The Goodyear Tire & Rubber Company Health and Welfare Plan for Salaried Employees

Summary Plan Description

Contents

Foreword

This booklet is the "Summary Plan Description" (SPD) required by the Employee Retirement Income Security Act of 1974, as amended (ERISA) for The Goodyear Tire & Rubber Company's ("Goodyear" or "the Company") Health and Welfare Plan for Salaried Employees (the "Health and Welfare Plan" or the "Plan"). The following health and welfare benefits are included in the Health and Welfare Plan: Medical, Dental, Vision, Flexible Spending Account, Short-Term Disability, Long-Term Disability, Life Insurance, and Accidental Death & Disability Insurance, as well as Critical Illness Insurance, Accident Insurance, Hospital Indemnity Insurance and the Health Savings Account.

For information on the Employee Severance Plan, the Management Severance Plan, the Salaried Employee Savings Plan, the Salaried Pension Plan and the Survivor Benefits Plan, see the SPDs for those plans.

This SPD for salaried employees, plus the insurance carrier and third-party administrator coverage summaries, is considered the Formal Plan document for the Medical, Life Insurance and Long-Term Disability plans. This SPD for salaried employees is considered the Formal Plan document for the other Health and Welfare Plans. The Short-Term Disability benefits that are reviewed in this booklet are not provided as a part of benefit plans subject to ERISA. If you have any questions or if you need any additional information about your benefits, contact the Goodyear Associate Service Center at (844) 449-4772.

Unless otherwise, and to the extent, specifically provided, the plans described in this booklet cover employees who are designated as salaried and who are employed at Company-designated locations as on file with the Plan Administrator. If you are covered by a collective bargaining agreement, you may participate in these plans only if that agreement specifically provides for your participation.

This SPD excludes associates working in a Retail, Commercial Tire and Service Center (CTSC), or Company Owned Wholesale Distribution (COWD) location, and associates covered under collective bargaining agreements unless the agreement specifies your participation in the Plan.

This SPD has been prepared especially for the group of salaried employees described under "Eligibility" in the "General Provisions" section. The Plans also cover employees at Social Circle, Georgia; hourly employees at Beaumont, Texas, and Statesville, North Carolina; employees in certain Company-owned Auto Service Centers; and certain salaried retirees and expatriate employees of the Company. Their benefits are described in other SPDs.

In all cases, your rights and benefits, and those of your dependents and beneficiaries, are governed by the terms and conditions of the Health and Welfare Plan as in effect from time to time. The Company, through its authorized representatives, reserves the right to modify or terminate the Health and Welfare Plan, and/or any of the benefits included in the Plan at any time. In addition, nothing in the Plans says or implies that participation guarantees your continued employment with the Company.

The Plan Administrator will have the sole and absolute discretionary authority and power to interpret plan provisions and make factual determinations in administering and carrying out the provisions of the Plan, including, but not limited to, the authority and power (a) to determine all questions relating to eligibility for the amount of any benefit to be paid under the Plan, (b) to determine all questions pertaining to claims for benefits and procedures for claims review, (c) to resolve all other questions arising under the Plan, including any questions of construction, and (d) to take such further action as the Plan Administrator deems advisable in the administration of the Plan. The actions taken and the decisions made by the Plan Administrator hereunder shall be final and binding on all interested parties. The Company may delegate to a third-party administrator or insurer the whole or any part of this authority.

General Provisions

The following is a description of the general provisions applicable to the Plan.

Eligibility

You become eligible for Plan benefits on your 31st day of active employment if you are a full-time employee of the Company who is designated as a "salaried employee," whose employment classification is "job share," and who is not a temporary, leased, intern or part-time employee. However, eligibility for Long-Term Disability (LTD) benefits occurs only after one year of service.

A "full-time employee" is defined as an employee who is reasonably expected to average at least 30 hours of service per week. A "part-time employee" is defined as an employee who is not reasonably expected to average at least 30 hours per week or was hired to work six months or less.

You are not eligible to participate in the Plan if:

- You are a leased employee who performs services through a non-affiliated service provider organization irrespective of whether or not you are a common law employee of the Company or its subsidiaries; or

- You have signed an agreement which comports to classify you as an independent contractor, consultant or a third party, irrespective of whether or not you are a common law employee of the Company or its subsidiaries; or

- You are working in a Retail, Commercial Tire and Service Center (CTSC), or Company Owned Wholesale Distribution (COWD) location, or are covered under a collective bargaining agreement unless the agreement specifies your participation in the Plan, or

- You are an employee working outside the United States.

Former employees whose employment terminated and who are rehired within 30 days will not be granted continuous service credit for any prior period of employment, and must meet the eligibility requirements for each benefit as stated in this booklet. This does not apply to employees who are transferred and have approved transfer documentation on file.

Change in Employment Status

If you are designated as a part-time employee, but you in fact average at least 30 hours of service per week in the 12 months (as determined by the Company pursuant to IRS Regulations) following your hire date, you will be eligible for Plan coverage no later than the beginning of the second month after the first anniversary of your hire date.

Employees who move from full-time to part-time status during the year will remain eligible for all coverage through the end of that year.

These eligibility rules generally apply to the benefits covered herein; however, if the section covering a particular benefit differs from these general rules, then those specific eligibility rules apply to such benefit.

Eligible Dependents

You may also enroll your eligible dependents in the Plan. An eligible dependent is:

- Your legal spouse, which is defined as a husband or wife, including a common law spouse.

- A child under the age of 26, who is:
  - A son, stepson, daughter or stepdaughter of the employee;
  - A legally adopted individual of the employee; or
  - An individual of whom the employee has legal custody for longer than three months through an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.
- A child over age 25 who is currently claimed as a dependent of the employee for federal income tax purposes and who became mentally or physically incapable of self-support prior to age 19.

Note: Dependent eligibility for Life and AD&D insurance is slightly different. See those sections for more information.

Dependent Eligibility Verification

Goodyear reserves the right to verify the eligibility of your dependents under the Health and Welfare Plan. These audits are for your protection to assure that Plan benefits are reserved for eligible participants and their eligible dependents. Information describing eligible dependents is located in this SPD. Failure to comply with an audit request can lead to a loss of benefits for your dependents.

In the future, if you are selected for an audit, you will be required to provide documentation proving that your dependent is eligible to participate in the Health and Welfare Plan. Requested documents may include birth and marriage certificates, legal guardianship documentation, court orders or tax returns. You will receive personalized instructions at the time of the audit.

If you do not respond to the request for documents needed under the dependent verification program, or if the documents provided do not demonstrate that eligibility requirements are satisfied, ineligible dependents will be disenrolled from the Health and Welfare Plan. In addition, you and/or your ineligible dependent may be liable for the repayment of any benefits provided to the ineligible individual. Misrepresentations relating to the Plan may result in disciplinary action, up to and including termination of employment.

Qualified Medical Child Support Orders

If a court orders you in divorce or legal separation procedures to provide medical coverage to a child of whom you will no longer have custody, you should contact the Goodyear Associate Service Center to obtain, without charge, a copy of such procedures for a Qualified Medical Child Support Order (QMCSO).

If you have questions regarding eligibility, contact the Goodyear Associate Service Center at (844) 449-4772.

Enrollment

Coverage Categories

The coverage category tells the Company which family members will receive coverage under certain plans. For Medical, Dental, Vision, Group Universal Life and Optional AD&D Insurance coverage, your choices are:

- Single coverage (You only)
- You + spouse
- You + children
- Family coverage (including you, your spouse, and your eligible children)
- No coverage

Only you are eligible for Disability Insurance. Coverage categories for the Flexible Spending Account are described in the Flexible Spending Account section.

Initial Enrollment

If you are a new employee, your participation in most Plan benefits starts on the 31st day of employment. However, eligibility for Long-Term Disability benefits will begin after one year of service. You may enroll in the Plan on the first day of the month after 31 days of employment.

Annual Enrollment

There is an annual enrollment period for Plan benefits. This period will usually be each fall. During the enrollment period, you will have an opportunity to make your choices for the next Plan year (January 1–December 31).

The annual enrollment website is selfservice.goodyear.com.

If you have enrolled in Plan benefits in a previous year and make no changes in any following year by the enrollment deadline, you will receive the same benefit choices you had made from your most recent enrollment in accordance with the current Plan provisions. Your Health Savings Account deductions do **not** roll over from year to year; the only exception is that no deposits will be made to the Flexible Spending Account.

If You Are Rehired

If you are rehired more than 30 days after you terminated from Goodyear, you will be treated as a new hire, and the rules under "Initial Enrollment" above apply.

If you are rehired within 30 days of your termination, the following applies:

- If you return as an eligible salaried employee in the same Plan year, you receive the same coverage you had when your employment ended, and your coverage is effective as of the date you return.
- If you return as an eligible salaried employee in a different Plan year, you enroll as a new hire, and your coverage is effective according to new-hire eligibility rules unless you previously satisfied the waiting period.

Changing Your Choices

Once you make your choices each year, they remain in effect for a full Plan year (January 1–December 31). However, you can change some of your choices during the year if you have a qualified change in status and notify your Human Resources Department or the Goodyear Associate Service Center within 31 days of the change. Events that trigger "changes in status" are governed by the Internal Revenue Code and its Regulations, and are defined as:

- Your marriage, annulment, legal separation or divorce;
- The birth, adoption or placement for adoption of a child;
- Your dependent child reaching an age where he or she is no longer eligible for benefits coverage, or re-qualifies as being eligible for benefits coverage;
- The death of your spouse or dependent child;
- A change in your, your spouse's or dependent's employment status, including work schedule, that causes a change in eligibility for benefits for you or your dependents;
- A change in the place of residence or work for you, your spouse or dependent.

If a change in status occurs, you will be permitted to change some of your elections, provided that:

- The change results in you, your spouse or dependent gaining or losing eligibility for coverage, and

- Your new elections are consistent with that gain or loss of coverage.

If you do have a change in family status and if consistent with that event, you can:

- Make new elections for your medical option and dependents covered;

- Change your dental and vision dependents covered;

- Increase your LTD option number by one increment. You may only increase your coverage by more than one increment if you provide proof of insurability;

- Make a new election for Optional Accidental Death & Dismemberment Insurance; and/or

- Begin or end your Flexible Spending Account deposits, or change your deposit amount, if it is permitted by the Regulations.

Note: If you fail to notify the Plan within 31 days, you will not be able to make changes to your coverage or add/drop dependents until the next Annual Enrollment period. If your spouse has or acquires other medical coverage, you must notify the Company by contacting your health care insurance carrier or third-party administrator to request a Coordination of Benefits form.

Notice of Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you additional flexibility regarding whom and when you can enroll in medical, dental, and vision benefits due to marriage, birth, or placement for adoption:

- **Non-enrolled employee:** If you are eligible but not enrolled, you can enroll as of the date of the event.

- **Non-enrolled spouse:** If you are enrolled, you can enroll your spouse when you marry or you become a parent through birth, adoption, or placement for adoption (unless your spouse has coverage through his or her employer).

- **New eligible dependents/spouse of a non-enrolled employee:** If you are eligible but not enrolled, you can enroll your spouse (unless your spouse has coverage through his or her employer) or child as a result of the event. However, you also must enroll.

Under HIPAA's special enrollment rules, you also can make a change during the year if you elect "no coverage" because you have coverage elsewhere (for example, under a spouse's plan) and that other coverage later ends. These loss-of-coverage rules also apply to a spouse or child. However:

- The coverage must end because of a loss of eligibility, such as a divorce, termination of employment, or the other employer not making contributions to that plan. You cannot make a mid-year change under this Plan if your other coverage is lost because of something you do or do not do, such as not making your required contributions.

- You must request enrollment within 30 days after your or your eligible dependents' other coverage ends or after the other employer stops contributing toward the other coverage.

If you or your eligible dependent is eligible but not enrolled for coverage, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event.

- You or your eligible dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage.
- You or your eligible dependent becomes eligible for premium assistance, with respect to coverage under the Plan, due to coverage with Medicaid or CHIP.

Other Changes in Circumstances

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event.

- A QMCSO requires you or another individual to provide health care coverage for an eligible dependent.
- You or your eligible dependent becomes eligible for or loses Medicaid coverage.
- COBRA coverage from another employer for you or your eligible dependent is exhausted (except if you lost COBRA coverage for non-payment of premiums or for cause).
- The enrollment period of another plan—for example, your spouse's—is different from Goodyear's Annual Enrollment period, and a comparable election could be made under each plan.

When "Default Coverage" Applies

At Initial Enrollment

If you do not enroll in Plan benefits when you first become eligible, you will be assigned default coverage as follows:

- No medical coverage.
- No dental coverage.
- No vision coverage.
- LTD coverage of 50% of pay, without inflation protection, if you have one year of employment.
- Basic Life and Accidental Death & Dismemberment Insurance.
- No Optional Accidental Death & Dismemberment Insurance.
- No deposits to a Flexible Spending Account.
- Nicotine user surcharge and non-discounted rates on your Healthy Choice Incentive.

This default coverage may change from year to year and will be communicated to you at enrollment time.

Once default coverage becomes effective, you cannot change it until the next Annual Enrollment, unless you have an eligible change in status and notify the Goodyear Associate Service Center within 31 days.

When you first become eligible you must complete a medical coordination of benefits questionnaire form that will be provided to you.

At Annual Enrollment

If you do not enroll in Plan benefits during Annual Enrollment, you will be assigned default coverage as follows:

- Your current medical coverage, if any.
- Your current dental coverage.
- Your current vision coverage.
- Your current Long-Term Disability coverage.
- Basic Life and Accidental Death & Dismemberment Insurance.

- No Group Universal Life or Optional Accidental Death & Dismemberment Insurance. (You can enroll later in the year, but you may be subject to Evidence of Insurability [EOI].)
- No deposits to the Flexible Spending Account.
- No deposits to the Health Savings Account.
- Nicotine user surcharge

You also must complete and submit the results of your designated wellness activities by the deadline stated in your enrollment materials to receive the Healthy Choice Incentive as described below.

Cost of Coverage

The amount you contribute toward the cost of your benefits generally is determined by several factors, which may include:

- The options you choose;
- The number of eligible dependents you cover; and
- Whether you use nicotine or tobacco and whether you complete your designated wellness activities (applicable to cost of medical plan only).

Each year, Goodyear will evaluate all costs and may adjust the cost of coverage for the next year's coverage. Your cost for the upcoming year is communicated during the Annual Enrollment period. You can enroll online as described in your enrollment materials.

With regard to medical, dental, and vision coverage, as well as Health Care FSAs, you pay for coverage with dollars deducted from your pay before taxes are withheld. Your contribution to a Health Savings Account is also made on a before-tax basis.

Although before-tax contributions reduce your taxable pay, they do not affect your pay-related coverage. The Company considers your before-tax contributions to be a part of your base salary for purposes of calculating life insurance, AD&D Insurance and STD/LTD benefits.

Contributions are withheld as soon as administratively possible after you become eligible and enroll for coverage. The amount of the salary reduction election available to you to pay for coverage is equal to your share of the premium required to pay for coverage or, in certain cases, the amount you elect to contribute to an account.

The Company pays the full cost of your Basic Life Insurance and Basic AD&D Insurance coverage.

You pay for STD/LTD, Group Universal Life, and Optional AD&D Insurance coverages with after-tax dollars deducted from your pay. Amounts you contribute on an after-tax basis are subject to federal and state income and employment taxes, just like the rest of your pay. These amounts will be taken into account when computing your federal Social Security benefit and for purposes of your pay-related benefits.

Deductions are withheld as soon as administratively possible after you become eligible, enroll, and are approved for coverage.

Generally, when you pay for coverage with after-tax dollars, the benefits you (or your beneficiary) receive are not subject to federal taxes. In a few cases, however, state taxes may apply. You should consult with your tax advisor to determine how these benefits apply to your specific tax situation.

If premium payments cannot be deducted from your paycheck for any reason, you will be billed directly for your premiums on a monthly basis by the Goodyear Associate Service Center. Failure to remit your premiums on a timely basis will result in cancellation of your coverage. If your coverage is canceled due to non-payment of premiums, you will not be eligible to re-enroll in coverage.

Nicotine Surcharge

The nicotine surcharge applies to you and/or your spouse if you are enrolled in a Company-sponsored medical plan and you are a tobacco/nicotine user. This monthly surcharge will be deducted from your paycheck.

When you enroll initially and during each Annual Enrollment period, you and your spouse will complete a Nicotine Declaration, indicating whether either of you uses tobacco/nicotine products.

- If you **do not use tobacco/nicotine products**, the surcharge will not appear in your paycheck.

- If you **do use tobacco/nicotine products**, a $100-per-month surcharge will appear in your paycheck ($200 per month if both you and your spouse use tobacco/nicotine products) one to two pay cycles after initial enrollment or a qualified status change enrollment and on the first pay cycle after Annual Enrollment.

- If you (or your spouse) do not complete the Nicotine Declaration, you will automatically be subject to the surcharge.

If, due to a medical condition or it is medically inadvisable for you to achieve the standards of this program, contact the Goodyear Associate Service Center at (844) 449-4772.

Note: If you use tobacco/nicotine products but answer on your Nicotine Declaration that you do not, you may be subject to disciplinary action, up to and including termination.

Nicotine Cessation Programs

Consumption of tobacco products is increasing globally. Lung cancer takes more lives than any other type of cancer. Smoking and tobacco use cause cancers of the lungs, esophagus, larynx (voice box), mouth, throat, kidney, bladder, pancreas and stomach, and acute myeloid leukemia.

Smoking is also responsible for many long-term illnesses, such as heart disease, stroke, asthma and COPD (a condition that makes it harder and harder to breathe).

If you smoke or use tobacco and want to quit:

- U.S. Goodyear associates and spouses enrolled in a company-sponsored medical plan can now access the Quit For Life program from the American Cancer Society at no cost. Visit: www.quitnow.net or call 1-866-QUIT-FOR-LIFE (1-866-784-8454) for more details.

Your state's assistance program can provide help as well. Visit www.naquitline.org/map to get state-specific information, or call 1-800-QUITNOW (1-800-784-8669).

To have the surcharge removed upon completion of the nicotine cessation program, review the Employee Assistance Program website at www.achievesolutions.net/goodyear and then call the Goodyear Associate Service Center at (844) 449-4772 to complete the Nicotine Declaration verbally. Your (or your spouse's) tobacco/nicotine user status will change to "No." Reimbursement will be retroactive to all surcharges imposed in the current Plan year.

Working Spouse Provision

The "Working Spouse" provision is designed to require other employers to pay their "fair share" of the health costs.

The Working Spouse provision takes effect when you have a spouse who works for an employer (other than Goodyear and its affiliates) and who is eligible for that employer's group-sponsored health care plan. This provision also applies to your spouse who has retired and is eligible for health care coverage through his or her former employer.

If your spouse is a USW or URW hourly retiree and a participant in the Retirees of the Goodyear Tire and Rubber Company Health Care Trust (VEBA), the Working Spouse rule also applies. Your spouse is required to enroll in the retiree medical coverage offered to him or her, and Goodyear will only pay as secondary.

How Does It Work?

When a spouse is working or retired and is eligible to be covered by another employer-sponsored group hospital, surgical, medical or prescription drug program and you are eligible for the Company's health care coverage, medical claims of the working or retired spouse will be coordinated whether or not the spouse enrolls in that coverage.

If your spouse elects not to enroll in his or her own employer-sponsored group health care coverage, coordination of benefits will still apply. This means that Goodyear will only pay benefits for the working or retired spouse as a secondary payor after applying the coordination of benefits provision on the basis of what the spouse's or dependent's employer group health care plan would have paid if coverage had been elected.

Like Goodyear, most employers that offer health care benefits have an open enrollment process each fall for the upcoming benefit year. Therefore, employees with full-time working or retired spouses who have access to health care coverage with their employer need to have their spouse take action during their open enrollment periods.

Note: Your spouse is not required to enroll in his or her employer's medical coverage if your spouse's employer does not share in the cost of coverage for the medical plan or if the coverage does not meet minimum essential coverage guidelines set under the Affordable Care Act.

Additional Information on the "Working Spouse" provision:

- If your spouse works full time with an employer other than Goodyear and is eligible for medical coverage from the employer, he or she must enroll in that employer's plan. You can enroll your spouse in Goodyear coverage as secondary.
- The first time your working spouse has a medical claim, he or she will receive a Coordination of Benefits form from the Goodyear medical benefits carrier or a third-party administrator.
- You or your spouse can fill out the form and send it to your medical insurance carrier or third-party administrator by (i) sending by mail, (ii) updating on the carrier's or administrator's website, or (iii) contacting the carrier or administrator by phone.
- Information will automatically be sent to the prescription carrier or pharmacy benefits manager. No action is needed on your part.
- **Note:** If your working spouse loses coverage during the year, he or she will need to contact the medical insurance carrier or third-party administrator to update his or her coverage status as primary. If no response is provided to the health plan administrator, all subsequent claims will be rejected. Claims will be adjusted accordingly once a response has been received.
- The "Working Spouse" provision does not apply to Medicare or to independent insurance policies purchased by the spouse.

Healthy Choice Incentive

The Healthy Choice Incentive Program, offered to those enrolled in a Company-sponsored medical plan option, will feature a designated wellness activity to gauge your current health. The activity may change from year to year. See your enrollment materials for the current year's activity.

See "Your Medical Coverage" for the amount of your Healthy Choice Incentive and how you will receive the incentive.

Your Medical Coverage

This section describes Goodyear's medical options available to you. See the insurance carrier and third-party administrator coverage summaries to review what is and what is not covered in the medical options.

When you first become eligible, you will be asked to make two choices:

- Which option you want coverage under; and
- The "coverage category" you want.

You will be required to complete a medical coordination of benefits questionnaire form regarding other medical coverage that is available to your spouse and other eligible dependents. This coordination of benefits provision is described in detail under the section entitled "Working Spouse Provision."

Goodyear provides its eligible salaried employees several medical options. Each medical option offers coverage for medical services and prescription drugs. Prescription drug coverage is included as part of your medical option. A Health Savings Account (HSA) is also available if you are covered under the High Deductible Health Plan (HDHP).

Your medical options are provided through Anthem, UnitedHealthcare, or SummaCare. Options available at certain locations are insured through HMSA and Cigna. Included with each option are the following programs:

- Healthy Choice Incentive—Features a designated wellness activity to gauge your current health.
- LiveHealth Online—Lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam.

Your Medical Options

As an eligible salaried employee, you have the following medical coverage options:

- HDHP option with HSA
- Preferred Provider Organization (PPO)
- Local Exclusive Provider Organization (EPO) Options
- No coverage

The insurance carrier or third-party administrator for the medical options has provided detailed information about the various options available to you. These summaries are available via the GO page (http://go.goodyear.com/) and can also be requested in print, free of charge, from the insurer or administrator. The coverage summaries will:

- Include any cost-sharing provisions, such as copayments, coinsurance, deductibles, and out-of-pocket maximum amounts.
- Include any applicable annual maximums or other limits.
- Define in-network health care providers, such as a doctor, physician, or hospital.
- Describe what preventive care services are covered and what other services and expenses are covered or not covered.

HDHP Option with HSA

The HDHP option with an HSA, administered by Anthem Blue Cross/Blue Shield, is a type of consumer-driven health care plan using a PPO plan base paired with a high annual deductible that must be satisfied before medical and prescription drug benefits are paid. You can receive care from either in- or out-of-network providers. The HDHP does not require you to select or have your care coordinated through a primary care physician (PCP). You also do not need a referral to see a specialist.

While these options include a higher deductible than the other medical options, they may also be paired with an HSA that you can use to help satisfy your deductible. After you meet the annual deductible, you pay a percentage of the cost—known as "coinsurance"—which will be higher if you use out-of-network providers. In addition, if your expenses for out-of-network care are more than the reasonable and customary (R&C) charges, you will pay the excess amount.

For all medical options, you should refer to the insurance carrier or third-party administrator coverage summaries for detailed information about limitations on benefits, covered preventive care services, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for obtaining in-network and out-of-network services.

Health Savings Account (HSA)

If you elected the HDHP, you can elect to have the Company deposit your before-tax contributions to an HSA at a financial institution designated by the Plan. You can elect to contribute up to the maximum amount allowed by the federal government for each year you participate. The maximum amount will be communicated in your enrollment materials. You, the employee, are responsible for making sure the IRS limits have not been exceeded.

What Is a Health Savings Account?

An HSA is a before-tax or after-tax account that allows eligible individuals covered by a qualified HDHP to pay for current and future qualified medical expenses. You can elect either to make contributions throughout the year, taken from your paycheck as a before-tax deduction, or to contribute on your own and submit for tax relief on your annual income tax return for an after-tax deduction.

The Health Savings Account is an FDIC-insured, interest-bearing account that allows you to save before-tax dollars, earn tax-free interest, and access your funds for qualified medical expenses on a tax-free basis. It is a bank account with an approved financial institution you may use for your HSA contributions. HealthEquity is the custodian for the FDIC-insured checking portion of the HSA.

How an HSA Works:

The account is portable, so it stays with you, even after retirement:

1. Eligible associates enroll in the HDHP and contribute to their HSA.

2. The associate can conveniently withdraw funds in the savings account to pay for qualified medical expenses. (Most accounts include a checkbook or debit card for easy withdrawal of funds to pay for eligible expenses.)

3. Any account balance carries over from year to year and earns tax-free interest.

4. You own your account, so you can take it with you when you leave Goodyear employment or retire.

Who Is Eligible for an HSA?

The IRS and Treasury have established the eligibility requirements for establishing and contributing to an HSA. To be eligible, an individual:

- Must be covered by a qualified HDHP.

- Must not be covered by any other health insurance—except certain permitted benefits such as dental or vision coverage.
- Must not be enrolled in Medicare.
- Must not currently be entitled to Tricare, a health care program of the U.S. Department of Defense Military Health System.
- Must not be eligible to be claimed as a dependent on someone else's tax return.
- Must not be participating or have a spouse participating in a broad-based medical Flexible Spending Account (FSA).

Can I Have Both an FSA and HSA with the HDHP?

You can have both types of accounts, but only under certain circumstances. You will be eligible to enroll in a "Limited Purpose FSA" that can only be used for reimbursement of eligible preventive care, dental or vision expenses, and medical expenses after you've met your annual deductible.

For those who elect a Limited Purpose FSA, you will receive two Health Equity cards. The Limited Purpose FSA card is blue, and the HSA card is purple,

When using your HealthEquity card, your Vision and Dental claims will first go through your Limited Purpose FSA. Any remaining balance will be charged to your Health Savings Account.

For post-deductible and preventive medical expenses, if you want to process through your Limited Purpose FSA, you will have to submit a claim via the website or with a paper claim form. Otherwise, if you use your HealthEquity card, all medical transactions will go through your Health Savings Account.

Do I Have to Enroll in the Health Savings Account Offered by the Company?

No, you are not required to enroll in the Health Savings Account offered by the Company. You may open a Health Savings Account at the financial institution of your choice, and you would have to make the contributions with after-tax dollars and take the deduction on your tax return.

An HSA gives you more choices, such as:

- You may modify your contributions at any time during the year by contacting the Goodyear Associate Service Center and completing an HSA change form.
- You can have investments to help grow your savings account.
- With an HSA, there's no "use it or lose it" rule; your account rolls over indefinitely.
- You can shop around for the best value and invest for future health care expenses.

An HSA can help you invest for future health care expenses, since the money in the HSA can be used tax-free for:

- Qualified medical services that may not be covered by your health plan.
- Medicare and other health coverage if you are age 65 or older (other than premiums for a Medicare supplemental policy, such as Medigap).
- Health plan coverage while an individual is receiving unemployment compensation.
- COBRA premiums.
- Qualified long-term care premiums, subject to certain dollar limitations.

An HSA is portable, so you have control of the account, regardless of:

- Whether you are employed
- Where you are employed
- Whether you move across state lines
- Your age

If you enroll in the HDHP, your prescription drug benefits are covered through the HDHP and will be tracked through OptumRx. Your prescription drugs will be subject to the deductible of the HDHP. For information on the cost of your prescriptions, you may use the OptumRx pricing tool on their website at www.optumrx.com.

You will have to register.

How to Enroll for Payroll Deductions:

- First, you must elect the High Deductible Health Plan for your medical coverage.
- Second, you must open an account with HealthEquity. You can do this at selfservice.goodyear.com if you elect to contribute via payroll deduction or when you receive your welcome kit from HealthEquity if you choose not to contribute via payroll deduction. You can change the amount of your payroll deductions anytime.
- You can also make your own deposits on an after-tax basis and file for a tax deduction on your annual tax return or if you want to open your own HSA with another financial institution, you need to make your own arrangements with your own financial institution.

As the accountholder owns and controls the HSA, it is not Goodyear's or HealthEquity's responsibility to monitor individual compliance with IRS rules in regards to contributions or distributions for qualified medical expenses.

For more information on the HSA, please contact the HealthEquity's Member Services Center at (866) 346-5800 or visit www.healthequity.com.

In addition to before-tax deposits through payroll deduction, you may also deposit after-tax contributions into your account. Transfers from existing HSAs can be made to consolidate your accounts you may have at other financial institutions. Contact the HealthEquity Member Services Center for more information.

Healthy Choice Incentive under the HDHP

The amount of your incentive will depend upon the date your medical benefits begin, and are subject to change from year to year. Any changes will be communicated during Annual Enrollment. Your incentive earned will be contributed to your HSA at the beginning of the quarter after your medical benefits begin. If your medical benefits begin:

- January–March: Your incentive is $420 for you or your covered spouse ($840 for both) starting in April
- April–June: Your incentive is $315 for you or your covered spouse ($630 for both) starting in July
- July–September: Your incentive is $210 for you or your covered spouse ($420 for both) starting in October
- October–December: Your incentive is $105 for you or your covered spouse ($210 for both) starting in January

Preferred Provider Organization (PPO)

The PPO medical option offers access to a network of physicians, hospitals, and other health care providers that have agreed to provide medical care at negotiated rates. You and your dependents are not required to use a primary care physician (PCP) to coordinate care under the PPO option. You can receive care from any health care provider you choose, but benefits are paid at a higher level when care is received from network providers. If you or your dependents receive care from a provider who is not in the PPO option's network, benefits are paid at a lower level or may be limited entirely in some areas.

Most PPO options also include an annual deductible that must be satisfied before the option pays benefits for covered services. In addition, you generally pay a copayment for office visits; for most other services, after you meet the annual deductible, you pay coinsurance, which will be higher if you use out-of-network providers. Also, if your expenses for out-of-network care are more than the reasonable and customary (R&C) charges, you will pay the excess amount. R&C is a charge for a service consistent with the average or usual charge for that service within your geographic area.

Healthy Choice Incentive under the PPO

Your incentive will be a $35-per-month reduction in medical premiums for each pledge per associate/covered spouse. You will receive your incentive through a credit on your paycheck throughout the year.

Exclusive Provider Organization (EPO)

Depending on where you live, the EPO option, if available, offers access to networks of physicians, hospitals and other health care providers that have agreed to provide medical care at negotiated rates. You and your dependents are required to use a primary care physician (PCP) to coordinate care under the EPO option. If you or your dependents receive care from a provider who is not in the EPO option's network, services are not covered.

Healthy Choice Incentive under the EPO

Your incentive will be a $35-per-month reduction in medical premiums for each pledge per associate/covered spouse. You will receive your incentive through a credit on your paycheck throughout the year.

Cost-Sharing

The following chart describes your Plan costs under each health care option. Please note that these amounts and percentages are subject to change from year to year. Any changes will be communicated during Annual Enrollment.

	HDHP with HSA	**PPO**	**EPO**
Deductible	$1,600 individual/ $3,200 family	$900 individual/ $1,800 family	$700 individual/ $1,400 family
Medical Coinsurance	20%	20%	10%
Rx Coinsurance	25%	20%	10%
Preventive Care	100% covered	100% covered	100% covered
Medical Out-of-Pocket Limit	$3,200 individual/ $6,400 family	$3,100 individual/ $6,200 family	$2,100 individual/ $4,200 family
Rx Out-of-Pocket Limit	Attached to Medical Out-of-Pocket Limit	$3,600 individual/ $4,200 family	$3,600 individual/ $4,200 family

	HDHP with HSA	PPO	EPO
HSA Annual Contribution Limit	$3,500 individual/ $7,000 family	N/A	N/A
HSA Catch-up Contribution (if you are age 55 or over)	$1,000	N/A	N/A

The cost-sharing specified in this SPD is intended to be a summary of the most common covered services offered across insurance carriers. It does not cover out-of-network cost-sharing. For a more detailed description of each medical option's benefits, see the coverage summaries.

LiveHealth Online Costs

LiveHealth Online costs depend on your medical insurer. You can pay by Visa, MasterCard, and Discover cards. Charges for prescriptions are not included in the cost of your doctor's visit.

Anthem: The cost of the visit is $49, but if you have met your annual deductible, the cost will only be subject to your coinsurance percentage of the cost of the visit.

SummaCare: You will pay the $49 visit fee, but you may submit a paper claim and have the visit applied to your in-network deductible and out-of-pocket maximum. If you have met your annual deductible, you may receive a reimbursement for part of the cost of the visit.

UHC: You will pay the $49 visit fee. Go to www.myuhc.com for information.

Florida and Georgia Residents under Anthem Plans

If you reside in Florida or Georgia and are an Anthem participant, your provider network will be:

- Florida: NetworkBlue
- Georgia: Blue Open Access Point of Service (POS)

Your benefits are the same, but you will need to make sure that your current health care provider is in the network named above.

Anthem has negotiated additional discounts with local doctors and hospitals in Florida and Georgia. When you use an in-network health care provider, these savings are passed on to you. You can choose any network provider in NetworkBlue (Florida) or Blue Open Access POS (Georgia) without needing a referral. When you are outside of Florida or Georgia, you'll use the BlueCard PPO network. You can also choose to go to a licensed out-of-network provider for covered services. Just remember that your out-of-pocket costs will be much higher if you do. By staying in network, your costs will be lower.

Duration of Coverage

If your employment with the Company ends, benefits under the Plan will end on the date your employment is terminated.

If you are enrolled for coverage, unless you terminate employment, you may continue coverage for you and your covered dependents under the following circumstances by paying, in advance, the required premium.

- While you are on sick leave and accumulating continuous service.
- While you are receiving benefits under the Long-Term Disability plan for up to one year.
- While you are on leave of absence for military duty of less than six months.
- While you are on leave of absence for pregnancy and accumulating continuous service.
- While you are on any other leave of absence for up to 90 days.

- You may elect coverage through COBRA by paying the applicable premiums for a period of up to 18 months.

If your death occurs while you are actively employed and your dependents are covered for medical benefits under the Plan, coverage will be continued for your spouse and dependent children for up to six months.

Non-Duplication of Benefits

See your medical coverage summaries for coordination of benefits information for your specific medical plan.

Medical Claims and Appeals Procedures

The claims and appeals procedure applicable to your ERISA-governed medical and prescription drug benefits are covered here. If you are denied medical or prescription drug benefits under the Plan, you may file an appeal. The claims and appeals process has been delegated to the specific providers under the Plan. Please refer to the coverage summary provided by the insurance carrier or third-party administrator (e.g., Anthem, UnitedHealthcare, SummaCare, or OptumRx) for its specific claims and appeals procedure, or you may call the provider's customer service number listed on your medical or prescription drug identification card to request a copy of its claims and appeals procedures. The procedures set forth in this SPD with respect to your medical and prescription drug benefit claims are ***illustrative*** of ERISA's procedures and will apply in the event that a specific provider does not have a claims and appeals procedure.

If you have any questions regarding the ERISA claims and appeals process, the U.S. Department of Labor website at dol.gov/ebsa/healthreform will maintain up-to-date information, or you can contact the Goodyear Associate Service Center at (844) 449-4772.

The following applies to medical and prescription drug benefits only. The claims and appeals procedure is slightly different, depending on whether you have an "**eligibility**" claim or a "**benefit**" claim. An **eligibility** claim is a claim to participate in a plan or plan option or to change an election to participate during the year. A **benefit** claim is a claim for a particular benefit under a plan. It typically will include your initial request for benefits.

Benefit claims and appeals are divided into four categories:

- ***Post-service claim***
  A claim for reimbursement of benefits or services already received. This is the most common type of claim.

- ***Pre-service claim***
  A claim for a benefit for which prior authorization is required by the Plan.

- ***Concurrent care claim***
  A claim for ongoing treatment over a period of time or a number of treatments. For example, if you have been authorized to receive seven treatments from a therapist and during the treatment your therapist suggests 10 treatments, your claim is a concurrent care claim. Some concurrent care claims also are urgent care claims.

- ***Urgent care claim***
  A claim for medical care or treatment that, if the longer time frames for non-urgent care were applied, the delay: (1) could seriously jeopardize the health of the claimant or his or her ability to regain maximum function; or (2) in the opinion of a doctor with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be managed without the care or treatment that is the subject of the claim.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Step 1: Internal Claims (Initial Benefit Determination)				
How to file a claim: To file an **eligibility** claim, request a Claim Initiation Form from the Goodyear Associate Service Center. You must return the form to the Goodyear Associate Service Center at the address on the form. To file a **benefit** claim, you should contact your insurance carrier or third-party administrator. See "Additional Plan Information" under the Administrative Information section for contact information, or refer to the telephone number and/or website shown on the back of your ID card. You must include: • A description of the benefits for which you are applying. • The reason(s) for the request. • Relevant documentation.				To file an urgent care claim, you should call the Goodyear Associate Service Center or your insurance carrier or third-party administrator. In addition, you must state that you are filing an urgent care claim.
What happens if you do not follow procedure: For pre-service and urgent care claims only, you will be notified of your failure to follow plan procedures and be provided the proper procedure **(see columns to the right)** for receipt of the claim.	Not applicable. Response time frame does not begin until claim is properly filed.	As soon as possible, but within 5 days.	Not applicable. Response time frame does not begin until claim is properly filed. If claim involves urgent care, within 24 hours.	As soon as possible, but within 24 hours.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
When you will be notified of the claim decision: You will be notified of the decision within **(see columns to the right)** of the Goodyear Associate Service Center's receipt of your Claim Initiation Form or the insurance carrier or third-party administrator's receipt of your claim letter.	30 days. If additional information is needed to process your post-service claim, you will be notified within the initial 30-day period. The Plan may request a one-time extension, not longer than 15 days.	15 days. If additional information is needed to process your pre-service claim, you will be notified within the initial 15-day period. The Plan may request a one-time extension, not longer than 15 days.	A time period sufficiently in advance of the reduction or termination of coverage to allow you to appeal and obtain a response to that appeal before your coverage is reduced or terminated. For concurrent care that is urgent, within 24 hours (provided that you submitted a claim at least 24 hours in advance of reduction or termination of coverage); otherwise, within 72 hours.	72 hours.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Failure to provide sufficient information procedure: If you fail to provide sufficient information, the claim ***may*** be decided based on the information provided. If the claims fiduciary decides to request additional information before deciding the claim, the Goodyear Associate Service Center or insurance carrier or third-party administrator may notify you within **(see columns to the right)** that additional information is needed.	30 days.	15 days.	Decision will be based on information provided, unless the concurrent care claim involves urgent care; see urgent care time frame.	24 hours.
You will have **(see columns to the right)** from receipt of the notice to provide the additional information. Otherwise, the claim will be decided based on information originally provided.	45 days.	45 days.		48 hours.
If you provide additional information, you will be notified of the decision by the Goodyear Associate Service Center or insurance carrier or third-party administrator within **(see columns to right)**.	The time period remaining for the initial claim.	The time period remaining for the initial claim.		Earlier of 48 hours or the time period given to you to provide information.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
How you will be notified of the claim decision: If your claim is approved, the Goodyear Associate Service Center or the insurance carrier or third-party administrator will notify you in writing. For benefit claims, this notification is commonly referred to as an explanation of benefits or EOB. If your claim is denied, in whole or in part, the Goodyear Associate Service Center or the insurance carrier or third-party administrator will notify you in writing, except for urgent care. Your denial notice will contain: • The specific reason(s) for the denial. • The Plan provisions on which the denial was based. • Any additional material or information you may need to submit to complete the claim. • Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request). • The Plan's appeal procedures. • Information sufficient to identify the claim involved (date of service, the health care provider, claim amount [if applicable], and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings). • The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process. Further, your notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.				If your claim is denied, the Goodyear Associate Service Center or the health plan will notify you by telephone. Within three days of this oral denial, you will receive a written denial notice, as explained under the general procedure. The denial notice also will explain the expedited review process.

If the Goodyear Associate Service Center or insurance carrier or third-party administrator relies on new evidence to deny your claim, you will be notified in advance, free of charge, with the rationale so that you can respond in advance of the final internal adverse benefit determination.

You have a right to review your claim file.

Step 2: Internal Claims (Benefit Determinations on Review)

About appeals and the claims fiduciary:
Before you can bring any action at law or in equity to recover Plan benefits, you must exhaust this process.

Specifically, you must file an appeal or appeals, as explained in this Step 2, and the appeal(s) must be finally decided by the claims fiduciary.

- Goodyear is the claims fiduciary for all eligibility claims.
- The insurance carrier or third-party administrator, as applicable, is the final authority for medical benefit claims.

The claims fiduciary is authorized to finally determine appeals and interpret the terms of the Plan in its sole discretion. The claims fiduciary will be independent from the party who reviewed your initial "claim." All decisions by the claims fiduciary are final and binding on all parties.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
How to file an appeal: If your claim is denied and you want to appeal it, you must file your appeal within **(see columns to the right)** from the date you receive notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. You also have the right to testify, present evidence, as well as submit written comments, documents, records, and other information relating to the claim. If you have an appeal for **eligibility** (i.e., you wrote to the Goodyear Associate Service Center at Step 1), write to the address specified on your claim denial notice. If you have an appeal for **benefits** (i.e., you wrote to your insurance carrier or third-party administrator at Step 1), write to the contact identified by your insurance carrier or third-party administrator in your claim denial notice.	180 days.	180 days.	180 days.	180 days. You may **orally** file your appeal with the claims administrator. At the time your claim is denied, the insurance carrier or third-party administrator will give you instructions about how to file your appeal, including who the claims administrator is. You must identify that you are appealing an urgent care claim.

You should include:

- A copy of your claim denial notice.
- The reason(s) for the appeal.
- Relevant documentation.

The individual/committee (and any medical expert) reviewing your appeal will be independent from the individual/committee who reviewed your claim. In addition, if your appeal involves a medical judgment, the claims administrator will consult with a health care professional who has appropriate relevant experience. You are entitled to learn the identity of such an expert, upon request.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
When you will be notified of the appeal decision: You will be notified of the decision within **(see columns to the right)** of the claims fiduciary's receipt of your appeal.	**Eligibility appeals:** 60 days. **Benefit appeals:*** 60 days, if the claims fiduciary provides one level of mandatory appeal. 30 days, if the claims fiduciary provides two levels of mandatory appeal.	**Eligibility appeals:** 30 days. **Benefit appeals:*** 30 days, if the claims fiduciary provides one level of mandatory appeal. 15 days, if the claims fiduciary provides two levels of mandatory appeal.	**Eligibility and benefit appeals:** Before a reduction or termination of benefits would occur. If the concurrent claim involves urgent care, 72 hours.**	**Eligibility and benefit appeals:** 72 hours.**

* If the claims administrator provides more than one level of mandatory appeal, the response time frame is shorter, as noted above. The claims administrator also may offer a **voluntary** level of appeal. You are not required to file a voluntary appeal before filing a civil action; however, you may find it helpful. The claims administrator will provide you with information regarding its voluntary appeal, if it applies. A voluntary appeal is not subject to the same time frames as a mandatory appeal.

** If the claims administrator provides two mandatory appeals, both appeals must occur within the 72-hour time frame.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim

How you will be notified of the appeal decision:
If your appeal is **approved or denied**, the claims administrator will notify you in writing.

If your appeal is **denied**, in whole or in part, your denial notice will contain:

- The specific reason(s) for the denial.
- The Plan provisions on which the denial was based.
- A statement regarding the documents to which you are entitled, upon request and free of charge.
- Any internal procedures or clinical information on which the denial was based (or a statement that this information will be provided free of charge, upon request).
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”
- Information sufficient to identify the claim involved (date of service, the health care provider, claim amount (if applicable), and upon request, the availability of the diagnosis and treatment codes and their corresponding meanings).
- Information pertaining to your right to an external review (and if applicable, any second level of internal appeal).
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman available to assist with the appeals process.

Further, your notice will be written in a culturally and linguistically appropriate manner. Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

When Goodyear is the claims administrator, only one mandatory appeal is available. The Company will not review your matter again, unless new facts are presented. You have a right to bring a civil action under Section 502(a) of ERISA. When the insurance carrier or third-party administrator is the claims administrator, the health plan may offer one or two mandatory appeals. If a voluntary appeal is available, you will be notified.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim

Step 3: External Review—Independent Review Organization (IRO)

If your benefit claim is denied following the mandatory appeal(s), i.e., benefit determination on review, you generally have a right to file a civil action. However, under the Affordable Care Act changes to benefit claims procedures, you also have a right to submit an external review to an IRO for any medical benefit claim or rescission.

Your claim will be reviewed *de novo* (afresh or anew) by an IRO, if it's eligible for the external review. The IRO is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Standard external review:
You may request a standard external review within four months after the date of receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

Expedited external review:
You may make a request for an expedited external review at the time you receive:

- An **internal adverse benefit determination** if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A **final internal adverse benefit determination**, if (1) you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function; or (2) the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

You should contact the claims fiduciary for more details.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Preliminary review: Within **(see columns to the right)** following receipt of the request, the claims administrator must complete a preliminary review of the request to determine whether: • You were covered under the Plan at the time the medical care, item, or service was requested; • The adverse benefit determination does not relate to your failure to meet the eligibility requirements under the terms of the Plan, except for a rescission (again, external review generally does not apply to eligibility-type requests or claims); • You have exhausted the Plan's internal appeal process; and • You have provided all the information and forms required to process the external review.	5 business days.	5 business days.	5 business days. Immediately if the concurrent care claim involves urgent care.	Immediately.

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Issue written notice to claimant: The claims administrator is required to issue a written notice and explain its preliminary review determination within **(see columns to the right)**: • If the request is eligible for external review, the claims administrator on behalf of the Plan must assign the review an IRO. • If the request is incomplete, the notice must state what is needed to complete the request for external review. If the request is complete but not eligible for external review, the notice must state the reasons for ineligibility and provide EBSA's contact information, (866) 444-EBSA (3272).	1 business day. ***If a request is incomplete, claimant*** must provide required information within the 4-month filing period or 48 hours following notice, whichever is later.	1 business day. ***If a request is incomplete, claimant*** must provide required information within the 4-month filing period or 48 hours following notice, whichever is later.	1 business day. Immediately if the concurrent care claim involves urgent care.	Immediately.
Provide IRO with all documentation: The claims administrator must provide the IRO any documents and information considered in making the adverse benefit determination within **(see columns to the right)** after the date of assignment.	5 business days.	5 business days.	5 business days. If the concurrent care claim involves urgent care, refer to "Expedited external review."	Refer to "Expedited external review."

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
Provide claimant with written notice of acceptance of external review request: The IRO must provide you written notice of acceptance of external review request within **(see columns to the right)** and include a statement that you may submit additional information in writing within 10 business days to be considered by the IRO. Upon receipt of additional information, the IRO has one business day to forward the information to the claims administrator.	Timely.	Timely.	Timely. If the concurrent care claim involves urgent care, refer to “Expedited external review.”	N/A.
Reconsider adverse benefit determination: Upon the IRO’s receipt of any information submitted by you, the IRO must forward the information to the claims administrator. The claims administrator may then **reconsider its adverse benefit determination**, but will not delay the external review. If the claims administrator **reverses** its decision, they must notify you and the IRO within **(see columns to the right) following the decision**, and the IRO must terminate the external review. The amount of time that it takes to review and reverse a decision may vary by claims administrator.	1 business day following decision.	1 business day following decision.	1 business day following decision. If the concurrent care claim involves urgent care, refer to “Expedited external review.”	Refer to “Expedited external review.”

General Procedure	Post-Service Claim	Pre-Service Claim	Concurrent Care Claim	Urgent Care Claim
When you will be notified of the external appeal decision: The IRO must provide (oral or written) notice of the final external review decision to you and the claims administrator within **(see columns to the right)** after the IRO receives the request for external review.	**Written notice:** 45 days.	**Written notice:** 45 days.	**Written notice:** 45 days. **Oral notice:** 72 hours, if the concurrent care claim involves urgent care. If the initial notice is not in writing, the IRO must provide written confirmation of decision to the claimant and the claims administrator within 48 hours.	**Oral notice:** 72 hours. If the initial notice is not in writing, the IRO must provide written confirmation of decision to the claimant and the claims administrator within 48 hours.
IRO external review decision notice: The decision notice must include: • General description of the reason for the request for external review, including sufficient information to identify the claim (i.e., date[s] of service, health care provider, claim amount [if applicable], diagnosis, treatment codes and their meaning, and the reason for the previous denial); • Date IRO received the assignment to conduct the external review and the date of the IRO's decision; • References to evidence or documentation, including specific coverage provisions and evidence-based standards considered; • Discussion of the principal reason(s) for its decision, including rationale and any evidence-based standards relied upon; • Statement that the determination is binding except to the extent other remedies may be available under state or federal law to either the Plan or to the claimant; • Statement that judicial review may be available to the claimant; and • Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.				
If IRO reverses claims administrator's decision: The claims administrator must provide coverage or payment for the claim within **(see columns to the right)**.	Immediately.	Immediately.	Immediately.	Immediately.
If IRO denies your appeal: You have the right to bring a civil action under Section 502(a) of ERISA.				

External Review Process—Self-Insured Claims Involving Health Care

For self-insured claims involving health care, the Affordable Care Act made changes to the claims and appeals procedure described above.

- The initial claim and first appeal of a claim are now referred to as the "internal" claims and appeals process.

- Generally, health care claims for which the final internal adverse decision is issued, and which involve medical judgment or rescission of coverage, are eligible for a "new" external review by an IRO unless the claim involves a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that you failed to meet the Plan's eligibility requirements. You will be provided with detailed information regarding this new external review if these guidelines apply to your denied claim.

- The details applicable to this new external review can be obtained from your claims administrator. To be eligible for the external review, your request must be filed within four months after the date of receipt of a notice of a final internal adverse benefit determination.

See your medical insurance carrier or third-party administrator's coverage summary for specific claims and appeals procedures.

Prescription Drug Coverage for You and Your Family

If you elect medical coverage, it will include prescription drug coverage through the OptumRx network of retail pharmacies and Home Delivery. If you elect medical coverage through the HDHP, prescription drug coverage is provided through OptumRx but is subject to the HDHP's deductibles, coinsurance, and out-of-pocket maximums, and not to any of the following rules except that if the Internal Revenue Service should determine that the reimbursement for any prescription drug is taxable income, such drug will not be a covered item under the HDHP.

Prescription drugs ordered by a physician or a dentist may be purchased from a retail pharmacy that is a "Participating Pharmacy" or through the "Home Delivery Prescription Service" designated by the Company.

See the OptumRx coverage summaries to review what prescription drugs are and are not covered.

Your Prescription Drug Coverage

As part of your medical option election, prescription drug coverage is included for medications that are approved by the U.S. Food and Drug Administration (FDA), prescribed by a physician, and filled at a participating retail pharmacy or through the Home Delivery Service program offered by OptumRx.

Detailed information about prescription drug coverage is included in the medical benefit coverage summaries available on the GO page (http://go.goodyear.com/). These summaries can also be requested in print, free of charge, from OptumRx. The coverage summaries will include any cost-sharing provisions including copayments, coinsurance, and any applicable maximums or other limits.

Your prescription drug coverage includes two components:

- **Retail Pharmacy Program:** Up to a 30-day supply of prescription drugs for immediate and short-term prescription drug needs. If refills are allowed, you can refill the prescription at a participating pharmacy generally after 75% of the initial prescription is used. You pay the retail copayment for the initial fill and the first refill. See your medical benefit coverage summary for additional information.

  If you buy your medications out-of-network, you pay the full cost and then submit a paper claim for reimbursement based on the eligible cost of the drug.

- **Home Delivery Program:** Up to a 90-day supply of medication for ongoing medical conditions (such as high blood pressure, asthma, etc.). Please note that Home Delivery may be mandatory depending on which medical option you choose. Refer to the medical benefit coverage summary for additional information.

  Note: If you change medical plan providers from the previous year and you are taking a maintenance medication, you will need to request a new prescription form from your doctor to submit to the new medical plan provider as soon as possible.

PPO and EPO Plans

If you are enrolled in a PPO or EPO medical plan, your plan offers the prescription drug benefits outlined in the table:

	Retail	**Home Delivery**
Generics	$15 copayment	$30 copayment
Formulary/Preferred Brand	25% coinsurance ($40 minimum; $150 maximum)	25% coinsurance ($55 minimum; $200 maximum)
Non-Formulary/Non-Preferred Brand	45% coinsurance $90 minimum; $300 maximum	45% coinsurance $110 minimum; $500 maximum
Specialty	10% coinsurance (30-day supply); additional $10 for non-formulary. Only initial fill allowed at retail; Home Delivery begins at refill.	
4th Tier for ED, Nail fungus	50% coinsurance (formulary); 100% coinsurance (non-formulary)	
Prescriptions for GERD	50% coinsurance (generic); 100% coinsurance (brand, formulary and non-formulary)	
Contraceptives	$0 generic/single-source brand/Dispense as Written multi-source brand Multi-source brand: 50% coinsurance (formulary); 100% coinsurance (non-formulary)	
Preventive medications allowed by ACA	$0 generics, $0 single-source brand Multi-source brand: 50% coinsurance (formulary); 100% coinsurance (non-formulary) Subject to certain guidelines not subject to minimums or maximums: Folic acid, aspirin, iron, tobacco cessation, vitamin D, bowel prep, Tamoxifen and Raloxifene in certain situations, and certain vaccines (flu, hepatitis B, pneumonia, shingles)	
Diabetic testing supplies (monitor/strips/lancets)	20% coinsurance (formulary); 40% coinsurance (non-formulary)	
Non-sedating antihistamines	Not covered	
Minimum: Least dollar amount per prescription for which member is responsible. Maximum: Maximum dollar amount per prescription for which member is responsible.		

In accordance with the Affordable Care Act of 2010, your prescription drug benefit for the PPO/EPO plans includes an in-network out-of-pocket maximum of $3,600 single/$4,200 family, adjusted annually based on HHS published maximums.

Please note that the annual out-of-pocket maximum for Specialty medications of $1,000 has been eliminated, and the overall annual out-of-pocket maximum of $3,600/$4,200 will apply.

Minimums and Maximums

Your PPO/EPO drug plan has minimums and maximums for formulary and non-formulary drug tiers only. These minimums and maximums do not apply to other tiers. Payment for drugs that are subject to coinsurance is based on a percentage of the discounted cost of the drug. The following are examples of how the minimum and maximum copayment amounts work with coinsurance when you purchase a Preferred Brand drug through a retail pharmacy.

Retail Pharmacy Preferred Brand Minimum = $40; Maximum = $150				
	Retail Cost	**25%**	**You Pay**	**Your Cost with Minimum/ Maximum**
Preferred Brand A	$40	$10	$40	Since $10 is less than the minimum copayment, you pay $40.
Preferred Brand B	$100	$25	$40	Since $25 is less than the minimum copayment, you pay $40.

Retail Pharmacy Preferred Brand Minimum = $40; Maximum = $150				
	Retail Cost	**25%**	**You Pay**	**Your Cost with Minimum/ Maximum**
Preferred Brand C	$400	$100	$100	Since $100 is between the minimum copayment ($40) and the maximum copayment ($150), you pay the full 25%.
Preferred Brand D	$1,000	$250	$150	Since $250 is greater than maximum copayment ($150), you pay only the maximum copayment.

Please note that Mandatory Generics program applies. If you or your physician requests a brand name when a generic is available, you will have to pay the copayment **plus** the difference in cost between the generic and the brand name. Please note that the amounts and percentages set forth above are subject to change from year to year. Any changes will be communicated during Annual Enrollment.

HDHP

The HDHP works differently than the PPO/EPO plans.

- The HDHP has a coinsurance of 25% for prescription drugs, but the participant must meet the deductible before the plan begins to pay—with the exception of preventive drugs. Examples of these preventive prescription drugs include medications to lower cholesterol and blood pressure, diabetic medications, etc.
- The HDHP has a separate preventive drug list, and for preventive prescriptions on the list, the participant will pay 25% of the cost and will bypass the deductible.
- All other prescriptions must first be applied to the deductible. The 25% coinsurance will apply to non-preventive medications after the deductible is satisfied.
- All costs paid by the participant (preventive and non-preventive) will be applied to meeting the out-of-pocket maximum.

Preventive Medications Allowed by the Affordable Care Act

Your medical plans include certain preventive medications allowed by the Affordable Care Act, including some over-the-counter preventive medications provided at no cost. These medicines are made available to you as long as you have a prescription and utilize either a retail pharmacy or the Home Delivery Service by OptumRx. You **must** have a prescription and provide your OptumRx identification card. These over-the-counter drugs are considered preventive if you have a prescription and meet certain guidelines:

- Folic acid for women who are planning or capable of pregnancy
- Aspirin, with strengths for certain age groups
- Iron for asymptomatic children aged 6–12 months and who are at risk of iron deficiency anemia
- Tobacco cessation products (both over-the-counter and prescription)
- Vitamin D for adults age 65 years or older who are at risk for falls
- Bowel prep (both over-the-counter and prescription) for men and women aged 50–75
- Over-the-counter contraceptives
- Generic Tamoxifen, Raloxifene, and brand Soltamox

Please contact OptumRx at (844) 265-1710 or visit www.optumrx.com for complete guidelines and therapy limitations on preventive over-the-counter medications.

Prescription drug benefits are payable for (unless otherwise excluded pursuant to the rules of this section):

- Drugs that, under federal law, are required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription;”
- Injectable insulin, and insulin needles and syringes, which in many states do not require a prescription;
- Up to a 90-day supply of allergy serum dispensed outside of the Home Delivery Service;
- Generic low- to moderate-dose statin drugs to lower cholesterol are free of charge through the Plan;
- A compound medication of which at least one ingredient is a prescription drug as defined above; and
- Any other drug which, under the applicable state law, may be dispensed only upon the prescription of a doctor.

Ineligible expenses under the Prescription Drug benefit include (but are not limited to):

- Any device used for contraceptive purposes, or for therapeutic devices or appliances;
- Any drugs or medication used in an infertility program;
- Any medication used for contraceptive purposes by a dependent;
- Any prescription filled in Mexico or Canada, except those obtained due to an emergency while traveling;
- Administration of covered drugs;
- More than a 90-day supply of any medication through the OptumRx Home Delivery Service or through a Goodyear Medical Center Pharmacy;

- More than a 30-day supply at any retail store pharmacy;
- Any refill dispensed after one year from the physician's order; or
- Any drug for which the reimbursement is considered taxable income by the Internal Revenue Service.

Some Definitions That Will Help You Understand the Coverage

In-Network Retail—If you use a retail pharmacy that participates in the OptumRx network, you will receive up to a 30-day supply. Please refer to your personalized worksheet for the copayments applying to you. The Mandatory Generic (Hard Mac) Program applies to this benefit. You can get information on which pharmacies participate in the OptumRx network by logging on to their website at www.optumrx.com. If you do not have online access, you may call OptumRx at (844) 265-1710.

Non-Network Retail Pharmacy—The copayments for prescriptions obtained from a non-network pharmacy are the same as in-network, except you must pay the difference between the network price and the non-network pharmacy's cash price. You will be responsible for paying for the prescription and filing a claim with OptumRx for reimbursement. The Mandatory Generic Program applies to this benefit.

Home Delivery—You may also use the OptumRx Home Delivery pharmacy, OptumRx by Mail. Please refer to your personalized worksheet for the copayments applying to you. You will be able to obtain up to a 90-day supply by Home Delivery. The Mandatory Generic Program applies to this benefit.

Retail Refill Allowance—You will pay more for your maintenance medications, including diabetic testing supplies, as well as those used to treat high blood pressure or high cholesterol **unless you order your prescriptions through the mail by using the OptumRx Pharmacy**. The first three times that you purchase maintenance medications at a participating retail pharmacy, you'll pay your retail copayment. **After the third purchase, you'll pay 100% of the cost** if you continue to purchase it at retail. Please refer to your personalized worksheet for the copayments that apply to you.

Mandatory Generic Program

If you or your physician requests a brand name drug when a Type A generic drug is available, you will have to pay the applicable copayment plus the difference in cost between the generic and the brand name. This applies to prescriptions filled at retail pharmacies as well as through the OptumRx Home Delivery Service and at Goodyear Medical Center Pharmacies.

Retail Copayment/ Participating Pharmacies

If you use a participating pharmacy within the OptumRx network, you may obtain up to a 30-day supply for prescriptions and refills.

Preferred or Formulary Drugs

For generic prescriptions, you will be expected to pay the lowest copayment (or the total cost, if lower than the copayment).

For brand name prescriptions, you will be expected to pay a larger copayment (or the total cost, if lower than the copayment).

Preferred Brand or Formulary Drugs change from time to time. A list of most frequently prescribed drugs is available from the OptumRx website at www.optumrx.com. If you do not have online access, you can contact OptumRx at (844) 265-1710.

Non-Formulary Drugs
For brand name prescriptions that are not on the formulary, you will pay a higher copayment.

In most cases there is a Formulary Drug within the therapeutic class that can be substituted for a Non-Formulary Drug. Plan participants should review the formulary with their physicians in those cases when a Non-Formulary Drug is prescribed.

Retail Copayment/ Non-Participating Pharmacies
If you use a non-participating pharmacy, you will still be able to obtain up to a 30-day supply for prescriptions and refills.

The copayment for prescriptions obtained from a non-participating pharmacy are the same as participating pharmacies, except you must pay any differences between the discounted network price and the non-participating pharmacy's retail cash price. You will be responsible for paying for the prescription and filing a claim with OptumRx for reimbursement. The Mandatory Generic Program also applies to this benefit.

Note: If you contribute to the Health Care Flexible Spending Account, the copayments on these medications are considered reimbursable expenses.

Home Delivery Copayment
If you use the Home Delivery Service through OptumRx, you may obtain up to a 90-day supply for prescriptions and refills.

Formulary Drugs
For generic prescriptions and brand name drugs on the formulary, you will be expected to pay a lower copayment (or the total cost, if lower than the copayment).

Non-Formulary Drugs
If your physician prescribes a brand name medication that is not on the formulary, you will pay a higher copayment.

The amount of the various copayments described will be set annually and communicated during Annual Enrollment to apply for the next plan year.

The Mandatory Generic Program applies to all prescriptions.

4th Tier Drug Level
Certain categories of prescribed drugs that are heavily advertised and frequently overutilized by the population fall into the 4th Tier category. These categories or classes of drugs may be considered "lifestyle" medications or may have lower-cost alternatives including generics and over-the-counter medications. These prescribed drugs fall into the following categories:

- Gastroesophageal Reflux Disease (GERD)
- Erectile Dysfunction (ED) (only covered when the prescription meets the Plan's criteria for coverage)
- Non-sedating antihistamines (NSA)
- Prescription medications for nail fungus
- Contraceptive prescriptions for the employee only

All prescription drugs in GERD, ED, and NSA classes as well as all prescription medications for nail fungus and contraceptives (for the employee only) are subject to a 4th Tier coinsurance as follows:

- Generics and Preferred Brands are subject to a 50% coinsurance of the discounted network price.
- Non-Preferred Brands are subject to a coinsurance of 100% of the discounted network price.

If your doctor wants to prescribe a drug in one of the categories, you should discuss whether an over-the-counter medication may be appropriate. If an over-the-counter medication is not available or possibly not appropriate due to your individual circumstances, then you should discuss the availability of generics as a lower-cost alternative to the Preferred or Non-Preferred Brands.

In addition, for new drugs approved by the Food and Drug Administration (FDA), the Company reserves the right to place these new medications on the 4th Tier level. The reason for this provision is to enable the Company to review new medications that do not offer significant improved therapy over the medications already available, or that have other lower-cost Preferred Brand, generic, or over-the-counter alternatives.

The 4th Tier has been initiated in an effort not only to control the increasing cost of providing a prescription drug benefit to all employees and their families, but to help Plan participants recognize that many of the medications within these specified drug classes are:

- Brand name drugs that are heavily advertised;
- Aggressively marketed by the pharmaceutical companies;
- Being overprescribed by physicians when possible lower-cost alternatives are available; and
- Sometimes being taken by Plan participants unnecessarily.

The most important thing that you can do if you are taking a medication that falls within these classes of drugs is to consult with your doctor to see what alternatives are available to you.

Prior Authorization, Step Therapies and Quantity Limits

Some medications require prior authorization to determine if they meet the Plan's criteria for coverage. These include, but are not limited to, the following:

- Specialty drugs
- Erectile Dysfunction drugs (Viagra, Cialis, and Levitra)
- Examples of drugs that have generic alternatives that can be tried first include:
  - Cholesterol-lowering therapies
  - Singulair® for asthma
  - Hypnotics
  - Osteoporosis therapy
  - Migraine therapy
  - Acne therapy
- Drugs that have a cosmetic indication (Retin-A, Botox®)
- Pain management
- CNS stimulants (Adderall, Ritalin)
- Anti-infectives

The Company reserves the right to add to this list from time to time. Drug examples listed are not all-inclusive. To determine if the medication meets the Plan's criteria for coverage, your physician should contact OptumRx at (844) 265-1710 and answer a few questions.

Making the Most of Your Prescription Drug Benefit

- Ask your doctor if the prescription is available in a generic form. Your doctor can write your prescription to allow for generic substitution. All 50 states have laws allowing your pharmacist—with your doctor's approval—to dispense generic drugs for prescriptions written for the brand name drug.
- If your doctor prescribes a drug, be sure to ask if there is a generic within the therapeutic class that you could take for your medical condition. While not all drugs have generic equivalents, there is frequently a generic used for treatment of your medical condition that is in the same therapeutic class.

- If a generic is not available, check to see if there is a Preferred Brand Name equivalent rather than a Non-Preferred Brand. This will also help you maintain lower prescription drug costs for you and your family until such time that a generic substitution becomes available.

- Make sure that your doctor does not indicate "DAW" (Dispense as Written) on your prescription, even if no generic is available at that time. If "DAW" is written on the prescription, when the generic does become available (comes off the manufacturer's patent), you will be required to pay the difference in cost as well as the applicable Preferred Brand or Non-Preferred Brand copayment. The pharmacist is required by law to fill the prescription as written.

- If it is a maintenance medication that you will be taking for some time, you should consider the OptumRx Home Delivery Service, as you will be able to obtain a 90-day supply instead of a 30-day supply. Home Delivery saves money for you and the Company.

- When you visit your doctor, take the list of the formulary drugs that is provided so that your doctor can consider your cost when medications are prescribed.

Remember, as always, if you have questions, ask your doctor or pharmacist.

Compounding Pharmacies

A compounded medication is a combination of medications prepared by a pharmacist when commercially available dosage forms are not available or do not meet the needs of the patient.

OptumRx, your prescription drug benefit manager, utilizes the Network Compound Credentialing Program (NCCP) to credential and qualify pharmacy providers that dispense compounded medications. The program requires participating pharmacies to have met specific compound credentialing criteria and includes a pricing management component to be considered a "credentialed" pharmacy.

If you use a pharmacy that is not credentialed for compound medications, your compound medication will not be covered.

Finding a Credentialed Pharmacy

To find an OptumRx-credentialed compound pharmacy, call OptumRx Member Services at the phone number listed on your pharmacy ID card. The representative will be able to provide you with a credentialed pharmacy licensed to dispense in your state. You may also be able to find information at www.optumrx.com.

Please note that a pharmacy that can dispense in your state may not be located near you. You may have to arrange for the pharmacy to mail you your compound medication. Allow enough time to make sure you don't run out of your medication.

Transferring Your Prescription to a Credentialed Pharmacy

To continue to have your compound medication covered by OptumRx, you will need to transfer your prescription to a credentialed network pharmacy. Here's what you need to do:

- Most compound prescriptions can be transferred. To transfer a prescription, contact the credentialed pharmacy with the information about your current prescription (including prescription number and the phone number of your previous pharmacy), and the pharmacist will do the rest.

- You can also ask your doctor to write, e-prescribe, or call in a new prescription to a credentialed compound pharmacy.

If you have questions, please call OptumRx Member Services at the phone number listed on your pharmacy ID card. Representatives are available to assist you 24 hours a day, 7 days a week.

Concurrent Drug Utilization Review (DUR) Program

This quality service drug program is designed to help protect employees and their covered family members from potentially harmful situations involving prescription drugs.

This program electronically analyzes each in-network retail and Home Delivery prescription to ensure safe and effective prescription drug therapy. If potential problems are detected, the claim processing system sends an online message to the pharmacist. The pharmacist will then discuss the therapy with the individual and/or the physician prior to dispensing the medication.

The DUR program employs numerous automated quality and safety advisory edits that alert pharmacists to check for:

- Adverse drug interactions
- Duplication of therapy
- Inappropriate drug dosages
- Inappropriate drug usage based on the age of the patient
- Drugs that should not be taken during pregnancy
- Excessive utilization
- Drugs which may interact and worsen an existing condition

Employees should continue to inform their pharmacist and physician of any medications being taken, including over-the-counter drugs, as their professional opinion is an integral part of your overall health care program.

Company Medical Centers

Prescription drug coverage through the Company's medical centers generally follows the same provisions as previously described, including use of Formulary and Non-Formulary Drug coverage as well as the Mandatory Generic Program. At the Medical Centers, like with Home Delivery, you may obtain up to a 90-day supply for prescriptions and refills. See the coverage summaries for more information.

Specialty Drugs

Specialty drugs are used by patients typically having serious medical conditions, including but not limited to rheumatoid arthritis, renal failure, hemophilia, multiple sclerosis, hepatitis, and AIDS/HIV. These drugs can have very serious side effects, and their use requires frequent dosage adjustments and monitoring. In addition, many of these medications require special handling such as refrigeration. The cost of these medications is often over $1,500 a month. Our prescription drug plan sometimes makes updates to the list of specialty drugs that the Plan covers.

Patients will typically be limited to a 30-day supply of a specialty drug to avoid wasted medication and allow for dosage adjustments. For the PPO/EPO plans only:

- The copayment for Specialty drugs on the formulary will be 10% of the discounted cost of the medication.
- The copayment for non-formulary Specialty drugs will be 10% of the discounted price plus $10 for each prescription.
- Specialty drugs should not be filled at retail pharmacies after the initial fill.

Note: Not all drugs used to treat these conditions are considered specialty. Contact OptumRx for more information. Specialty medications will be subject to case management, and some may require prior authorization and/or step therapy.

How to File a Prescription Drug Benefit Claim

Participating Pharmacy

If you or a dependent incurs expenses for covered prescription drugs, present your Plan Identification Card to your participating pharmacy, which will file your claim directly with OptumRx. You will only be responsible for the copayment.

Non-Participating Pharmacy

If you purchase a prescription from a non-participating pharmacy, you must pay the full cost of the prescription, complete the prescription drug claim form, and send the claim with the detailed pharmacy receipt attached to OptumRx for reimbursement. Claim forms are available from OptumRx. If no claim form is available, make sure the receipt contains all of the information required for processing: the name and NCPDP number of the pharmacy, full name of person for whom the prescription was written, date of service, day's supply and description of the drug—including the National Drug Code—and price. This information is needed to obtain reimbursement for your eligible expenses once you have secured a non-participating claim form. The amount of reimbursement will be equal to the amount that would have been paid if you had used a participating pharmacy and not necessarily the actual charge.

Affordable Care Act Protections for Medical and Pharmacy Benefits

Since 2011, the Affordable Care Act has required that medical and prescription drug plans such as Goodyear's implement additional changes—sometimes referred to as "group market reforms" or "consumer protections." Many of these changes have already been incorporated into the medical options and/or explained in the applicable section of the SPD. A few examples:

- The medical options do not impose any lifetime or annual dollar limit on essential health benefits.

- The medical options provide preventive care benefits, as required by the Affordable Care Act, in-network without cost-sharing.

The following additional "protections" have been incorporated into your benefits. The Company is explaining these here so that you are aware of these recent changes:

In-Network Out-of-Pocket Maximum

The Affordable Care Act requires that Goodyear ensure that your in-network out-of-pocket maximum meet specific requirements. In 2019, your total in-network out-of-pocket costs under the medical options available to you are listed under "Cost-Sharing" above. The dollar thresholds generally increase annually as determined by government guidance.

The maximum imposed by the Affordable Care Act may not change the out-of-pocket maximum in place by a particular medical plan option; however, each medical option available to you will ensure that the limit on in-network out-of-pocket costs will include additional costs (such as copayments) and count toward these limits even if they do not apply toward the medical option's out-of-pocket maximum. Costs that apply toward your total Affordable Care Act in-network out-of-pocket maximums include deductibles, copayments, and coinsurance. Out-of-pocket expenses that do not apply toward your Affordable Care Act in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and, potentially, the additional cost if you purchase a brand name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician. The Affordable Care Act also requires that your individual Affordable Care Act in-network out-of-pocket maximum is embedded in the family out-of-pocket maximum so that the individual will never satisfy more than his or her individual amount. Please contact your third-party administrator for more details.

Provider Nondiscrimination

The medical options offered by the Plan will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.

Coverage of Emergency Services

If you need "emergency services," the medical options offered by the Plan will provide you with coverage regardless of whether the provider for such "emergency" services is in-network or out-of-network. Also, "emergency services" are subject to special cost-sharing rules that require non-grandfathered group health plans, such as the Goodyear medical benefit options, to not impose a higher copayment or coinsurance, for example, for out-of-network emergency services than for in-network emergency services, but in certain circumstances you may be "balance billed." For details on this requirement, including what constitutes an emergency service, contact your third-party administrator.

Coverage for Individuals Participating in Approved Clinical Trials

Under the medical benefit program options offered by the Plan, you are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your medical insurance carrier for details.

Availability of Summary Health Information Required

As an employee, the medical benefit program available to you represents a significant component of your compensation package. It also provides important protection for you and your family in the case of illness or injury.

The Plan offers a series of medical coverage options. Choosing a medical coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any medical coverage option in a standard format to help you compare across options.

As required by the Affordable Care Act, SBCs for the medical coverage options available to eligible salaried employees are available on the GO page (http://go.goodyear.com/). If you would like paper copies of the SBCs (free of charge), you may contact the Goodyear Associate Service Center at (844) 449-4772.

Your Dental Coverage

Goodyear offers eligible salaried employees a dental coverage plan with a choice of two networks of providers. The Goodyear dental program is administered by Delta Dental. If you choose to enroll in dental coverage, you will have access to two of the nation's largest networks of participating dentists—the Delta Dental PPO network and the Delta Dental Premier® network.

You can go to any licensed dentist, but it will cost less if you go to a dentist who participates in one of these two networks. You will save the most money and receive a higher annual maximum by going to a Delta Dental PPO member dentist. A Delta Dental PPO dentist has agreed to a discounted fee for services rendered. However, you can still save money and no balance billing from a dentist who participates in the Delta Dental Premier plan. Delta Dental has established a Maximum Approved Fee for nearly all dental services, and participating dentists in both networks agree to accept these fees as full payment for those services. If the dentist's fee is higher than Delta Dental's, he or she cannot charge you the difference. Thus, you are responsible only for your copayments and deductibles, if any, when you visit a Delta Dental participating dentist, as well as any amounts that exceed the coverage limits.

Participating dentists also agree to abide by Delta Dental's processing policies, including filling out and filing your claim forms.

If you are a new employee and do not make an election by the enrollment deadline, you will not be enrolled for dental coverage.

In any event, if you have a "change in status" as defined by the Internal Revenue Service, such as your marriage or divorce, or the birth or adoption of a child, you may be able to change the dependents you have elected to cover under the Plan if the change is consistent with your change in status, but not drop your coverage. You will only be able to elect coverage outside of Annual Enrollment if you qualify for special enrollment rights as described in the Eligibility section of this booklet.

Plan Costs

You and the Company share the cost of dental coverage for you and your covered dependents. You pay for dental coverage with before-tax dollars from your pay.

Each enrollment period, you will receive information about the benefit options available and the corresponding monthly price tags for dental coverage. Because dental contributions are based on your election, whom you choose to cover will affect the price you pay.

If you have an eligible change in status during the year, you may be able to change the dependents you have elected to cover under the Plan if the change is consistent with your change in status but not drop your coverage. You will only be able to elect coverage if you qualify for special enrollment rights as described in the Eligibility section of this booklet.

Please read the following chart carefully to see how the dental plan works. If you elect dental coverage, your dental coverage will be administered through Delta Dental.

	PPO Dentist	**Premier Dentist**	**Non-participating Dentist**
What is the payment based on?	The submitted fee or the amount in your dentist's local PPO Fee Schedule,[1] whichever is less.	The submitted fee or the Maximum Approved Fee, whichever is less.	The submitted fee or the Non-participating Dentist Fee,[2] whichever is less.
Special things to consider	Participating Dentists: • Will submit claim forms for you • Cannot balance bill you • Will only charge your copayment and deductible (if applicable) up front • Added benefits for posterior resin fillings • Simple restorations covered at 80% • Implants covered, subject to annual maximum • Annual maximum of $1,500	Participating Dentists: • Will submit claim forms for you • Cannot balance bill you • Will only charge your copayment and deductible (if applicable) up front • Annual maximum of $1,200	Non-participating Dentists: • May have you submit your own claim information • Will bill you the total difference between what was charged and what was paid • May charge the full amount up front • Annual maximum of $1,200
Payment examples	• Submitted Fee: $100 PPO Fee Schedule[1] amount: $70 • Plan pays 80% of the PPO fee schedule: $56 • You pay: $14 • The PPO dentist cannot charge you the $30 difference between the PPO Fee Schedule[1] amount and the submitted fee.	• Submitted Fee: $100 Maximum Approved Fee: $90 • Plan pays 50% of the Maximum Approved Fee: $45 • You pay: $45 • The Premier dentist cannot charge the $10 difference between the Maximum Approved Fee and the submitted fee.	• Submitted Fee: $100 Nonparticipating Dentist Fee:[2] $85 • Plan pays 50% of the Non-participating Dentist Fee: $42.50 • You pay: $57.50 • Because the dentist does not participate, you are responsible for the difference between the Plan's payment and the submitted fee.

1. A PPO Dentist is one who has agreed to the PPO Fee Schedule, which is lower than the Maximum Approved Fee used for a dentist who participates in Delta Dental Premier.
2. The Non-participating Dentist Fee is the maximum fee allowed when the dentist does not participate in either Delta Dental network.

Finding a Dentist

To find dentists in the Delta Dental Network:

- You can get a customized list of participating providers in your area by accessing Delta Dental's website at www.deltadentaloh.com.

- Or call Delta Dental's Customer Service Department toll-free at (800) 524-0149, and Delta's Automated Service Inquiry system (DASI) can give you a listing of providers in your area. This option is available 24 hours a day, 7 days a week.

- If you prefer to speak to a Customer Service representative, you can exit DASI to speak to a Customer Service representative at any time during normal business hours. Tell the Customer Service representative:

  - The name of your Dental Plan is Delta Dental PPO;

  - The type of dentist you need (general, orthodontist, etc.); and

  - Your address.

The Customer Service representative will give you the names of providers in your area.

You can call the Customer Service Department Monday through Friday, 8:30 a.m. to 8 p.m. Eastern Time.

The Customer Service Department gives you the most up-to-date information on Delta Dental's expansive network of dentists.

How Dental Coverage Works

The Plan is designed to emphasize preventive treatment detecting and treating smaller dental problems before they get larger. Basically, the way the Plan pays benefits depends on the type of service you or a covered family member receives.

Dental Plan Coverage

Annual Deductible	You do not pay deductibles before the Plan pays benefits—regardless of the type of service you receive.
Predetermination	When a proposed treatment plan will cost more than $200, Delta Dental recommends that the dentist submit it to them for predetermination. Delta Dental never dictates treatment, only payment for services rendered. Delta Dental will evaluate the necessity of the proposed treatment and explore whether there are alternatives that will produce satisfactory results according to accepted standards of dental practice. **Predetermination of benefits is strongly suggested for all temporomandibular joint (TMJ) or temporomandibular joint dysfunction (TMD) procedures in excess of $250.** This applies even if you go to a participating dentist. You must make sure that your dentist requests such predetermination. This predetermination will also provide an understanding of any financial obligation before the treatment begins. Predetermination is strongly recommended for other services in excess of $200.
Maximum Payments:	
PPO Dentist	$1,500 per person total per calendar year on all services except gingival flap procedures, osseous surgery, some TMD treatment, and orthodontic services. $1,500 per person total per lifetime on orthodontic services for dependent children to age 19.
Premier Dentist or Non-Participating Dentists	$1,200 per person total per calendar year on all services except gingival flap procedures, osseous surgery, some TMD treatment, and orthodontic services. $1,500 per person total per lifetime on orthodontic services for dependent children to age 19.
These are not separate maximums by type of dentist.	

If you obtain services through a Delta PPO or Premier participating dentist, you will only be responsible for copayments. You will not be responsible for additional fees charged until you reach the annual maximum. Reimbursement for non-participating dentists will be at a lower fee schedule, and you will be responsible for the difference up to the submitted fee.

Diagnostic and Preventive Services

You are encouraged to see your dentist for preventive dental care to make sure you stay healthy, and to reduce the risk of more serious and costly dental treatment. The Plan will pay 100% of the maximum approved fee for the following services if obtained through a participating dentist. If not obtained through a participating dentist, the payment will be less:

	PPO Dentist—Plan Pays	**Premier/Non-participating Dentist—Plan Pays**
Diagnostic and Preventive Services—exams, cleanings, fluoride, and space maintainers	100%	100%
Emergency Palliative Treatment—to temporarily relieve pain	100%	100%
Sealants—to prevent decay of permanent teeth	100%	100%
Brush Biopsy—to detect oral cancer	100%	100%
Radiographs—X-rays	100%	100%

Service	What's Covered
Oral Exams and X-rays	Routine oral examinations and bitewing X-rays are eligible for benefits only twice during a calendar year. Full-mouth X-rays are eligible for benefits only once every three years. Benefits also include certain temporomandibular joint (TMJ) or temporomandibular joint dysfunction (TMD) procedures, subject to consultant review.
Dental Prophylaxis	Cleaning of teeth and, for dependent children, topical application of fluoride, space maintainers, and dental sealants. Routine cleanings are eligible for benefits only twice during a calendar year. Local application of fluoride and space maintainers are eligible services only for dependent children under age 19. Dental sealants are eligible for benefits once every three years for dependent children under age 15. Coverage for sealants will be for specific teeth in accordance with accepted standards of dental practice.

Basic Dental Services

The plan will generally pay 85% of the maximum approved fee for the following services if obtained through a participating dentist. If not obtained through a participating dentist, the payment will be less:

	PPO Dentist—Plan Pays	Premier/Non-participating Dentist—Plan Pays
Endodontic Services—root canals	85%	85%
Periodontic Services—to treat gum disease	85%	85%
Oral Surgery—extractions and dental surgery	85%	85%
Other Basic Services—miscellaneous services	85%	85%
Relines and Repairs—to bridges, dentures, and implants	85%	85%
TMD Treatment—treatment of the disorder of the temporomandibular joint, including related films	85%	85%
Minor Restorative Services—fillings and crown repair	80%	50%

Service	What's Covered
Endodontics	Treatment of the nerve canal in a tooth (e.g., pulp capping, root canal therapy).
Periodontic	Treatment of diseases of the gums, and bone-related diseases of the supporting structures of the teeth (e.g., subgingival curettage, osseous surgery, periodontal scaling).
Oral Surgery	Surgical procedures, including simple extractions and removal of impacted wisdom teeth (e.g., excision of tumors, cysts, bone tissue, reduction of dislocation, and surgical correction of temporomandibular joint [TMJ or TMD] dysfunctions are subject to consultant review. Prior to surgery to correct a dysfunction with the temporomandibular joint, benefits will be paid for appliance therapy that is intended to correct the condition without surgery. If the appliance therapy does not correct the condition, and surgery to correct the condition is subsequently necessary, the benefits previously paid for the appliance therapy will be deducted from the total payable for the surgical procedure, which includes any benefits payable for post-surgery therapy.) Benefits include local anesthesia, or general anesthesia (when medically necessary), and routine post-operative care.
Accidental Injuries	Treatment of accidental injuries to sound natural teeth rendered within 12 months of the date of the accident.

Restorative and Prosthodontic Services

The Plan will pay 50% of the maximum approved fee for the following services if obtained through a participating dentist. For simple restorations (fillings), the Plan will pay 80% of the maximum approved fee if performed by a PPO dentist. If not obtained through a participating dentist, the payment will be less:

	PPO Dentist—Plan Pays	**Premier/Non-participating Dentist—Plan Pays**
Major Restorative Services—crowns	50%	50%
Prosthodontic Services—bridges and dentures	50%	50%
Oral Surgery—extractions and dental surgery	50%	50%
Implants—endosteal implants to replace missing teeth	50%	50%
Orthodontic Services—braces	50%	50%
Orthodontic Age Limit	Up to age 19	Up to age 19

Service	**What's Covered**
Restorative	Fillings, using silver or resin (tooth-colored) materials, including fillings placed after a nerve is removed from a tooth. Cast restorations, crowns, caps, and jackets are covered when fillings cannot restore teeth satisfactorily.
Prosthodontic	Installation and replacement of fixed bridgework, partial dentures, and complete dentures. Replacement of an existing partial denture or fixed bridgework is a covered benefit only if the existing denture or bridge is at least five years old and cannot be made serviceable. Endosteal implants are a covered benefit when rendered by a PPO participating dentist only. Benefits will not be payable for the fittings of bridges and crowns that were ordered while you or your dependents were not covered under the Plan, or that were ordered while you were covered, but are finally installed or delivered more than 60 days after termination of coverage.
Orthodontic	Treatment for the prevention and correction of irregularities of the teeth and malocclusion (teeth straightening) is a benefit for dependent children under age 19. The maximum payment allowable for orthodontics is limited to a lifetime benefit of $1,500 for each eligible dependent child under age 19. Your dentist must file a treatment plan with Delta Dental before treatment begins. Payment will be based on the usual, customary and reasonable fee for the procedure. Benefits will be paid as services are performed on a quarterly basis. Benefits cannot be prepaid to the dentist, nor will the benefits be paid in a $1,500 lump sum.

Maximum Approved Fee

A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- The Submitted Amount.
- The lowest fee regularly charged, offered, or received by an individual dentist for a dental service, irrespective of the dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstance.

Delta Dental may also approve a fee under unusual circumstances.

Participating dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the covered service. In all

cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the covered service.

Ineligible Expenses, Exclusions, Limitations, and When Benefits Will Not Be Paid

Ineligible Expenses, Exclusions, Limitations

- Services performed solely for cosmetic reasons or for correction of congenital or developmental malformations, or dentistry for aesthetic reasons.

- Replacement of a lost, missing, or stolen appliance of any type or replacement or repair of orthodontic appliances.

- Replacement of a bridge, crown, or denture within five years after the date it was originally installed unless:

  - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or

  - The bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits.

- Any replacement of a bridge, crown, or denture that is or can be made usable according to common dental standards.

- Procedures, appliances, or restorations (except full dentures) whose main purpose is to:

  - Change vertical dimension;

  - Stabilize periodontal involved teeth;

  - Alter, restore, or maintain occlusion; or

  - Replace tooth structure loss resulting from attrition, abrasion, or erosion.

- Orthodontic services or supplies for any person other than a dependent child under age 19.

- Porcelain, porcelain substrate, and cast restorations are not payable for children under age 12. Porcelain fused to metal and porcelain crowns on posterior teeth—the Plan will pay only the applicable amount that it would have paid for a full metal crown.

- Porcelain/ceramic onlays—the Plan will pay only the applicable amount that it would have paid for a metallic onlay.

- Porcelain/ceramic inlays—the Plan will pay only the applicable amount that it would have paid for an amalgam or composite resin restoration (depending on the tooth being restored).

- Benefits for root planing by the same dentist or dental office are payable once in any two-year period. Periodontal surgery, including subgingival curettage, by the same dentist or dental office is payable once in any three-year period.

- Bite registrations, precision or semi-precision attachments, or splinting.

- Veneers of any type.

- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).

- Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.

- Services that are deemed to be medical services.

- Charges for hospitalization, laboratory tests, and histopathological examinations.

Under some circumstances, the Plan will not pay benefits. These situations include:

- Services due to or resulting from an injury or illness from any employment (other than for this Company) for wage or profit or covered under any Workers' Compensation or similar law.
- Charges made by a hospital owned or operated by the United States government.
- Charges that you are not legally required to pay.
- Charges that would not have been made if you had no insurance.
- Charges that exceed the usual, customary and reasonable fee.
- Charges for unnecessary care, treatment, or surgery as determined by the standards of generally accepted dental practice.
- Charges if you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program other than Medicaid.
- Services due to or resulting from experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Charges for hospitalization, laboratory tests, and histopathological examinations.
- Prescription drugs (except intramuscular injectable antibiotics), medicaments/ solutions, pre-medications, and relative analgesia.

For more information on benefits not payable, contact Delta Dental.

Duration of Coverage

If your employment with the Company ends, dental benefits under the Plan will end on the date your employment is terminated.

If you are enrolled for coverage, unless you terminate employment, you may continue coverage for you and your covered dependents under the following circumstances by paying, in advance, the required premium.

- While you are on sick leave and accumulating continuous service.
- While you are receiving benefits under the Long-Term Disability plan for up to one year.
- While you are on leave of absence for military duty of less than six months.
- While you are on leave of absence for pregnancy and accumulating continuous service.
- While you are on any other leave of absence for up to 90 days.

Non-Duplication of Benefits

You or your dependents may have other group dental coverage in addition to this Plan, through your spouse's employer, for example. If so, the Plan will coordinate benefit payments with the other plan. This coordination is designed to guard against duplicate or excess dental benefit payments.

Under non-duplication of benefits, the benefits will be equal to the amount payable under this Plan minus the amount paid by the other plan. However, the amount payable can never be more than what the Company's Plan would have paid in the absence of any other plan.

Non-duplication does not apply to individual or private insurance plans.

Which Plan Pays First

Under non-duplication rules, the plan that pays benefits first is called the primary plan. The plan that pays next is secondary. If there are more than two plans providing coverage, non-duplication rules help decide the order of any additional payments.

A plan without non-duplication or coordination of benefits rules is always primary, which means it always pays benefits first. If all plans have non-duplication or coordination of benefits rules, benefits are paid according to the following:

- A plan covering a patient as an employee pays before a plan covering that patient as a dependent.

- A plan covering a patient as an active employee pays before a plan covering that patient as a retiree.

- For dependent children, the plan covering the parent whose birth date (month and day only) occurs earlier in the calendar year pays benefits first. For example, let's say the father was born on June 15, and the mother's birthdate is March 11. The mother's plan would pay first, because her birthday comes earlier in the year.

  This rule applies only if both plans have primary plan rules based on birth date. If one of the plans doesn't use the birthday rule, the father's plan pays first for the dependent children.

- If both parents have the same birth date, the plan that has covered the patient longest pays first.

If you are legally separated or divorced, special coordination rules apply to your children. If a court decree says that one parent must pay for a child's health care, the plan of that parent pays first. Otherwise, benefits are paid in the following order:

- The plan of the parent with custody of the child;

- The plan of the stepparent who is married to the parent with custody of the child; or

- The plan of the parent who does not have custody of the child.

How to File a Dental Care Benefit Claim

If you have dental coverage, your participating dentist will file your claim for you. However, if you go to a non-participating dentist, you may have to file your own claim. To submit your dental claim:

1. Complete your portion on the standard dental claim form. (You may obtain this form from Delta's website or Delta's Customer Service Center.) Be sure to enter your Social Security number or your dental ID number, which is listed on your dental card and the toolkit (or call the Goodyear Associate Service Center at (844) 449-4772).

2. Sign the space where it says subscriber.

3. Attach your dentist's itemized bill. The bill must show the patient's name, relationship to you, date and nature of service. Or take your claim form to your dentist's office and ask your dentist to complete the dentist's portion.

4. Send the itemized bill and claim form directly to:

   Delta Dental
   P.O. Box 9085
   Farmington Hills, MI 48333-9085
   Telephone Number: (800) 524-0149

5. Normally, your participating dentist will receive within three weeks from the date the claim was submitted a check from Delta Dental for the amount of benefits payable. You will receive an explanation of benefits (EOB) statement advising you of the amount of benefits paid to your dentist. You will be responsible for your copayment. If, after 30 days, you have not heard from Delta Dental, contact them at:

   Delta Dental
   P.O. Box 30416
   Lansing, MI 48909-7916
   Telephone Number: (800) 524-0149

If you go to a non-participating dentist, you will receive a check for the amount of benefits payable and a claim payment statement. If, after 30 days, you have not heard from Delta Dental, contact them at:

Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916
Telephone Number: (800) 524-0149

In the meantime, do not wait for the payment, but pay your dentist promptly.

Major Dental Services

Major dental services should be planned and scheduled. To assist you and your dentist in such planning, the Plan provides for a predetermination.

Predetermination

You can request a predetermination for any proposed service regardless of the expenses you expect. However, predetermination of benefits is strongly suggested for all temporomandibular joint (TMJ) or temporomandibular dysfunction (TMD) procedures in excess of $250. This applies even if you go to a participating dentist. This predetermination will provide an understanding of any financial obligation before the treatment begins. Predetermination is strongly recommended for other services in excess of $200.

You are urged to ask your dentist to submit the proposed course of treatment for a predetermination. By using the predetermination procedure, you will understand both your own financial obligations and the amount payable under the Plan before treatment begins.

To obtain a Predetermination:

1. Complete your portion of the standard dental claim form. You may obtain this form from Delta Dental. Be sure to enter your Social Security number or your dental ID number, which is listed on your dental card and the toolkit (or call the Goodyear Associate Service Center at (844) 449-4772).

2. Ask your dentist to complete the dentist's portion and forward the form directly to:

   Delta Dental
   P.O. Box 9085
   Farmington Hills, MI 48333-9085

   The Predetermination Notice will be sent to your dentist promptly, with a copy to you, usually well before your next appointment, but within 15 days unless additional information is needed.

3. Discuss the predetermination with your dentist during your next appointment. Based on the Delta Dental estimate, your dentist may suggest alternate methods of treatment.

4. After the work is completed, your dentist must return the Predetermination Notice to Delta Dental, indicating the actual dates the services were performed. Delta Dental will send you an explanation of benefits statement advising you of the amount of benefits paid to your dentist. You will be responsible to pay your dentist your copayment amount. If you have not received notification of payment within 30 days after the dentist submits the form, you should write to Delta Dental at:

   Delta Dental
   P.O. Box 30416
   Lansing, MI 48909-7916
   Telephone Number: (800) 524-0149

Claims Appeal Procedure

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was not a covered service, including a service that was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a copayment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

- First, you or your dentist should contact Delta Dental's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly.
- You may also mail your inquiry to the Customer Service department at P.O. Box 30416, Lansing, MI, 48909-7916. When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim.
- This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of your claim, send your formal request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, MI 48909-7916

Please include your name and address, the subscriber's Social Security number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it Certified Mail, return receipt requested.

Delta Dental will make its decision within 30 days of receiving your request for denial of a service preformed. If the denial is for a predetermination, then the decision will be made within 15 days or within 72 hours if it is for an urgent care claim. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by Delta Dental will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to Delta Dental's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If Delta Dental's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of this adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If Delta Dental consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he or she will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time.

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure, or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (800) 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 2100 Stella Court, Columbus, OH 43216-1067.

Your Vision Coverage

Goodyear offers eligible salaried employees a vision coverage plan that includes an eye exam and lenses/contacts every calendar year. New frames are covered every other calendar year. The Goodyear vision program is administered by EyeMed. If you enroll for vision coverage when you first become eligible, your coverage remains in effect until the next Annual Enrollment period.

Plan Costs

You and the Company share the cost of vision coverage for you and your covered dependents. You pay for vision coverage with before-tax dollars from your pay.

Each enrollment period, you will receive information about the benefit options available and the corresponding monthly price tags for vision coverage. Because vision contributions are based on your coverage election, whom you choose to cover will affect the price you pay.

Plan costs are paid through a third-party administrator, which administers the benefits. This company processes claims and approves all benefit payments.

How Vision Coverage Works

The Plan is designed to help you pay eligible vision expenses for yourself and covered family members. The way the Plan pays benefits depends on whether you go to a "participating provider."

If you go to a non-participating provider, the benefits for exams, lenses, and frames will be paid according to a schedule of maximum benefits. You will be responsible for any amounts in excess of these maximums.

Vision Care Providers

Services may be obtained from either a participating provider or a non-participating provider.

Participating Provider

A participating provider is one who has signed an agreement with the third-party administrator to provide vision care services.

Providers Covered under the Plan

The following providers are covered under the Plan:

- **Ophthalmologists:** Physicians licensed to practice medicine who specialize in the diagnosis and treatment of disorders of the eye, and the prescription of lenses relating to the eye.

- **Optometrists:** Persons licensed to practice optometry, which is the measurement of vision and the prescription of lenses to improve visual acuity.

- **Opticians:** Persons licensed to supply eyeglasses, to grind or mold lenses according to prescription, to fit them into a frame, and to adjust the frames to fit the face.

Listing of Participating Providers

A listing of participating providers in your area is available by calling EyeMed Vision's Customer Service at (866) 723-0596 or going to www.eyemed.com (select the "Access Network").

Non-Participating Provider

Any provider that has not entered into an agreement with the third-party administrator is a non-participating provider. You should pay the provider the full cost for their services and then request reimbursement as described in "Schedule of Covered Vision Benefits."

Schedule of Covered Vision Benefits

You are covered for vision benefits up to the amounts specified in the following schedule:

Vision Care Services	Member Cost – "Access" Network Provider	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$0 copayment	$50
Fundus Photography Benefit	Up to $39	N/A
Exam Options:		
Standard Contact Lens fit and follow-up	Up to $55	N/A
Premium Contact Lens fit and follow-up	10% off retail price	N/A
Frames: Any available frame at provider location	$0 copayment; $75 allowance, 20% off balance over $75	$55
Standard Plastic Lenses, including:		
Single	$0 copayment	$80
Bifocal	$0 copayment	$90
Trifocal	$0 copayment	$100
Lenticular	$0 copayment	$110
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate–Adults	$40	N/A
Standard Polycarbonate–Children under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive Lens	$65	$90
Premium Progressive Lens	$65, 80% of charge less $120 allowance	$90
Polarized	20% off retail price	N/A
Other Add-ons	20% off retail price	N/A
Contact Lenses: (Contact lens allowance includes materials only)		
Conventional	$0 copay; $90 allowance, 15% off balance over $90	$90
Disposable	$0 copay; $90 allowance, plus balance over $90	$90
Medically Necessary	$0 copay; paid in full	$90
Laser Vision Correction:		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

Vision Care Services	Member Cost – "Access" Network Provider	Out-of-Network Reimbursement
Frequency:		
Examination	Once every calendar year	
Lenses or Contact Lenses	Once every calendar year	
Frame	Once every other calendar year	

Please note that these amounts and percentages are subject to change from year to year. Any changes will be communicated during Annual Enrollment.

Exclusions

Among the items excluded are:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes, or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear;
- Services provided as a result of any Workers' Compensation law or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date a participant ceases to be eligible for the Plan, except when vision materials ordered before coverage ended are delivered, and the services rendered to the participant are within 31 days from the date of such order;
- Services or materials provided by any other group benefit plan providing vision care; and
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

Reasonable and Customary Determination

The reimbursement of eligible charges will be calculated on the basis of the "reasonable and customary" fee employed with the service performed.

Duration of Coverage

If your employment with the Company ends, or you stop paying any required monthly payments for vision coverage, vision benefits under the Plan will end on the date your employment is terminated.

If you are enrolled for coverage, unless you resign, you may continue coverage for you and your covered dependents under the following circumstances by paying, in advance, the required premium.

- While you are on sick leave and accumulating continuous service.
- While you are on leave of absence for military duty of less than six months.
- While you are on leave of absence for pregnancy and accumulating continuous service.
- While you are on any other leave of absence for up to 90 days.

- You may elect coverage through COBRA by paying the applicable premiums for a period of up to 18 months.

If your death occurs while you are eligible for vision benefits under the Plan, coverage will be continued for your spouse and dependent children for up to six months.

Non-Duplication of Benefits

If you or your spouse both work, your family may have vision coverage under other plans. The Goodyear Vision Plan does not coordinate its payments with payments from other plans under which you or your dependents are covered. EyeMed will always be the primary carrier.

How to File a Vision Care Claim

If you have chosen a participating provider, the provider will submit the claim form to the third-party administrator for payment. You may be responsible for a portion of the cost of the services. Please review the participating provider information for more details.

If you or a covered dependent incurs expenses for covered vision care services from a non-participating provider, complete the employee portion of the vision claim form. To obtain a claim form, please contact EyeMed's Customer Service Department at (866) 723-0513. You must pay the full cost of the services and send the claim form to EyeMed for reimbursement. EyeMed will then send you a check according to the Schedule of Covered Vision Benefits.

Your completed claim form and receipts for non-participating provider claims should be directed to:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111
Fax number: (866) 293-7373

Email: oonclaims@eyemedvisioncare.com

The Customer Service line for claim information is available Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

Claims and Appeals Procedure

If you are denied a vision benefit under the Plan, you may file an appeal. The Goodyear Tire & Rubber Company as the Plan Administrator has delegated the claims and appeals procedure to EyeMed. To file an appeal with EyeMed, you must follow the procedure as outlined below:

When you use a Goodyear network provider, you will pay your copayment and any amounts for services and materials not covered by the Plan. No paperwork is required for your claim to be filed when you use a Goodyear network provider.

If you select an out-of-network provider, you must pay in full at the time when services are rendered. For reimbursements, simply call the EyeMed Customer Service Center at (866) 723-0513 to verify eligibility and receive a claim form. Then mail a completed claim form with a copy of your bill to:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

You must submit notice of the claim within 15 months of the service to which the claim relates. Unless you lacked legal capacity, claims cannot be accepted later than one year from the date the claim was otherwise required to be filed.

Notice of Claim Denial/ Right of Appeal

Written notification of a denied claim will be delivered to you within a reasonable period of time, but not later than 30 days after the claim is received. The written notification is provided on an explanation of benefits statement (EOB) and is provided by EyeMed. The 30-day period can be extended under special circumstances. If special circumstances apply, you will be notified before the end of the 30-day period after the claim was received. The notice will identify the special circumstances. It will also specify the expected date of the decision. When special circumstances apply, you will be notified of the decision not later than 45 days after the claim is received.

The written decision (the EOB) that denies the claim will include:

- The reasons for the denial.
- Reference to the plan provisions on which the denial is based.
- A description of additional materials or information needed to process the claim. It will also explain why those materials or information are needed.
- A description of the procedure to appeal the denial, including the time limits applicable to those procedures. You must complete the Plan's appeal procedure before filing a civil action in court.

If you do not receive notice of the decision on the claim within the prescribed times periods, the claim is deemed denied. In that event, you may proceed with the appeal procedure described below.

The claimant may file a written appeal of a denied claim with:

EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

EyeMed Vision Care is the named fiduciary under ERISA for purposes of the appeal of the denied claim. The appeal must be sent at least 180 days after the claimant received the denial of the initial claim. If the appeal is not sent within this time, then the right to appeal the denial is waived.

You may submit materials and other information relating to the claim. EyeMed Vision Care will appropriately consider these materials and other information, even if they were not part of the initial claim submissions. You will also be given reasonable and free access to or copies of documents, records, and other information relevant to the claim.

Written notification of the decision on the appeal will be delivered to you within a reasonable period of time, but not later than 60 days after the appeal is received.

A denial of the appeal will include:

- The reasons for the denial.
- Reference to the provisions on which the denial is based.
- A statement that the claimant may receive free of charge reasonable access to or copies of documents, records, and other information relevant to the claim.
- A description of any voluntary procedure for an additional appeal, if there is such a procedure. It will also state that the claimant may file a civil action under section 502 of the Employee Retirement Income Security Act of 1974.

If you do not receive notice of the decision on the appeal within the prescribed time periods, the appeal is deemed denied. In that event, you may file a civil action in court. The decision regarding a denied claim is final, and no additional appeals regarding that claim are allowed.

Your Flexible Spending Account (FSA)

Participating in the Health Care Flexible Spending Account (FSA)

At the time you are eligible for Plan benefits (as described in the Eligibility section of this SPD), you will be asked to make choices for the Health Care Flexible Spending Account (FSA). Basically, you have two choices to make:

- Whether you wish to participate or not; and
- The amount you wish to contribute to the account.

You participate for a calendar year at a time, so if you wish to continue in the Plan for the following year, you must make an election during the Annual Enrollment period. If you do not make an election and you were previously enrolled in the Plan, your election will not automatically be carried over to the next Plan year.

Your election to participate or not to participate lasts for a full calendar year, unless you're hired by the Company after the annual election period, then your first election must be made within 31 days of your date of hire and will last through the end of that calendar year.

Note: Effective January 1, 2019, the Dependent Day Care FSA is no longer offered.

Enrollment Decision

If you contribute to the FSA, you need to decide how much to deposit in your account for the year and how you will use your account for health care expenses.

However, if you have an HSA, you are only eligible to participate in a Limited Purpose Health Care FSA, which can only reimburse dental and vision expenses (and medical expenses once you pay your medical annual deductible). See the Medical section of this booklet for more information.

You make new elections effective each January 1. Before making your elections, it is important to carefully consider your benefit needs and estimate predictable expenses for the year. Once you make elections, they cannot be changed during the year unless you have a change of status, and your change to the Flexible Spending Account is consistent with your change and permitted by law as described in the Eligibility section of this booklet.

Contributions to Your FSA

The FSA allows you to voluntarily reduce your pay, and to direct that amount to be contributed on a before-tax basis to the Health Care FSA to reimburse you for certain out-of-pocket health care expenses.

Your Tax-Free Contributions

You can authorize the Company to reduce the amount you are paid and deposit that amount as tax-free dollars to your Flexible Spending Account. You may direct up to $2,700 annually (up to a maximum of $225.00 per month) to your health care account. Then you can use these dollars to be reimbursed for eligible expenses, as explained later in this section.

If your tax-free dollars are deposited in a spending account, they will not be included as taxable income on your W-2 form for income tax purposes. So you will not have federal, state (in most states), or Social Security taxes withheld on this money.

Your tax-free dollars are not considered part of your taxable income, so you save on taxes.

Forfeitures

Current IRS regulations require that any money remaining in your account be forfeited if it is not used for expenses incurred during the Plan year. Forfeitures may be used to partially offset the administrative expenses of the Plan.

This means that each year you must carefully anticipate what your expenses will be for the coming year. As a guide, you may want to add up the expenses you had in the previous year for health-related items, decide which expenses were "one-time" expenses and which are likely to recur, and plan for any unusual expenses you expect to have in the coming year. Forecasting your expenses will help you avoid forfeitures.

Grace Period Claims

Claims for eligible expenses incurred during the FSA grace period (January 1–March 15) may be submitted against the unused balance from the prior plan year. Eligible expenses for the grace period include preventive care medical and drug claims, and dental or vision claims. All other expenses incurred after December 31 are not eligible for reimbursement from the prior plan year's balance of contributions.

All eligible expenses, whether incurred before December 31 of the current plan year or during the grace period (January 1–March 15 of the following plan year), must be submitted by April 15 of the following plan year to be considered for reimbursement.

Coordination with HSA

If you elect to participate in the HDHP medical option, which may be paired with an HSA, IRS regulations prohibit you from participating in the traditional Health Care FSA if you contribute to the HSA. Likewise, if you elect to participate in the traditional Health Care FSA, you can participate in the HDHP medical option but only if you do not contribute to the HSA. However, if you elect to participate in the HDHP medical option and contribute to the HSA, IRS regulations permit you to participate in a Limited Purpose FSA to reimburse eligible vision and dental expenses. Or, if your medical plan deductible is satisfied, your Limited Purpose FSA may be used for eligible health care expenses for the remainder of the year. You may also submit eligible preventive care expenses that do not require satisfaction of the annual deductible.

Funds from both the HSA and the Limited Purpose FSA are available for use on your HealthEquity card. When using your HealthEquity card, your dental and vision claims will first go through your Limited Purpose FSA. Any remaining balance will be charged to your HSA. For post-deductible and preventive medical expenses, if you want to process them through your Limited Purpose FSA, you must submit a claim via www.healthequity.com or with a paper claim form. Otherwise, all medical transactions will go through your HSA if you use your HealthEquity card.

You may also obtain IRS Publication 969 "Health Savings Accounts and Other Tax-Favored Health Plans" for a description of eligible expenses under an HSA and Health Care FSA.

Eligible Expenses

Eligible health care expenses are charges you (or an eligible dependent) have as long as the expenses:

- Are incurred during a Plan year in which you participated in the account;
- Are incurred while you actively contribute to the account;

- Are not reimbursed under any plan sponsored by the Company or a plan maintained by any other source (such as your spouse's health care plan); and
- Are not incurred before you participate in the account.

Unless you have an HSA, specific medical expenses eligible under the Plan are those not paid in full under any health care plan in which either you or your spouse participates, including annual deductibles, copayments, prescription drug copayments, and fees over the reasonable and customary limits, certain over-the-counter medications (OTC), and any other expenses which would be deductible as medical expenses for federal tax purposes without regard to income limitations and are not otherwise reimbursable by this Plan. If you have a limited FSA, then reimbursements are limited to dental and vision expenses not reimbursed by a dental or vision plan, although medical expenses are allowed after you meet the medical deductible.

Premium amounts are not eligible for reimbursement. These include any tax-free dollars you use to pay for medical, dental, or vision coverage under the Plan or any of your spouse's health care plans.

Examples of Eligible Health Care Expenses

The following are examples of expenses that are reimbursable through the health care spending account except for the limited FSA:

- Deductibles, coinsurance, and copayments for medical and prescription drug plans.
- Routine physical examinations.
- Services provided by a doctor or recommended by a licensed doctor.
- Non-formulary prescription drugs and medicines.
- Vaccinations and immunizations.
- X-rays.
- Hospitalization (including private room expenses).
- Laboratory fees.
- Nursing services by a registered nurse, licensed practical nurse, or nurse's aide.
- Mileage to medical providers.
- Physical or occupational therapy by a licensed therapist.
- Psychotherapy by a licensed practitioner.
- Ambulance transportation.
- Chiropractic care.
- Acupuncture.
- Treatment of obesity (excluding dietary supplements).
- Crutches and wheelchairs.
- Nursing home fees.
- Oxygen.
- Tutoring by a licensed school or therapist for a child with a severe learning disability.
- Hearing aids.
- Vision expenses—You can use the health care account to pay for vision expenses if you choose not to participate in the Plan's vision benefits. Even if you do participate in the vision benefits under the Plan, you can use the account to pay for expenses not otherwise covered. You will be required to submit an EOB if you are enrolled in dental or vision coverage.

- Dental expenses—You can use the health care account to pay for dental expenses if you choose not to participate in the Plan's dental benefits. Even if you do participate in the dental benefits under the Plan, you can use the account to pay for expenses not otherwise covered.

- Expenses in excess of Medical, Vision, and Dental benefit limits.

- The difference in cost between a brand name drug and a generic drug for a prescription.

- Eligible OTC medical supplies (itemized receipt required). Examples include:

  - Pregnancy test kits
  - Contact lens solution
  - Insulin and other diabetic supplies
  - First aid supplies
  - Hearing aid batteries
  - Heat wraps

- Eligible OTC items requiring a doctor's prescription (HealthEquity card may not be used) and filled by the pharmacist. Examples of some covered items:

  - Allergy medications (unless filled as a "prescription" by the pharmacist)
  - Anti-itch medications
  - Cold/flu remedies
  - Diaper rash ointment
  - First-aid creams
  - Lactose intolerance pills
  - Pain relievers and fever reducers

Note: Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. Effective January 1, 2011, distributions from Health Care FSAs are allowed to be used to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

Ineligible Expenses

Some ineligible expenses are not reimbursable:

- Cosmetic surgery, when not medically necessary to improve a deformity arising from a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

- Cosmetics or beauty products (face cream, moisturizers, makeup, lip balms, etc.).

- Diagnostic supplies (ovulation predictors, pregnancy tests, thermometers, etc.).

- Expenses claimed on your income tax return or not eligible to be claimed as an income tax deduction.

- Expenses reimbursed by other sources, such as insurance companies.

- Hair transplants.

- Health club dues, vitamins, dietary or nutritional supplements, weight loss supplements or programs (unless prescribed by a physician for a health condition).

- Insurance premiums.

- Marriage or family counseling.

- OTC digestive enzymes—hydrochloric acid, HCL supplements or lactose intolerance supplements.

- OTC medical supplies such as:
  - Cosmetic expenses
  - Insect repellants
  - Lip balms
  - Shampoo and soap
  - Sunscreen
  - Toothpaste and toothbrushes
  - Teeth-whitening products
  - Wrinkle reducers
- OTC medicines or drugs without a prescription.
- Premiums for coverage under health care plans (including dental and vision benefits) or other insurance plans.
- Prescription drugs purchased outside the United States or prescriptions filled in Canada or Mexico if the patient is a resident of the United States.
- Pretreatment estimates.
- Workers' Compensation charges.

To obtain a list of reimbursable expenses, contact the claims administrator. You may also refer to IRS Publication 502 for additional information (see www.irs.gov) or at www.healthequity.com.

IMPORTANT TAX INFORMATION YOU SHOULD BE AWARE OF:

You cannot be fully reimbursed for health care expenses from your account and claim those same expenses as tax deductions on your income tax return. You may want to consult a qualified tax advisor to determine whether a Health Care FSA is the best choice for you.

Your Eligible Dependents

For purposes of Health Care FSA eligibility, an eligible dependent does not include your domestic partner or his or her children. Accordingly, expenses for those individuals are not eligible for reimbursement, even if they otherwise satisfy the definition of tax dependent under the Health Care FSA.

You can, however, submit eligible expenses for your child even if you are divorced or separated and have agreed to let your ex-spouse claim the child as a tax dependent.

Under the Affordable Care Act, expenses incurred for any non-prescription medication or drug (other than insulin) are not eligible for reimbursement through your Health Care FSA without a prescription. This change does not apply to items for medical care that are not medicines or drugs, such as crutches, bandages, and blood sugar test kits.

The Advantage of Tax-Free Dollars

Through the FSA, you pay your share of eligible expenses before you pay federal income taxes. Tax-free amounts are deducted from your pay before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower taxable income—lower federal income taxes and lower Social Security taxes. In most areas, you also pay no state or local taxes on money you put into the Plan.

Effect on Social Security Benefits

Your taxable pay is reduced by the amount you deposit in the FSA. This reduction in taxable pay affects not only federal income taxes, but also your Social Security taxes—if you earn less than the Social Security taxable wage base (for 2019 the Social Security Taxable Base Wage is $132,900). You should be aware that any future Social Security benefits you receive at retirement or during a qualified disability may be slightly reduced. For more information on the reduction, contact your local Social Security Administration Office or call (800) 772-1213.

Effect on Other Benefits

None of your pay-related benefits, such as life insurance and LTD benefits, and your retirement benefits, are affected by your participation in the FSA. These benefits will continue to be based on your full pay.

How to File a Claim

If you file a claim for eligible expenses for health care, you will be reimbursed to the extent that you are eligible for reimbursement. To have your expenses reimbursed, request a claim form from the Goodyear Associate Service Center at (844) 449-4772. You can submit a claim for reimbursement at any time during the Plan year.

Your completed claim form and receipts should be directed to www.healthequity.com. Once you complete the online claim process, the system will produce a cover page you use to submit the receipts for the manual claim. The cover page will give you instructions on how to submit the required receipts for the claim.

Filing a Claim

If you are submitting a claim for eligible health care expenses, you need to attach to the claim form:

- The explanation of benefits (EOB) statement you receive from the medical, dental, or vision plan that provides you or your dependent coverage; or
- Original itemized bills for eligible expenses that are not covered by the medical plan you chose or another plan (for example, your spouse's); or
- Original receipts for over-the-counter (OTC) medications. Receipts for OTC medications should itemize the medications and be submitted with a claim form and the name of the participant whom the medications were intended for.
- If you are covered by another medical, dental, or vision plan (your spouse's plan, for example), you must submit your health care expenses to both plans before you can file for reimbursement from your Health Care FSA. Attach both sets of EOBs to the claim form.

If your expense is eligible and fully documented: You can expect a decision within five business days of the date your claim is received.

If your claim is incomplete or ineligible: You will receive notice of the denial within five business days of the date your claim is received. The denial will give you the options and instructions for repaying the FSA plan for the expense, providing additional documentation to show the expense is eligible, or submitting additional expenses to offset the ineligible amount. The notice will also include instructions for appealing the denial of the expense.

Here is how reimbursements are handled:

- **For health care expenses,** you can be reimbursed for the full amount you signed up to contribute to the health care account that Plan year.
- Please note that a $25 minimum will apply to reimbursements from the Health Care FSA. You must wait until you have claims totaling a minimum of $25 before you can submit them for reimbursement. (Any claims submitted that total less than $25 will be returned.)

The only exception to this policy will be made at the end of each plan year or when your account balance is less than $25. Your final reimbursement for the plan year may be for claims totaling less than $25.

Participants may use their HealthEquity card to pay for eligible expenses.

The IRS requires all FSA transactions to be substantiated, including payment card transactions. The claim administration process will attempt to auto-substantiate as many expenses as possible, but in some cases employees will be asked to supply documentation of their payment card expense.

You will be notified within five days of the expense being received if substantiation is required. You will receive two additional reminders to substantiate. After those reminders, the payment card will be suspended from use until the required documentation is received. Cards will be reactivated once the transaction has been substantiated.

In the case of an expense that was charged on the payment card that is deemed ineligible, the participant will receive notice of the denial. The participant will also be given the option and instruction for repaying the FSA plan for the expense, providing additional documentation to show the expense is eligible, or submitting additional expenses to offset the ineligible amount. The notice will also include instructions for appealing the denial of the expense.

Duration of Coverage

Your participation in the FSAs will end when your employment with the Company ends, when you no longer meet the eligibility rules, or on the first day you stop making any required contributions. If you are not having payroll deductions but are still an employee, you may make the required contribution to continue your participation.

Claims for eligible expenses incurred prior to the termination of your participation in the Plan can continue to be submitted to your account through March 31 after the end of the Plan year in which you become ineligible. Any money remaining in your account at the end of the Plan year will be forfeited.

Even if you stop contributing to the FSAs, you are still eligible to continue filing for reimbursement of claims for eligible expenses incurred prior to the termination of your participation in the Plan until March 31 following the end of the Plan year in which you leave, as your account balances allow.

Situations Affecting Plan Benefits

The FSA is designed to provide a tax-effective way to pay for eligible health care costs. But some situations could affect your benefits:

- If you don't complete your reimbursement claim form properly, fail to provide the Company with your current address, or fail to provide other necessary information, your reimbursement could be delayed.

- If you decide not to deposit any tax-free dollars in your account in any Plan year, no expenses can be paid from the account for that Plan year.

- If, by March 31 following each Plan year, you haven't applied for all the dollars in your spending account, you forfeit the unclaimed remaining dollars. Reimbursable expenses must be incurred by December 31 of the Plan year to be claimed for reimbursement by the following March 31.

- If you have claims outstanding that you haven't submitted for reimbursement by the March 31 cutoff date, those claims cannot be paid.

- If you die while enrolled in the account, any reimbursements you would have been entitled to are paid to your surviving spouse or beneficiary upon receipt of a completed claim. A member of the Goodyear Associate Service Center can help your beneficiary fill out and submit the necessary forms.

- If you are terminated or leave the Company for any other reason, deposits to your account end with your final paycheck unless you elect to continue participation through COBRA. You can, however, continue to file for reimbursement of claims for eligible expenses incurred prior to your exit until March 31 of the next Plan year, even though you are no longer employed by the Company.

Your Employee Assistance Program

The following EAP programs are provided as a service to employees and their eligible dependents living at home.

Assistance with Substance Abuse Problems

The decision to seek treatment for alcohol or chemical dependency is the responsibility of the employee. Employees who need assistance with a substance abuse problem are encouraged to contact one of the following regarding admissions to the Company's substance abuse rehabilitation program:

- Human Resources Leader
- Employee Assistance Program Administrator

Admission to the Substance Abuse Rehabilitation Program

Eligibility

- An active employee actively employed for 31 days or more.
- Inactive employee currently on Short-Term Disability leave.
- Eligible dependents of eligible employees.
- Must receive treatment in a contracted facility.

Exclusions

- Not a current active employee or eligible dependent of a current active employee.
- Inactive for reason other than Short-Term Disability leave or dependent of ineligible employee.
- Actively employed less than 31 days.
- Dual diagnosis—certain diagnosis in addition to chemical dependency.
- Previous admission to the Company's Substance Abuse Rehabilitation Program. (Only one admission per person per lifetime permitted.)

Return-to-Work Requirements Following a Rehabilitation Program

- Employees will be subject to testing (at the Company's expense) for the duration of the prescribed aftercare program and for 12 months following completion of the prescribed aftercare program up to a maximum of 24 months.
- Employees will be tested a minimum of six times during the first 12 months and a minimum of three times during the second 12 months.
- The aftercare provider or the Company may administer testing.

Additional questions or concerns may be directed to Achieve Solutions at (877) 606-1129.

Achieve Solutions Work/Life Program

Achieve Solutions is the confidential provider of EAP and work/life services to all U.S. associates and their households. Participation is voluntary, and, as always, your information is kept confidential. Through the Work/Life Program you and your family can receive professional counseling and guidance when faced with personal problems. This program is completely voluntary and confidential. The program is administered by Behavior Management Employees, Inc.

The range of services Achieve Solutions provides includes confidential assistance with the following areas:

- Work/life balance
- Financial stability
- Fulfilling relationships
- Sound mental health
- Healthy living
- Professional success
- Recovery
- Child and elder care

For more information about Achieve Solutions and its services, visit www.achievesolutions.net/goodyear or call (877) 606-1129.

How Employee Assistance Works

Employee Assistance encourages employees to voluntarily seek confidential assistance for problems that may disrupt work or family life. This service is available 24 hours a day, 365 days a year. Every effort is made to provide services at times that are convenient for you and your family.

Employee Assistance is a three-part program:

1. **Referrals –** Online feature—guide to community resources at www.achievesolutions.net/goodyear, or call a representative at (877) 606-1129.

2. **Crisis Intervention –** The Employee Assistance coordinator provides immediate help, either on the phone or face to face, and helps work to establish the next step.

3. **Counseling –** Up to five counseling sessions will be provided without charge. The counseling services are available to each family member on a per-problem basis.

The Company pays for services such as referrals, telephone counseling, work/life services, and the initial five face-to-face counseling sessions for eligible employees and their family members. However, if a long-term counseling or other treatment is recommended, you may incur some costs or fees, depending on the service or assistance required.

Your Disability Benefits

Short-Term Disability (STD) benefits are provided to assist you with income replacement while you are unable to work, according to the STD definition, due to your own disability during the first 52 weeks of disability.

Long-Term Disability (LTD) benefits are provided to assist you with income replacement while you are unable to work, according to the LTD definition, due to a disability after the first 52 weeks of disability.

Short-Term Disability (STD)

Full STD Defined	• Continuously unable to perform all the substantial and material duties of your own occupation due to an illness or injury; and • Under the appropriate and regular care of a legally qualified physician, whose specialty or expertise is the most appropriate for your disabling condition(s) according to Generally Accepted Medical Practice.
Requirements	• When you have an absence due to a non-occupational illness or non-occupational injury, you must report to the STD carrier on the earlier of when you have been absent seven calendar days; or • On your first hospitalized day, whichever occurs first; or • On your first day of injury or • On your first day of outpatient surgery if there are no 100% Sick Pay hours to use.
How Long	• Your STD benefits end after 52 weeks of benefits paid due to disability; or • When you are medically released to return to work; or • Until your layoff date or exit (including retirement) from the Company.
How Much	Full pay for an initial period (described later), then 50%, 70%, or 80% of pay, depending on your service.

STD benefits are a payroll practice, and may differ at some locations. Associates at Social Circle have a different STD practice and should contact their Human Resources Department for the practice applicable to them.

Partial Short-Term Disability Benefits

Partial Short-Term Disability Benefits are provided when you return to work with restrictions as defined below.

Partial STD Defined	• Unable to perform all the substantial and material duties of your own occupation due to an illness or injury for a full scheduled work day or shift; or • Are able to perform one or more, but not all of the substantial and material duties of your own occupation due to an illness or injury for a full work day or shift; and are participating in a transitional work program; and • Are under the appropriate and regular care of a legally qualified physician, whose specialty or expertise is the most appropriate for your disabling condition(s) according to Generally Accepted Medical Practice.
Requirements	• A doctor's order for restricted duty must be submitted to the Company and STD administrator.
When Payable	• You are on an authorized partial absence from work because of an injury or illness that is reported to, and approved by, the Company and/or the STD administrator, return to work under a doctor's restricted duty order; or • You have been placed on a restricted duty because of an illness or injury that is reported to, and approved by, the Company and/or STD administrator without prior absence; and • You have not been under and exhausted a Transitional Work program within the last 52 weeks for the same disability.
How Long	• Up to a maximum of 90 days, with an additional 30 days available upon medical review; and

	• Approval by the non-occupational and occupational disability insurance carrier.
How Much	The combination of pay for hours worked plus your partial STD pay will equal 100% of your pay immediately before the disability for an initial period for hours not worked (described later under Sick Pay with Full Pay), then Short-Term Disability at 50%, 70%, or 80% of pay, depending on your service;

STD benefits will be reduced by other income benefits you may be eligible to receive, such as pay for hours worked, Social Security Disability benefits, state disability benefits and Workers' Compensation benefits.

The STD and Partial Short-Term Disability benefits are provided as a payroll practice out of the general assets of the Company. The following applies to most locations. Please contact your Human Resources Department for the specifics at your employment location.

100% Sick Pay Days

While you are off work for your own illness/injury on an authorized medical absence and not currently on layoff, are not engaging in alternate employment or participating in other activities that are inconsistent with the documented reason for being off work, you will receive your full base pay for the appropriate maximum number of days set forth in the table below. The table takes your continuous service and sick days already recorded into consideration. For purposes of the STD benefit, "continuous service" is defined as the period of time from your date of hire moved forward to adjust for any absences from service which are deductible in computing continuous service.

An absence of more than seven consecutive calendar days, first day of hospital confinement, or first day of injury, whichever occurs first, must be approved by the disability vendor.

- An associate on 100% non-occupational/vocational leave of absence on December 31 (and it is not their last day of 100% Sick Pay) will receive the new year's entire allocation on January 1 and will be able to use those days until exhausted or return to work.

- An associate on Partial STD benefits on December 31 will receive the new year's entire allocation of 100% Sick Pay Days upon return to full-time, unrestricted duty.

- Unused 100% Sick Pay Days not used as of December 31 cannot roll over to the following calendar year.

To find out the maximum days you are eligible to receive, find your continuous service in the left-hand column and the corresponding days in the right.

Continuous Service	Maximum Number of 100% Sick Pay Days	Equivalent Hours
0 to 90 days	0	0
91 days up to 1 year	11	88
On 1 year up to 5 years	22	176
On 5 years up to 10 years	33	264
On 10 years and over	44	352

If you have an occupational disability, your maximum number of STD days for non-occupational causes is not reduced. So your full allowance will be available should you incur a non-occupational absence.

STD Benefits After Full STD Pay Is Exhausted

When you use all your available STD with full pay, or are not yet eligible for STD with full pay, the amount of your benefits will be determined according to the following schedule. Benefits generally continue until the end of the 52nd week in which your disability absence began or until the date you are released to return to work, until your layoff date, or until you exit (including retirement) from the Company—whichever happens first.

Continuous Service	Pay Replaced
On 31st day up to 1 year	50% of Base Pay
On 1 year up to 20 years	70% of Base Pay
On 20 years and over	80% of Base Pay
31st day and over—Vocational (WC)	80% of Base Pay

To receive Sick Leave partial pay, you must have an approved disability benefit claim by the disability vendor that exceeds seven calendar days, be hospitalized, or be out due to an injury occupational illness, or outpatient surgery, whichever occurs first. Shorter time periods of medical absence less than eight calendar days or does not meet the other absence criteria will not be paid. The Company reserves the right to audit and recoup any overpayments made.

Certain Conditions and How They May Apply To You:

If your absence is due to an occupational cause, your pay replacement percentage will be 80% of your base pay—regardless of your length of service.

If you pass a service date while you are on STD with partial pay, your pay replacement percentage does not increase, nor are you entitled to additional days of 100% Sick Pay Days during the current absence. In other words, you will continue to receive the benefit amount in effect when your disability began for the duration of the period STD benefits are paid.

If your disability is due to an occupational accident or illness, partial pay Sick Leave benefits are payable immediately after 100% Sick Pay Days are exhausted.

If any new disability period is not due to an occupational accident or illness, partial-pay benefits are paid when you use all your available 100% Sick Pay Days.

If you are employed on a schedule that is less than your normal work week, your benefit will be prorated based upon your normal work schedule.

Periods of Disability

The 52-week STD benefit period is applied to the days you are unable to return to work full time, full duty, and unrestricted due to a disabling illness or injury.

If you are receiving STD benefits, return to work, and then become disabled again, the following rules apply:

- Periods of disability due to the same cause will be considered the same period of disability unless you return to full-time, full-duty unrestricted work for 90 days.

- Periods of disability due to different causes will be considered different periods of disability if you return to full-time, full-duty unrestricted work for any period of time.

If you return to full-time, full-duty unrestricted work after receiving, or becoming eligible to receive, LTD benefits, and again become disabled due to the same or a related cause within six months from your date of return to work as defined, you will revert directly to LTD benefits rather than being covered under STD benefits.

Social Security Benefits

If you are permanently disabled, you may be eligible to receive disability insurance benefits from Social Security before your Social Security Normal Retirement Age (age 65–67, depending on your date of birth). These benefits equal your accrued Social Security benefit payable as if you had retired at your Social Security Normal

Retirement Age. Benefits may be payable after a five-month waiting period.

For more information, contact your Human Resources Department or local Social Security Administration office at (800) 772-1213.

Requirement to File for Social Security Disability Benefits

To receive STD benefits previously described, you are required by the insurance carrier to meet the following three requirements:

1. You must apply for Social Security Disability benefits as early as the fifth month of disability.

2. You must sign and return the "Reimbursement Agreement." The "Reimbursement Agreement" allows the Company to recover overpayment of Company-paid STD benefits that may result from retroactive awards of Social Security Disability benefits.

3. If your request for Social Security Disability benefits is denied, you are required to follow the provisions regarding the Appeal of Denial of Social Security Benefits as outlined below.

If you fail to complete these requirements, your STD benefits will be reduced by the maximum individual and family Social Security Disability benefit amount. Failure to comply with the first two requirements will result in a reduction of your STD benefits upon notification from the STD administrator. Failure to comply with the third requirement will result in a reduction of your STD benefits one month following the denial of your application for Social Security Disability benefits.

If you subsequently complete these requirements, or you return to full-time work for more than 90 days within the first 52 weeks of disability, you will receive payment of any reductions in your STD benefits.

Appeal of Denial of Social Security Disability Benefits

If your request for Social Security Disability benefits is denied, you may be required to file an appeal of the denial of benefits if your physician considers your disability to meet the Social Security definition of disability and entitles you to such benefits. The procedures to initiate an appeal (reconsideration) of the denial of Social Security Disability benefits are provided in the documents you will receive from Social Security.

If your physician does not consider your disability to entitle you to Social Security Disability benefits, then you are required to furnish the STD administrator or insurance carrier with a written statement from your physician confirming this assessment. Otherwise, you are required to furnish the STD administrator or insurance carrier with a copy of the appeal (reconsideration) you filed. Failure to comply with this requirement will result in a reduction of your STD benefits, and possibly your Long-Term Disability benefits.

If you use an attorney to help in the appeal process and the appeal results in a retroactive award of benefits, the amount of overpaid disability income benefits due to the Company will be reduced by the amount of the actual attorney fees paid up to a maximum of 25% of retroactive disability benefits awarded or $4,000, whichever is less, provided the overpayment is promptly returned to the Company.

If you are approved for Social Security Disability benefits at any step of the process, including your initial application, you are required to notify the Company and the insurance carrier immediately to avoid overpayment of disability benefits.

Long-Term Disability Benefits (LTD)

LTD Defined	• For the first year of the LTD period, a disability is defined as: you are continuously unable to perform your own occupation. The second year of LTD is defined as: you are continuously unable to perform any and all occupations for which you are or will become qualified by education, training, or experience; **and you are** • Under the appropriate and regular care of a legally qualified physician, whose specialty or expertise is the most appropriate for your disabling condition(s) according to Generally Accepted Medical Practice.
When Payable	On the first day following a 52-week absence from work because of a disability approved by the STD administrator or insurance carrier.
How Long	• If you are disabled before reaching age 63, until age 65 or retirement (that is commencement of a pension or retirement contribution benefit) or you fail to meet the definition of LTD—whichever occurs first. • If you are disabled after reaching age 63, for 12 months.
How Much	You decide how much LTD coverage you need when you enroll. Depending on the choice you make, you may receive 50%, 60%, or 70% of your monthly LTD pay, with or without inflation protection, up to certain limits. Your LTD pay excludes overtime but includes any bonus, commission, or profit sharing compensation plan during the previous calendar year up to $400,000.

Each fall, during the Annual Enrollment period, you choose the LTD option with the coverage you want for the coming year. Your choice is effective on the next January 1.

If you do not return an enrollment form, in the event you qualify for LTD as determined by the insurance carrier, you will receive "default coverage," which is 50% of your pay. See "When 'Default Coverage' Applies" in the General Provisions section for more information. At hire or during your first year of service, you choose the level of LTD coverage you want.

Once you have made your choice each fall, the option you elect stays in effect from January 1 to December 31. You cannot change your coverage during the year unless you have a change in status, and your election change is consistent with that change in status. For more information on status changes, refer to "Changing Your Choices" in the General Provisions section.

Eligibility

You will only be eligible for LTD benefits after you have exhausted your eligibility for STD benefits (i.e., completed a 52-week absence from work approved by the Company and/or the insurance carrier due to disability). For the first year of LTD, you must be continuously unable to perform your own occupation and be under the care of a legally qualified physician. To receive LTD benefits in excess of one year, you must be continuously unable, solely due to Disability or Partial Disability, to perform any and all occupations for which you are or will become qualified by education, training, or experience, and be under the care of a legally qualified physician.

Cost of LTD Coverage

You and the Company share the cost of your LTD coverage. You pay for your LTD coverage with after-tax dollars from your pay.

Each enrollment period, you will receive information including the monthly price tags for each option. Because LTD benefits are based on your pay, so are the price tags. Inflation protection is provided at no cost to you.

One special feature of the LTD benefit is that LTD premiums are waived if you are receiving LTD benefits. In other words, if you become disabled, your LTD coverage is provided free of cost.

The cost of the benefit is paid as premiums to an insurance company, which insures and administers the benefits. The insurance company processes claims and approves all benefit payments.

LTD Coverage Options

LTD benefits work with Social Security and income from other sources to replace a percentage of the pay you were earning before becoming disabled. You have six coverage options. Options 1–3 are identical—except for the percentage of your monthly pay they would replace, and maximum benefit, if you became disabled. Options 4–6 have an inflation-protection feature. For each year you are disabled, your LTD benefit will increase by the general inflation rate, up to 5% a year. The maximum monthly benefit for Options 4–6 increases with the inflation rate.

LTD Option	Pay Replaced	Maximum Monthly Benefit
1	50% without Inflation Protection	$16,667
2	60% without Inflation Protection	$20,000
3	70% without Inflation Protection	$23,333
4	50% with Inflation Protection	$16,667
5	60% with Inflation Protection	$20,000
6	70% with Inflation Protection	$23,333

If you increase your coverage option by more than one level (e.g., you go from 50% to 70%) or you increase your coverage option by one level while moving from a no Inflation Protection option to an option with Inflation Protection, you will be required to provide Evidence of Insurability (EOI). Forms will be available on the GO page (http://go.goodyear.com/). EOI forms can also be obtained by contacting the Goodyear Associate Service Center at (844) 449-4772.

Changing Your LTD Choice

If you are on Sick Leave at the time coverage would otherwise take effect, your new coverage will not begin until you return to work.

When and How Your Benefit Is Paid

The Company or the STD administrator/ insurance carrier reserves the right to require proof of your disability before disability benefits are paid. For example, the Company or the insurance carrier may require medical documentation from your attending physician, or examination by a physician of the Company's or insurance carrier's choice as a condition of an STD or LTD benefit payment. In addition, the insurance carrier may require that you apply for Social Security Disability benefits.

If you meet the eligibility requirements, and your application is approved by the carrier, LTD benefits become payable following a 52-week absence from work due to STD because of an LTD approved by the insurance carrier (the LTD benefit is set up to begin after STD benefits are no longer payable).

Plan benefits for LTD are paid monthly. Each month, you will receive a benefit to bring you up to the pay replacement target of the option you have elected.

In some instances a participant may be eligible to receive a lump-sum settlement of future LTD benefits. By accepting the lump-sum payment, you are still considered to be continuing disability benefits and are therefore not eligible to apply for commencement of a pension benefit until age 65.

Monthly Earnings

For purposes of LTD benefits, "monthly earnings" means your total monthly LTD compensation excluding overtime, night shift differential, prizes, and other similar items, as of the date your disability began.

Your earnings do include any tax-free dollars you have used to buy benefits. In addition, your pay, for LTD benefit purposes, will include an appropriate adjustment for items of compensation that are variable or paid other than monthly.

If you are paid on a weekly basis, your "earnings" are based on a 40-hour weekly rate, multiplied by 52, then divided by 12. Commissions, profit sharing compensation, and/or annual bonuses will also be considered, if applicable.

Additional STD & LTD Benefit Information

The Company and insurance carrier reserve the right to collect from the employee and/or reconcile overpayments and STD or LTD benefits that may occur.

Other Income Sources

Your total disability benefit is payable from several sources, and all work with your STD or LTD benefits to reach the percentage for which you are eligible under STD, or the percentage offered by the LTD option you have elected. Other income sources include:

- Workers' Compensation or any other statutory occupational disability plans;
- Any non-occupational disability plans required by law;
- The amount of any primary individual and family Social Security Disability benefits.
- The amount of any other federal or state disability benefits; including military disability benefits if the disability is caused by or during the military assignment, Workers' Compensation.

If any of the above other income sources is paid in a single sum through a compromise settlement or an advance on future liability, the amount of your benefit will be determined as follows:

a) The total amount will be divided by the number of months for which the settlement or advance was provided; or

b) If the number of months for which the settlement or advance is not known, the amount of the settlement or advance will be divided by the expected remaining number of months that the insurance carrier will provide benefits, up to a maximum of 60 months.

This amount will be deducted from your weekly or semi-monthly STD benefit or your monthly LTD benefit.

STD Subrogation

When a covered employee's injury or illness appears to involve third-party (person, corporation, or other source) liability, benefits otherwise payable under this benefit policy for loss of time as a result of that injury or illness will not be paid unless the covered associate or his or her legal representative agree(s):

1. To repay the Company for STD benefits to the extent paid for losses, which compensation is paid to the covered employee by or on behalf of the third party at fault;
2. To allow the Company a lien on such compensation and to hold such compensation in trust for the Company; and

3. To provide written notice in advance of any action that you or your representatives are considering that might adversely affect the Company's rights, such as settlement with any third party; and

4. To execute and give to the Company any instruments needed to secure the rights under numbers one and two above.

Further, when the Company has paid benefits to or on behalf of the injured or sick covered employee, the Company will be subrogated to all rights of recovery that the covered employee has against the third party at fault, even if you are not fully compensated or made whole from the recovery. These subrogation rights will extend only to recovery of the amount the Company has paid. The covered employee must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the Company.

The subrogation process may be managed by a third-party administrator chosen by the Company and operating on the behalf of the Company.

If you recover any money, directly or indirectly, the Plan has first priority for repayment of the full amount of the benefits it provided to you, even if you are not made whole, and the Plan will pay a portion of the reasonable legal and other expenses incurred by you and/or your dependent in obtaining such recovery from the third party. If money is recovered from more than one party, the same rule shall apply to the amount recovered from each party.

LTD Subrogation

When a covered employee's injury or illness appears to involve third-party liability, benefits otherwise payable under this benefit policy for loss of time as a result of that injury or illness will not be paid unless the covered employee or his or her legal representative agree(s):

1. To repay the insurance carrier for LTD benefits to the extent paid for losses, which compensation is paid to the covered employee by or on behalf of the third party at fault;

2. To allow the insurance carrier a lien on such compensation and to hold such compensation in trust for the insurance carrier; and

3. To execute and give to the insurance carrier any instruments needed to secure the rights under numbers one and two above.

Further, when the insurance carrier has paid benefits to or on behalf of the injured or sick covered employee, the insurance carrier will be subrogated to all rights of recovery that the covered employee has against the third party at fault. These subrogation rights will extend only to recovery of the amount the insurance carrier has paid. The covered employee must execute and deliver any instruments needed and do whatever else is necessary to secure those rights to the insurance carrier.

Returning to Work

If you have been absent because of illness or accident for more than seven consecutive calendar days, or if you have been hospitalized, you must bring a doctor's release to your manager, your Human Resources contact, and the Good Life Health Center (if available at your location) prior to returning to work.

Duration of Benefits

STD benefits end the earlier of 52 weeks from the date of disability for which benefits have been paid, when a medical review acceptable to the Company indicates you are capable of returning to work, or when you exit (including retirement) from the Company.

If you do not return to work when capable, employment will be terminated.

Prior to the end of the 52 weeks of STD benefits, the insurance carrier will review the claim for LTD eligibility. If you are approved for LTD benefits, the insurance carrier will start disability payments and will continue to manage the process after 52 weeks of disability.

If you receive LTD benefits, continuous service accumulates for up to two years following the last day worked, and then you are exited from the Company.

If you become disabled before reaching age 63, LTD benefits stop when you reach age 65 or receive any pension payment from the Company—whichever happens first. If you become disabled on or after reaching age 63, LTD benefits continue for up to 12 months or retirement—whichever happens first.

If you are not approved for LTD benefits, you will be exited unless a medical review acceptable to the Company and/or the insurance carrier indicates that you are unable to return to work, with or without reasonable accommodation. In the event a medical review indicates you cannot return to work, you will remain on leave of absence. In any event, employment will terminate at the expiration of the 24-month period from the date the leave commenced or if you do not return to work after a medical review indicates you are capable of working, whichever occurs first.

Returning to Work

If you have been absent because of illness or accident for seven consecutive calendar days or more, you must bring a doctor's release to your manager prior to returning to work, or to the Medical Department at your location, if available.

Termination of Coverage

Your eligibility for STD and LTD coverage terminates when your employment terminates, or when you are no longer eligible for STD or LTD benefit coverage under the terms of the Plan.

Your LTD coverage may continue for up to 90 days while you are on an unpaid, approved leave of absence, by paying in advance any required premium.

When Benefits Will Not Be Paid

LTD and STD benefits will not be paid for disabilities resulting from:	• Intentionally self-inflicted injuries (whether sane or insane); • War or participation in a riot; or • The commission of a crime, such as assault, battery, or a felony.
In addition, STD will not be paid for:	• Absences due to alcohol and drug abuse except during the period an employee is being treated at a rehabilitation facility under the Alcohol and Chemical Dependency program (through the EAP), and with the approval of the Corporate Medical Director. • Absences for elective cosmetic medical treatment intended primarily to improve appearance (including, but not limited to, restoration of hair and appearance of skin) and that is not to restore body function or correct deformity from disease, trauma, birth or growth defects, or prior therapeutic processes.

No LTD benefit will be paid during periods of incarceration.

How to File a Disability Benefit Claim

When you are absent from work due to an illness or injury, you need to follow the process which is outlined below. By following these steps, you will ensure your disability claim is processed in a timely manner and your pay will continue uninterrupted.

1. Call your Manager

- Call your manager on the first day you are away from work due to an illness or injury. After the initial contact with your manager, you must keep him or her informed of your status/condition. If your absence is not approved, you may be denied STD benefits.

- If you are incapacitated, a family member or friend should call your manager and Disability vendor on your behalf.

2. Call the Vendor Disability Claim Unit (non-work-related absences only)

- On the first day of hospital confinement or if you will be out of work more than seven calendar days for your own serious illness or injury, you the employee need to call the disability vendor to begin the claims process. Claim professionals are available 24 hours a day, 7 days a week. To meet the requirement for a timely claim filing you need to report your non-occupational disability claim to the non-occupatrional disability benefit carrier within 90 days from the first day missed. Failure to do so will result in benefit denial.

- If you fail to call the the disability vendor after seven consecutive calendar days of absence or if earlier, the first day of hospital confinement, first day of injury, your pay may be delayed until the disability vendor is notified and determines if you are eligible for benefits.

- If you know ahead of time that you will be hospital-confined, or absent for seven or more consecutive calendar days, such as for maternity or scheduled surgery, call the disability vendor in advance.

On the day that the claim is reported, the disability vendor will give you further instructions regarding your responsibilities to maintain benefit coverage eligibility. The disability vendor will send a confirmation letter to you acknowledging receipt of the claim.

You will also receive a release-of-information document, which you will need to execute and return to The disability vendor.

Please note: Failure to comply with the instructions of the insurance carrier or your manager may result in a delay or denial of your disability payments.

Work-related injuries or illnesses must continue to follow current Workers' Compensation procedures as set forth by your work location. If you sustain a work-related injury or illness, you do not have to report the claim to the disability vendor. Once your work location receives a work-related claim, it is then submitted to the Workers' Compensation carrier and the disability vendor for case management. At that time you will receive further instructions from the Workers' Compensation carrier.

Claims and Appeals Procedures

If you are denied a disability benefit, you may file an appeal. The Long-Term Disability benefit claims and appeals procedure has been delegated to the disability vendor. The disability vendor has also been delegated the discretion to determine the applicable facts and interpret the plan provisions for the LTD Plan. To file an appeal with the disability vendor, you must follow the procedure as outlined below, provided, however, that in the event of any difference between the procedure included below and the procedure used by the disability vendor, the disability vendor's procedure will control. You may contact the disability vendor for information regarding how to file claims and appeals.

If your claim is denied, the disability vendor will notify you of the adverse decision within a reasonable period of time, but no later than 45 days after receiving the claim. The 45-day period may be extended for up to 30 days if the disability vendor: (1) determines the extension is necessary because of matters beyond the Plan's control, and (2) notifies you, before the end of the 45-day period, why the extension is needed and the expected decision date. If, before the end of the first 30-day extension, the disability vendor determines, due to matters beyond the Plan's control, a decision cannot be rendered within the extension period, the determination period may be extended for up to an additional 30 days, provided the disability vendor notifies you, before the end of the first 30-day extension period, why the extension is needed and the expected decision date.

How to Appeal a Denied Claim

The notice of extension shall explain: (1) the standards on which benefit entitlement is based, (2) the unresolved issues that prevent a claim decision, and (3) the additional information needed. You have at least 45 days to provide the information.

The claim determination time frames begin when a claim is filed, without regard to whether all the information necessary to make a claim determination accompanies the filing.

If an extension is necessary because you failed to submit necessary information, the days from the date the disability vendor sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If Your Claim Is Denied

The disability vendor's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those specific Plan provisions on which the denial is based;

2. A description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary;

3. A description of the Plan's appeal procedures and time frames, including a statement of the claimant's right to bring civil action under ERISA following an adverse decision on appeal;

4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

You, or your authorized representative, may appeal a denied claim within 180 days after you receive the disability vendor's notice of denial. You have the right to:

1. Submit to the disability vendor, for review, written comments, documents, records, and other information relating to the claim;

2. Request, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to your claim;

3. A review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim decision;

4. A review that does not afford deference to the initial adverse decision and which is conducted neither by the individual who made the adverse decision nor the person's subordinate;

5. If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and

6. The identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

The disability vendor will make a full and fair review of your appeal and may require additional documents as it deems necessary in making such a review. A final decision on the review will be made within a reasonable period of time but not later than 45 days following receipt of the written request for review unless the disability vendor determines that special circumstances require an extension. In such case, a written notice will be sent to you before the end of the initial 45-day period. The extension notice shall indicate the special circumstances and the date by which the disability vendor expects to render the appeal decision. The extension cannot exceed a period of 45 days from the end of the initial period.

If an extension is necessary because you failed to submit necessary information, the days from the date of the extension notice until you respond to the request for additional information are not counted as part of the appeal determination period.

The disability vendor's Notice of Denial Shall Include:

1. The specific reason or reasons for denial, with reference to those Plan provisions on which the denial is based;

2. 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 information relevant to your claim;

3. A statement describing any voluntary appeal procedures offered by the disability vendor and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;

4. If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and

5. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

To send an appeal, or to get more information regarding the plan, you should contact the regional claims office with which you have been corresponding.

Note: Effective April 1, 2018, new disability claims and appeals procedures are effective. You should contact the disability vendor for details.

A summary of these new changes are as follows:

- *Disclosure requirements:* Disability denial notices will contain a more complete discussion of why the Plan denied a claim and the standards it used to make the decision (e.g., explain why a denial occurred if it disagreed with a disability determination made by the Social Security Administration).

- *Claim file and internal protocols:* Disability claim file must offer that the claimant is entitled to receive the claim file and other relevant documents as part of the claim (not just the appeal).

- *Review and respond to new information.* Plans may not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given a fair opportunity to respond.

- *Conflicts of interest:* For example, a claims adjudicator or medical expert cannot be hired, promoted or compensated based on the likelihood of such individual denying benefit claims.

- *Coverage rescissions:* Certain rescissions (retroactive termination) of disability benefits due to alleged misrepresentation of fact (e.g., errors in the application for coverage) must be treated as an adverse benefit determination (i.e., claim denial) that would trigger the Plan's appeal procedures.

- *Communication requirements in non-English languages:* An adverse benefit determination of disability benefits must be provided in a "culturally and linguistically appropriate manner." Depending on what country you live in, you may be able to receive such information in Spanish, Chinese, Tagalog, and Navajo.

Your Life and Accidental Death & Dismemberment (AD&D) Insurance

This section describes Goodyear's Life and AD&D insurance available to you. See the life insurance vendor's coverage summaries for more details.

Note: To be eligible, dependent children must be under the age of 19 and:

- A son, stepson, daughter, or stepdaughter of the employee;
- A legally adopted individual of the employee; or
- An unmarried child of any age who became mentally or physically incapable of self-support prior to age 19.

Basic Life and AD&D Insurance

The Company automatically provides you with Basic Life Insurance of the higher of:

- Your highest annual pay as calculated before January 1, 2009; or
- One times your current annual base pay.

Your maximum basic life insurance benefit will be $2 million, unless you had coverage of more than $2 million before January 1, 2009. The minimum coverage amount is $25,000.

The Company also provides you with Basic AD&D insurance equal to one times your annual pay up to $50,000.

Basic Life and AD&D Insurance is administered by Alight Solutions.

Imputed Income

Under federal tax law, the "value" of employer-paid life insurance coverage over $50,000 is subject to federal income and Social Security tax. This tax liability is known as "imputed income" and is used when you receive the value of a benefit as opposed to actual cash. If you have imputed income, it will be added to your earnings and shown on your Form W-2. The imputed income value is determined by IRS tax tables based on age. It is your responsibility to make sure that taxes are paid on this imputed income. You may wish to consult with a tax advisor.

Group Universal Life Insurance

You may enroll for Group Universal Life (GUL) Insurance for yourself and your family. The minimum coverage amount is $25,000.

Plan Costs

You pay the price of GUL Insurance coverage with after-tax dollars from your pay.

Each enrollment period, you will receive information including the monthly price tags for GUL Insurance. Premiums are based on the amount of coverage you select and whether you select coverage for only yourself, you and your spouse, you and your children, or family coverage.

Amount of Benefit

As the chart below shows, you may select GUL Insurance for yourself, your spouse, and/or your children. You can choose one of the following amounts in each category:

<table>
<tr><th colspan="3">Coverage Amount*</th></tr>
<tr><th colspan="2">You only</th><th>Spouse</th><th>Child(ren)</th></tr>
<tr><td>No Coverage</td><td>0.5 x Pay</td><td rowspan="5">$10,000–$250,000 (in $10,000 increments)</td><td>$2,500</td></tr>
<tr><td>1 x Pay</td><td>2 x Pay</td><td>$5,000</td></tr>
<tr><td>3 x Pay</td><td>4 x Pay</td><td>$7,500</td></tr>
<tr><td>5 x Pay</td><td>6 x Pay</td><td>$10,000</td></tr>
<tr><td colspan="2"></td><td>No Coverage</td></tr>
</table>

*You decide if you want coverage for yourself only, you and your spouse, you and your children, or family coverage.

Coverage for you only has a maximum benefit of $3 million. Pay is rounded to the nearest $1,000 and then multiplied.

Spouse coverage cannot exceed 50% of your benefit.

Evidence of Insurability (EOI)

EOI, or proof of good health, may be required for coverage over 3 x Pay to enroll for the first time or later increase coverage over one level from your current coverage (e.g., you elect 4 x Pay and your current coverage is 2 x Pay) or over $20,000 for your spouse's coverage. If EOI is required, the highest available coverage that does not require EOI is assigned until EOI is approved.

EOI may require a medical examination at your expense. Your coverage will take effect after your EOI is approved.

During Annual Enrollment, EOI is required for any increase in coverage.

EOI is not required for your children's coverage.

Accelerated Death Benefit

If you are terminally ill, you can request to receive up to 100% of your life insurance benefit (up to $1 million maximum) while you are still living. Payment is in one lump sum. Once you receive the accelerated benefit, your total benefit is reduced by the amount you receive. After you die, your beneficiary will receive the remaining balance. Please consult a tax advisor to assess the impact of this benefit.

If your spouse is terminally ill, he or she can request to receive up to 100% of his or her spouse benefit under Supplemental Life Insurance (up to $250,000 maximum) while still living. Payment is in one lump sum. Once your spouse receives the accelerated benefit, his or her total benefit is reduced by the amount he or she receives. After your spouse dies, you will receive the remaining balance. Please consult a tax advisor to assess the impact of this benefit.

To qualify for the accelerated benefit option, you must provide the life insurance vendor with satisfactory proof that life expectancy is 12 months or less or such other period as required by state law. See the life insurance certificate for details. To request this option, contact the Goodyear Associate Service Center at (844) 449-4772 for the required form.

Assignment of Benefits

You can transfer your ownership rights to Basic Life Insurance by "assigning benefits." The assignee can be either a person or a trust. The assignment is an absolute assignment and assigns "all rights, title, and interest" under the policy. Only you can make an assignment. If you have dependent coverage in effect, the dependent coverage is also included in the assignment.

The assignment becomes effective on the date you sign the transfer but only after it is approved by the Insurer. After your assignment becomes effective, you can no longer make changes, including:

- Changing your beneficiary.
- Changing your coverage amount.
- Converting coverage.

These rights belong to the assignee.

Because of the various legal and tax implications involved, it is recommended that you consult with a lawyer or tax advisor before assigning your benefits. Contact Alight for additional information.

Converting Coverage and Portability Benefits

You may be able to convert Life Insurance coverage to an individual policy, without providing a statement of health form, if your Basic and/or GUL Insurance ends or is reduced. In some situations, you also may be able to convert Spouse and Child Life Insurance. You will receive information about how to convert coverage to an individual policy from the Goodyear Associate Service Center. You then will need to contact the life insurance vendor within 31 days from your benefits termination date to initiate the conversion process.

Portability allows you and your eligible dependents to continue GUL Insurance coverage under a Group Portability policy when coverage would otherwise end due to certain events, such as your employment ending prior to age 70. You will receive information about portability from the Goodyear Associate Service Center. You then will need to contact the life insurance vendor within 31 days from your benefits termination date to elect portability.

Limitations and Exclusions

Any limitations on benefits, age reductions, and exclusions are described in the insurance certificate provided by **the life insurance vendor**.

Changing Your Life Insurance Coverage

It is not part of Annual Enrollment, and you may change your coverage amount when you have a qualified status change or at any other time with evidence of good health. To change your coverage amount or if you have questions about your life insurance coverage, **contact the life insurance vendor**.

Optional AD&D Insurance

You may enroll for Optional Accidental Death & Dismemberment Insurance (Optional AD&D) for yourself and your family.

Optional AD&D covers occupational and non-occupational accidents that result in a loss of life or dismemberment. Benefits will not be paid for losses resulting from suicide.

Optional AD&D also covers you for any accidental loss you suffer as a passenger on any commercial or company aircraft. You are also covered while flying as a pilot or crew member in the normal course of your employment. Special rules and coverage amounts apply to employees while participating in flying activities that are not a part of their normal course of employment. The following are not covered:

- Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
- Acting as a pilot or a crew member of any aircraft, unless doing so in the normal course of your employment; or
- Parachuting, except when the insured has to make a parachute jump for self-preservation.

See the coverage summary for a complete list of what is not covered.

Plan Costs

You pay the price of Optional AD&D Insurance coverage with after-tax dollars from your pay.

Each enrollment period, you will receive information including the monthly price tags for Optional AD&D Insurance. Premiums are based on the amount of coverage you select and whether you select coverage for only yourself, you and your spouse, you and your children, or family coverage.

Amount of Benefit

As the chart below shows, you may select insurance in multiples of $50,000, up to a maximum of $300,000 of coverage.

Option	Coverage Amount*
1	$50,000
2	$100,000
3	$150,000
4	$200,000
5	$250,000
6	$300,000
7	No Coverage

*You decide if you want coverage for yourself only, you and your spouse, you and your children, or family coverage.

How Optional AD&D Insurance Works

Benefits will also be paid for the following losses caused by a covered accident within 365 days of its occurrence:

Benefit Level	
100% of the benefit amount will be paid for the accidental loss of:	• Both hands or both feet • One hand and one foot (or any two limbs) • Complete loss of sight in both eyes • Total loss of speech and hearing
75% of the benefit amount will be paid for the accidental loss of:	• One leg • One arm
50% of the benefit amount will be paid for the accidental loss of:	• One hand or one foot • Complete loss of sight in one eye • Total loss of speech • Total loss of hearing
25% of the benefit amount will be paid for the accidental loss of:	• Thumb and index finger of the same hand • Loss of hearing in one ear
Seat Belt Coverage: In addition, if you or an eligible family member dies as a result of an automobile accident while wearing a seat belt, an additional benefit of 10% of your coverage amount will be payable, with a minimum of $10,000 and maximum of $25,000.	

The Optional AD&D Insurance Benefit is insured and administered by the life insurance vendor.

Education Benefit

Children

Also, if you select family coverage and die as a result of an accident, each of your eligible children may receive an Education Benefit. To be eligible, your dependent must either be enrolled in a school for higher learning above the 12th grade level on the date of your death or be in the 12th grade and enroll as a full-time student in a school for higher learning within one year after the date of your death. A school for higher learning includes any state university, private college, or trade school.

The Education Benefit is equal to 5% of your insurance amount per year, subject to a maximum of $10,000 for each of your eligible children, for each year that your eligible child continues full-time education, but not to exceed four consecutive years. If you have children but there are no children eligible for the Education Benefit, an additional one-time, lump-sum payment of $1,000 will be paid to your beneficiary.

Spouse

If you die as a result of a covered accident, and your spouse chooses to enroll in an occupational training program for the purpose of obtaining an independent source of income, a benefit will be payable of the lesser of the actual costs incurred or a maximum of $5,000 for tuition reimbursement incurred within 12 months of the date of loss. If this benefit is in effect on the date you die and there is no spouse who could qualify for it, an additional one-time, lump-sum payment of $1,000 will be paid to your beneficiary.

Paralysis Benefits

If you or an eligible family member suffers a loss of use of one or more limbs as a result of a covered accident, a benefit will be payable as shown in the schedule below.

Quadriplegia (total paralysis of all four limbs)	100%
Paraplegia (total paralysis of two limbs)	50%
Hemiplegia (total paralysis of one leg and one arm)	50%

Coma

If you or a covered dependent is involved in an accident that results in a coma within 30 days of the accident that lasts longer than one month and is diagnosed by a competent medical authority to be permanent, complete, and irreversible, you will be entitled to a monthly benefit of 1% of the covered amount each month that the individual remains in a comatose state. There is a seven-day waiting period before coverage begins, and a maximum coverage duration of 60 months.

Brain Damage Benefit

If you or a covered family member sustains brain damage within 30 days of a covered accident and is hospitalized at least five days within the 12 months following the accident, and a licensed physician determines that the brain damage is permanent, complete, and irreversible, a benefit of 100% of the covered amount is payable one year after the accident.

"Brain Damage" is defined as physical damage to the brain that results in the inability to perform all substantial and material functions and activities normal to everyday life.

Exposure and Disappearance Benefit

This benefit covers against losses resulting from unavoidable exposure to the elements. If the body of you or an eligible family member is not found within one year of the disappearance, stranding, sinking, or wrecking of any vehicle in which the covered individual was an occupant, then it shall be presumed that a loss of life has occurred.

Travel Assistance (with Voluntary AD&D Only)

This benefit provides voluntary worldwide travel assistance to you or your covered dependents. Service will be provided to help you with local medical referrals, emergency medical payments, replacement of medication and glasses, emergency messages, emergency travel arrangements, emergency cash, location of lost luggage, legal assistance/bail, and interpretation/translation. You are responsible for payment for the actual services received. There is no charge for the assistance in helping you obtain the service.

Certain services are provided at no cost to you. They include:

- Medical evacuation—When medically necessary, arrangements and payment for emergency medical evacuation are covered.

- Companion travel—If you or a covered dependent becomes hospitalized, arrangements will be made to return dependent children home with escort if necessary; to return a traveling companion home when he or she has forfeited his or her return air fare due to the medical emergency; and to arrange for round-trip airfare for one family member or friend to visit the insured if hospitalized for over 10 days.

- Return of remains—If an insured dies while traveling, arrangements will be made to return the mortal remains home. This includes securing government authorization.

This is provided by Worldwide Assistance Services, Inc., and multilingual professionals are available to assist a covered employee or dependent with necessary arrangements.

Worldwide Assistance is not available in all countries at all times. The employee or covered dependent is responsible to find out whether a country is "open" for assistance prior to departure.

Any questions about this service should be made directly to Worldwide Assistance. The toll-free number is (800) 913-9777. Service is available 24 hours a day, 365 days a year.

Day Care Benefit

In the event that you or your spouse dies in a covered accident, there is a day care benefit to assist you in providing care for your children under the age of 13. The benefit is paid annually for each covered child under the age of 13 who is enrolled in an accredited day care facility.

Enrollment must commence within a year of the accident. The benefit is equal to 5% of your covered amount or $7,500, whichever is less, until the earlier of the child attaining age 13 or a maximum of four day care payments have been made.

Limitations and Exclusions

Basic and Optional AD&D benefits are **not** paid if your or your eligible dependent's death or injury results from any loss caused by:

- Intentionally self-inflicted injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time, active duty as a member of the armed forces of any country or any international authority except National Guard or organized Reserve Corps duty or the first 31 days of military leave;
- Injury sustained while committing or attempting to commit a felony; or
- Injury sustained while driving while intoxicated, as determined under the law of the state where the accident occurred.

Refer to the insurance certificate and coverage summaries for any additional exclusions or limitations that may apply to your coverage. If your claim is wholly or partly denied, you or your beneficiary will be furnished with written notification of the decision.

Naming a Beneficiary

A beneficiary is the person, persons, estate, trust, or charity that will receive benefits if you die. You can designate one person or several individuals to receive benefits. Contact the Goodyear Associate Service Center if you need assistance completing your Basic Life beneficiary designation, or contact the life insurance vendor for GUL coverage beneficiary designation.

If you want benefits to be shared, you need to indicate the percentage (instead of a dollar amount) of the total benefit for each beneficiary. All percentages must be in whole numbers; no fractions are allowed. For example, you can designate 65% of the benefit for one person and 35% for another person, for a total of 100%.

Unless you choose otherwise, multiple beneficiaries will share equally in the benefit. For example, three beneficiaries would be allocated benefits at 34%, 33%, and 33% for a total of 100%. If one or more of your beneficiaries is no longer living when you die, the benefit that would have gone to that beneficiary will be redistributed among your remaining beneficiaries, unless you designate otherwise on your beneficiary designation form.

If you die and do not leave a surviving beneficiary, your benefits generally will be paid in the following order:

- Your surviving spouse or domestic partner, if any.
- Your surviving children equally, if there is no surviving spouse or domestic partner.
- Your surviving parents equally, if there is no surviving spouse or child.
- Your surviving siblings equally, if there is no surviving parent.
- Your estate, if there is no surviving sibling.

Dependent Life Insurance Beneficiary

You are the beneficiary for any Optional Spouse or Child Life Insurance you elect—no beneficiary designation is required.

Claims and Appeals Procedures

Procedures for Presenting Claims for Life and Accidental Death & Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the employer that will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the employer that is usually able to provide the necessary information.

Claim Submission

In submitting claims for life and accidental death and dismemberment benefits (Benefits), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After your claim for Benefits is received, the vendor will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date they receive your claim, unless the vendor notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If the vendor denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the vendor did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by the life insurance vendor. This request for review should be sent in writing to Group Insurance Claims Review at the address of the vendor's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believes the claim was improperly denied and submit in writing any written comments, documents, records, or other information you or, if applicable, your beneficiary deems appropriate. Upon your written request, the vendor will provide you free of charge with copies of relevant documents, records, and other information.

The life insurance vendor will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date if they receive your request for review, unless the vendor notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the vendor denies the claim on appeal, the vendor will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, the vendor will provide you free of charge with copies of documents, records, and other information relevant to your claim.

Your Voluntary Supplemental Insurance Benefits

The following voluntary supplemental benefits are provided by Aflac:

- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance

To be eligible for this coverage, you must be actively at work and legally authorized to work in the U.S. Spouses and dependents must reside in the U.S. to receive coverage. The voluntary group insurance program under which these benefits are provided is intended to be a payroll practice exempt from the Employee Retirement Income Security Act of 1974 (ERISA), in accordance with Labor Regulations Section 2510.3-1(j).

These benefits complement your core Goodyear benefits by providing additional income for your initial out-of-pocket expenses like transportation, child care, deductibles and coinsurance. There are no pre-existing condition limitations on these benefits.

If you are enrolled in the HDHP medical option, supplemental benefits can provide you with benefits that may help pay for treatments or expenses before the health plan benefits begin to pay. Further, you can use these benefits to pay for expenses and save your Health Savings Account for future expenses.

You pay the full cost for these benefits with after-tax contributions.

Critical Illness Insurance

Critical Illness Insurance can help with the treatment costs of covered illnesses, such as cancer, stroke, or heart attack. You can elect a $15,000 or $30,000 lump-sum benefit. You receive cash benefits directly (unless otherwise assigned), giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Critical Illness Benefits

- Benefit for a recurrence of the same critical illness if separated by at least 12 months or an additional occurrence of a different critical illness if separated by at least six months.
- $50 health screening benefit paid once per calendar year (not payable for dependent children).
- Spouse coverage is available for one-half of the employee benefit amount.
- Dependent children coverage is available at 50% of your amount and at no additional cost.

Accident Insurance

After an accident, you may have expenses for which you did not account. Accident Insurance can help you with the expenses that accumulate. The amount of your coverage is dependent on the benefit you elect. More than 50 events will trigger benefit payments, including fractures, dislocations, hospitalization, ambulance transport, and physical therapy.

Accident Insurance Benefits

- Medical fees
- Accidental death
- Hospital admission
- Hospital confinement

Hospital Indemnity Insurance

If you have a hospital stay, costs can rise quickly. Cash benefits from Hospital Indemnity Insurance may offer a measure of financial protection due to a covered illness or accident. The amount of your coverage is dependent on the benefit you elect.

Hospital Indemnity Benefits

- Hospital stays and expenses
- Hospital admission, confinement, and intensive care

How to File a Claim for Voluntary Benefits

To file a claim for Critical Illness, Accident Insurance, or Hospital Indemnity Insurance:

www.aflacgroupinsurance.com	Access Frequently Asked Questions; Download claim forms; Download service request forms for: • Beneficiary change • Name change • Address change • Ownership transfer • A copy of your certificate
(800) 433-3036, Monday – Friday, 8 a.m. to 8 p.m. ET	Check on the status of your claim; Check your plan information; Keep your contact information updated

How to File a Claims Appeal

You need to provide a written appeal request to the address below. Include the reason you are appealing the decision along with any supporting documentation.

Aflac Group
P.O. Box 427
Columbia, SC 29202
Fax: (866) 849-2970

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. This is a brief description of coverage and is not a contract. Read your certificate carefully for exact terms and conditions.

Non-Duplication of Benefits

You or your dependents may have other group health insurance in addition to coverage under this Plan, for example through your spouse's employer. If so, the Plan will coordinate benefit payments with the other plan. This coordination is designed to guard against duplicate or overinsurance.

When benefits are coordinated, benefits will be equal to the amount payable under this Plan minus the amount paid by the other plan. However, the amount payable can never be more than what the Company's Plan would have paid in the absence of any other plan.

In those cases where your dependent is eligible to be covered by another Company-sponsored or other "employer-sponsored" flexible benefits plan, if coverage was available and not elected, unless such election was waived by that plan, health benefits under the Plan will be payable as if such coverage was elected for purposes of coordination of benefits.

Non-duplication does not apply to individual or private insurance plans.

Which Plan Pays First

Under non-duplication rules, the plan that pays benefits first is called the primary plan. The plan that pays next is secondary. If there are more than two plans providing coverage, non-duplication rules help decide the order of any additional payments.

A plan without non-duplication or coordination of benefits rules is always primary—that means it always pays benefits first. If all plans have non-duplication or coordination of benefits rules, benefits are paid according to the following:

- A plan covering a patient as an employee pays before a plan covering that patient as a dependent.
- A plan covering a patient as an active employee pays before a plan covering that patient as a retiree.
- For dependent children, the plan covering the parent whose birth date (month and day only) occurs earlier in the calendar year pays benefits first. For example, let's say the father was born on June 15, and the mother's birth date is March 1. The mother's plan would pay first, because her birthday comes earlier in the year.

  This rule applies only if both plans have primary plan rules based on birth date. If one of the plans does not use the birthday rule, the father's plan pays first.
- If both parents have the same birth date, the plan that has covered the dependent child longest pays first.
- If you are legally separated or divorced, special coordination rules apply to your children. If a court decree says that one parent must pay for a child's health care, the plan of that parent pays first. Otherwise, benefits are paid in the following order:
  - The plan of the parent with custody of the child;
  - The plan of the stepparent who is married to the parent with custody of the child; or
  - The plan of the parent who does not have custody of the child.

Coverage for medical benefits under an active associate's coverage will normally be primary over Medicare and any other federal, state, or government-sponsored hospital, surgical, medical, prescription drug, or vision care program (including Medicaid and Champus).

For associates working beyond age 65, Medicare will become primary upon exit from the Company.

Continuing Coverage

In certain situations, coverage may continue for you and your eligible dependents when you are not at work, as long as you continue to pay any required premiums. Your payments will be made on an after-tax basis through direct billing unless you are receiving your pay while you are on a paid leave from work, in which case your premium payments will continue to be deducted on a before-tax basis to the extent applicable. You will receive information from the Goodyear Associate Service Center describing the options available for paying your share of costs if you are taking an unpaid leave of absence, including military or FMLA leave, or will be absent from work for an extended period of time.

Family and Medical Leave Act of 1993 (FMLA)

Health coverage remains in effect while you are on FMLA leave. The FMLA, as amended, allows eligible employees to take leave for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care.
- You are needed to care for a family member (child, spouse, or parent) with a serious health condition.
- Your own serious health condition makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is a covered member in the U.S. Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the U.S. Armed Forces with a serious injury or illness if you are the spouse, son, daughter, parent, or next of kin of the "covered service member."

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under USERRA, Goodyear will provide you with employer-provided health coverage (medical, dental, and life insurance) for up to 24 months at active employee rates during an approved military leave of absence. You must continue to pay your portion of the premium. This may be paid on an after-tax basis during any uncompensated portion of a leave. Short- and Long-Term Disability coverage and basic and optional AD&D coverage will end after the first 31 days of an employee's most recent military leave. A Health Care FSA can be stopped if such election is made within 31 days of military duty. If no change is made within 31 days, the current spending account deductions will continue until the next benefit enrollment cycle.

Beginning with the 25th month of leave, your health coverage will cease unless you choose COBRA continuation coverage and pay 102% of the premiums for those health care benefits in which you are enrolled. This continuation coverage, if elected, will continue for up to an additional 18 months. Contact the Goodyear Associate Service Center to obtain additional information about your benefits while on military leave.

State Family and Medical Leave Laws

Goodyear must comply with any state law that provides greater family or medical leave benefits than those provided under the federal FMLA. If your leave qualifies under both the federal FMLA and under a state law, you will receive the greater benefit.

Contact the Goodyear Associate Service Center for additional information about leaves of absence.

If You Begin Receiving Long-Term Disability (LTD) Benefits and You Are an Active Employee with the Company

If you are or remain an active employee with the Company and you are receiving LTD benefits, you and your eligible dependents may be eligible to continue coverage under certain employee benefit plans. You will receive additional information from the Goodyear Associate Service Center if you begin receiving 9ltd0 benefits.

Administrative Information

The following information is provided in compliance with the Employee Retirement Income Security Act (ERISA). The following plans are included in this SPD:

Plan Name	Type	Identification Number and Type of Administration
Life Insurance Plan for Salaried Employees	Life Insurance Plan	502 Insured
Benefit Plan for Employees at Designated Locations	Group Health, Dental, Vision, Long-Term Disability, Optional AD&D Insurance, and Health Savings Account benefits	531 Insured and contract
Health Care Spending Account for Salaried Employees	Flexible Spending Account	532 Contract

Plan Sponsor, Plan Administrator and Named Fiduciary

The Goodyear Tire & Rubber Company is the Plan Sponsor, Plan Administrator and named fiduciary for the Medical, Dental, Vision, Health Savings Account, and Health Care Spending Account benefits described in this booklet. The Plan Sponsor's address and other pertinent data are as follows:

The Goodyear Tire & Rubber Company
200 Innovation Way
Akron, OH 44316
Telephone No.: (330) 796-2121

Employer Identification No.:
34-0253240

The Goodyear Tire & Rubber Company is the Plan Sponsor, and the life insurance vendor is the Plan Administrator and named fiduciary for the Basic Life, Group Universal Life and Dependent Life Insurance Plan (Plan 502). The Goodyear Tire & Rubber Company is the Plan Sponsor, and the disability vendor is the Plan Administrator and named fiduciary for the Long-Term Disability and Optional AD&D plans. Please contact the Plan Sponsor for contact information regarding the life insurance vendor and the disability vendor.

Agent for Service of Legal Process

The Secretary of The Goodyear Tire & Rubber Company is the agent for service of legal process at Goodyear's address listed above.

For the Basic Life, Group Universal Life and Dependent Life Insurance Plan, Long-Term

Disability and Optional AD&D, service of legal process can be made upon the life insurance vendor or disability vendor at one of their local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Plan Year

January 1 through December 31.

Insured/Self-Insured Benefits

The Short-Term Disability, Health Care Spending Account, Medical (including prescription drugs), Dental, and Vision benefits are self-insured and are paid from the Company's general assets. The Basic Life, Basic AD&D, GUL and Dependent Life Insurance, Long-Term Disability, and Optional AD&D benefits are insured through the life insurance vendor and the disability vendor, and all benefits are determined and paid by such insurance carriers.

Insurers/Claims Administrators

The Plan Administrator has the full discretionary authority to interpret the plans in accordance with their terms and the provisions of ERISA and to resolve all disputed eligibility claims. In the case of insured benefits, the applicable Insurer has complete discretionary authority to determine eligibility for participation (although state eligibility laws may also apply) and benefit payment under its respective plan.

The Plan Administrator has also delegated administrative duties to claims administrators that determine and pay claims.

The claims administrators for self-insured benefits have:

- The authority to make determinations regarding eligibility and benefit claims under the Short-Term Disability benefit program for eligible employees described in this SPD.

- Discretionary authority to:

  - Interpret the health and welfare plans based on provisions of the governing instruments and applicable law and make factual determinations about claims arising under such plans and programs.

  - Determine whether a claimant is eligible for benefits.

  - Decide the amount, form, and timing of benefits.

  - Resolve any other matter raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the decision of the applicable claims administrator shall be final and binding on all parties to the full extent permitted under applicable law.

Payment of Benefits

Benefits will be payable to the covered participant. The Plan Administrator, in its discretion, may authorize payments to be issued to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The Goodyear Tire & Rubber Company and its affiliates (the "Company") offers its employees a number of benefits, including medical, dental, prescription drugs, vision, Flexible Spending Account, employee assistance programs, and others. This federally mandated Notice applies to active and retired members (and their covered dependents) enrolled in one of the Company's Group Health Plans.

Note that employees who choose to receive benefits through a health maintenance organization (HMO) will receive a Notice of Privacy Practices related to those benefits directly from those insurers.

How the Group Health Plans May Use or Disclose Your Health Information

For Payment

The Group Health Plans may use and disclose your health information to others for purposes of facilitating payment for treatment and services that you receive.

For example, the Group Health Plans may provide information to a provider or a third-party payor, such as an insurance company, regarding amounts that are covered under the Group Health Plans. The information may identify you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations

The Group Health Plans may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to employees of the Group Health Plans, or third parties retained or hired by the Group Health Plans, for quality improvement, business planning, and cost management purposes. This information may identify you, your diagnosis, and treatment or supplies used in the course of treatment.

Plan Sponsor

The Group Health Plans may disclose health information to the Company, the sponsor of the Group Health Plans, for health care operation purposes. At no time will the Group Health Plans disclose information to the sponsor for employment-related actions or decisions.

Required by Law

The Group Health Plans may use and disclose information about you as required by law. For example, the Group Health Plans may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority.
- Report information related to victims of abuse, neglect, or domestic violence.
- Assist law enforcement officials in their law enforcement duties.

Public Health

Your health information may be used or disclosed for public health activities, such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents

Your health information may be disclosed to funeral directors or coroners, if required by law, to enable them to carry out their lawful duties.

Organ/Tissue Donation

If you are a donor, your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Health and Safety

Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions
Your health information may be disclosed for specialized government functions, such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation
Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other Issues
Other uses and disclosures will be made only with your written authorization, and you may revoke the authorization, except to the extent that the Group Health Plans have taken action in reliance on such.

Your Health Information Rights
You have the right, by submitting a request in writing to the office identified below, to:

- Request a restriction on certain uses and disclosures of your health information as provided by 45 C.F.R. §164.522; however, the Group Health Plans are not required to agree to a requested restriction.
- Obtain a paper copy of this Notice upon request.
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524 (you may be charged for the costs of copying, mailing, or other supplies directly associated with your request).
- Request that your health record be amended as provided in 45 C.F.R. §164.526.
- Request communications of your health information by alternative means or at alternative locations.
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Personal Representatives
You may exercise your health information rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health information or allowed to take any action for you.

The Group Health Plans retain discretion to deny access to your health information to a personal representative if the personal rights or safety of an individual might be compromised.

Complaints
You may complain to the Group Health Plans and to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of the Group Health Plans
The Group Health Plans are required to:

- Maintain the privacy of protected health information.
- Provide you with this Notice of their legal duties and privacy practices with respect to your health information.
- Abide by the terms of this Notice.
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.
- Accommodate the reasonable requests that you may make to communicate health information by alternative means or at alternative locations.

The Group Health Plans reserve the right to change the terms of this Notice and to make the new provisions effective for all protected health information they maintain. Revised Notices will be made available to you through the office identified below.

State law may provide for additional protection of your health information.

Contact Information

If you have any questions or complaints, please contact:

Office of Privacy Official
The Goodyear Tire & Rubber Company,
Department 825
200 Innovation Way
Akron, OH 44316-0001
(330) 796-2142

This Notice is also available through the GO page (http://go.goodyear.com/).

No Guarantee of Employment

Nothing contained in this Notice shall be construed as a contract of employment between the Company and any employee, or as a right of any employee to be continued in the employment of the Company, nor as a limitation of the right of the Company to discharge any of its employees, with or without cause.

No Change to Plans

Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Group Health Plans. You should refer to the Group Health Plans documents for complete information regarding any rights or obligations you may have under the Group Health Plans.

No Guarantee of Tax Consequences

The Company is not liable for any taxes or other liability incurred by a participant or any individual claiming benefits through a participant by virtue of participation in the Plan. The Company does not represent or guarantee that amounts paid to or for the benefit of a participant will be excludable from the participant's gross income for federal, state, or local income tax purposes. It is the obligation of the participant to determine whether a payment is excludable from the participant's gross income for federal, state, or local income tax purposes and to notify the Plan Administrator if the participant has any reason to believe that any such payment is not so excludable.

Non-Alienation of Benefits

Except as explicitly permitted under the terms of the plans or programs, no benefit payable under the plans or programs described in the SPD may be subject in any manner to anticipation, sale, transfer, assignment, pledge, encumbrance, security interest, or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or grant a security interest in the same is void and of no effect; nor may any such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such benefit.

Expenses

To the extent permitted by applicable law, all expenses incurred in connection with the administration of the Plan will be paid by the Plan except to the extent that the Company elects to pay such expenses.

Fraud

No payments will be made if you or your provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator or, for fully insured benefits, the Insurer, will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of facts has been made. The Plan or Insurer will have the right to recover any amounts, with interest, improperly paid by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

The Company shall indemnify each associate who acts in the capacity of an agent, delegate, or representative of the Plan (Plan Administration Associate) from and against any and all losses, liabilities, costs, and expenses, including attorneys' fees, incurred by the Plan Administration Associate in connection with or arising out of any pending, threatened, or anticipated action, suit, or other proceeding in which the Plan Administration Associate is involved by having been a Plan Administration Associate, other than such losses, liabilities, costs, and expenses, including attorneys' fees, as may result from the gross negligence or willful misconduct of such Plan Administration Associate.

Refund of Premium Contributions

For fully insured benefit programs, the Plan will comply with Department of Labor (DOL) guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a Plan asset to the extent amounts are attributable to participant contributions, such assets will be: (1) distributed to current Plan participants within 90 days of receipt, (2) used to reduce participants' portion of future premiums under the Plan (e.g., premium holiday); or (3) used to enhance future benefits under the Plan. The determination of which option, or combination of options, shall apply will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Nondiscrimination

In accordance with Code Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416(i)(1)) or Highly Compensated Individuals as to eligibility to participate or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. If, in the operation of the Plan, more than the legally permitted nontaxable benefits are found to be provided to Key Employees, or the Plan discriminates in any other manner, then notwithstanding any other provision contained herein, the Plan Administrator may reduce or adjust such contributions and/or benefits under the Plan as shall be necessary to ensure that the Plan will not discriminate. All rules, procedures, and decisions of the Plan Administrator shall be adopted, made, and applied in such fashion to not discriminate in favor of Highly Compensated Individuals, Highly Compensated Participants, or Key Employees.

The Company shall have no liability with respect to the income tax consequences that may be experienced by Highly Compensated Participants, Highly Compensated Individuals, or with respect to amounts re-characterized by reason of discrimination testing under the Plan.

Type of Administration

The Plan is administered by Goodyear through arrangements with the insurers and/or third-party claims administrators.

Plan Funding

Goodyear and associates both contribute to the Plan. Funding for this Plan consists of an aggregation of the funding from associates and the Company for all benefits. For some plans, benefits are paid solely by the Company; others are paid by a combination of Company and employee contributions.

For fully insured benefits, Goodyear pays the Insurer a premium from Company general assets for providing coverage under the insured options. Benefits are offered under the applicable insurance contracts. The Insurer or its delegate processes claims and makes all benefit determinations.

Any benefit funded by the purchase of insurance will be payable solely by the Insurer, and the Company shall not have any further responsibility to pay such benefit.

For self-insured benefits, Goodyear pays a fee to the claims administrators to process claims for the self-insured benefit programs, and the claims are paid from the Company's general assets.

The Company has the right at any time to amend the funding arrangements for the Plan and to change insurers, claims administrators, or third-party administrators.

Reservation of Right to Amend or Terminate Benefit Plans

Goodyear reserves the right to amend or terminate any of the plans and programs described in the SPD at any time.

Severability

If any provision of the Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the Plan shall be construed and enforced as if such provision had not been included, and the remaining provisions shall continue to be fully effective.

Corporate Actions

As a matter of prudent business planning, the Company continually reviews and evaluates various proposals for changes in its benefit programs. Because of the need for confidentiality, such proposals are not evaluated below high levels of management. Employees below such levels do not know whether future changes will be made and/or new benefit programs adopted. Unless and until the Company formally announces such changes, no one is authorized to give assurances that such changes will or will not occur.

COBRA Continuation Coverage

This section applies to health care benefits.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the Company offer you and/or your dependents the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end ("qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

Affordable Care Act Note: You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For additional information about your rights and obligations under this Plan and under federal law, contact the Goodyear Associate Service Center at (844) 449-4772.

What COBRA Continuation Coverage Is

COBRA coverage is a temporary continuation of health plan (e.g., medical, dental, vision, EAP, or Health Care FSA) coverage when it otherwise would end because of a life event, known as a "COBRA qualifying event." (Specific qualifying events are listed later in this section.)

After a qualifying event, COBRA continuation coverage must be offered to each "Qualified Beneficiary." You, your spouse, and your children could become Qualified Beneficiaries if you are covered under a health plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified Beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Qualified Beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

Qualified Beneficiaries

- **Employee.** You become a Qualified Beneficiary if you lose your coverage under the health plans because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than your gross misconduct.
- **Your Spouse.** Your spouse becomes a Qualified Beneficiary if he or she loses coverage under the health plans because of one of the following qualifying events:
  - You die.
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You become divorced or legally separated from your spouse.
- **Your Dependent Children.** Children become Qualified Beneficiaries if they lose coverage under the health plans because of one of the following qualifying events:
  - You die.
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You become divorced or legally separated.
  - Your child loses eligibility for coverage.

Note that while domestic partners are not Qualified Beneficiaries for purposes of COBRA continuation, a child of a domestic partner is a Qualified Beneficiary if he or she is your tax dependent.

Although domestic partners do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover such individuals even if they are not considered Qualified Beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA coverage terminates. Under "How Long COBRA Coverage Lasts With Respect to Medical, Dental, Vision, and EAP Benefits" below, please note that the two bullets regarding "Disability extension of 18-month period of continuation coverage" and "Second qualifying event extension of 18-month period of continuation coverage" are not applicable to these individuals.

When COBRA Coverage Is Available

The health plans offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred (contact the Goodyear Associate Service Center at (844) 449-4772).

Notification of Qualifying Events

When the qualifying event is the end of employment, reduction in hours of employment, or death of the employee, the employer must notify the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation of the employee and spouse or a child losing eligibility for coverage) or the occurrence of a second qualifying event, you or the Qualified Beneficiary must notify the Company within 60 days after the later of the date the qualifying event occurs or the day you lose coverage on account of the qualifying event by contacting the Goodyear Associate Service Center. If you or the Qualified Beneficiary fails to notify the Company within 60 days after the qualifying event, then your Qualified Beneficiary will not be entitled to elect COBRA continuation coverage.

How COBRA Coverage Is Offered

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each Qualified Beneficiary.

Information is sent to the COBRA claims administrator via the Goodyear Associate Service Center. The claims administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event. You may also elect to receive notices electronically via the Goodyear Associate Service Center portal. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage.

Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that you (or anyone who may become a Qualified Beneficiary) maintain a current address on file to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your Qualified Beneficiaries have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect continued participation under COBRA. If you or your Qualified Beneficiary fails to elect COBRA coverage within the applicable time frame, then such individual will lose the opportunity to continue coverage under COBRA.

How Long COBRA Coverage Lasts with Respect to Medical, Dental, Vision, and EAP Benefits

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce.
- A child losing eligibility.

COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of employment or reduction of your hours of employment. This 18-month period of COBRA continuation coverage can be extended in two ways:

- **Disability extension of 18-month period of continuation coverage.** If a Qualified Beneficiary covered under the health plans is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and all other Qualified Beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:
  - Your COBRA qualifying event was a termination of employment or reduction in hours.
  - The disability started at some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage.
  - A copy of the Notice of Award from the Social Security Administration is provided to the Goodyear Associate Service Center within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.
  - An increased premium of 150% of the monthly cost of coverage is paid, beginning with the 19th month of coverage.
- **Second qualifying event extension of 18-month period of continuation coverage.** If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the health plan (as described under "Notification of Qualifying Events" above).

This extension may be available to your spouse and any children receiving continuation coverage if you die, get divorced, or if your child is no longer eligible, but only if the event would have caused your spouse or child to lose coverage under the health plans had the first qualifying event not occurred.

COBRA Qualifying Events

Qualifying Event	Maximum continuation period (months) for:		
	You	Spouse	Covered Child
You lose coverage because of reduced work hours or taking unpaid leave, other than leave under the FMLA	18	18	18
You terminate employment for any reason (other than gross misconduct)	18	18	18
You or your spouse/child is disabled—as defined by the Social Security Act—at the time of the qualifying event or during the first 60 days of COBRA continuation coverage	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)	29 (initial 18 months, plus additional 11 months)
Your covered child is no longer eligible	N/A	N/A	36
You die	N/A	36	36
You and your spouse divorce or legally separate	N/A	36	36

Medicare Extension for Your Dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Qualified Beneficiaries will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

How Long COBRA Coverage Lasts with Respect to the Health Care FSA

You and your Qualified Beneficiaries may be eligible to continue participation in the Health Care FSA for the remainder of the calendar year in which participation otherwise would end due to a COBRA qualifying event. You will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA coverage will be available to you only if you have a positive Health Care FSA balance at the time you become eligible for COBRA (taking into account all claims submitted by you before the date of the qualifying event). However, you will no longer have access to your HealthEquity card. Coverage will cease at the end of the calendar year and will not be continued for the next year. The contributions you make under COBRA for the Health Care FSA will be made on an after-tax basis.

Any Health Care FSA amounts carried over from a prior Plan year will also be available under COBRA, but the availability of any carried over amounts will end as of the calendar year.

What COBRA Coverage Costs

COBRA enrollees must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

If you or a Qualified Beneficiary elects COBRA continuation coverage:

- You or your Qualified Beneficiary can keep the same level of coverage you had as an active employee or choose a lower level of coverage.
- Your or your Qualified Beneficiary's coverage is effective as of the date of the qualifying event. However, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your Qualified Beneficiary may change your coverage:
  - During your Annual Enrollment period.
  - If you have a qualified status change.
- You may enroll any newly eligible spouse or child under Plan rules.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your Qualified Beneficiaries become covered under another health plan.
- You or your covered Qualified Beneficiaries fail to make contributions by the due date as required.
- Goodyear stops providing health benefits to any associate.
- You or your Qualified Beneficiaries become entitled to Medicare after electing COBRA.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Trade Act

The Trade Act of 2002 created the Health Coverage Tax Credit (HCTC) for certain individuals who become eligible for trade adjustment assistance (TAA). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of premiums paid for qualified health coverage, including COBRA continuation coverage. The HCTC expired at the end of 2013; however, the Trade Preferences Extension Act of 2015 extended and modified the HCTC through 2019, and also made the HCTC retroactive to 2014. For more information about the HCTC, visit the IRS website at www.irs.gov.

If You Have Questions

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website.

Your Responsibilities under the Law

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the date of the event. In addition, the employee or a family member must inform the Plan Administrator of a determination by the Social Security Administration that the employee or covered family member was disabled during the 60-day period after the employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform the Plan Administrator of this re-determination within 30 days of the date it is made. You inform the Plan Administrator by sending such notice to:

The Goodyear Associate Service Center
P.O. Box 64069
The Woodlands, TX 77387-4069

Employer's Responsibilities under the Law

The Company as Employer and Plan Administrator must notify you and your dependents within 44 days of a loss of coverage because of a death, termination of employment, reduction in hours, or a bankruptcy that you have the right to choose continuation coverage. Under the law, you have a maximum of 60 days from the later of qualifying event (which is the date of the event which causes loss of coverage) or the notice of your COBRA rights to inform the Plan Administrator that you want continuation of coverage.

Choosing Continuation Coverage

If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end. If you choose continuation coverage, the Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. ("Similarly situated" refers to current employees or their dependents who would have the same choice of options as you but who have not had a qualifying event.)

Veterans Reemployment

The Company will also comply with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. This law enables employees who take leaves of absence to serve in the armed forces to continue their medical, dental, and vision coverage for up to 24 months in a manner similar to but in lieu of COBRA.

Your Rights under ERISA

As a participant in one of Goodyear's ERISA-covered plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants are entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make 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 this summary annual report.

Continue Group Health Coverage

- Continue health care coverage for yourself, your spouse, and/or your other eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 31 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 Plan Administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

Health Insurance Portability and Accountability Act (HIPAA)

Under HIPAA, a certificate of group health plan coverage is provided for evidence of your prior health coverage with the Company. You may need to furnish this certificate if you become eligible for another group health plan that excludes coverage for certain medical conditions that you have before you enrolled (pre-existing conditions). This certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the six-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the Plan Administrator to see if you need to provide this certificate. You may also need this certificate to purchase, for yourself or your dependents, a personal health insurance policy that does not exclude coverage for pre-existing conditions.

HIPAA Privacy Regulations

Title II of HIPAA and the regulations in 45 C.F.R. §160 through 164 contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. An explanation of those rights as they pertain to your health insurance benefits will be provided by the Insurer or claims administrator, according to its policies described for each coverage. A separate "Notice of Privacy Provisions" contains additional information about how your individually identifiable health information is protected and whom you should contact with questions or concerns, and is incorporated into this SPD by reference.

PHI is information created or received by HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. The information typically identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

To the extent it receives PHI, the Plan Administrator will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA regulations and any other applicable federal, state, or local law. If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer or claims administrator involved with the PHI in question. The Insurer or claims administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company with respect to such information. The Company or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA regulations.

In accordance with the Health Breach Notification Rule (16 C.F.R. §18), the Plan agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor becomes aware.

Required Notices

Your Maternity Rights (Newborns' and Mothers' Health Protection Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights Following a Mastectomy (Women's Health and Cancer Rights Act of 1998)

Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered eligible dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles and coinsurance provisions as all other medically necessary procedures under your medical option are.

Important Notice: Genetic Information Nondiscrimination Act of 2008

Under the Genetic Information Nondiscrimination Act of 2008 (GINA), the Plan may not collect genetic information (including family medical history) prior to or in connection with your enrollment in any health care benefits. In addition, the Plan may not collect or use genetic information for "underwriting purposes," which include the determination of eligibility for benefits under the Plan, the computation of premium or contribution amounts, and the creation, renewal, or replacement of a contract of health insurance or health benefits. GINA also generally prohibits group health plans from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request (but not require) that a participant or beneficiary undergo a genetic test.

Right of Recovery and Subrogation

If you receive health care benefits from the Plan, and you also recover money (by settlement or otherwise) from a third party (including any insurance company) for an injury or illness relating to those same health care expenses, the Plan has the right to reimbursement of amounts paid as benefits. For example, this could occur if you have a car accident and receive medical benefits from the Plan and a settlement from the insurance company. In addition, the Plan can pursue and join in all rights and claims that you may have against that third party to recover the expenses it paid. This does not apply to any individual policies issued to you or a dependent, unless such coverage is primary under the Plan's non-duplication of benefits rules.

The Plan's subrogation and reimbursement rights:

- Extend to any money you receive because of the injury or illness from any person, corporation or other source, and

- Entitle the Plan to recover all expenses it paid because of the injury or illness, even if the total amount you receive from other sources does not fully compensate you for the damage you suffered as a result of the injury or illness (i.e., you are not made whole by the recovery). Under these circumstances, the Plan shall agree to a reasonable fair sharing of all recoveries.

If you recover any money, directly or indirectly, the Plan has first priority for repayment of the full amount of the benefits it provided to you even if you are not made whole, and the Plan will pay a portion of the reasonable legal fees and expenses incurred by you and/or your dependent in obtaining such recovery from the third party. If money is recovered from more than one party, the same rule shall apply to the amount recovered from each party.

When you accept benefits under the Plan, you agree that you will do nothing to interfere or compromise the Plan's subrogation or reimbursement rights.

The Plan reserves the right to examine the facts of each case to determine a reasonable fair sharing of all recoveries from all parties involved.

You must:

- Provide the Plan with written notice in advance of any action that you or your representatives are considering that might adversely affect the Plan's rights, such as a settlement with any third party; and

- Until the Plan is fully reimbursed, obtain the Plan's consent before you reach a settlement of any claim or action against a third party that you claim to be legally responsible to you based upon your injury or illness.

The Plan is not obligated to provide you any representation, legal or otherwise, in your attempts to recover from a third party.

In addition, if the Plan determines that benefits have been paid in error or obtained fraudulently, the Plan has the right to recover such amounts from the participant.

Note that some state laws govern subrogation in different ways. The Plan is covered by federal law; state laws on subrogation do not apply.

Right to Recover Overpayment

In the event of any overpayment of benefits, the Plan will have the right to recover the overpayment from you or from a provider, in the discretion of the Plan Administrator. If you receive a benefit greater than allowed, in accordance with the provisions of the Plan, you (or the provider) will be requested to refund the overpayment. If the refund is not received, the amount of overpayment will be deducted from future benefits or from your paychecks.

Contact Information

Contacts	Mailing Address	Web Link/Email Address	Phone Contact
Goodyear Associate Service Center	Customer Service P.O. Box 64069 The Woodlands, TX 77387-4069	selfservice.goodyear.com	(844) 449-4772 Fax: (847) 554-1980
Medical Plan – Anthem Member Services	Anthem Blue Cross/Blue Shield P.O. Box 105187 Atlanta, GA 30348	www.anthem.com	(800) 792-7484
Anthem – Claims	Anthem Blue Cross/Blue Shield P.O. Box 105187 Atlanta, GA 30348 Provider claims are filed to the local BCBS plan	www.anthem.com	(800) 792-7484
Anthem 24-Hour Nurse Line	N/A	N/A	(888) 596-9473
Medical Plan – UnitedHealthcare Customer Service	UnitedHealthcare P O Box 740800 Atlanta, GA 30374-0800	www.myuhc.com	(866) 633-2474
UnitedHealthcare – Claims	UnitedHealthcare P O Box 740800 Atlanta, GA 30374-0800	www.myuhc.com	(866) 633-2474
UnitedHealthcare 24-Hour Nurse Line	N/A	N/A	(888) 887-4114
Medical Plan – SummaCare Customer Service		www.summacare.com	(800) 996-8701
SummaCare – Claims		www.summacare.com	(800) 996-8701
SummaCare 24-Hour Nurse Line	N/A	N/A	(800) 379-5001
OptumRx Prescription Drug Program	OptumRx P.O. Box 509075 San Diego, CA 92150-9075	www.optumrx.com	(844) 265-1710
Health Savings Account Member Services Center	HealthEquity 15 W. Scenic Pointe Dr., Ste 100 Draper, UT 84020	www.healthequity.com memberservices@healthequity.com	(844) 310-0502
Delta Dental Finding a Dentist Customer Service	Delta Dental P.O. Box 30416 Lansing, MI 48909-7916	www.deltadentaloh.com	(800) 524-0149

Contacts	Mailing Address	Web Link/Email Address	Phone Contact
Delta Dental Fraud Hotline	Focused Review Delta Dental P.O. Box 30416 Lansing, MI 48909	www.deltadentaloh.com	(800) 524-0147
Delta Dental Predetermination & Claims	Delta Dental P.O. Box 9085 Farmington Hills MI 48333-9085	www.toolkitsonline.com/dotWeb/appmanager/dot/desktop	(800) 524-0149
EyeMed – Customer Service Unit	EyeMed Attn: Customer Service 4000 Luxottica Place Mason, OH 45040	www.eyemed.com	(866) 723-0596
EyeMed – Claims	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111	oonclaims@eyemedvisioncare.com	(866) 723-0596
Health Care Flexible Spending Account – Claims	The Goodyear Associate Service Center P.O. Box 64069 The Woodlands, TX 77387-4069	selfservice.goodyear.com	(844) 449-4772
Basic Life Insurance and Group Universal Life Insurance	MetLife P.O. Box 14402 Lexington, KY 40512-9890	www.metlife.com/mybenefits	(888) 343-6897
Optional AD&D Customer Service Center	MetLife P.O. Box 14402 Lexington, KY 40512-9890	www.metlife.com/mybenefits	(877) 275-6387
Long-Term Disability	The Goodyear Associate Service Center P.O. Box 64069 The Woodlands, TX 77387-4069	selfservice.goodyear.com	(844) 449-4772
Achieve Solutions Employee Assistance Program	Beacon Health Options c/o Achieve Solutions 3800 Paramount Parkway Suite 300 Morrisville, NC 27560	www.achievesolutions.net/goodyear	(877) 606-1129
Critical Illness, Accident Insurance, and Hospital Indemnity Insurance – Claims	Aflac Group P.O. Box 427 Columbia, SC 29202	www.aflacgroupinsurance.com	(800) 433-3036 Fax: (866) 849-2970
Social Security Administration Office	Social Security Administration Office of Public Inquiries 1100 West High Rise 6401 Security Blvd. Baltimore, MD 21235	www.ssa.gov	(800) 772-1213

Contacts	Mailing Address	Web Link/Email Address	Phone Contact
Travel Worldwide Assistance	International SOS 3600 Horizon Blvd. Suite 300 Trevose, PA 19053	https://www.internationalsos.com/MasterPortal/default.aspx?membnum=11BCMA000144	(215) 942-8226