the secondary plan, the American Standard health plan will reduce benefits to reflect whatever Medicare would have paid had the disabled individual elected the full Medicare Part A and B coverage.

These Medicare primary rules also apply to Medicare-eligible individuals who are over age 65 and covered under an American Standard health plan as a retired employee or as a dependent of a retired employee.

If you are Medicare-eligible and you elect Medicare Part D, you are not covered for prescription drug benefits under American Standard's plan.

### **Recovery provisions**

Our claims administrators can exchange benefit information with other employers, administrators and insurers to determine responsibility for benefits between the company's benefit plans and other coverage.

### ***Overpayment of benefits***

Our claims administrators have the right to recover any overpayment or make adjustments to the payment of future claims to meet our COB provisions.

### ***Subrogation and reimbursement***

The American Standard benefit plans (medical, prescription drug, dental, vision and disability plans) contain subrogation and reimbursement provisions. Subrogation and reimbursement provisions may be different for insured health care options and disability benefits. You should refer to an insured option's certificate of coverage for more information on applicable subrogation and reimbursement provisions.

If you or your covered dependent(s) are injured or otherwise harmed due to the conduct of another party, the plan administrator has the right to recover from you, your covered dependents and/or any other person, entity or trust in possession of the benefits paid by

any of the American Standard benefit plans for which you or they recover monies from a third party. The plan shall have a first priority lien for the full amount of the benefits that are paid to you and/or your covered dependents should you seek to recover any monies from the third party that caused the injuries. These amounts may come directly from the third party or his or her insurance company, or any other source (including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance), or from any amount received by you or your covered dependents from the third party, his or her insurance company or any other source. This is referred to as the plan's right of "subrogation and reimbursement." This right exists with respect to any amount received or receivable through a "third party" claim, lawsuit, settlement or any other manner, whether or not characterized as related to medical expenses. The plan may seek recovery through subrogation and/or any other equitable or legal relief available under state or federal law.

The plan administrator may delegate to our claims administrators all or any portion of its rights and/or obligations regarding the plan's right of subrogation and reimbursement.

We strongly recommend that if you are injured as a result of the negligence or wrongful act of a third party, you should contact your attorney for advice and counsel. However, this plan cannot and does not pay for the fees your attorney might charge. Furthermore, the plan does not require you to seek any recovery whatsoever against a third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the plan for any of the benefits that you applied for and accepted.

When you accept benefits from an American Standard benefit plan, you are agreeing to reimburse the plan the full amount of any benefits paid to you or your covered dependents from the proceeds of any compromise, settlement, judgment and/or verdict to the extent permitted by law. The plan administrator, in its own discretion, may also commence an action against any party it feels caused an injury to you or a covered dependent for which the plan provided benefits. The plan will not provide you with legal representation if you decide to commence your own legal action.

You also must take any reasonably necessary action to protect the American Standard benefit plan's subrogation and reimbursement right. By accepting plan benefits, you agree to notify the plan administrator or its delegate within 10 days after either you or your attorney first attempt to recover monies, or institute a lawsuit, or other action, or enter into settlement negotiations with another party (including his/her insurance company) in connection with or related to the conduct of another party. You must also cooperate with the reasonable requests of the plan administrator or its delegate concerning the plan's subrogation and reimbursement rights and keep the plan administrator informed of any important developments in your actions and also provide the plan administrator or its delegate with any information or documents upon request, that pertain to or are relevant to your actions. If litigation is commenced, you are required to give at least five days notice to the plan administrator prior to any action to be taken as

part of such litigation, including, but not limited to, any pretrial conferences or other court dates. Representatives of the plan reserve the right to attend pretrial conferences or other court proceedings.

In the event that you fail to notify the plan as provided for above, and/or fail to reimburse the plan as provided for above, the plan reserves the right, in addition to all other remedies available to it at law or equity, to withhold any other monies that might be due you from the plan for past or future claims, until such time as the plan's lien is discharged and/or satisfied.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from a third party, his or her insurance carrier and/or any other source, if paid directly to you, will be held by you in constructive trust for the plan. The receipt of such funds makes you a fiduciary for the plan with respect to such funds and, therefore, subject to the fiduciary provisions and obligations of ERISA.

By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict received from the third party, his or her insurance carrier and/or any other party settling on his behalf, and paid to a person or entity other than you, including but not limited to, a trust, an attorney or an agent thereof, shall be held by such other person, entity or trust in constructive trust for the plan. The recipient of such funds is a fiduciary for the plan with respect to such funds and is subject to the fiduciary provisions and obligations of ERISA. The plan reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the plan's subrogation or restitution rights.

By applying for benefits, you agree that any lien the plan may seek will not be reduced by any attorney fees, court costs or disbursements that you and/or your attorney might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the plan for the full amount of the lien. Further, you agree that any recovery will not be reduced by and is not subject to the application of the common fund doctrine for the recovery of attorney's fees.

If you or your covered dependent has received plan benefits and also receives payment from a third party, his or her insurance company or any other source as a result of an injury or harm due to the conduct of another party, you must reimburse the plan first for the amount of medical expenses paid on your or your covered dependent's behalf by the plan. The amount you (or your covered dependent) receive from a third party may not compensate you (or your covered dependent) fully for all of the financial expenses incurred. Where the recovery from a third party is partial or incomplete, the plan's right to reimbursement takes priority over your or your covered dependents' right of recovery, regardless of whether you or your covered dependents have been made whole for injuries or losses. The plan does not recognize and is not bound by any application of the "make whole" doctrine.

## **Continuation of coverage**

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and their covered dependents the opportunity to temporarily extend health coverage at group rates in certain instances where coverage under the plan would otherwise end. (Health coverage includes medical, dental and vision coverage, as well as the health care reimbursement account.)

Your rights and obligations under COBRA are as follows:

### *Who may elect COBRA coverage*

If you are covered by a company health plan as an employee, you are a qualified beneficiary and have a right to choose COBRA coverage if:

- You lose your coverage because of a reduction in your hours of employment
- You lose coverage because you terminated your employment (for reasons other than gross misconduct on your part)

If you do not lose your coverage completely, a reduction in hours is still a qualifying event if it results in an increase in your cost for coverage. Special rules may apply if you are offered other medical, dental or vision coverage as an alternative to COBRA coverage. For more information, contact our COBRA administrator, CobraServ, at 1-800-877-7994.

If your spouse is covered by a company health plan on the day before a qualifying event, he/she is a qualified beneficiary and has the right to choose COBRA coverage if coverage is lost because:

- You die
- Your employment is terminated (for reasons other than gross misconduct), or your hours are reduced
- You and your spouse become divorced or legally separated (in states where legal separation equals divorce)
- You become enrolled in Medicare (Part A, Part B or both)

If your dependent child is covered by a company health plan on the day before a qualifying event, he/she is a qualified beneficiary and has the right to choose COBRA coverage if coverage is lost for any of the following reasons:

- You die
- Your employment is terminated (for reasons other than gross misconduct), or your hours are reduced
- You and your spouse become divorced or legally separated (in states where legal separation equals divorce)
- You become enrolled in Medicare (Part A, Part B or both)
- Your dependent is no longer eligible for health coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to American Standard, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

If you elected COBRA and you have a newborn or newly adopted child during your COBRA coverage period, that child will have an independent right to elect COBRA coverage. To elect this coverage, you must notify CobraServ in writing within 31 days after your child's birth, adoption, or the date you become legally obligated to provide support for that child in anticipation of adoption. If you do not notify CobraServ within the 31-day period, that child will not have an independent right to elect COBRA coverage.

If you take a leave of absence under the Family and Medical Leave Act (FMLA) and you do not return to work at the end of your FMLA leave, you may elect COBRA coverage. You will experience a qualifying event on the last day of your FMLA leave, which is the earliest of:

- When you unequivocally inform the company that you are not returning at the end of your leave,
- The end of your leave, assuming you do not return, or
- When your FMLA entitlement ends.

For purposes of an FMLA leave, you will be eligible for COBRA only if:

- You or your eligible dependents were covered by an American Standard health plan on the day before your FMLA leave started,
- You do not return to work at the end of your FMLA leave, and
- You or your covered dependents lose coverage under an American Standard health plan before the end of what would be the maximum COBRA continuation period.

### *Your duties under the law*

You must notify the company in writing through your local benefit representative within 60 days from the date of divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event). If your child drops out of school, you should notify the company in writing through your local benefit representative within 60 days of the date your dependent child is no longer attending school. If we do not receive written notification during this 60-day period, any covered dependent that loses coverage will not be permitted to elect COBRA coverage. We also need the following information for each qualified beneficiary who is losing coverage:

- Full name
- Mailing address
- Date of birth
- Relationship to you
- Social Security number

If you or your dependent fails to notify us and any claims are mistakenly paid for expenses incurred after the date coverage ceased, then you or your covered dependent will be required to reimburse the plan for any claims mistakenly paid.

Once you notify us, CobraServ will mail information and election forms to you, your spouse or dependent children.

After you receive the information and election form, you and your eligible dependents then have 60 days from the date coverage ends or the date this information package is mailed to you (whichever is later) to accept or decline COBRA coverage.

#### *American Standard's duties under the law*

Our COBRA administrator will automatically notify qualified beneficiaries of the right to elect COBRA coverage if coverage is lost because:

- You die
- Your employment is terminated (for reasons other than gross misconduct), or your hours are reduced
- You become enrolled in Medicare (Part A, Part B or both)
- American Standard commences a proceeding in bankruptcy

Our COBRA administrator will mail information and election forms to you, your spouse or dependent children.

After you receive the information and election form, you and your eligible dependents then have 60 days from the date coverage ends or the date this information package is mailed to you (whichever is later) to accept or decline COBRA coverage. If elected, COBRA coverage is effective as of the date coverage is lost.

#### *Electing COBRA coverage*

**Time Period for Elections**—A qualified beneficiary must elect COBRA coverage within 60 days from the date coverage is lost as a result of one of the events described earlier, or, if later, 60 days after CobraServ provides a qualified beneficiary with notice of the right to elect COBRA coverage. A third party, such as a health care provider, may also elect and pay for coverage on behalf of a qualified beneficiary. *If COBRA coverage is not elected within the time period described above, COBRA coverage cannot be elected later.*

A qualified beneficiary may change or revoke a COBRA election until the election period expires. If a qualified beneficiary waives COBRA coverage prior to the end of the election period, he/she can revoke the waiver and elect coverage at any time before the election period ends. COBRA coverage begins on the date the waiver is revoked, which is considered the COBRA election date.

**Separate Elections**—Each qualified beneficiary has an independent right to elect COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary is entitled to make a separate election. Your spouse or dependent child can elect COBRA coverage even if you do not. Similarly, your spouse or dependent child may elect different coverage than what you elect.

**Limited Second Election Period**—The Trade Act of 2002 created a special COBRA right applicable to employees who have been terminated or experienced a reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance.” These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended. If you have questions about Trade Act provisions or if you qualify or may qualify for assistance under the Trade Act of 2002, you may contact CobraServ for additional information or you may call the Health Coverage Tax Credit Customer Contact Center toll free at 1-866-628-4282. You must contact CobraServ promptly after qualifying for assistance under the Trade Act of 2002 or you will lose any special COBRA rights.

#### *Types of coverage you will receive; changes to coverage*

If you choose COBRA coverage, it must be identical to the coverage provided under the plan to similarly situated employees or covered dependents. If the coverage for similarly situated employees or covered dependents is modified, your coverage will be modified in the same way. “Similarly situated” refers to a current eligible employee or eligible dependent who has not had a qualifying event.

As a qualified beneficiary, you have the same opportunity to change your benefit elections as an active employee. At open enrollment, you can choose different coverage or change which eligible dependents are covered under the plan. You also have the same right as active employees to enroll family members under the Health Insurance Portability and Accountability Act of 1996 “HIPAA” special enrollment rules (for example, in the case of a new dependent acquired through marriage, birth, adoption or a dependent’s loss of other medical coverage). See the *Flexible Benefits Eligibility* section of your SPD for more information.

### *Duration of COBRA coverage*

**Employment Termination or Reduction in Hours**—The law requires that you be given the opportunity to purchase COBRA coverage for 18 months following a termination of employment or a reduction in hours, which causes a loss in coverage. This includes an increase in the cost of coverage caused by your employment termination or reduction in hours.

If you experience an employment termination or reduction in hours following Medicare enrollment, however, your spouse and dependent children who are qualified beneficiaries may elect COBRA for up to 36 months from the date of Medicare enrollment or 18 months from your termination or reduction in hours, whichever is longer.

**Other Qualifying Events**—A 36-month period of coverage applies to spouses and dependent children who experience qualifying events other than due to your termination of employment or reduction in hours. This longer period applies to a loss of coverage due to:

- Your death,
- Divorce or legal separation of you and your spouse (in states where legal separation equals divorce),
- If you lose benefits because of entitlement to Medicare (your spouse and dependent may elect COBRA coverage for up to 36 months from the date you became enrolled in Medicare), or
- Your dependent is no longer eligible for coverage under the plan.

**Second Qualifying Events**—A 36-month period also applies if one of these qualifying events occurs during the initial 18-month COBRA period described earlier, or during a 29-month COBRA period applicable to disabilities, described below. These events can result in an extension of an 18- or 29-month COBRA period to 36 months from the date of employment termination or reduction in hours, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

You must notify CobraServ, the COBRA administrator, in writing within 60 days of the second qualifying event in order to be eligible for the 36-month COBRA period.

**Special rules for disability**—An 11-month disability extension (total of 29 months) is also available if a qualified beneficiary is disabled under the rules of the Social Security Administration. If a qualified beneficiary is disabled, this extension is available to other covered family members who are not disabled. It also applies to children born to, or adopted by you after the initial qualifying event, who are determined to be disabled within the first 60 days of COBRA coverage.

To qualify for this disability extension, you or a family member must provide CobraServ with a copy of a determination by the Social Security Administration that you or a covered dependent was disabled at some time during the 60-day period after your termination of employment or reduction in hours. You must provide this notice within 60 days of the latest of the date such disability determination is made; the date of the qualifying event or the date coverage would be lost under the plan; and before the end of your original 18-month COBRA coverage period. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify CobraServ in writing of that fact within 30 days of the Social Security Administration determination.

**Health care reimbursement account**—Regardless of the type of qualifying event, COBRA coverage for this account will stop at the end of the year in which the qualifying event occurs and cannot be continued into the next plan (calendar) year.

#### *Early termination of COBRA coverage*

Your COBRA coverage may stop prior to the expiration of the 18-, 29-, or 36-month period for any of the following reasons:

- The company no longer provides group health coverage to any of its employees
- You do not pay the COBRA premium within 30 days of the due date, or the initial premium is not paid within 45 days after the initial election
- After the date COBRA is elected, a qualified beneficiary becomes covered under another group health plan (whether or not as an employee) that does not contain any exclusion or limitation for pre-existing conditions (COBRA coverage ends only for the person covered by the other group health plan)
- After the date COBRA is elected, a qualified beneficiary becomes enrolled in Medicare (COBRA coverage ends only for the person enrolled in Medicare)
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. Coverage for all qualified beneficiaries who received a COBRA disability extension may end as of the first day of the month that is more than 30 days after such final determination, provided that the termination date is after the end of the initial 18-month COBRA period.

Finally, the company reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

#### *Paying for COBRA coverage*

You do not have to show that you are insurable to choose COBRA coverage. However, you will be required to pay the full cost of covering an employee, and any eligible dependents, if applicable. In addition, there is a 2% administrative fee, making your payment a total of 102% of the cost of coverage. If your coverage is extended from 18-to-29 months for a disability, you may be required to pay up to 150% of the cost of covering

an employee and any eligible dependents, if applicable. This cost increase begins with the 19<sup>th</sup> month of COBRA coverage, provided that the disabled individual is one of the individuals that elected the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified of any cost changes.

COBRA coverage is not effective until you elect it *and* make the required payment. You have an initial grace period (45 days from the date of your initial election) to make your first premium payment. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you pay part, but not all, of the premium, and the amount you paid is not significantly less than the full amount due, you will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

### ***COBRA administration/notices***

If you have any questions about COBRA coverage or the application of the law, please contact CobraServ. You may also contact the nearest Regional or District office of the U.S. Department of Labor Employee Benefits Security Administration (EBSA). Addresses and phone numbers for the Regional and District offices of the EBSA are available online at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

Also, if your marital status has changed, or you, your spouse or your dependent has changed addresses, or your dependent ceases to be a dependent eligible for coverage under the terms of our plan, you must notify CobraServ in writing immediately.

CobraServ is our COBRA administrator. Except as otherwise provided above, all notices and other communication regarding COBRA and any of the American Standard health plans should be directed to the following:

CobraServ  
3201 34<sup>th</sup> Street South  
St. Petersburg, FL 33711-3828  
1-800-877-7994

### ***Converting coverage after termination***

When your coverage under an insured health care plan ends (or at the expiration of your COBRA continuation period), an insurance provider may allow you to convert your coverage to an individual policy sponsored by the insurance provider. In that case, you will not have to provide evidence of insurability. You will need to complete a written application and pay your first premium within 31 days after your coverage ends.

## **Your rights under your medical benefits**

### *Newborns' and Mothers' Health Protection Act*

Under federal law, group health plans and health insurance issuers can't 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
- Less than 96 hours following a cesarean section
- Or require a provider to obtain authorization from the plan or insurance issuer for a length of stay that is within these time periods. However, if the mother agrees, either mother or newborn may be released earlier.

### *Women's Health and Cancer Rights Act*

All options cover reconstructive surgery following treatment of breast cancer for:

- Reconstruction of the breast that has been removed
- Reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of any physical complications of the mastectomy, including lymph edemas

These reconstructive benefits are subject to any annual plan deductibles, copays and coinsurance provisions like other medical and surgical benefits covered under the company's medical plans.

## **CLAIMS REVIEW AND APPEAL PROCESS**

Procedures for filing claims are outlined in each benefit plan's SPD. Claims and appeals procedures may be different under insured options. You should refer to an insured option's certificate of coverage for applicable claims and appeals procedures. In general, any participant or beneficiary or his/her duly authorized representative (the "claimant") may file a written claim for benefits using the proper form and procedure.

A benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed. If you have any questions regarding how to file or appeal a claim, contact the appropriate claims administrator (see the *Plan Funding and Administration Chart*).

### **Initial notice**

The law allows a reasonable amount of time for the plan administrator or claims administrator to evaluate a claim and to decide whether to pay benefits based on the

information contained in the written claim. If your claim is not acted upon within a reasonable time, you may proceed to the appeal process as if the claim had been denied.

The following charts highlight the timeframes that apply to the various types of claims that you may make under the retirement, health care, life insurance, accidental death and dismemberment, disability and business travel accident plans, and the health care and dependent care reimbursement accounts.

***Timeframes for initial claim decisions***

Timeframes generally start when the plan receives a claim filed in accordance with the plan’s procedures. Notices of benefit determinations by the plan generally should be provided through hand delivery, mail or electronic delivery before the period expires. Oral notices may be permitted in limited cases. A reference to “days” means calendar days.

|                                       | <b>Health care plans and health care reimbursement account—urgent care claims</b>                                                                                                                                                                                                                                                                            | <b>Health care plans and health care reimbursement account—non-urgent “pre-service” claims</b>                                                                            | <b>Health care plans and health care reimbursement account—non-urgent “post-service” claims</b>                      | <b>Health care plans and health care reimbursement account “concurrent care” decision to reduce benefits</b>                                                                                   |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Timeframe for providing notice</b> | <p>Notice of approval or denial must be provided by the plan as soon as possible considering medical circumstances, but not later than 72 hours.</p> <p>If you request to extend ongoing treatments in advance, the notice of determination must be provided as soon as possible taking into account medical circumstances, but not later than 24 hours.</p> | <p>Notice of approval or denial must be provided by the plan within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.</p> | <p>Notice of approval or denial must be provided within a reasonable period of time, but not later than 30 days.</p> | <p>Notice of approval or denial must be provided by the plan sufficiently in advance to give you an opportunity to appeal and obtain a decision before a benefit is reduced or terminated.</p> |

|                                              | Health care plans and health care reimbursement account—urgent care claims                                                                                                                                  | Health care plans and health care reimbursement account—non-urgent “pre-service” claims                                                           | Health care plans and health care reimbursement account—non-urgent “post-service” claims                                                          | Health care plans and health care reimbursement account “concurrent care” decision to reduce benefits |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Extensions*</b>                           | The plan has up to 48 hours (subject to a decision being made as soon as possible) for missing claim information; this period is measured from when information is received or an extension period expires. | The plan has up to 15 days, if necessary, due to matters beyond the plan’s control and must provide an extension notice before the period ends.** | The plan has up to 15 days, if necessary, due to matters beyond the plan’s control and must provide an extension notice before the period ends.** | N/A                                                                                                   |
| <b>Period for claimant to complete claim</b> | You have a reasonable period of time to provide any missing information (not less than 48 hours).                                                                                                           | You have at least 45 days to provide any missing information.                                                                                     | You have at least 45 days to provide any missing information.                                                                                     | N/A                                                                                                   |
| <b>Other related notices</b>                 | Notice that a claim is improperly filed or missing information must be provided by the plan as soon as possible (not later than 24 hours).                                                                  | Notice that a claim is improperly filed must be provided by the plan as soon as possible (not later than five days).                              | N/A                                                                                                                                               | N/A                                                                                                   |

\* In addition to extensions listed in the chart, you may agree to a further extension of the time period within which the plan must decide your claim.

\*\* 15- or 30-day extension period (whichever is applicable) is suspended until the earlier of the date on which a response from the claimant is received by the plan or the date for furnishing the requested information.

|                                              | <b>Long-term and short-term disability benefits &amp; other claims for benefits based on disability</b>                                                                                                 | <b>Pension, savings, ESOP, life insurance, AD&amp;D, business travel accident plans and dependent care reimbursement account</b> |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Timeframe for providing notice</b>        | Notice of approval or denial must be provided by the plan within a reasonable period of time, but not later than 45 days.                                                                               | Notice of approval or denial must be provided by the plan within a reasonable period of time, but not later than 90 days.        |
| <b>Extensions*</b>                           | The plan has up to 30 days if necessary due to matters beyond the plan's control. A second 30-day extension may also be permitted. The plan must provide the extension notice before the period ends.** | The plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.               |
| <b>Period for claimant to complete claim</b> | You have at least 45 days to provide any missing information (including the report of a required examination).                                                                                          | No rule                                                                                                                          |
| <b>Other related notices</b>                 | N/A                                                                                                                                                                                                     | N/A                                                                                                                              |

\* In addition to extensions listed in the chart, you may agree to a further extension of the time period within which the plan must decide your claim.

\*\* 15- or 30-day extension period (whichever is applicable) is suspended until the earlier of the date on which a response from the claimant is received by the plan or the date for furnishing the requested information.

## Timeframes for appeals process

Timeframes for filing an appeal start when you receive written notice of the denial of all or part of your claim. The timeframes applicable to the plan for providing a notice of the appeal decision (a “notice of benefit determination on review”) start when the appeal is filed in accordance with the plan’s procedures. The notice of appeals decision by the plan should be provided through hand delivery, mail or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile or other available expeditious method. References to “days” mean calendar days.

|                                       | Health care plans and health care reimbursement account—urgent care claims*                 | Health care plans and health care reimbursement account—non-urgent care pre-service claims*                                                                                                                                               | Health care plans and health care reimbursement account—non-urgent care post-service claims*                                                                                                         |
|---------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Period for filing appeal</b>       | You have at least 180 days.                                                                 | You have at least 180 days.                                                                                                                                                                                                               | You have at least 180 days.                                                                                                                                                                          |
| <b>Timeframe for providing notice</b> | As soon as possible taking into account medical circumstances, but not later than 72 hours. | Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days. Maximum two levels of mandatory review (see page 24). If two levels are used, notice must be provided within 15 days of each appeal. | Within a reasonable period of time, but not later than 60 days. Maximum two levels of mandatory review (see page 24). If two levels are used, notice must be provided within 30 days of each appeal. |
| <b>Extensions</b>                     | None                                                                                        | None                                                                                                                                                                                                                                      | None                                                                                                                                                                                                 |

\* An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.

|                                       | Long-term and short-term disability benefits & other benefits based on disability                                                                   | Pension, savings, ESOP, life insurance, AD&D, business travel accident plans and dependent care reimbursement account |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <b>Period for Filing Appeal</b>       | You have at least 180 days.                                                                                                                         | You have at least 60 days.                                                                                            |
| <b>Timeframe for Providing Notice</b> | Within reasonable period of time, but not later than 45 days. Maximum two levels of mandatory review for long-term disability claims (see page 24). | Within a reasonable period, but not later than 60 days.                                                               |
| <b>Extensions*</b>                    | Additional 45 days if special circumstances require extension (with period suspended until you respond to any information request).                 | Additional 60 days if special circumstances require extension.                                                        |

\* In addition to extensions listed in the table, you may agree to a further extension of the time period within which the plan must decide your claim.

## CLAIM PROCEDURES FOR HEALTH PLANS

### **Determining if care is medically necessary**

In general, our health care plan only covers medically necessary care. The procedures we follow to determine if your care is covered under our health plan will vary based on:

- The type of service or care received, and
- The type of health plan you are enrolled in.

Determining whether your medical care is covered under our health plan may be done before, during or after the care is received, depending on the type of care it is, as described below.

To be covered, certain services must be approved before care is received. Getting prior authorization is called a “pre-service medical necessity determination.” Your SPD describes who is responsible for obtaining this review. You or your authorized representative must follow the procedures described in this SPD and your health plan’s SPD to request a pre-service medical necessity determination.

If we determine that a service or benefit is not medically necessary or not covered under the group health plan, you will receive a written description of the adverse determination. You may appeal the determination. Appeal procedures are described in this SPD and in the determination notice you receive.

*For the purposes of this section, any reference to “you,” “your,” or “member” also refers to your authorized representative or health care provider that you designate to act on your behalf, unless otherwise noted.*

### ***Urgent care claims***

**Urgent care claims** are claims (other than post-service claims) for which the application of non-urgent care timeframes:

- Could seriously jeopardize your life or health, or your ability to regain maximum function, or
- Could cause you severe pain, which cannot be adequately managed without the requested services (as determined by a physician with knowledge of your medical condition).

### ***Pre-service claims***

**Pre-service claims** are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

### *Post-service claims*

**Post-service claims** are claims involving the payment or reimbursement of costs for health care that has already been provided.

### *Concurrent care claims*

**Concurrent care claims** are claims in which the plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the plan later reduces or terminates coverage for those treatments.

A concurrent care claim may be treated as an urgent care claim, pre-service claim or post-service claim. How it is treated depends on when during the course of your care you file the claim. However, the plan must give you sufficient advance notice of any reduction or termination in the course of treatment so that you may appeal the claim before the benefit is reduced or terminated.

In addition, in an urgent care situation in which the plan previously approved a course of treatment and you wish to extend such treatments past the time period or number of treatments previously approved, you may request an extension to the course of treatments at least 24 hours prior to the time the treatments are scheduled to expire. The plan must notify you of its determination regarding whether to grant the request within 24 hours of receipt of the claim.

### **If your claim is denied**

If the plan does not fully agree with your claim, you will receive an adverse benefit determination—a denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. This can also include a denial to participate in the plan. For health care plans, an adverse benefit determination also means a denial for a benefit resulting from the application of any utilization review or a claim denial on the grounds that the treatment is experimental or investigational, or not medically necessary or appropriate. This also includes concurrent care determinations.

In the event of an adverse benefit determination, you will receive notice of the determination. The notice will include:

- Specific reasons for the adverse determination,
- Specific plan provisions on which the determination is based,
- A description of any additional information needed to perfect the claim and the reason this information is needed,
- A description of the plan's review procedures and the time limits applicable to such procedures,
- A statement that you have a right to appeal the adverse determination,
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review,

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request,
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request, and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims (this notice may be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three days after the oral notice).

### *Appeals procedure*

The health plan has a two-step appeals process. If your claim for benefits is denied in whole or in part you may appeal in writing to the claims administrator within 180 days of receipt of a denial notice. Your request should state the reason why you feel your appeal should be approved and include any information supporting your appeal, including written comments, documents, records and other information relating to your claim for benefits. When appealing a claim denial, you may request copies of all documents, records and other information “relevant” to your claim for benefits (referred to in these procedures as “relevant plan information”). A document, record or other information is relevant if it:

- Was relied upon in making the benefit determination,
- Was submitted, considered or generated in the course of making the benefit determination (even if it was not relied upon in making the benefit determination),
- Demonstrates compliance with the administrative processes and safeguards in making the benefit determination, or
- Is a statement of the plan’s policy or guidance concerning the denied treatment option or benefit, even if it was not relied upon in making the benefit determination. (This applies only to health care plans or disability plans.)

### **Level one appeal**

When you submit your claim for a Level One Appeal, your claim will be reviewed and the decision will be made by someone not involved in the initial decision or a subordinate of the individual who made the initial decision. In addition, a health care professional will be consulted for appeals involving a medical judgment including the medical necessity or clinical appropriateness of the care you received. The health care professional consulted with on appeal will not be the same professional who was consulted for the initial decision. You may request the identity of any health care professional whose advice was obtained in connection with your denied claim.

If your claim involves a pre-service determination, you will receive a decision, in writing, from the claims administrator within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after receipt of your appeal.

If your claim involves care you have already received, you will receive a decision on your appeal, in writing, from the claims administrator within a reasonable period of time, but in no event later than 30 days after receipt of your request for an appeal.

The claims administrator will expedite the appeal process if your claim involves urgent care, including the non-authorization of an admission or continuing inpatient hospital stay. You will be notified of a determination on your urgent claim appeal as soon as possible, but no later than 72 hours from when the claims administrator received your request. Your request for an appeal that involves urgent care may also be made orally. All necessary information, including the claims administrator's determination on review, may be transmitted between you and the claims administrator by telephone or facsimile or any other similar expeditious method.

For urgent care claims only, the decision made upon completion of a Level One Appeal shall be final and binding on all parties.

### **Level two appeal**

If you are dissatisfied with the decision on Level One Appeal, you may request a second review within 45 days of the date that the Level One Appeal decision is rendered. To initiate a Level Two Appeal, follow the same process required for a Level One Appeal, except that your Level Two Appeal should be sent to the plan administrator at the address in the Plan Funding and Administration chart found at the end of this section.

Anyone involved in the prior decision on your claim may not take part in the Level Two Appeal. A health care professional will be consulted for appeals involving a medical judgment including the medical necessity or clinical appropriateness of the care you received. The health care professional consulted with on the Level Two Appeal will not be the same professional who was consulted for any previous decision. You may request the identity of any health care professional whose advice was obtained in connection with your denied claim.

You will be notified of the plan administrator's decision on your claim no later than 15 days after receipt of your request for a Level Two Appeal where the claim involves care that has not yet been received or is in progress, and no later than 30 days after receipt of your request for a Level Two Appeal where the claim is for care already received. The notice will be provided in writing or electronically. If your claim was denied, it will include the specific reason(s) for the adverse determination with references to the specific plan provisions on which the determination is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other relevant plan information (as defined above). Upon

completion of both levels of appeal, all decisions on review are final and binding on all parties.

### *When you have a complaint or a question*

If you have a concern or a question regarding a person, a service, the quality of care, or contractual benefits, call the toll-free number on your ID card and speak to a Member Services representative. You can also express your concern by writing to the claims administrator at the address listed in the *Plan Funding and Administration Chart* at the end of this section.

Our claims administrator will do its best to resolve the matter on your initial contact. If our claims administrator needs more time to review or investigate your concern, someone will get back to you as soon as possible, but not later than 30 days.

If your concern involves a claim for benefits that was denied and you want to appeal this decision, you must follow the procedures for filing an appeal.

## **CLAIMS PROCEDURES FOR RETIREMENT, LIFE INSURANCE, AD&D AND BUSINESS TRAVEL ACCIDENT PLANS AND THE DEPENDENT CARE REIMBURSEMENT ACCOUNT**

If your claim is denied in whole or in part, you, your beneficiary or your authorized representative will receive written or electronic notification from the plan administrator. Plan administrators are listed in the *Plan Funding and Administration Chart* at the end of this section.

Ordinarily, you will receive this written notice within 90 days after your claim is filed. If special circumstances warrant an extension, this deadline may be extended for up to an additional 90 days. You will be notified in writing in advance of the date a decision is expected and the reasons for the extension. In addition, you may agree to a further extension of the time period within which the plan must decide your claim.

The notice that your claim is denied will include:

- Specific reason or reasons for the denial,
- Specific plan provisions or documents that the denial is based on,
- A description of additional material or information that you must provide to perfect the claim and the reason this information is needed,
- A description of the plan's review procedures and relevant time limits, including a statement of your right to bring a civil action under ERISA following a denial on review, and
- A statement that you have a right to appeal the plan administrator's decision.

## **Appealing a claim**

You, your beneficiary or authorized representatives are entitled to appeal a claim that is denied within 60 days of the date you received the denial notice. To do so, write to the plan administrator. State the reasons why you believe your claim should not have been denied and include any written comments, documents, records and other information related to the claim that you believe supports your claim. In addition, after receipt of a notice denying a claim for benefits, you, your beneficiary or an authorized representative has a right, upon request and free of charge, to review and receive copies of relevant plan information.

Upon receipt of an appeal, the plan administrator will re-examine your claim, along with all comments, documents, records and other information that you submit relating to the claim, regardless of whether it was submitted or considered in the initial benefit determination.

Ordinarily, the plan administrator must then issue a final decision within 60 days after the date that you filed an appeal in accordance with these procedures. The plan administrator may determine that special circumstances warrant an extension. If this occurs, the plan administrator must notify you in writing before the end of the initial 60-day period, indicating the special circumstances warranting an extension and the date by which the plan administrator expects to render a decision on the claim. The extension may not be more than 60 days after the end of the initial 60-day period. If such an extension occurs due to your failure to submit needed information, the period for making the benefit determination on review will be suspended from the date that notification of the extension is sent to you until the date you respond to the request for additional information. In addition, you may agree to a further extension of the time period within which the plan administrator must decide your claim.

The plan administrator's final decision will be in writing or in electronic form and will include:

- Specific reason or reasons for the denial,
- Specific plan provisions on which the determination was based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other relevant plan information (defined above), and
- A statement that you have a right to bring a civil action under ERISA.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

## CLAIMS AND APPEALS PROCESS FOR CLAIMS BASED ON DISABILITY (INCLUDING CLAIMS UNDER THE RETIREMENT PLANS THAT ARE BASED ON DISABILITY)

If your claim is denied in whole or in part, you, your beneficiary or your authorized representative will receive written or electronic notification from the claims administrator. Claims administrators are listed in the *Plan Funding and Administration Chart* at the end of this section.

Ordinarily, you will receive this written notice within 45 days after your claim is filed. If special circumstances warrant an extension, this deadline may be extended for up to two additional 30-day periods. You will be notified in writing in advance of the date a decision is expected and the reasons for the extension. In addition, you may agree to a further extension of the time period within which the plan administrator must decide your claim.

The notice that your claim is denied will include:

- Specific reason or reasons for the denial,
- Specific plan provisions or documents that the denial is based on,
- A description of additional material or information that you must provide to perfect the claim and an explanation as to why you must do so,
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request,
- A description of the plan's review procedures and relevant time limits, including a statement of your right to bring a civil action under ERISA following a denial on review, and
- A statement that you have a right to appeal the plan administrator's decision.

### **Appealing a claim based on disability**

You, your beneficiary or authorized representatives are entitled to appeal a claim that is denied within 180 days of the date you received the denial notice. Generally, to do so, write to the plan administrator. In the case of a claim for long-term disability benefits, your appeal should go to the claims administrator. State the reasons why you believe your claim should not have been denied and include any written comments, documents, records and other information related to the claim that you believe supports your claim. In addition, after receipt of a notice denying a claim for benefits, you, your beneficiary or an authorized representative has a right, upon request and free of charge, to review and receive copies of relevant plan information.

Upon receipt of an appeal, the plan administrator or claims administrator, as the case may be, will re-examine your claim, along with all comments, documents, records and other

information that you submit relating to the claim, regardless of whether it was submitted or considered in the initial benefit determination.

The review shall:

- Not afford deference to the initial adverse benefit determination,
- Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claim, without regard to whether the advice was relied upon in making the initial determination or the determination on appeal, and
- Be conducted by someone that did not take part in the adverse determination and is not a subordinate of anyone who did.

In deciding an appeal that is based in whole or in part on a medical judgment, the decision maker shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in connection with the initial adverse determination and is not the subordinate of any such individual.

The plan administrator or claims administrator (“administrator”) must then issue a decision within 45 days after the date that you filed an appeal in accordance with these procedures. The administrator may determine that special circumstances warrant an extension. If this occurs, the administrator must notify you in writing before the end of the initial 45-day period, indicating the special circumstances warranting an extension and the date by which the plan administrator expects to render a decision on the claim. The extension may not be more than 45 days after the end of the initial 45-day period. If such an extension occurs due to your failure to submit needed information, the period for making the benefit determination on review will be suspended from the date that the notification of extension is sent to you until the date you respond to the request for additional information. In addition, you may agree to a further extension of the time period within which the administrator must decide your claim.

The administrator’s decision will be in writing or in electronic form and will include:

- Specific reason or reasons for the denial,
- Specific plan provisions on which the determination was based,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other relevant plan information (defined above), and
- A statement that you have a right to bring a civil action under ERISA.

With the exception of an appeal of a denial for a claim for long-term disability benefits from Prudential, all decisions on initial appeal are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction. For long-term disability

claims from Prudential only, there is a mandatory second level of appeal and a voluntary third level of appeal.

### ***Second level of appeal for long-term disability claims from Prudential***

If you are not satisfied with the decision of the initial appeal, you may request a second review within 180 days of the date that the initial appeal decision is rendered. To initiate a second appeal, follow the same process required for the first appeal.

Anyone involved in the prior decision on your claim may not take part in the Second Level Appeal. You will be notified of the decision on your second appeal within 45 days of receipt of your appeal request. This period may be extended by up to 90 days if the claims administrator determines that special circumstances warrant such an extension. If this occurs, the claims administrator must notify you in writing before the end of the initial 45-day period, indicating the special circumstances warranting an extension and the date by which the claims administrator expects to render a decision on the claim. If such an extension occurs due to your failure to submit needed information, the period for making the benefit determination on review will be suspended from the date that the notification of extension is sent to you until the date you respond to the request for additional information. In addition, you may agree to a further extension of the time period within which the claims administrator must decide your claim.

If your second appeal is denied, it will include the specific reason(s) for the adverse determination with references to the specific plan provisions on which the determination is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other relevant plan information (as defined above). It will also inform you of your right to further appeal the decision.

### ***Third level of appeal for long-term disability claims from Prudential***

If you are not satisfied with the decision of the second appeal, you may request a third review within 180 days of the date that the initial appeal decision is rendered. To initiate a third appeal, follow the same process required for the first and second appeal.

Anyone involved in the prior decision on your claim may not take part in the Third Level Appeal. You will be notified of the decision on your third appeal within 45 days of receipt of your appeal request. This period may be extended by up to 90 days if the claims administrator determines that special circumstances warrant such an extension. If this occurs, the claims administrator must notify you in writing before the end of the initial 45-day period, indicating the special circumstances warranting an extension and the date by which the claims administrator expects to render a decision on the claim. If such an extension occurs due to your failure to submit needed information, the period for making the benefit determination on review will be suspended from the date that the notification of extension is sent to you until the date you respond to the request for

additional information. In addition, you may agree to a further extension of the time period within which the claims administrator must decide your claim.

If your third appeal is denied, it will include the specific reason(s) for the adverse determination with references to the specific plan provisions on which the determination is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other relevant plan information (as defined above).

Your decision to submit your claim to a third level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit under ERISA without submitting to a third level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit your claim to a third level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the third appeal is pending.

## CLAIMS PROCEDURES AND GENERAL INFORMATION

### **Legal action; exhaustion of claims procedures**

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. However, in most cases, you, your beneficiary and your representatives may not initiate any action or proceeding for a claim for benefits in any court or before any administrative tribunal or arbitrator until you exhaust the claim procedures described earlier. You will generally lose your right to file any action or proceeding for a claim for benefits in any court or before any administrative tribunal or arbitrator if you fail to follow the claims procedures described earlier in a timely fashion.

## OTHER IMPORTANT INFORMATION

### **Limitations on rights**

Neither this SPD nor your participation in any of the American Standard benefit plans should be construed as a contract of employment, nor do they give you or any other plan participant the right to:

- Be retained in the employ of the company, or
- Interfere with the prerogative of the company to discharge any individual at any time with or without cause, except as may be otherwise agreed to in writing, or provided by applicable law.

### **Future of the plans**

American Standard, through its Board of Directors, or any officer(s) or employee(s) of the company who is so authorized by the Board, reserves the right to amend, modify,

suspend, discontinue or terminate any or all of the benefits, coverage, plans or programs, in whole or in part, at any time and for any reason. For example, American Standard reserves the right to amend or terminate covered expenses, benefit copays, lifetime maximums and reserves the right to amend the plan to require or increase employee contributions. American Standard also reserves the right to amend the plan to implement any cost control measures that it may deem advisable. American Standard's decision to change or terminate any of the plans may be due to changes in federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, or for any other reason.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to American Standard to the extent permitted under applicable law, unless otherwise stated herein or in the applicable plan document.

### **Non-assignment of benefits**

You cannot sell, transfer or assign, either voluntarily or involuntarily, the value of your benefit under the pension plan, savings plan or ESOP. However, under certain circumstances, a court may award all or part of your benefit under one or more of these plans to a present or former spouse, child or other dependent through a qualified domestic relations order (QDRO). Your benefits can also be assigned if you are subject to a federal tax lien.

A QDRO is a court order, judgment or decree that:

- Is made under a state domestic relations law (including community property laws),
- Relates to child support, alimony payments or marital property rights, and
- Creates or recognizes an alternate payee's right to receive all or part of your benefits under either plan.

If the QDRO so provides, your accrued benefit as of a specific date may be divided. In this instance, the alternate payee may be set up with a separate benefit. If you are affected by a QDRO, you should have your attorney contact the QDRO administrator at the following address to make sure the appropriate paperwork is filed:

American Standard Inc.  
Corporate Benefits Department  
One Centennial Avenue  
Piscataway, NJ 08855

You and your beneficiaries can obtain, at no charge, a copy of the procedures governing QDROs. Contact the QDRO administrator in the Corporate Benefits Department of American Standard at the address shown above.

## YOUR RIGHTS UNDER ERISA

As a participant in an employee benefit plan, 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:

### Review information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an SPD. The administrator may assess a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of the summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65), and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

### Continue group health plan coverage

- Continue health care coverage for yourself, spouse or dependent(s) if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependent(s) may have to pay for such coverage. Review the previous *Continuation of Coverage* section of this SPD and the documents governing the plans or the rules governing continuation coverage rights under COBRA.
- Your creditable coverage from our plans may reduce or eliminate exclusionary periods of coverage, due to pre-existing conditions, under another group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under our plans,
  - You become entitled to elect COBRA continuation coverage, or
  - Your COBRA continuation coverage ceases.

However you must request it before losing coverage, or up to 24 months after losing coverage. If you do not receive the certificate, contact CobraServ at 1-800-877-7994. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after you enroll in another group health plan.

## **Prudent actions by plan fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of employee benefit plans. The people who operate your plans, called fiduciaries of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

## **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. You also have the right 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 materials from the plan 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 that is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction.
- In addition, if you disagree with the plan's decision or lack of a decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.
- If the 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 plans, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area 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, NW, Washington, D.C. 20210.

If you have any specific questions about any of the plans discussed in this SPD, contact your human resources office. All requests, appeals, elections, and other communication should be mailed to the human resources office. Further assistance may be obtained by writing to the plan administrator. See the *Plan Funding and Administration Chart* at the end of this section.

## HIPAA PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) gives you certain rights with respect to your health information, and it also imposes certain obligations on the health plans. The following describes the ways your health information is protected, as it relates to coverage under one or more of American Standard’s group health benefit plans (the “plan”). The group health plan is part of an organized health care arrangement. Protected health information means information that is created or maintained by the plan and relates to the physical or mental health or condition of an individual, the provision of health care to the individual or the payment for health care, and which can reasonably be expected to be used to identify the individual.

In order for the plan to disclose any protected health information to the plan sponsor (American Standard), we must first certify that the plan documents have been amended to incorporate certain provisions required under HIPAA. The company amended the plan effective April 13, 2003 to incorporate the following provisions and agrees to abide by these provisions:

- The plan will disclose protected health information to the company only for it to carry out plan administration functions, as such term is defined under the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Parts 160-64) (the “Act”) and in accordance within the requirements of the Act.
- We will use or disclose protected health information only as permitted or required by the plan documents or as required by law.
- We will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the company.
- We will only disclose protected health information to an agent or subcontractor if the agent or subcontractor agrees to the same restrictions and conditions included in the plan documents with respect to protected health information.

- We will report to the plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under the plan documents of which it becomes aware.
- We will make available our internal practices, books and records, relating to our use and disclosure of protected health information, to the plan and the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- We will, if feasible, return or destroy all protected health information in whatever form or medium (including in any electronic medium under the company's custody or control) received from the plan when protected health information is no longer needed for the plan administration functions for which the disclosure was made. This includes all copies of any data or compilations derived from and allowing identification of any participant or beneficiary who is the subject of the protected health information. If it is not feasible to return or destroy all of protected health information, we will limit the use or disclosure of any protected health information we cannot feasibly return or destroy to those purposes that make the return or destruction of the information not feasible.

### **Right of access to protected health information**

You have the right to obtain access to protected health information that the plan may use in making decisions about your care. Requests for access should be submitted in writing to your claims administrator or faxed to the Privacy Office at 1-732-980-6193. All requests for claims and medical management records should be submitted to your claims administrator. This right of access is subject to certain restrictions. If your request for access is denied, you will receive a notice, which describes the reasons for the denial. You may be charged a reasonable fee for copying, mailing and other preparation costs.

### **Right to amend protected health information**

You have the right to request that the plan amend your protected health information if you believe that such information is not accurate or complete. Your request for amendment should be submitted in writing to the claims administrator or faxed to the Privacy Office at 1-732-980-6193, and must be dated, signed and specify the information to be amended and a reason to support the requested amendment.

All requests to amend claims and medical management records should be submitted to your claims administrator. If the plan approves the request for amendment, it will notify you in writing, make the amendment and provide the amendment to any parties who it knows have the protected health information that is the subject of the amendment. The plan will provide you with written notice of denial of a request for amendment, including the reason for such denial. If the request for amendment is denied, you may submit a statement of disagreement with the denial and the plan may submit a rebuttal to that statement of disagreement. Both your statement of disagreement and the rebuttal statement from the plan will be included with any future disclosures by the plan of the

protected health information subject to the request for amendment. If the plan is notified by another entity covered under HIPAA of an amendment to your protected health information that has been disclosed to the company by the plan, we will amend this information in our records.

### **Right to an accounting of disclosures**

The company will track disclosures it may make of protected health information received from the plan so that it can make available the information required for the plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528. You have the right to request an accounting (or listing) of certain disclosures of protected health information that the plan has made about you in the six-year period immediately preceding the request for disclosure.

Requests for a list of disclosures should be submitted in writing to your claims administrator or faxed to the Privacy Office at 1-732-980-6193, and should state the time period for which you are requesting the accounting, which cannot exceed the six-year period prior to the request and cannot include dates prior to April 14, 2003. This right is subject to certain restrictions. The plan will provide you with one free list of disclosures in a twelve-month period. The plan may charge you for the cost of providing additional lists of disclosures within the same twelve-month period.

### **Access to protected health information**

The following employees or classes of employees or other workforce members under the control of the company may be given access to protected health information received from the plan or a health insurance issuer or business associate servicing the plan:

- Employee Benefits Committee
- Corporate Benefits Department
- Corporate Legal Department
- Business Services
- Human Resources Information Systems
- Privacy Office

This list includes every employee or class of employees or other workforce members under the control of the company who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified above will have access to protected health information only to perform the plan administration functions that the company provides for the plan.

The employees, classes of employees or other workforce members identified above will be subject to appropriate disciplinary action, up to and including termination of

employment, for any use or disclosure of protected health information in violation of the provisions of the plan documents. We will impose appropriate disciplinary action on each employee or other workforce member causing the violation and will work to mitigate any harmful effect of the violation on any participant or beneficiary whose privacy has been violated.