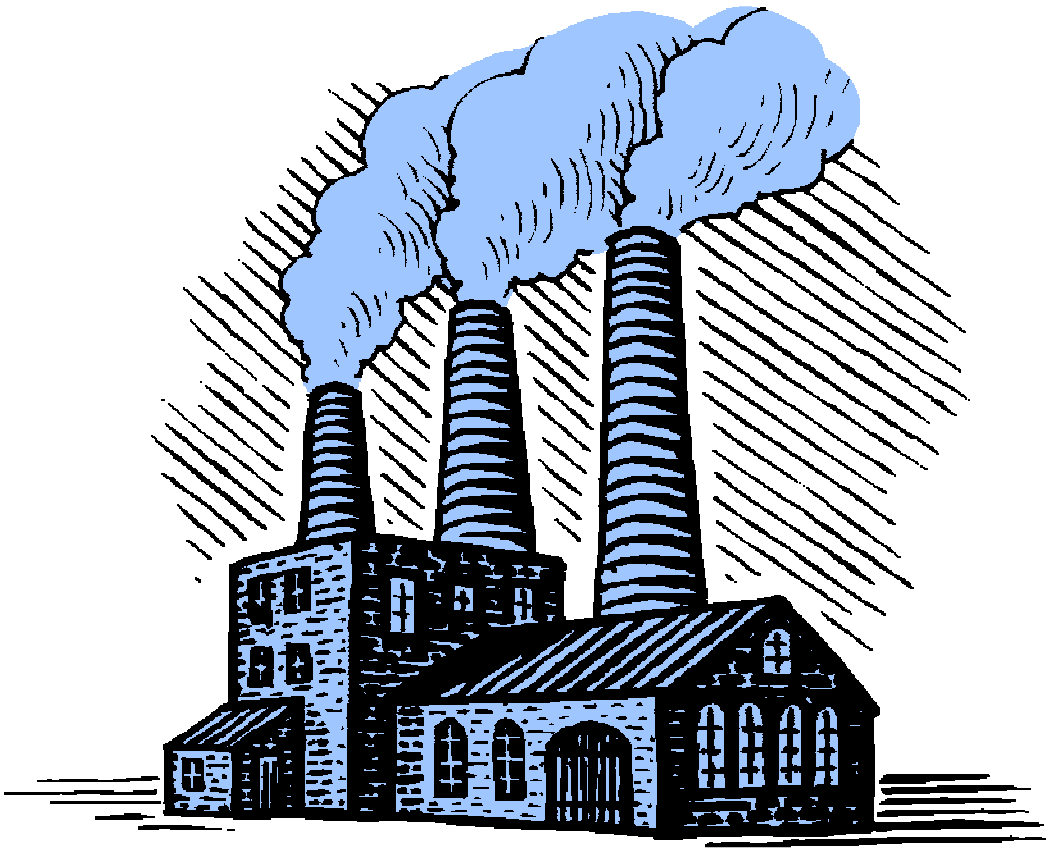
GOODYEAR RETIREE VEBA

HEALTH CARE PLAN



SUMMARY PLAN DESCRIPTION
Post 1991 Retirees
Enrolled in the Catastrophic Plan

Effective January 1, 2010

Goodyear Retiree VEBA

Health Care Plan

Summary Plan Description
Post May 1, 1991 Retirees
Enrolled in the Catastrophic Plan

Effective January 1, 2010

Goodyear Retiree VEBA
60 Boulevard of the Allies
Fifth Floor
Pittsburgh, PA 15222
Phone: (866) 694-6477
Fax: (412) 224-4465
Email: gyveba@cdsadmin.com

To All Goodyear Retiree VEBA Participants:

The Retirees of The Goodyear Tire & Rubber Company Health Care Trust (the "Goodyear Retiree VEBA") is pleased to furnish you with this Summary Plan Description describing the benefits available to Goodyear Retiree VEBA Participants under The Retirees of The Goodyear Tire & Rubber Company Health Care Plan ("Plan"). This Summary Plan Description contains information that you and your family need to know about the Plan and how best to take advantage of it, including:

- A Description of the Plan
- Eligibility Requirements
- Enrollment Requirements
- Coverage
- Goodyear Retiree VEBA Administration
- Your Rights under ERISA

This Summary Plan Description contains provisions that apply to all Goodyear Retire VEBA participants regardless of which provider serves them.

The Plan offers medical, prescription drug and dental care benefits, as well as certain additional benefits. The specific level of benefits and required monthly contribution rates applicable to you depend upon your (or your former spouse's) date of retirement and whether you are eligible for Medicare.

Included with this Summary Plan Description are sections which describe the specific benefits for which you are enrolled based upon your participant status and the plan option which you have elected.

If you have any questions regarding the administration of the Goodyear Retiree VEBA or the Plan, eligibility requirements, enrollment, or the amount of your contribution toward your coverage, you may contact the Goodyear Retiree VEBA Office at the address and telephone number shown on the front page of this booklet.

Sincerely,

The Retirees of The Goodyear Tire & Rubber Company
Health Care Trust Committee

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VEBA INTRODUCTION

The Retirees of The Goodyear Tire & Rubber Company Health Care Trust Committee (the "VEBA Committee") as Plan Sponsor has established a program of health benefits in accordance with a Settlement Agreement dated October 29, 2007. The Settlement Agreement settled a lawsuit, titled *Redington, et. al. v. The Goodyear Tire & Rubber Company*, in the United States District Court for the Northern District of Ohio. The court approved the Settlement Agreement on August 22, 2008. (The Settlement Agreement, its exhibits, and related documents are collectively referred to in the rest of this document as the "Settlement Agreement.") The Settlement Agreement provides for the establishment of The Retirees of The Goodyear Tire & Rubber Company Health Care Trust (The "Goodyear Retiree VEBA") and the VEBA Committee. The VEBA Committee is the Plan Sponsor and named fiduciary of The Goodyear Tire & Rubber Company Health Care Plan (the "Plan").

The VEBA Committee consists of nine members who were appointed pursuant to the Settlement Agreement. In accordance with the Settlement Agreement, the VEBA Committee has established the Plan. The Plan provides health care benefits to certain eligible retirees (and their eligible spouses and dependents) of The Goodyear Tire & Rubber Company, ("Goodyear"), and Goodyear Dunlop Tires North America, Ltd. and the former Dunlop Tire Corporation ("GDTNA").

The benefits available under the Plan are summarized in this booklet. This document constitutes the Summary Plan Description required by the federal law known as the Employee Retirement Income Security Act of 1974 ("ERISA").

As a self-funded plan, the Goodyear Retiree VEBA, rather than an insurance company pays the actual cost of medical benefits that are not otherwise paid by covered Participants. The initial claims decision and the first and second appeal of that decision are the responsibility of your benefits provider unless specifically indicated otherwise. The VEBA Committee has established a Claims and Appeals Subcommittee which has responsibility for the third and final appeal of claims decisions. The VEBA Committee has the final authority to exercise discretion in a nondiscriminatory manner to make any final decisions as to the validity or eligibility of appeals and the benefits payable as a result thereof.

Whenever used in this document, the term "Plan" shall refer to The Retirees of The Goodyear Tire & Rubber Company Health Care Plan as established by the Goodyear Retiree VEBA Committee.

Masculine pronouns as utilized throughout this document shall be considered synonymous with the female pronoun at all times unless the context indicates otherwise.

In the event of a conflict between this Summary Plan Description and a plan booklet or administrative service contract, the plan booklet or administrative service contract will control.

GENERAL INFORMATION

The following important information is provided to help you understand your legal rights under the benefit plans provided by The Retirees of The Goodyear Tire & Rubber Company Health Care Plan ("Plan"). The Plan has specific conditions that you must meet to be eligible to receive benefits under any of the benefit plans provided by the Plan. Please see the "Eligibility" section below.

Circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are described in the "When Coverage Ends" section below. You also may lose benefits if the Goodyear Retiree VEBA ceases to provide benefits.

Subject to any limitations contained in the Settlement Agreement, the Plan provided by the Goodyear Retiree VEBA can be amended, discontinued, or terminated at any time without prior notice to you. Any such change in coverage may take effect immediately for you and your dependents and could include a reduction or termination of benefits you would otherwise receive.

Questions About Health Benefits

There are three basic types of health benefits provided by the Plan: hospital and medical benefits, prescription drug benefits and limited dental care benefits. Hospital and medical benefits are, at present, provided by Highmark Blue Cross and Blue Shield ("Highmark"). Prescription drug benefits are at present provided by Express Scripts. Limited dental care benefits are at present provided by Delta Dental.

If you have a question about benefits such as deductibles, co-payments, whether a particular service or treatment is covered and to what extent, or whether prior approval is required, you should first consult the applicable benefit section included in this Summary Plan Description.

If you still need assistance, you should contact the benefit provider using the phone number provided in the benefit booklet, on the back of your identification card, its website, or other materials you have received.

If you need direction as to whom you should call to get help with your benefits you may call the Goodyear Retiree VEBA Office at (866) 694-6477.

If you have questions about eligibility for health benefits in general, such as whether your dependent is eligible for coverage or what is your monthly contribution, you should contact the Goodyear Retiree VEBA Office at (866) 694-6477.

Plan Sponsor: Retirees of The Goodyear Tire & Rubber Company Health Care Trust Committee

Plan Name: Retirees of The Goodyear Tire & Rubber Company Health Care Plan

Address and Telephone Number of the Plan:

Goodyear Retiree VEBA
60 Boulevard of the Allies, Fifth Floor
Pittsburgh, PA 15222
(866) 694-6477

Plan Number: 501

Employer Identification Number (EIN): 26-6330284

Plan Effective Date: August 22, 2008 and amended effective January 1, 2010

Plan Renewal Date: January 1

Named Fiduciary and Plan Administrator: The Retirees of The Goodyear Tire & Rubber Company Health Care Trust Committee ("VEBA Committee") is the named fiduciary of the Plan and the Plan Administrator. The Plan Administrator has the discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefit determination; and such interpretations and determinations are final and binding.

Agent for Service of Legal Process: Thomas F. Duzak, Chair of the VEBA Committee, is the agent for service of process at the address for the Plan listed above.

Type of Plan: A Health and Welfare Benefit Plan

Type of Administration of the Plan: The Plan is managed on behalf of the Plan Administrator by cds administrators, inc., with claims being processed by various benefit providers in accordance with the provisions of the Plan. Eligibility for benefits is determined by the Plan Administrator based on information provided to the Goodyear Retiree VEBA from Participants and Goodyear.

Funding and Source of Contributions for the Plan: The Plan is a self-funded plan and is not an insured plan. The Goodyear Retiree VEBA pays for the Plan benefits from its assets in amounts necessary to pay for such benefits. The initial funding of the Goodyear Retiree VEBA included a payment made by Goodyear pursuant to the Settlement Agreement. Additional contributions are being made by Goodyear on behalf of active employees covered under certain collective bargaining agreements between Goodyear and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union,

AFL-CIO, CLC ("USW"). These additional payments to the Goodyear Retiree VEBA may or may not continue to be paid, depending on the outcome of collective bargaining between Goodyear and USW.

Plan Year: The Plan Year is the twelve month period ending on December 31.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration [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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Healthcare coverage can continue health care coverage for yourself, spouse or 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.

A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GOODYEAR VEBA PLAN

Enrolling in the Plan

Plan Options

The Plan offers two general types of hospital and medical coverage:

- National PPO Option
- National Catastrophic PPO Option

Certain rules govern your eligibility for each option:

- The National PPO Option is available to all retirees, but retirees who have fewer than 95 points will be required to pay a higher monthly premium (refer to ***"Cost of Plan"*** below for an explanation of "points).
- The National Catastrophic PPO Option is available only to retirees who have fewer than 95 points.

With regard to available benefits the following rules apply:

- The National PPO Option includes greater medical and prescription drug coverage (see description in this SPD) and limited dental expense coverage.
- The National Catastrophic PPO Option includes lesser medical and prescription drug coverage and limited dental expense coverage.

If you enroll in the Plan, you will be asked to fill out an enrollment form with information about yourself and your eligible dependents. You also will be asked to choose which type of coverage you desire. Whatever coverage you choose for yourself will control the type of coverage your dependents receive. After you become enrolled in the Plan, you will be responsible for informing the Goodyear Retiree VEBA of any changes in your personal situation that may affect your Plan coverage. **You must report to the Goodyear Retiree VEBA within thirty-one (31) days any changes in: your employee status; your marital status; the number of dependents or the eligibility status of dependents; your spouse's employer or health coverage; or your residence.**

Option to Decline Coverage/Special Enrollment Period

When you first become eligible to participate in the Plan, you may instead elect to decline coverage for yourself or your dependents.

If you decline coverage, you may not enroll in the Plan until the next open enrollment period, with coverage becoming effective on January 1st of the next calendar year.

However, if you are declining enrollment solely because you have other group healthcare coverage, in the future you may be able to enroll yourself or your dependents in the Plan prior to January 1, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement

for adoption, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after such event.

Also note that if you are eligible for Medicare, you will not be eligible for the Special Medicare Part B Reimbursement Benefit for any period for which you are not enrolled in this Plan.

No Pre-existing Condition Limitation

The Plan has no pre-existing condition limitation.

Cost of the Plan

You may be required to make contributions to participate in the Plan. The VEBA Committee will determine the amount of any required contributions and may change these amounts at any time. You will be notified if any contributions are due in order to participate in each benefit program provided under the Plan. If you do not pay the required contributions, you may not participate in such program.

Initially, the cost of the Plan to you is determined by your age and service credits (or "points") which are computed by Goodyear and reported to the VEBA Committee along with your pension eligibility status. If you have questions about your age and service credits, you should contact Goodyear. As noted above, the VEBA Committee in its sole discretion may change the contribution amount which you are required to make.

The following is a summary of how age and service points are used to determine your contribution rate:

> While employed by Goodyear or its related companies, an employee earns one point for each year of attained age and one point for each year of attained continuous service. Total points are derived by adding together the attained age and attained continuous service points at the time of retirement.
>
> An Employee who retires with thirty (30) or more years of continuous service at any age will receive 95 points at retirement.
>
> An Employee who retires with a disability pension with ten (10) or more years of continuous service will receive an additional 30 points at retirement.
>
> An Employee who does not preferentially hire and subsequently retires as a result of a plant closure will receive an additional 25 points at retirement.
>
> An Employee will receive an additional 15 points, which will be added to the Employee's point total at the time of retirement, if on January 1, 1996, the Employee was:
>
> (i) age 50 or older and had 10 or more years but less than 30 years of continuous service; or
>
> (ii) any age and had 20 or more years but less than 30 years of continuous service.

The amount that the Goodyear Retiree VEBA contributes toward the total cost of coverage will be reduced by 2% for every point less than 95. Retirees will be required to pay the balance of the total plan cost as estimated by the VEBA annually in advance.

In order to receive benefits, Retirees who have fewer than 95 points at the time of retirement will therefore be required to contribute an additional amount beyond the contribution that they would pay if they had 95 points. Also, as stated earlier in this booklet, failure to pay the required monthly contribution will result in cancellation of coverage.

As an alternative to the National PPO option an Employee who has fewer than 95 points at the time of retirement may elect the National Catastrophic PPO Option.

Who is Eligible for Coverage

Eligibility for coverage is determined by the VEBA Committee. The rules for coverage are set forth below. If after reading these rules, you still have questions regarding whether or not you are eligible to receive benefits coverage, you should call the Goodyear Retiree VEBA Office at (866) 694-6477.

Retiree and Surviving Spouse Eligibility

Eligibility to receive benefits was initially established by the Settlement Agreement. It provides that certain "Current Retirees," "Eligible Retirees," and "Surviving Spouses" are entitled to benefits from the Goodyear Retiree VEBA. This means the following individuals are eligible for benefits from the Goodyear Retiree VEBA:

1. Current Retirees are all individuals who separated from service with Goodyear, or Goodyear Dunlop Tires North America, Ltd. and the former Dunlop Tire Corporation ("GDTNA") on or before January 1, 2007, and who as of such date were eligible for coverage under The Goodyear Tire & Rubber Company Medical Benefits Program for Retirees and Their Dependents, as set forth in Exhibit E of the Pension & Insurance Agreements between Goodyear or GDTNA and the USW as in effect on January 1, 2007 ("Original Plan"), and incorporating the requirements for commencing a monthly pension benefit under the 1950 Pension Plan of The Goodyear Tire & Rubber Company, the GDTNA Huntsville 1970 Pension Plan, or the GDTNA Buffalo Pension Plans ("Pension Plan") as such plans were in effect on the date a Current Retiree retired (regardless of whether such individual opted out of such coverage).

2. Eligible Retirees are all individuals other than Current Retirees:

   - As of the day before their separation from service (including separation due to death of an employee) from Goodyear or GDTNA, were Active Employees ("Active Employees" means all employees in a bargaining unit listed in Exhibit 2 of the Settlement Agreement who were covered by the 2006 CBA on or after January 1, 2007 or a subsequent collective bargaining agreement between Goodyear or GDTNA and

USW) and who in connection with such separation satisfy the eligibility requirements provided in the Original Plan.

- Are eligible for health care benefits under the Original Plan pursuant to any shutdown, sale or other purchase agreement or collectively bargained agreement with USW or an arbitration decision regarding any location in Exhibit 2 to the Settlement Agreement, which addressed the eligibility requirements of employees covered under those agreements and which were in effect on or before January 1, 2007, including but not limited to the agreements applicable to (i) the shutdown of the Huntsville, Alabama plant; (ii) the sale of the Freeport, Illinois plant; and (iii) the shutdown of the Tyler, Texas plant.

- Were Active Employees and who upon retirement satisfy such eligibility requirements as the VEBA Committee in accordance with section 6 of the Settlement Agreement may set forth in the Plan from time to time. Eligible Retirees do not include former Active Employees who are eligible to benefit from a plan of benefits funded by the Goodyear Engineered Products Business Unit.

3. Surviving Spouse is a spouse of a deceased individual who on the day before such individual's death was (a) an Active Employee who satisfied the applicable eligibility requirements under the Original Plan, (b) a Current Retiree or (c) an Eligible Retiree. The term "Surviving Spouse" also shall mean a surviving dependent to the same extent that such surviving dependent was eligible for benefits under the Original Plan, so long as the dependent continues to qualify as an eligible dependent (but for being dependent on the retiree).

   A Surviving Spouse shall be entitled to the benefits under the Plan until death or remarriage under the same conditions and amounts that such Surviving Spouse was entitled to such benefits as a dependent immediately prior to the death of such deceased individual provided such Surviving Spouse was either an eligible spouse at the time of the individual's retirement or had been legally married to the individual for at least 12 consecutive months preceding the individual's death.

   Coverage for a Surviving Spouse and any dependent children shall terminate when the Surviving Spouse remarries.

   In the event there is no surviving spouse as described above, coverage shall also continue for a surviving dependent provided such surviving dependent was an eligible dependent at the time of the Retiree's death and continues to qualify as a dependent (but for being dependent on the retiree) and pays the monthly contribution due.

   If you meet one of the above definitions then you may be eligible to receive benefits in accordance with the Plan. However, effective January 1, 2010, the benefits among classes of Current Retirees and Eligible Retirees will vary.

Dependent Eligibility

Only dependents who meet the conditions for eligibility receive benefits. Dependents can include:

- Your wife or husband
- Your unmarried children under age 19
- Your unmarried children 19 years or older, provided they are dependent on you and upon attainment of age 19 are full-time students at an accredited post-secondary institution.

  Eligibility as a full-time student terminates upon ceasing to be a full-time student or attaining age 27. Coverage for an unmarried full-time student will be extended for 90 days following termination of status as a full-time student provided no other group medical coverage of any kind is in effect on such student.

  In the event that an otherwise eligible full-time student who is covered under the Plan:

  (a) is attending a postsecondary educational institution on the last day immediately following a medically necessary leave of absence or medically required reduction in academic hours; and

  (b) such individual ceases to become eligible for coverage because of the medically necessary leave of absence or reduction in academic hours; then,

  such individual may continue coverage under the Plan for a period of up to 12 months after the leave of absence or reduction in hours began, so long as the Retiree continues to be enrolled in the plan and pays the required monthly contribution.

  The 12 month period, however, does not extend coverage beyond another independent event that would terminate such individual's dependent status, such as the parent's termination of coverage or the student exceeding the Plan's age limit. COBRA coverage will not be offered until the earlier of the expiration of the 12 month extension or the loss of coverage due to some independent event.

  In the case of a full-time student the child over age 19, who ceases to be a full-time student may again be deemed to be an eligible dependent if within 24 months following the date the child ceases to be a full-time student they re-qualify as a full-time student and the child otherwise meets the requirements of this section.

  In order to qualify as a full-time student, an eligible dependent child must attend on a full-time basis an accredited high school, college, or similar institution of higher education in a course of study leading to a high school diploma, an Associate degree, a Bachelor's degree, or a higher degree.

- Your unmarried children 19 years or older, provided (1) they are dependent on you and (2) prior to attainment of age 19, were mentally or physically incapable of self-support as determined by the VEBA Committee or its designee.

  Eligibility terminates when the dependent is no longer mentally or physically incapable of self-support. Eligibility is also extended for a full-time student who becomes disabled after age 19 up to age 27.

- Children placed with you for adoption when you have a legal obligation for support.

- The donor of an organ for transplant.

  When a transplant recipient is covered for hospital, surgical, and medical benefits under this Plan, the donor will also be covered for such benefits as though the donor were a covered dependent child of such recipient, but only with respect to charges in connection with the procedure in which such organ is removed from the donor.

The word "child", in addition to your natural children, includes stepchildren, foster children, children for whom you are appointed their guardian, or other children (all unmarried) who live with you and depend on you for support and maintenance as evidenced by your claiming them as dependents on your income tax return. The Plan will cover a child for whom a Qualified Medical Child Support Order has been served upon and approved by the VEBA Committee.

If you acquire a dependent child other than by birth, legal adoption, placement for adoption, or marriage such a dependent child shall not become eligible until three months have elapsed from the date such child was added to your enrollment record.

The term "unmarried children" means children who have never been married. When a dependent child becomes married even though the marriage may later be dissolved, such child ceases to be an eligible dependent forever.

To be eligible for dependent coverage, proof that dependents meet the above criteria may be required.

Duration of Coverage Under the Plan

When Coverage Begins

Retiree

You will begin participating in the Plan on the later of August 22, 2008, or the first day of the month immediately following the month in which you have satisfied the eligibility requirements and have submitted your properly completed enrollment application. Unless you qualify for "delayed participation" in the Plan, you must begin to participate in the first month immediately following the month in which you have satisfied the eligibility requirements. You may qualify for "delayed participation" if you submit evidence to the VEBA Committee that since you were first eligible to participate in the Plan you have been continuously covered by a "qualifying group health plan" and that such coverage has been involuntarily discontinued. For these purposes, coverage will be considered "involuntarily discontinued" only where you have terminated employment with the employer maintaining the qualifying group health plan or where such plan has been discontinued or altered so as to cause your participation to cease. A "qualifying group health plan" is a plan contributed to by an employer to provide medical care for its employees, former employees, or dependents of such employees, and which provides substantially equal or better coverage as the Plan.

If you are considering delayed participation in the Plan, it is highly recommended that you discuss the requirements with the Goodyear Retiree VEBA Office before making your decision. A misunderstanding of the requirements for participation could result in the loss of your eligibility to participate in the Plan.

If you enroll in the Plan during a re-enrollment/open enrollment period, your coverage becomes effective on January 1, the first day of the next Plan year.

Dependent

When you become eligible for retiree coverage, you will be given the opportunity to enroll for dependent coverage.

Your dependents will generally be eligible for Plan benefits on the date your coverage begins, provided (a) you are eligible to receive Plan benefits, (b) each of your dependents meets the Plan's definition of a dependent, and (c) you have made proper application for enrollment.

When Coverage Ends

Your coverage under the Plan will terminate on the earliest of the following: (i) the last day of the month in which you cease meeting the conditions for eligibility; (ii) the last day of the month preceding the month for which you fail to make any required contributions; or (iii) the date the Plan is terminated or amended to terminate coverage for you, all retirees of Goodyear, or the class of retirees to which you belong.

For your dependents, coverage will terminate on the earliest of the following: (i) on the same date when your coverage terminates; (ii) up to 90 days following termination of a dependent

child's status as a full-time student (subject to a possible 12 month extension for students who take a medically necessary leave or reduction in academic hours as explained above) provided no other group medical coverage of any kind is in effect on such student; (iii) for a child placed with you for adoption, on the date of termination of your legal obligation for the total or partial support of such child; (iv) on the last day of the month in which a dependent ceases to meet the definition of dependent set forth above; or (v) the date the Plan is terminated or amended to eliminate coverage for your dependents.

It is important that you understand that the VEBA Committee has the authority to amend, modify, or terminate benefits subject only to certain restrictions contained in the Settlement Agreement, and that benefits can be maintained only if there are sufficient funds in the Goodyear Retiree VEBA trust fund to pay for those benefits. In other words, there are possible situations where even though you are otherwise eligible for benefits, those benefits may be reduced or terminated.

Permanent Loss of Coverage for Failure to Pay Premiums

If your coverage, including coverage for your dependents, terminates as a result of your failure to pay required premiums on a timely basis, you will not be allowed to re-enroll in the Plan.

For more specific questions about termination of coverage under the Plan, contact the Goodyear Retiree VEBA Office.

Changes in Membership Status

In order for there to be consistent coverage for you and your dependents, you must keep the Goodyear Retiree VEBA Office informed about any address changes or changes in family status (births, adoptions, deaths, marriages, divorces, etc.) that may affect your coverage.

Your newborn child may be covered under the Plan for a maximum of 31 days from the moment of birth. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under the Plan within such period.

Medicare

If you or a dependent are entitled to Medicare benefits (either due to age or disability), the Plan will not duplicate payments or benefits provided under Medicare; however, the Plan may supplement the Medicare benefits, including the deductible and coinsurance not covered by Medicare, provided that the services are eligible for coverage under the Plan. Contact your benefit provider for specific details.

The deductible and coinsurance will not be covered if the services are not covered under the Plan, even if they are covered under Medicare.

Plan Amendment

The Goodyear Retiree VEBA Committee, subject to certain restrictions contained in the Settlement Agreement, has the power and authority to amend or terminate the Plan at any time and in such manner as it may deem advisable.

Continuation of Plan Coverage

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Plan when coverage would otherwise end because of a circumstance known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan qualified beneficiaries who elect COBRA continuation coverage will be required to pay for COBRA continuation coverage. Contact the Goodyear Retiree VEBA Office at (866) 694-6477 for premium payment requirements.

The spouse of an eligible retiree will become a qualified beneficiary if he or she loses coverage under the Plan as a result of divorce or legal separation from the retiree. Also, a covered spouse who has not been married to a covered retiree for at least 12 months prior to the covered retiree's death will become a qualified beneficiary.

A dependent child will become a qualified beneficiary if coverage under the Plan terminates because the child ceases to qualify as a "dependent child."

You Must Give Notice of Some Qualifying Events

For qualifying events (divorce or legal separation of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child) you or the qualifying beneficiary must notify the Plan within 60 days after the qualifying event occurs. You may contact the Goodyear Retiree VEBA Office by calling (866) 694-6477 or writing to it at 60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222.

How is COBRA Coverage Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

If You Have Questions

Questions concerning your COBRA continuation of coverage rights and options should be addressed to the Goodyear Retiree VEBA Office at 60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222 or by calling (866) 694-6477. For more information about your rights

under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting the Goodyear Retiree VEBA 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 phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Notice

The description of COBRA rights is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to application of these provisions in any particular circumstances.

Appeals

Appeal of a Benefit Decision

Each benefit section of this booklet describes the procedure for filing benefit claims with the appropriate benefit provider. This section describes how you appeal a providers benefits decision. You must follow the appeals process, including any time limits, described for each provider if you wish to appeal a claim which has been denied in full or in part. If, after the first and second appeal, you or your dependent is not satisfied with the decisions regarding benefits, you have a right to make a final appeal to the VEBA Claims and Appeals Subcommittee.

These procedures include any applicable time limits within which your claims must be filed. **Please consult the appropriate benefit section of this booklet to find out how you may appeal a benefit claim decision made by a specific provider. If you still have questions, you may call the Goodyear Retiree VEBA Office at (866) 694-6477.**

Appeal Procedure for Decisions Concerning Eligibility or Other Plan Rules

While initial decisions and appeals regarding benefits are made by the entity which administers the benefits (Highmark for medical and hospital claims; Express Scripts for drug benefit claims; and Delta Dental for dental benefit claims), decisions and appeals regarding eligibility to participate in the Plan or the application of Plan rules are made under the direction of the Committee. The initial decision concerning eligibility to participate in the Plan or application of Plan rules is made by cds Administrators, Inc. ("cds"), the Goodyear Retiree VEBA Office manager. Generally this initial decision happens when you or a dependent is denied participation in the Plan or is denied coverage (in whole or in part) for a service because of eligibility or coordination of benefits issue or other Plan rule. If you have a question about why your claim was denied for one of these reasons, you should contact the Goodyear Retiree VEBA Office at (866) 694-6477. If you feel the initial decision was in error you have the right to request that this decision be reviewed. This review by the Goodyear Retiree VEBA Office manager is a Level 1 review. One appeal from the Level 1 review is allowed (Level 2). Level 2 appeals are considered by the VEBA Claims and Appeals Subcommittee.

You have the right to designate a representative to represent you in a Level 1 or Level 2 appeal. If a representative is filing a claim or an appeal on your behalf, the Goodyear Retiree VEBA Office must obtain a signed Designation of Representation Form from you before the VEBA Office manager or the VEBA Claims and Appeals Subcommittee can begin processing your claim or appeal. A Designation of Representation Form can be obtained by calling the Goodyear Retiree VEBA Office at (866) 694-6477, or by visiting the Goodyear Retiree VEBA website at www.goodyear-veba.com.

Once an appeal (Level 1 or Level 2) has been filed in writing as described below, the VEBA Office will accept oral or written comments, documents, or other information relating to your appeal from you, your designated representative or your provider by telephone, facsimile, email, or other reasonable means. You are entitled to receive, upon request and free of charge,

reasonable access to, and copies of, documents, records, and other information relevant to your appeal.

Except for Expedited Appeals described below, the Goodyear Retiree VEBA requires you to submit all requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to: Appeals, Goodyear Retiree VEBA, 60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA, 15222. If you wish, you may fax your appeal to (412) 224-4465 or send it by email to gyveba@cdsadmin.com

Level 1 Appeal

The VEBA Office manager will review the materials supplied to it and provide a written response not later than 20 business days after your appeal request is received. If your appeal is denied in whole or in part, the written response will state the specific reason or reasons for the adverse determination; reference the specific Plan provision, rule or guideline on which the determination is based; provide a description of any additional material or information necessary for you to perfect the claim and an explanation of why such information is necessary; and provide a description of how you can appeal the determination. You also will be provided a copy of any rule or guideline upon which the determination is based.

Level 2 Appeal

If you are dissatisfied with the Level 1 Appeal decision, you may request a Level 2 Appeal. At Level 2, the appeal is reviewed by the VEBA Claims and Appeals Subcommittee. Level 2 Appeals will be resolved the Subcommittee not later than 90 days from the date that your Level 2 Appeal was received by the Goodyear Retiree VEBA Office. You will receive a written response to your Level 2 Appeal. If your appeal is denied in whole or in part, the written response will state the specific reason or reasons for the adverse determination and will reference the specific Plan provision, rule, or guideline on which the determination is based. If you have not already been provided a copy of any rule or guideline upon which the determination is based, you be will provided one.

Expedited Appeals

If your physician believes that the standard appeal time frames could seriously jeopardize your health or could subject you to severe pain that cannot be adequately managed, your appeal will be expedited. The Goodyear Retiree VEBA Office manager, by applying a prudent lay person standard, may also determine when an appeal may be expedited.

The Goodyear Retiree VEBA Office manager will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation, but not later than forty-eight (48) hours after it receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending physician or the ordering provider. The Office manager also will provide written notice of the Plan's determination to you, your attending physician or ordering provider, and the facility rendering the service. The VEBA Claims and Appeals Subcommittee will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and circumstances permit. The Plan's decision will be communicated by telephone to your attending physician or the ordering provider. The

Administrator will also provide a written notice of the Plan's determination to you, your attending physician or ordering provider, and to the facility rendering the service.

The VEBA Committee has sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan and any other regulations, procedures, or administrative rules adopted by the Goodyear Retiree VEBA. Decisions of the VEBA Committee (or, where appropriate, decisions of a VEBA Claims and Appeals Subcommittee) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the VEBA Committee or a subcommittee is challenged in court, it is the intention of the VEBA Committee that such decision is to be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the VEBA Committee's authority to change them. The Committee has the authority to increase, decrease, change, amend, or terminate benefits, eligibility rules, or other provisions of the Plan.

HIPAA Information, Records, Privacy and Confidentiality

At times, the VEBA Committee or a benefits provider may need additional information from you. When you enroll in the Plan you must agree to furnish the VEBA Committee or a benefits provider with all information and proofs that may be reasonably required regarding any matters pertaining to the Plan. If you do not provide this information when requested, payment of your Plan benefits may be delayed or denied.

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the VEBA Committee and its designees with all information or copies of records relating to the services provided to you. This applies to all Participants and Dependents, whether or not they have signed the Participant's enrollment form. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Plan protect the confidentiality of your private health information. The Plan maintains a Notice of Privacy Practices, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Goodyear Retiree VEBA Office. This summary is not intended and cannot be construed as the Plan's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice of Privacy Practice shall control.

The Plan will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law.

The VEBA Committee hires professionals and other companies to assist it in providing benefits under the Plan. These entities, called "Business Associates," are required to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan designees. It will describe your rights with respect to benefits provided by that organization.

Under federal law you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you and to request confidential communications. You also have the right to file a complaint with the Plan Administrator or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information or if you wish to file a privacy violation complaint, please contact the Goodyear Retiree VEBA Office.

Medical Plan of Benefits

Highmark
Blue Cross Blue Shield
National Catastrophic PPO Program

Retirees of The Goodyear Tire &
Rubber Company Health Care Plan -
VEBA Medicare and Non-Medicare
Retirees
(Catastrophic)
Group 16196 and 16238

Member Handbook
Effective January 1, 2010

Language Assistance Services Available for Multiple Languages

ENGLISH

Please Read This Important Message

It is important for you to understand all of the enclosed information about your health care coverage. This information includes rights you have and requirements you must meet to take full advantage of your health care benefits.

Language services are available to you, free of charge, upon request. Call the toll-free phone number on the back of your identification card for help.

SPANISH

Lea este importante mensaje

Es importante que comprenda toda la información adjunta sobre su cobertura de atención de salud. Esta información incluye los derechos con los que usted cuenta y los requisitos que debe cumplir para aprovechar al máximo los beneficios de atención de salud.

Si los solicita, se encuentran a su disposición servicios de idiomas gratuitos. Llame al número de teléfono gratuito en el reverso de su tarjeta de identificación.

VIETNAMESE

Xin Đọc Tin Nhắn QuanTrọng Này

Điều quan trọng là quý vị hiểu rõ tất cả các thông tin đính kèm về bảo hiểm sức khỏe của quý vị. Thông tin này bao gồm quyền lợi mà quý vị được và các đòi hỏi mà quý vị cần đáp ứng để tận dụng toàn bộ các quyền lợi chăm sóc sức khỏe của mình.

Quý vị sẽ được dịch vụ về ngôn ngữ miễn phí khi yêu cầu. Xin gọi số điện thoại miễn phí ghi ở phía sau thẻ ID của quý vị để được giúp đỡ.

RUSSIAN

Пожалуйста, ознакомьтесь с этой важной информацией

Очень важно, чтобы Вы хорошо понимали всю информацию, которая изложена в приложении и описывает Вашу программу страхового медицинского покрытия. В этой информации представлены права, которые Вам предоставлены, а также условия, которым Вы должны соответствовать, чтобы получить полный доступ к страховому медицинскому покрытию.

Вы имеете возможность воспользоваться языковыми услугами, которые предоставляются бесплатно и по требованию. Позвоните по бесплатному номеру телефона, указанному на обороте Вашей идентификационной карты, чтобы получить эту помощь.

ITALIAN

Leggere attentamente il presente messaggio

E’ molto importante che comprenda perfettamente le informazioni allegate relative alla sua copertura sanitaria. Tali informazioni includono i diritti in suo possesso e i requisiti da soddisfare per usufruire dei vantaggi offerti dalla sua copertura sanitaria.

Sono disponibili servizi linguistici gratuiti su richiesta. Chiami il numero verde gratuito sul retro della sua tessera identificativa per un’ulteriore assistenza.

CHINESE (MANDARIN/SIMPLIFIED)

请阅读以下重要信息

理解随附的所有有关您的健康护理保赔的信息十分重要。该信息包括您享有的权利以及充分利用您的健康护理福利必须符合的要求。

可应您的请求免费向您提供语言服务。请拨印在您的会员卡背面的免费电话号码，获取帮助。

Table of Contents

Disclosure

Your health benefits are entirely funded by your Plan Sponsor. Highmark Blue Cross Blue Shield provides administrative and claims payment services only.

Introduction to Your PPO Program

This booklet provides you with the information you need to understand your PPO program offered by your group. We encourage you to take the time to review this information so you understand how your health care program works.

For a number of reasons, we think you'll be pleased with your health care program:

- ***Your PPO program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call 1-800-810-BLUE (2583), log onto www.bcbs.com or log onto Highmark's Web site, www.highmarkbcbs.com.

- ***Your PPO program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can save you time and medical expenses down the road.

Furthermore, as a member of your PPO program, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Call℠, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to help you "Have A Greater Hand in Your Health®" by helping you make and maintain healthy improvements.

You can review Preventive Care Guidelines, check eligibility information, order ID cards and medical claim forms and even review claims and Explanation of Benefits (EOB) information all online. You can also access health information such as the comprehensive Healthwise Knowledgebase®, full-color Health Encyclopedia, and the Health Crossroads® guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

If you have any questions on your PPO program, please call the Member Service toll-free telephone number on the back of your ID card.

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

As always, we value you as a member, look forward to providing your coverage, and wish you good health.

How Your Benefits Are Applied

To help you understand your coverage and how it works, here’s an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Your benefit period is a calendar year starting on January 1.

Medical Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "copayment," "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which is deducted from the provider's reasonable charge and is your responsibility. See your Summary of Benefits for the copayment amounts.

Deductible

The deductible is a specified dollar amount you must pay for covered services in a benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance, copayment or deductible incurred for covered services a benefit period. When the specified dollar amount is attained, the Plan begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include amounts in excess of the provider's reasonable charge.

Family Out-of-Pocket Limit

The family out-of-pocket limit refers to the amount of coinsurance, copayment or deductible incurred by you or your covered family members for covered services received in a benefit period.

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received for all covered family members during the remainder of the benefit period will be payable at 100% of the provider's reasonable charge.

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime is specified in your Summary of Benefits.

The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group medical care expense plan maintained by the Goodyear Retiree VEBA since August 22, 2008 for the purpose of calculating the lifetime maximum applicable to each individual.

Summary of Benefits
National Catastrophic PPO Program

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 $600 $1,200	 $1,200 $2,400
Plan Payment Level - Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met; then 100% copayment does not apply.	60% after deductible until out-of-pocket limit is met; then 100% copayment does not apply.
Out-of-Pocket Limits Individual Family	 $4,000 $8,000	 $8,000 $16,000
Lifetime Maximum (per individual)	$2,000,000	
Office Visits		
Primary Care Physician Office Visits[1]	100% after $20 copayment; deductible does not apply	60% after deductible
Specialist Office Visits	100% after $30 copayment; deductible does not apply	60% after deductible
Preventive Care Services		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	100%; deductible does not apply	Not Covered
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	Not Covered
Mammograms Annual routine	 100%; deductible does not apply	 Not Covered
Medically necessary	100%; deductible does not apply	60% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	Not Covered
Emergency Services		
Emergency Room	100% after $150 copayment (waived if admitted); deductible does not apply	100% after $150 copayment (waived if admitted); deductible does not apply
Freestanding Urgent Care Facility	100% after $35 copayment; deductible does not apply	Not Covered
Professional	100%; deductible does not apply	100%; deductible does not apply
Hospital Services		
Hospital Services – Inpatient	80% after deductible	60% after deductible
Hospital Services - Inpatient Rehabilitation Therapy	80% after deductible	60% after deductible
	Combined Limit: 60 days per Benefit Period	
Hospital Services - Outpatient[2]	80% after deductible	60% after deductible

Therapy and Rehabilitation Services		
Spinal Manipulations	100% after $15 copayment; deductible does not apply	60% after deductible
	Combined Limits: 12 visits per benefit period; $100 maximum per calendar year for chiropractic x-rays	
Physical Medicine & Occupational Therapy	100% after $15 copayment; deductible does not apply	60% after deductible
	Combined Limit: 60 visits per benefit period	
Speech Therapy	100% after $15 copayment; deductible does not apply	60% after deductible
	Combined Limit: 20 visits per benefit period	
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	80% after deductible	60% after deductible
Infusion Therapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	80% after in-network deductible
Diagnostic Services		
Diagnostic Services (includes pre-admission testing) ***Advanced Imaging*** *(*MRI, CAT Scan, PET scan, etc.) ***Basic Diagnostic Services*** *(*standard imaging, diagnostic medical, lab/ pathology, allergy testing)	80% after deductible	60% after deductible
Diagnostic Service performed in conjunction with Primary Care Physician office visit	100% after $20 copayment; deductible does not apply	60% after deductible
Diagnostic Service performed in conjunction with Specialist office visit	100% after $30 copayment; deductible does not apply	60% after deductible
Behavioral Health Services		
Mental Health Care Services - Inpatient	80% after deductible	60% after deductible
Mental Health Care Services - Outpatient	100% after $30 copayment; deductible does not apply	60% after deductible
Substance Abuse Services - Inpatient Detoxification	80% after deductible	60% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	Not Covered	
Substance Abuse Services - Outpatient	Not Covered	
Other Services		
Assisted Fertilization Treatment	Not Covered	
Ambulance	100%; deductible does not apply	100%; deductible does not apply
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics & Prosthetics	90% after deductible.	80% after deductible
Services received in conjunction with Primary Care Physician office visit	100% after $20 copayment; deductible does not apply	90% after deductible

Services received in conjunction with Specialist office visit	100% after $30 copayment; deductible does not apply	90% after deductible
	Combined Limits: Wigs are limited to one per benefit period; Mastectomy bras are limited to two per benefit period.	
Enteral Formulae	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	80% after in-network deductible
Home Health Care	80% after deductible	60% after deductible
		Limit: 30 visits per benefit period
Hospice	100%; deductible does not apply	60% after deductible
Maternity (facility and professional services)	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible	60% after deductible
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Medical/Surgical Expenses (except office visit services)	80% after deductible	60% after deductible
Transplant Services Except for Kidney & Cornea transplants, which are subject to program Hospital & Professional benefit limitations including lifetime maximum.	100%; deductible does not apply. Transplant Maximum: $1,000,000 per lifetime.	Not Covered
	Transportation, Lodging & Meals Maximum: $10,000 per occurrence	Not Covered
Precertification Requirements	Yes[3]	

[1] A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

[2] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[3] Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Covered Services - Medical Program

The PPO program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits. Network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility;
- between hospitals; or
- between a hospital and a skilled nursing facility;
- when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from a hospital to your home, or
- from a skilled nursing facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

- when ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse.

Dental Services Related to Accidental Injury

Dental services rendered by a physician which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, injection aides, needles and syringes and insulin infusion devices

- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
  - Visits medically necessary and appropriate upon the diagnosis of diabetes
  - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

*__Diabetes Education Program –__ an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark Blue Cross Blue Shield's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

Advanced Imaging Services

Include, but are not limited to, computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), positron emission tomography/computed tomography (PET/CT scan).

Basic Diagnostic Services

- **Standard Imaging Services** - procedures such as skeletal x-rays, ultrasound and fluoroscopy
- **Laboratory and Pathology Services** - procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
- **Diagnostic Medical Services** - procedures such as electrocardiograms (ECG), electroencephalograms (EEG), echocardiograms, pulmonary studies, stress tests, audiology testing
- **Allergy Testing Services** - allergy testing procedures such as percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

The rental or, at the option of Highmark, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider acting within the scope of his/her license. Rental costs cannot exceed the total cost of purchase.

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Additional coverage for enteral formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be your sole source of nutrition and:

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or
- when provided orally and identified as one of the following types of defined formulae:
  - with hydrolyzed (pre-digested) protein or amino acids; or
  - with specialized content for special metabolic needs; or
  - with modular components; or
  - with standardized nutrients.

Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

Home Health Care/Hospice Care Services

This program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- Family counseling related to the member’s terminal condition

- Prescription Drugs (only if provided and billed by a Home Health Care Agency)

No home health care/hospice benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- custodial care; and
- food or home-delivered meals.

Home Infusion Therapy Services

Benefits will be provided when performed by a home infusion therapy provider in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Hospital Services

This program covers the following services received in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Inpatient Services

Bed and Board

Bed, board and general nursing services are covered when you occupy:

- a room with two or more beds;
- a private room. Private room allowance is the average semi-private room charge;
- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending

professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;

- medical and surgical dressings, supplies, casts and splints;
- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

Ancillary Services
Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms, offices and other facility settings, and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints.

Pre-Admission Testing
Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery
Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Emergency Care Services

As a member, you're covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately.*

Your outpatient emergency room visits may be subject to a copayment, which is waived if you are admitted as an inpatient. (Refer to the Summary of Benefits section for the Plan's specific amounts.)

In true emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency Accident Care
Services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident.

Emergency Medical Care
Services and supplies, including drugs and medicines, for the outpatient emergency treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention and with which the absence of immediate medical attention could reasonably result in:

- placing the patient's health in jeopardy;
- causing serious impairment to bodily functions;
- causing serious dysfunction of any bodily organ or part; or
- causing other serious medical consequences.

Freestanding Urgent Care Facility

A Freestanding Urgent Care Facility is designed to respond to urgent medical conditions and perform minor surgical procedures. The facility is not connected to the hospital.

See your Schedule of Benefits for benefit limitations.

Maternity Services

If you are pregnant, now is the time to enroll in the Baby BluePrints® Maternity Education and Support Program offered by Highmark. Please refer to the Member Services section of this booklet for more information.

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital that is covered at the maximum level of benefits.

Hospital, medical and surgical services rendered by a facility provider or professional provider for:

Complications of Pregnancy
Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Normal Pregnancy
Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Benefits are not provided for normal pregnancy services for dependent children.

Elective Abortion
The Plan pays Covered Services from a Provider for elective abortion services.
Benefits are not provided for elective abortion services for dependent children.

Nursery Care
Covered services provided to the child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Maternity Home Health Care Visit
You are covered for one maternity home health care visit provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery, or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a network provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your network provider.

Under Federal law, your self-insured group health program generally may not 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 as applicable). In any case, under Federal law, your self-insured program can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Services

Inpatient Medical Services
Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

Consultation

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one consultation per consultant per admission.

Inpatient Medical Care Visits

Medical care rendered to you by a professional provider when you are an inpatient.

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness, and other covered services, supplies or treatments received in the course of a single Primary Care Physician or Specialist office visit for which an office visit copayment ($20 or $30) applies

Please note that as a Highmark member, you enjoy many convenient options for where you can receive outpatient care:

- Primary care physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Freestanding Urgent Care Facility
- Retail site, such as in a pharmacy or other retail store

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Highmark benefits.

Therapeutic Injections

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Mental Health Care Services

Your mental health is just as important as your physical health. That’s why your PPO program provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. The PPO program covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services
Inpatient hospital services provided by a facility provider for the treatment of mental illness.

Inpatient Medical Services
Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

Partial Hospitalization Mental Health Care Services
Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services
Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as described above, are also available when you are an outpatient.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home only when Highmark determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Benefits will be provided for a wig when loss of hair occurs from cancer treatment. Wigs are limited to one per Benefit Period; Mastectomy bras are limited to two per Benefit Period.

Preventive Care Services

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically reviewed based on recommendations from organizations such as the American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force, the American Cancer Society and the Blue Cross and Blue Shield Association. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member Web site, www.highmarkbcbs.com, or call Member Service at the toll-free telephone number listed on the back of your ID card.

Adult Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history.

Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening for all female members.
- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

Pediatric Care
Routine physical examinations, regardless of medical necessity and appropriateness.

Pediatric Immunizations
Benefits are provided to members and dependent children for those pediatric immunizations, including the immunizing agents, which with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services.

Allergy Extract, Allergy Injections, Allergy Testing
Benefits are provided for allergy extract, allergy injections and allergy testing.

Hearing Care Services
Benefits include coverage for an audiometric examination when prescribed by a professional provider.

Routine Eye Examination
Benefits will be provided for comprehensive routine eye examinations, including routine vision screening for disease or abnormalities, and a diabetic eye examination once every benefit period.

Skilled Nursing Facility Services
Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:
- after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;
- when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Spinal Manipulations
Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Substance Abuse Services
Benefits are provided for:
- Inpatient hospital or substance abuse treatment facility services for detoxification

No benefits are payable for:
- Individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse.

- Outpatient hospital or substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is not a covered service.

When you are admitted to a facility, *you are responsible* for notifying Healthcare Management Services of your admission.

Surgical Services

This program covers the following services you receive from a professional provider. See the Healthcare Management section for additional information which may affect your benefits.

Anesthesia

Administration of anesthesia for covered surgery when ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for covered oral surgical procedures in an outpatient setting when ordered and administered by the attending professional provider.

Assistant at Surgery

Services of a physician who actively assists the operating surgeon in the performance of covered surgery. Benefits will be provided for an assistant at surgery only if a house staff member, intern or resident is not available.

Second Surgical Opinion

A consulting physician's opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

Keep in mind that:

- the second opinion consultant must not be the physician who first recommended elective surgery;
- elective surgery is covered surgery that may be deferred and is not an emergency;
- use of a second surgical opinion is at your option;
- if the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are covered services; and
- if the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Special Surgery

- Sterilization
- Sterilization of medical necessity and appropriateness.
- Oral surgery
- Benefits are provided for oral surgical procedures determined to be medically necessary and appropriate as long as the services are accident related and performed by a provider other than a dentist. Benefits include:
- Treatment of accidental injury to the jaw or structures contiguous to the jaw
- Mastectomy and Breast Cancer Reconstruction
- Benefits are provided for a mastectomy performed on an inpatient or outpatient basis and for the following:
- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedema

Surgery

- Surgery performed by a professional provider. Separate payment will not be made for pre- and post-operative services.
- If more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure and no allowance shall be made for additional procedures except where Highmark deems that an additional allowance is warranted.

Therapy and Rehabilitation Services

This program covers the following services when such services are ordered by a physician:

- Cardiac rehabilitation
- Chemotherapy
- Dialysis treatment
- Infusion therapy when performed by a facility provider and for self-administration if the components are furnished and billed by a facility provider
- Occupational therapy
- Physical medicine
- Radiation therapy
- Respiratory therapy
- Speech therapy

Transplant Services

The following transplant services will be covered when provided within a Covered Transplant Benefit Period.

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissue or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are members, each is entitled to the benefits of this program;
- when only the recipient is a member, both the donor and the recipient are entitled to the benefits of this program subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross and Blue Shield coverage or any government program; and 2) benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient's own expenses have been paid;
- when only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
- if any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipient's program limit.

Travel, lodging and meal reimbursement is only available for reasonable and necessary expenses incurred within a Covered Transplant Benefit Period in connection with covered transplant services and related follow-up care when the Facility provider is more than 75 miles from the recipient's home. Reimbursement is available for the transplant recipient and one companion or, if the recipient is under eighteen years of age, for the recipient and two companions. Reimbursement will be provided upon submission of eligible receipts.

A Covered Transplant Benefit Period starts one day prior to a covered transplant procedure and continues for 364 days. If, within this time frame, a second covered transplant procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second covered transplant procedure and will continue for 364 days.

For more information, please call the Member Service toll-free telephone number on the back of your ID card.

What Is Not Covered

Your medical program will not provide benefits for services, supplies or charges:

- Which are not medically necessary and appropriate as determined by Highmark Blue Cross Blue Shield.
- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than facility providers, professional providers or suppliers.
- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Goodyear Retiree VEBA.
- Rendered or incurred prior to your effective date of coverage.
- Rendered or incurred after the date of termination of your coverage except as provided herein.
- For which you would have no legal obligation to pay.
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of the Goodyear Retiree VEBA, a mutual benefit association, labor union, trust, or similar person or group.
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage.
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government’s workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
- For loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war whether declared or undeclared.
- To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service connected illness or injury, unless you have a legal obligation to pay.
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
- For prescription drugs and medications, except those which are administered to an inpatient in a facility provider, or provided and billed by a Home Health Care Agency.
- For nicotine cessation support programs and/or classes.

- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
- Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
- Rendered by a provider who is a member of your immediate family.
- Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
- For ambulance services, except as provided herein.
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; b) surgery to correct a congenital birth defect; and c) surgery to correct a functional impairment which results from a covered disease or injury.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
- For inpatient admissions which are primarily for diagnostic studies.
- For inpatient admissions which are primarily for physical medicine services.
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietitian services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals.
- For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness.
- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
- For respite care.
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.

- For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- For hearing aid devices and tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
- Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.
- For reversal of sterilization.
- For contraceptive services, including contraceptive prescription drugs, contraceptive devices, implants and injections, and all related services.
- For eyeglasses or contact lenses except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury.
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
- For nutritional counseling, except as provided herein.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- For treatment of obesity, except for medical and surgical treatment of morbid obesity or as provided herein.
- For the following services associated with the additional enteral formulae benefits provided under the Plan: blenderized food, baby food, or regular shelf food when used with an enteral system; milk or soy-based infant formulae with intact proteins; any formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates, natural intact

protein/protein isolates, and intact protein/protein isolates, when provided orally; normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For well-baby care visits, except as provided herein.
- For allergy testing, except as provided herein or as mandated by law.
- For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.
- For elective abortions for dependent daughters.
- For immunizations required for foreign travel or employment.
- For treatment of sexual dysfunction that is not related to organic disease or injury.
- For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation, extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modification and/or training; d) services related to the treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and g) services provided for which, based on medical standards, there is no established expectation of achieving measurable, sustainable improvement in a reasonable and predictable period of time.
- For any care, treatment or service which has been disallowed under the provisions of Healthcare Management program.
- For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- For any illness or injury suffered during your commission of a felony.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- For missed or cancelled appointments.

- For mileage costs or other travel expenses except as authorized by the administrator, on behalf of the Goodyear Retiree VEBA.
- Charges in excess of the Maximum Allowable Amount.
- For marital counseling.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- For care received in an Emergency room which is not Emergency Care, except as specified in this Benefit Booklet.
- For expenses incurred at a health spa or similar facility.
- For self-help training and other forms of non-medical self care, except as otherwise provided herein.
- For stand-by charges of a Physician.
- Related to any mechanical equipment, device, or organ.
- For Private Duty Nursing Services except when provided through the Home Care Services benefit.
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part of a specific New FDA Approved Drug Product or Technology.
- For (services or supplies related to) alternative or complementary medicine. Service in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- For prescription Legend Drugs or Mail Service Drugs.
- For alcohol and substance abuse rehabilitation services, including inpatient residential treatment.
- For biofeedback services.
- Obstetric services for dependent daughters, including abortion services.
- Acupuncture, including hospital admissions for the primary purpose of performing acupuncture.
- For any other medical or dental service or treatment except as provided herein or as mandated by law.

How your PPO Program works

Your PPO program lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two levels of health care services: **network** or **out-of-network.**

Network Care

Network care is care you receive from providers in the PPO program's network.

When you receive health care within the PPO network, you enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

Out-of-Network Care

Out-of-network care is care you receive from providers who are not in the PPO network.

Even when you go outside the network, you will still be covered for most eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, you may need to obtain precertification from Highmark before services are received. For specific details, see your Summary of Benefits.

You may be responsible for paying any difference between the provider's actual charge and the PPO program's payment.

When you receive care from an out-of-network provider, coverage is almost always paid at the lower level - *even if you are directed to an out-of-network provider by a network provider*. **That's why it is critical - in all cases - that you check to see that your provider is in the network before you receive care.**

Out-of-Area Care

The Plan also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield PPO network will be covered at the higher level of benefits. If you receive covered services from a provider who is not part of the local Blue Cross and Blue Shield PPO network, these services will be covered at the lower level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic:

- If the illness or injury is a true emergency, it will be covered at the higher benefit level, regardless of whether the provider is in the local Blue Cross and Blue Shield PPO network. If

the treatment results in an admission, you need to obtain precertification from Highmark. If precertification is not obtained and the admission is not considered to be medically necessary and appropriate, you will be responsible for all costs associated with the stay. For specific details, see the Healthcare Management section of this booklet.

- If the illness or injury is not an emergency, you are required to use providers in the local Blue Cross and Blue Shield PPO network in order to be covered at the higher benefit level. If you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level of benefits.

The BlueCard Worldwide® Program

Your coverage also travels abroad. The Blue Cross and Blue Shield symbols on your ID card are recognized around the world. That is important protection. PPO program all of the services of the BlueCard Worldwide Program. These services include access to a worldwide network of health care providers. Medical Assistance services are included as well. You can access these services by calling 1-800-810-BLUE or by logging onto www.bcbs.com.

Services may include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special medical help is needed;
- making arrangements for medical evacuation services;
- processing inpatient hospitalization claims; and
- for outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

Your Provider Network

Your PPO provider network is your key to receiving the higher level of benefits. The network includes: primary care physicians; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories.

To determine if your current provider is in the network or to locate the provider nearest you, call 1-800-810-BLUE (2583), log onto www.bcbs.com or log onto www.highmarkbcbs.com.

Please note that while you or a family member can use the services of any network physician or specialist and receive the maximum coverage under your benefit program, you are encouraged to select a personal or primary care physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises.

Remember:
If you want to enjoy the higher level of coverage, it is *your* responsibility to ensure that you receive network care. You may want to double-check any provider recommendations to make sure the doctor or facility is in the network.

A Note to Medicare Participants:
For Medicare Participants, Medicare generally provides primary coverage and your Plan provides secondary coverage. When selecting a provider you may want to double check that your provider accepts Medicare in order to maximize your benefits under the Plan.

How to Get Your Physicians' Professional Qualifications

To view board certification information, hospital affiliation or other professional qualifications of your PCP or network specialist, visit our Web site at www.highmarkbcbs.com. and click on "Find Providers". Type in your zip code and choose the type of professional. Click on the physician's name to view credentials and hospital affiliation. Or call a Member Service Representative at the telephone number printed on your ID card.

Eligible Providers

Eligible network providers include facilities, general practitioners, internists, obstetricians or gynecologists and a wide range of specialists.

Facility Providers

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/night psychiatric facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Skilled nursing facility
- Substance abuse treatment facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Clinical social worker
- Dentist
- Licensed practical nurse
- Marriage and family therapist
- Nurse-midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Professional counselor
- Psychologist
- Registered nurse
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

Contracting Suppliers (for the sale or lease of):

- Durable medical equipment
- Supplies
- Orthotics
- Prosthetics

**Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.*

Healthcare Management

Medical Management

For your benefits to be paid under the Plan, at either the network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

Healthcare Management Services (HMS), a division of Highmark Blue Cross Blue Shield, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

An HMS nurse will review your request for an inpatient admission to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

You are responsible for notifying HMS of your admission. However, some facility providers will contact HMS and obtain preauthorization of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for preauthorization. If not, you are responsible for contacting HMS.

You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission, or as soon as reasonably possible. You can contact HMS via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify HMS of your admission to a facility provider, HMS may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be medically necessary and appropriate, you will be solely responsible for all costs not covered by the Plan.**

Healthcare Management Services' Care Utilization Review Process

In order to assess whether care is provided in the appropriate setting, HMS administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, HMS assists hospitals with discharge planning. These activities are conducted by an HMS nurse working with a physician advisor. Here is a brief description of these review procedures:

Prospective Review
Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, HMS:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is medically necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for inpatient admissions

Concurrent Review
Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning
Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, HMS will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Procedure or Covered Service Precertification
Precertification may be required to determine the medical necessity and appropriateness of certain procedures or covered services as determined by Highmark. Network providers in the Highmark Blue Shield service area and the Plan Service area are responsible for the precertification of such procedures or covered services and you will be held harmless whenever certification for such procedures or covered services is not obtained. If the procedure or covered service is deemed not to be medically necessary and appropriate, you will be held harmless, except when Highmark provides prior written notice to you that charges for the procedure or covered service will not be covered. In such case, you will be financially responsible for such procedure or covered service.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

Case Management Services
Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. Highmark case managers can provide educational support, assist in coordinating needed health care services, put

you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Highmark case managers are a free resource to all Highmark members. If you have an inpatient hospital admission, you may be contacted as part of our Outreach program. If your claims history indicates that your needs appear to be more complex, you may be contacted by a case manager from our Complex program. In either case, you are always free to call and request case management if you feel you need it by contacting Member Services at the telephone number listed on the back of your ID card.

Precertification, Preauthorization and Pre-Service Claims Review Process

- ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for precertification or other pre-service claim on your behalf. Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by Highmark will, in the case of an urgent care claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

- ***Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims***

You will receive written notice of any decision on a request for precertification or other pre-service claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives your claim. However, this 15-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your pre-service claim.

- ***Decisions Involving Urgent Care Claims***

If your request involves an urgent care claim, Highmark will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your urgent care claim not later than 72 hours following receipt of your claim.

If Highmark determines in connection with an urgent care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your

coverage, you will be notified within 24 hours following Highmark's receipt of your claim of the specific information needed to complete your claim. You will then be given not less than 48 hours to provide the specific information to Highmark. Highmark will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date Highmark informed you that it must receive the additional specific information.

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim seeks to extend a previously approved course of treatment and that request is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, Highmark will notify you of its decision concerning your urgent care claim seeking to extend that course of treatment not later than 24 hours following receipt of your claim.

- ***Notices of Determination Involving Precertification Requests and Other Pre-Service Claims***

Any time your request for precertification or any other pre-service claim is approved, you will be notified in writing that your claim has been approved. If your request for precertification or approval of any other pre-service claim has been denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse determination involving a request for precertification or any other pre-service claim, see the Appeal Procedure subsection in the “How to File a Claim” section of this benefit booklet.

Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Employers that are subject to COBRA must temporarily extend their health care coverage to certain categories of employees and their covered dependents when, due to certain "qualifying events," they are no longer eligible for group coverage.

Please refer to your Summary Plan Description for an explanation of how COBRA works. If you did not receive the notice or have any questions about COBRA rights, contact the Goodyear Retiree VEBA Office at (866) 694-6477.

Conversion

If the Plan does not offer continuation of coverage, or if you do not wish to continue coverage through the Plan, you may be able to enroll in an individual conversion program. , conversion is available to anyone who has elected continued coverage through the Plan and the term of that coverage has expired.

If your coverage through the Plan is discontinued for any reason, except as specified below, you may be able to convert to a direct payment program.

The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care benefits program through your place of employment.
- When the Plan is terminated and replaced by another health care benefits program.

Certificates of Creditable Coverage

The Plan is required to issue a certificate to you if you change jobs or lose your health care coverage. This Certificate of Coverage provides evidence of your prior coverage.

Certificates will be mailed automatically to everyone who changes or loses their health . You can also request a certificate from your previous employer or insurance company.

Benefits After Termination of Coverage

If you are an inpatient on the day your coverage terminates, facility provider benefits for inpatient covered services will be continued as follows:

- Until the maximum amount of benefits has been paid; or
- Until the inpatient stay ends; or
- Until you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program; whichever occurs first.

If you are pregnant on the date coverage terminates, no additional coverage will be provided.

Coordination of Benefits

Most health care programs, including your PPO program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one health care plan. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments. If you are a Medicare Participant, generally Medicare will be the primary provider of benefits and the Plan will be secondary. This means that Plan benefits will be coordinated with Medicare.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.

- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
  - The parent with custody of the child pays first.
  - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  - the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
  - the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Subrogation

Subrogation means that if you incur health care expenses for injuries caused by another person or organization, the person or organization causing the accident may be responsible for paying these expenses.

For example, if you or one of your dependents receives benefits through the Plan for injuries caused by another person or organization, the Plan has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

The Plan will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support the Plan in any subrogation efforts.

Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

BlueCard® Program

When a member obtains covered services through BlueCard outside the geographic area Highmark serves, the amount a member pays for covered services is calculated on the **lower** of:

- The billed charges for a member's covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (Host Blue) passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price an amount expected from settlements, withholds, any other contingent payment arrangements and non-claims transactions with a member's health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with a member's health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount a member pays is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, Highmark would then calculate a member's liability for any covered services in accordance with the applicable state statute in effect at the time a member received care.

A Recognized Identification Card

The Blue Cross and Blue Shield symbols on your (ID) card are recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor, pharmacy, or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by logging onto www.highmarkbcbs.com.

Below is a sample of the type of information that will be displayed on your ID card:

- Your name and your dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Premier Pharmacy network logo (when applicable)
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)
- "PPO in Suitcase" symbol

There is a logo of a suitcase with "PPO" inside it on your ID card. This PPO suitcase logo lets hospitals and doctors know that you are a member of a Blue Cross and Blue Shield PPO, and that you have access to PPO providers nationwide.

How to File a Claim

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself.

The procedure is simple. Just take the following steps:

- ***Know Your Benefits.*** Review this information to see if the services you received are eligible under your medical program.
- ***Get an Itemized Bill.*** Itemized bills must include:
  - The name and address of the service ;
  - The patient's full name;
  - The date of service or supply;
  - A description of the service or ;
  - The amount charged;
  - The diagnosis or nature of illness;
  - For durable medical equipment, the doctor's certification;
  - For private duty nursing, the nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;
  - For ambulance services, the total mileage.
  - Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills. Submission of an itemized receipt for diabetic or colostomy supplies purchased will be accepted.

- ***Copy Itemized Bills.*** You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- ***Complete a Claim Form.*** Make sure all information is completed properly, and then sign and date the form. *Claim forms are available from the Goodyear Retiree VEBA office, or call the Member Service telephone number on the back of your ID card.*
- ***Attach Itemized Bills to the Claim Form and Mail.*** After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member.

If you file the claim yourself, your claim must be submitted within 90 days of the date of service, but in no event will it be accepted later than one year from the 90-day timeframe.

Your Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement lists: the provider's charge; allowable amount; copayment; deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

Additional Information on How to File a Claim

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Filing Benefit Claims

- ***Authorized Representatives***

You have the right to designate an authorized representative to file or pursue a request for reimbursement or other post-service claim on your behalf. Highmark Blue Cross Blue Shield reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

- ***Requests for Precertification and Other Pre-Service Claims***

For a description of how to file a request for precertification or other pre-service claim, see the Precertification Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

- ***Requests for Reimbursement and Other Post-Service Claims***

When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider's agreement with Highmark or the local licensee of the Blue Cross and Blue Shield Association serving your area. Highmark will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that EOB or notice. If you believe that the copayment, coinsurance or deductible amount identified in that EOB or notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark. For instructions on how to file such claims, you should contact the Member Service Department using the telephone number on your ID card.

Determinations on Benefit Claims

- ***Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims***

For a description of the time frames in which requests for precertification or other pre-service claims will be determined by Highmark and the notice you will receive concerning its decision, whether adverse or not, see the Precertification Pre-Service Claims Review Processes subsection in the Healthcare Management section of this benefit booklet.

- ***Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims***

Highmark will notify you in writing of its determination on your request for reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Highmark for an additional 15 days, provided that Highmark determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period. If an extension of time is necessary because you failed to submit information necessary for Highmark to make a decision on your post-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your post-service claim.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other post-service claim, see the Appeal Procedure subsection below.

Claims Appeal Procedure for Highmark Benefits

Your benefit program maintains an appeal process involving three levels of review with the exception of urgent care claims (which are subject to one level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify Highmark in writing of the designation.

For purposes of the appeal process, “you” includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

Highmark reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by Highmark shall, in the case of an urgent care claim, permit your physician or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

Initial Review

If you receive notification that a claim has been denied by Highmark, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from Highmark of the adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

- When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the Plan sections on which the denial is based, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a pre-service claim, a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a second level review of a pre-service claim (other than an urgent care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a pre-service claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the second level review; and

- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of pre-service claims, you should contact Member Service using the telephone number on your ID card.

Second Level Review

If you are dissatisfied with the decision following the initial review of your appeal (other than an urgent care claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of an adverse benefit determination.

Upon request to Highmark, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from the Appeal Review Department will review the second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any

individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by Highmark. The Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and Highmark will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-urgent care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the appeal; or

- When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event Highmark renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, the Plan sections on which the denial is based, the procedure for appealing the decision and, in the case of an adverse benefit determination involving a post-service claim, a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

Your decision to proceed with a third level review of a claim is voluntary. In other words, you are not required to pursue the third level review of a claim before pursuing a claim for benefits in court under §502 of ERISA. Should you elect to pursue the third level review before filing a claim for benefits in court, your Plan:

- Will not later assert in a court action under §502 of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a third level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the claim for benefits under §502 of ERISA will not commence (i.e. run) during the third level review; and

- Will not impose any additional fee or cost in connection with the third level review.

If you have further questions regarding third level reviews of claims, you should contact Member Service using the telephone number on your ID card.

Third Level Review

If you are dissatisfied with the decision following the second level review of your appeal, you may request to have the decision reviewed by the VEBA Claims and Appeals Subcommittee in accordance with procedures outlined in this Summary Plan Description

Member Service

As a Highmark Blue Cross Blue Shield member, you have access to a wide range of readily available health education tools and support services, all geared to help you "Have A Greater Hand in Your Health."

Blues On Call

Blues On Call, your health information and support service, provides you with up-to-date, easy to understand information about medical conditions and treatment options.

A Health Coach is available at the toll-free telephone number -- 1-888-BLUE-428 -- 24 hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans. Blues On Call offers three levels of health coaching and support:

- Information and support regarding medical procedures and treatment decisions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics

- Support for making medical and surgical decisions that reflect personal preferences, information regarding treatment options, and ongoing support and follow-up throughout treatment, plus links to health information sources

- Condition management for those at risk for hospitalization, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources

Member Service For Highmark

Whether it’s for help with a claim or a question about your benefits, you can call your Member Service toll-free telephone number on the back of your ID card or log onto the Highmark Web site, www.highmarkbcbs.com. A Highmark Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely and accurately.

Highmark Web site

As a Highmark member, you have a wealth of health information at your fingertips. And now it's easier than ever to access all your online offerings. Whether you are looking for a health care provider or managing your claims…want to make informed health care decisions on treatment options…or lead a healthier lifestyle, Highmark can help with easy-to-use online tools and resources.

Go to www.highmarkbcbs.com. Then click on the "Members" tab and log in to your homepage to take advantage of all these health tools:

- ***At "Your Coverage" you can:*** research plan options, review your member information and benefits, get coverage information and request replacement identification cards.
- ***At "Your Spending" you can:*** view your claims, track your health care costs, get information about the costs of medical services and access information on your spending account if you have one.
- ***At "Your Health" you can:*** assess your wellness, link to health care decision support, explore treatment options, and get information on lifestyle improvement and preventive health care recommendations. For example, this tool offers the following programs to you if you are interested in tobacco cessation:

  - **Telephonic Smokeless®** offers two options for smoking cessation. This telephone-based program can be self-guided at your own pace or coordinated by a professional tobacco cessation specialist. Helpful topics include behavior modification, coping with withdrawal, stress reduction and weight management. Participants have unlimited toll-free access to a qualified tobacco cessation specialist to address additional concerns. Discounted nicotine replacement products are available to enrolled participants. Members can participate in one Smokeless program per year, determined from day of enrollment. For more information or to enroll, call Telephonic Smokeless at 1-800-345-2476.

  - **HealthMedia® Breathe™** is an online smoking cessation program that provides a customized, four-part action plan. The program length is based on your chosen quit date. Participants receive one initial and three follow-up tailored action plans. The follow-up plans promote confidence and motivation, increase active participation in the change process and help prevent relapse.

Other lifestyle improvement programs include:

- **HealthMedia® Succeed™** is an online health risk assessment that identifies individual risk, readiness and confidence to make lifestyle changes. Each participant receives a personalized wellness plan with recommendations to improve or maintain their health.
- **HealthMedia® Nourish™** is an eight-week nutrition program, including a tailored action plan.
- **HealthMedia® Balance™** is a six-week weight management and physical activity program that offers a personally tailored action plan.
- **HealthMedia® Relax™** is a five-week stress management program, including a tailored action plan that helps adults effectively cope with stress.
- **HealthMedia® Care™ For Your Health** is a self-management program designed to help individuals take charge of their chronic conditions such as diabetes, asthma, migraines, high blood pressure and high cholesterol.
- **HealthMedia® Care™ For Your Back** is a self-management program designed to help participants with preventing back pain or managing existing back pain.
- **HealthMedia® Care™ For Diabetes** is a program that simulates a one-on-one session with a nurse counselor, providing a high-quality behavior change intervention addressing various diabetes management factors.

- **HealthMedia® Overcoming™ Depression** is a clinically sophisticated self-help online program providing 24/7 access to coping strategies and skills for a wide range of symptoms associated with depression.
- **HealthMedia® Overcoming™ Insomnia** is a six-week online program that uses proven techniques based on sound clinical evidence to help individuals recover from insomnia.

- ***At "Choose Providers" you can:*** access our provider directory which includes a wide range of information on doctors, hospitals and other providers; you can also take advantage of a Wellness Discount Program which offers discounts on complementary and alternative medicine, products and services such as fitness centers and spas, nutrition counseling, yoga and pilates, tai chi, massage and body work, health magazines, mind-body therapies, holistic practitioners, acupuncture, personal trainers, vitamins and chiropractic.

- ***At "Health Topics" you can:*** read articles, get information in the Health Encyclopedia, go "Inside the Human Body," and find the latest information on surgeries and procedures.

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to your Web site wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward.* This newsletter contains new product updates, as well as a wide variety of health and preventive care articles and "stay healthy" tips. Watch for your copy in the mail!

Baby BluePrints

If You Are Pregnant, Now Is the Time to Enroll in Baby BluePrints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about you and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program you will have access to printed and online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy. For participating you will be sent valuable gifts!

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy. Once you enroll, you will receive a Welcome Package that includes:

- A comprehensive Maternity Guide with important health information;
- A guide to educational resources found on your member Web site;
- Flyers on available discount programs/services;
- A Childbirth Education Class Reimbursement form;
- A Child Immunization and Preventive Care pamphlet; and
- Vouchers for the three free gifts:

- Gift at initial enrollment -- choice of book on pregnancy/childcare;
- Gift at the end of the second trimester -- baby photo album; and
- Gift after delivery -- child's dish set and book on child emergency and first aid care.

For More Information

If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting program.

Member Rights and Responsibilities Highmark PPO

Your participation in PPO program vital to maintaining quality in the Plan and services. Your importance to this process is reflected in the following statement of principles.

You have the right to:

1. Receive information about your group health plan, its practitioners and providers, and your rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision-making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Your group health plan does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.
5. Voice a complaint or file an appeal about your group health plan or the care provided and receive a reply within a reasonable period of time.
6. Make recommendations regarding the 'Rights and Responsibilities' policies.

You have a responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

Terms You Should Know

Assisted Fertilization - Any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum. This includes, but is not limited to, artificial insemination, In Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Peritoneal Ovum Sperm Transfer, Zona Drilling, and sperm microinjection.

BlueCard Program - A program comprised of licensees of the Blue Cross and Blue Shield Association which allows you to receive covered services from participating professional, contracting supplier and participating facility providers located outside the plan service area. The local licensee of the Blue Cross and Blue Shield Association that services that geographic area where the covered services are provided is referred to as the "on-site" licensee of the Blue Cross and Blue Shield Association.

Blues On Call - A 24-hour health decision support program that gives you ready access to a specially-trained health coach.

Claim – A request for precertification or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-Service Claim** – A request for precertification or prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent Care Claim** – A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.
- **Post-Service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Custodial Care - Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Designated Agent - An entity that has contracted with the health plan to perform a function and/or service in the administration of this program. Such function and/or service may include, but is not limited to, medical management and provider referral.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined be medically effective for the condition being treated. An intervention is considered to be experimental/investigative if:

the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical Researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "experimental/investigative" and is not generally covered. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new pharmaceuticals. The Pharmacy and Therapeutics (P & T) Committee assesses new pharmaceuticals based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

Situations may occur when you elect to pursue experimental/investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Highmark's Member Service to determine coverage.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Medically Necessary and Appropriate - Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

Methadone Maintenance - The treatment of heroin or other morphine-like drug dependence where you are taking methadone hydrochloride daily in prescribed doses to replace the previous heroin or other morphine-like drug abuse.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Plan - Refers to Highmark, which is an independent licensee of the Blue Cross and Blue Shield Association. Any reference to the plan may also include its designated agent as defined herein and with whom the plan has contracted to perform a function or service in the administration of this program.

Precertification (Preauthorization) - The process through which selected covered services are pre-approved by Highmark.

Preferred Provider Organization (PPO) Program - A program that does not require the selection of a primary care physician, but is based on a provider network made up of physicians, hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

Primary Care Physician (PCP) - A physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care.

Provider's Reasonable Charge ***(also called "Allowable Charge")*** - The allowance or payment that is determined to be reasonable for covered services based on the provider who

renders such services. The PRC is the portion of the provider's billed charge that is used to calculate the payment to that provider and your liability.

Specialist - A physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your immediate family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

You or Your - Refers to individuals who are covered under the program.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark al número al réves de su tarjeta de identificación de Highmark. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00, y los sábados de 8:00 a 17:00.

HIGHMARK INC.
NOTICE OF PRIVACY PRACTICES

PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark, we are committed to protecting the privacy of your protected health information. "Protected health information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

We will inform you of these practices the first time you become a Highmark Inc. customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice became effective April 1, 2003, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

For example:
We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business and the like.

B. Uses and Disclosures of Protected Health Information to Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to our members.

(i) Business Associates.
In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization

management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Other Covered Entities.
In addition, we may use or disclose your protected health information to assist health care providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected Health Information

In addition to uses and disclosures for payment, and health care operations, we may use and/or disclose your protected health information for the following purposes:

A. To Plan Sponsors

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law

We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions.

Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. **Abuse or Neglect**

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. **Legal Proceedings**

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. **Law Enforcement**

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. **Coroners, Medical Examiners, Funeral Directors, and Organ Donation**

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. **Research**

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. **To Prevent a Serious Threat to Health or Safety**
Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. **Military Activity and National Security, Protective Services**
Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. **Inmates**
If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. **Workers' Compensation**
We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. **Others Involved in Your Health Care**
Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

III. Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make:

A. **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. **Disclosures to You**

We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of

your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights

The following is a description of your rights with respect to your protected health information:

A. Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

B. Right to an Accounting

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Privacy Department, 1800 Center Street, Camp Hill, PA 17089. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the

alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate.

E. Right to Request Amendment

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice

If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints

If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH–BLILEY)

Highmark is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark customer and will annually reaffirm our privacy policy for as long as the group remains a Highmark customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member‘s participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators. This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status, dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.
- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.
- We may disclose information under order of a court of law in connection with a legal proceeding.
- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.
- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Privacy Department
Telephone: 1-866-228-9424 (toll free)
Fax: 1-717-302-3601
Address: 1800 Center Street
Camp Hill, PA 17089

You are hereby notified that Highmark Blue Cross Blue Shield provides administrative services only on behalf of your self-funded group health plan. Highmark Blue Cross Blue Shield is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct operation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Cross Blue Shield is neither the insurer nor the guarantor of benefits under your group health plan. Your Group remains fully responsible for the payment of group health plan benefits.

HIGHMARK® Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Plan of Benefits

Goodyear Retiree VEBA Health Care Plan

Catastrophic Prescription Drug Benefits

Post May 1, 1991 Retirees
Enrolled in the Catastrophic Plan

Effective: January 1, 2010

Table of Contents

(A) General

(1) The prescription drug benefit is administered by Express Scripts.

(2) Prescription drug benefits will be provided if a Participant, as a result of an accident or sickness, incurs expenses for covered prescription drugs dispensed by any person or organization legally licensed to dispense drugs upon the order of a physician licensed to practice medicine, subject to the rules and limitations set forth herein.

(B) Benefits

Benefits are provided through participating providers who have agreed to accept, as full payment for a covered prescription drug, the amount payable by the Plan, plus a co-payment by the Participant as indicated on the chart below.

Post 1991 Catastrophic Benefits	
Retail (30 day supply)	
Generic	$10.00
Preferred Name Brand (formulary)	$25.00
Non Preferred Name Brand	$50.00
Specialty Drugs- CuraScript Pharmacy (30 day supply)	
Generic	$8.33
Preferred Name Brand (formulary)	$20.00
Non Preferred Name Brand	$41.66
Mail Order – Exclusive Home Delivery (90 day supply)	
Generic	$25.00
Preferred Name Brand (formulary)	$60.00
Non Preferred Name Brand	$125.00

(1) The co-payment amount is to be paid by the Participant and is applicable to each separate prescription order and to each refill of that prescription. Coverage is limited to a 30 day supply. Maintenance prescriptions may be filled up to two times at a retail pharmacy and then must be obtained through Express Scripts Exclusive Home Delivery Service (EHD), or through CuraScripts in the case of certain Specialty medications as described below.

(2) Maintenance drug requirements must be filled through the Express Scripts Exclusive home Delivery Service (EHD). The co-payment amount is to be paid by the Participant and is applicable to each separate prescription order and to each refill thereof. Coverage is limited to a 90 day supply.

(3) Drugs in the following drug groups will be subject to a co-payment of 50% of the discounted cost at retail pharmacies and through the Exclusive Home Delivery (EHD) Service, as follows:

(i) Drugs to treat Gastro Esophageal Reflux Disease, including Histamine-2 Receptor Antagonists (examples: Zantac, Pepcid) and Proton Pump Inhibitors; (examples: Nexium, Aciphex, Prevacid)

(ii) Drugs to treat sexual dysfunction, including erectile dysfunction; including drugs such as Viagra, Levitra and Cialis; and

(iii) Non-Sedating Antihistamines; which includes drugs such as Clarinex and Allegra

(4) If a covered prescription drug is dispensed by a non-participating retail provider, the amount of the benefit for each separate prescription order and each refill thereof will be:

(i) The dispensing fee for the covered prescription drug which would have been paid to a participating provider for dispensing similar drugs, plus

(ii) the amount that would have been paid to a participating provider, plus

(iii) any applicable state sales tax for the covered prescription drug, less the applicable copayment stated in the paragraphs above.

(5) If a name brand drug is dispensed in lieu of a generic equivalent drug the reimbursement will be limited to the amount payable as if the generic drug had been dispensed. If a participant chooses a brand drug and there is a generic available, the participant will be required to pay the brand (preferred or non-preferred) copay plus the difference in cost between the brand and the generic drug.

(C) Covered Prescription Drugs

Covered prescription drugs covered include:

(1) Injectable insulin or any Prescription Legend Drug for which a prescription is required;

(2) A compound medication of which at least one ingredient is a Prescription Legend Drug; and

(3) Any other drug which under the applicable state law may be dispensed only upon the prescription of a physician provided that a prescription drug shall not be covered under this Paragraph if:

i. the cost thereof is included in the cost of other services or supplies provided to or prescribed for the Participant; or

ii. such drug is consumed at the time and place the prescription is ordered, except however a drug dispensed by a licensed pharmacy doing business with the public will be covered; and

iii. the drug has not been approved by the Food and Drug Administration for treatment of the medical condition for which it was prescribed.

"Prescription Legend Drug" means, any medical substance the label of which under the Federal Food, Drug, and Cosmetic Act, as from time to time amended, is required to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription".

(D) Exclusions and Limitations

(1) No benefit shall be payable to a Participant who is entitled to receive reimbursement under any Workers' Compensation Laws or is entitled to benefits from any municipal, state, federal or any other governmental program.

(2) No benefit shall be payable for any medication or device which is to be used for contraceptive purposes, or for any therapeutic device or appliance (e.g., hypodermic needles, syringes, support garments and other non-medicinal substances).

(3) No benefit shall be payable for the administration of any medication.

(4) When a prescription drug is dispensed no benefit shall be payable for any medication for which the customary and usual charge is less than the co-payments stated above.

(5) No benefit shall be payable for more than a 90-day supply of any medication through the Express Scripts Exclusive Home Delivery (EHD) Service (or more than 30-day supply when dispensed at a retail pharmacy), except as noted in paragraph (7), or for any refill in excess of the number specified by the physician or for any refill dispensed after one year from the physician’s order.

(6) No benefit shall be payable for any drug defined in paragraph (C) above the reimbursement for which is considered taxable income by the Internal Revenue Service.

(7) Notwithstanding the above, benefits shall be payable for up to a 90-day supply of allergy serum medication dispensed at a retail pharmacy.

(8) No benefit shall be payable for any drug prescribed for treatment of a medical condition that has not been approved by the Food and Drug Administration or that is experimental.

(9) No benefit shall be payable for any drugs used in treatment of a non-covered medical condition or that is not medically necessary.

(10) The eligible charges payable herein by the Participant will not be included for purposes of meeting the deductible of the Medical Benefits program nor will they apply towards the out-of-pocket maximum of the Medical Benefits program.

(E) Coordination of Benefits with Other Plans

The primary payer is considered primary because claims are sent to them first for processing. This payer usually pays the largest portion of the cost of your medications and supplies. Secondary payers typically pay a smaller portion of the costs and only process the claim after the primary payer has determined its responsibility.

If you or your dependents are covered by another plan as primary, Express Scripts will coordinate payments in the following manner:

Point of Sale COB – At the retail pharmacy the participant provides both primary and secondary insurance cards and the Participant will pay the lower of the two copays.

Member Submit COB – If the Participant sends in a claim form along with pharmacy receipts from the primary payer, he/she will be reimbursed the difference between the copay he/she paid at the retail pharmacy and this plan's copay.

Member Submit COB – If a participant sends in a claim form along with an Explanation Of Benefits from the primary payer that shows what the primary carrier paid for that particular drug, Express Scripts will subtract that amount from this plan's allowable cost. Express Scripts will then subtract the Plan's copay and determine the reimbursement amount.

(F) Coordination with Medicare Part B

For Medicare Part B-covered medications and supplies, Medicare Part B is the primary payer and this plan is the secondary payer. Medicare Part B generally pays up to 80% of Part B-covered medication and supply costs after you have met the annual Medicare Part B deductible.

Express Scripts, your pharmacy benefit manager, is working with NationsHealth, for the delivery of your Medicare Part B-covered prescription medications and medical supplies. With home delivery from NationsHealth you can relax, knowing your Medicare Part B-covered items are delivered right to your home. Additional information on Nations Health can be obtained at the following website: http://nationshealth.bgallegos.webfactional.com/dev/

If you are prescribed Medicare Part B medications and supplies and want to take advantage of the convenient home delivery program, simply call NationsHealth at 1-800-608-7619. You may continue to pick up your supplies and/or medications at your local network retail pharmacy if the pharmacy is a participating Medicare Part B pharmacy. Even if you normally use a local retail pharmacy, you may find that the NationsHealth home delivery program offers a more convenient solution for receiving your Medicare Part B medications and supplies.

Which prescription medications and medical supplies are covered by Medicare Part B?
Most prescription medications are not covered under Medicare Part B and you will continue to receive them as usual through this Plan. The following are categories of medications and supplies that are generally covered under your Medicare Part B:

Diabetes Testing Supplies
- Glucose meters
- Test strips
- Lancets
- Lancing devices
- Control solutions
- Batteries
- Insulin pump supplies

Respiratory Medications
- Unit dose nebulizer medications
  - Albuterol
  - Ipratroprium
  - Cromolyn sodium

Respiratory Supplies
- Tubing and circuits
- Masks

Immunosuppressive Medications
- Cyclosporine

- Tacrolimus
- Prednisone

Anti-Cancer Medications

- Busulfan
- Capecitabine
- Etoposide

Anti-Nausea Medications

- Aprepitant
- Dexamethasone
- Nabilone

(G) Specialty Drug Program

The Plan offers Curascripts, as an option for obtaining certain specialty medications. This option provides broad access to specialty medications and maximum flexibility by allowing participants to use the CuraScript Specialty Pharmacy, which is recommended, or their retail network for specialty medications.

Participants (and their physicians) filling specialty medications at retail will receive a letter upon each fill providing them with the benefits and instructions for switching to a CuraScripts pharmacy. Participants can contact CuraScripts at 866-292-4398 with any questions.

Specialty medications are not available through the Exclusive Home Delivery program.

(H) Participant Submit Claims

If you receive services from a provider or pharmacy which cannot submit a claim electronically, or if you are filing a claim for secondary coverage, you will have to file a paper claim.

A claim form may be requested by contacting Express Scripts Customer Service at 1-800-451-6245.

Each paper submission must include:

Prescription receipts/labels **or** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that claims received missing any of the above information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple or glue.

Participants should submit a claim form along with pharmacy receipts to:

Express Scripts, Inc.
Member Reimbursements
PO Box 66583
St. Louis, MO 63166

(I) Prescription Drug Management Programs

This section applies to all classes of retirees

- **Step Therapy** (Effective March 1, 2010)
  Certain medications may require step therapy. Step Therapy guides participants and physicians into using first-line therapies when appropriate. It applies an edit at the point-of-service to encourage the use of first-line therapies, which are often generic medications or lower cost brand alternatives. Coverage of the drug is based on the Participant's specific profile, and based on whether or not the Participant has tried the first-line agent, which is usually a generic medication. Participants and/or prescribers may request an override through the Prior Authorization process described below.
- **Drug Quantity Management (DQM)** (Effective January 1, 2010)
  Certain medications are limited to quantities aligned with FDA-approved dosage guidelines. In addition, consolidation of dosing ensures that the most cost-effective product strength is dispensed. Participants and/or prescribers may request an override through the Prior Authorization process described below.

- **Prior Authorization** (Effective March 1, 2010)
  Certain medications require that a statement from the prescribing physician must be obtained before a medication is dispensed verifying that the medication is being used for a medically approved indication. Prior Authorization (PA) promotes clinically appropriate, cost-effective therapy by ensuring that higher-cost medications are used only for medically appropriate conditions before the claim is processed.

(J) Appeals

Express Scripts, Inc. provides claim administration services to the Goodyear Retiree VEBA for its Prescription Drug Benefit Program, including the review of requests for reconsideration of prescription drug benefit and coverage determinations.

At any time you may request a review of your benefit denial by contacting the member service phone number on the back of your card. If you are still not satisfied with the decision of Express Scripts, you may then file an official appeal of this benefit determination by following the below process.

Initial Review

Express Scripts will notify you if you receive an adverse benefit determination. 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 claim you sought. This includes determinations based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate.

Appeals may be submitted as soon as possible, however all appeals must be submitted within 180 days of receipt of the initial denial letter. You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim.

You should know that you have the right, upon written request and free of charge, to access and receive copies of the documents, records and other information that are relevant to your claim for benefits and that were utilized to reach the decision.

Appeals may be submitted by sending the request directly to Express Scripts at the following address:

Express Scripts, Inc.
Attn: Pharmacy Appeals – AN2
Mail Route BL 0390
6625 West 78th Street
Bloomington, MN 55439
Fax (877) 852-4070

Should you have a question about the determination, you may call Express Scripts Appeal Department at (800) 417-8164.

Final Determination

You have the right to a final appeal of this decision. If you wish to appeal, you may send your written request and all documentation regarding your claim, within 180 days from the date you receive your final determination letter from Express Scripts to:

Chairman, Appeals Sub-Committee
Retirees of the Goodyear Tire and Rubber Company Health Care Trust
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222

Dental Plan of Benefits

Delta Dental PPO

Our National Point-of- Service program

Welcome!

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 524-0149 or access our Web site at www.deltadentaloh.com.

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.deltadentaloh.com and selecting the link for our Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms and ID cards, search our dentist directories, and read oral health tips.

We look forward to serving you!

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Note: This Dental Care Certificate should be read in conjunction with the Summary of Dental Plan Benefits that is provided with the Certificate. The Summary of Dental Plan Benefits lists the specific provisions of The Goodyear Retiree VEBA dental Plan.

Notice: If you or your family members are covered by more than one health care and/or dental care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific Dentists, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

Summary of Dental Plan Benefits

Delta Dental PPO (Point-of-Service)
For Group #1011-0001, 0002, 0005

This Summary of Dental Plan Benefits shou ı conjunction with your Dental Care Certificate. Your Dental Care Certificate wi ɔu with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental`s programs, you may be responsible for more than the percentage indicated below.

Control Plan – Delta Dental of Ohio
Benefit year – January 1 through December 31
Covered Services -

	PPO Dentist	**Premier Dentist**	**Nonparticipating Dentist**
	Plan Pays	Plan Pays	Plan Pays
All Other Radiographs - other X-rays	100%	100%	100%
Periodontic Services - to treat gum disease	100%	100%	100%
Endodontic Services - includes root canals	100%	100%	100%
Oral Surgery Services - extractions and dental surgery	100%	100%	100%
TMD Treatment - treatment of the disorder of the temporomandibular joint	100%	100%	100%

- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint, including appliance therapy and surgical correction. This does not include services that would normally be provided under medical care. Predetermination is required when TMD treatment will exceed $250 or no coverage will be made.

- All oral surgery services performed by a dentist are Covered Services, including IV sedation and general anesthesia when performed in conjunction with periodontic, endodontic, and oral surgery services.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to the International SOS Assistance (I-SOS) worldwide network of dentists and dental clinics. English-speaking I-SOS operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – None.
Deductible – None.

Summary of Dental Plan Benefits

Delta Dental PPO (Point-of-Service)
For Group #1011-0003, 0004

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental`s programs, you may be responsible for more than the percentage indicated below.

Control Plan – Delta Dental Plan of Ohio
Benefit year – January 1 through December 31
Covered Services -

	PPO Dentist	**Premier Dentist**	**Nonparticipating Dentist**
	Plan Pays	Plan Pays	Plan Pays
All Other Radiographs - other X-rays	80%	80%	80%
Periodontic Services - to treat gum disease	80%	80%	80%
Endodontic Services - includes root canals	80%	80%	80%
Oral Surgery Services - extractions and dental surgery	80%	80%	80%
Other Basic Services - misc. services	80%	80%	80%
TMD Treatment - treatment of the disorder of the temporomandibular joint	80%	80%	80%

- Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint, including appliance therapy and surgical correction. This does not include services that would normally be provided under medical care. Predetermination is required when TMD treatment will exceed $250 or no coverage will be made.

- All oral surgery services performed by a dentist are Covered Services, including IV sedation and general anesthesia when performed in conjunction with periodontic, endodontic, and oral surgery services.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to the International SOS Assistance (I-SOS) worldwide network of dentists and dental clinics. English-speaking I-SOS operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.
Maximum Payment – None.
Deductible – None.

I. Delta Dental PPO Dental Care Certificate

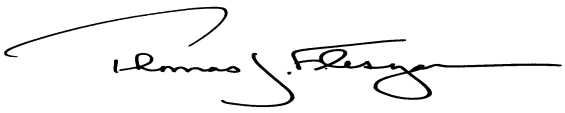
Delta Dental issues this Certificate to you, the Subscriber. The Certificate is an easy-to-read summary of your dental benefits Plan. It reflects and is subject to the agreement between Delta Dental and The Goodyear Retiree VEBA.

The benefits provided under the Plan may change if any state or federal laws change.

Delta Dental agrees to provide dental benefits as described in this Certificate.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Thomas J. Fleszar, DDS, MS
President and CEO
Delta Dental Plan of Ohio, Inc.

II. Definitions

Certificate
This document. Delta Dental will provide dental benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Plan.

Completion Dates
Some procedures may require more than one appointment before they can be completed. For root canals and periodontal treatment, treatment is complete on the date of the final procedure that completes treatment.

Control Plan (Delta Dental)
The Delta Dental Plan that contracts with your group. The Control Plan will provide all claims processing, service, and administration for a group. The Summary of Dental Plan Benefits identifies your Control Plan. The Control Plan will be referred to as Delta Dental in this document.

Concurrent Care Claims
Claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or the administrator of your Plan and the coverage for that treatment is reduced or terminated before the treatment has been completed. A Concurrent Care Claim may also arise if you ask the Plan to extend coverage beyond the time period or number of treatments previously agreed to.

Covered Services
The unique benefits selected in your Plan. The Summary of Dental Plan Benefits provided with this Certificate lists the Covered Services provided by your Plan.

Delta Dental
Delta Dental Plan of Ohio, Inc., a health-insuring corporation providing dental service benefits. Delta Dental is not a commercial insurance company.

Delta Dental Plan
An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO (Point-of-Service)
Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a non-PPO Dentist

Delta Dental Plan
An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO (Point-of-Service)
Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from one of Delta Dental's PPO Dentists. This program has back-up coverage through Delta Dental Premier when treatment is received from a non-PPO Dentist.

Delta Dental Premier
Delta Dental's national fee-for-service dental benefits program that covers you when you go to a non-PPO Dentist.

Dentist
A person licensed to practice dentistry in the state or country in which dental services are rendered.

- **Delta Dental PPO Dentist (PPO Dentist)** or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

- **Delta Dental Premier Dentist (Premier Dentist)** or Participating Dentist – a Dentist who has signed an agreement with the Delta Dental Plan in his or her state to participate in Delta Dental Premier. Delta Dental Premier Dentists agree to accept Delta Dental's fee determination as payment in full for Covered Services.

  Wherever a term of this Certificate differs from your state Delta Dental and its agreement with a Participating Dentist, the agreement in that state with that Dentist will be controlling.

- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to participate in Delta Dental PPO or Delta Dental Premier.

- **Out-of-Country Dentist** – A Dentist whose office is located outside of the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

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 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 circumstances.
- 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.

Nonparticipating Dentist Fee
The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

Out-of-Country Dentist Fee
The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist.

Plan
The arrangement for the provision of dental benefits to eligible people established by the contract between Delta Dental and The Goodyear Retiree VEBA.

Post-Service Claims
Claims for benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

PPO Dentist Schedule
The maximum amount allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Predetermination (Pre-Service Claims)
An estimate of the costs of Covered Services to be provided. A Dentist may submit his or her treatment plan to Delta Dental before providing services. Delta Dental reviews the treatment plan and advises you and your Dentist of what services are covered by your Plan and what Delta Dental's payments may be. Delta Dental's payment for predetermined services depends on continued eligibility and the annual or lifetime Maximum Payments available under your Plan. You are not required to seek a Predetermination for any other services. You will receive the same benefits under your Plan whether or not a Predetermination is requested. Predetermination is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under your Plan. Since you may be responsible for any cost not covered under your Plan, this is likely to be useful information for you when deciding whether to incur those costs. (EXCEPTION: Predetermination *is* required when TMD treatment will exceed $250, or no coverage will be made.)

Processing Policies
Delta Dental's policies and guidelines used for Predetermination and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount or Submitted Fee
The fee a Dentist bills to Delta Dental for a specific treatment.

Subscriber
You, when The Goodyear Retiree VEBA notifies Delta Dental that you are eligible to receive dental benefits under your organization's Plan.

Summary of Dental Plan Benefits
A description of the specific provisions of this dental Plan. The Summary of Dental Plan Benefits is, and should be read as, a part of this Dental Care Certificate.

Urgent Care Claims
Those potentially life-threatening claims as defined in the U.S. Department of Labor Regulations at 29 CFR 2560.503-1(M)(1)(I). Any such claims that may arise under this dental coverage are not considered to be Pre-Service Claims and are not subject to any Predetermination requirements.

III. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental PPO Dentist. PPO Dentists agree to accept payment according to the PPO Dentist Schedule, and, in most cases, this results in a reduction of their fees. Delta Dental may also pay a higher percentage for Covered Services if you go to a PPO Dentist.

If the Dentist you select is not a PPO Dentist, you will have back-up coverage through Delta Dental Premier. Again, your out-of-pocket expenses will vary depending on the participating status of the Dentist. Your coverage levels may be slightly lower, but you can still save money. In this case, there are two options:

- If you go to a non-PPO Dentist who participates in Delta Dental Premier, the fee reduction is not the same as with the PPO Dentists. However, Premier Dentists agree to accept Delta Dental's Maximum Approved Fee as payment in full for Covered Services.
- If you choose a Dentist who does not participate in either program, you will be responsible for any difference between Delta Dental's allowed fee and the Dentist's Submitted Fee, in addition to any Copayment.

A list of Participating Dentists will be provided. Although this list is accurate as of the date printed on it, it changes frequently. To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.deltadentaloh.com or call (800) 524-0149.

IV. Accessing Your Benefits

To use your Plan, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with the benefits, payment mechanisms, and provisions of your Plan.

2. Make an appointment with your Dentist and tell him or her that you have dental benefits coverage with Delta Dental. If your Dentist is not familiar with your Plan or has questions about the Plan, have him or her contact Delta Dental by (a) writing Delta Dental, Attention: Customer Service, P.O. Box 30416, Lansing, Michigan, 48909-7916, or (b) calling the toll-free number, (800) 524-0149.

3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:

    a. The Subscriber's full name and address;

    b. The Subscriber's Member ID number;

    c. The name and date of birth of the person receiving dental care;

    d. The group's name and number.

Claims and completed information requests should be mailed to:

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

Delta Dental recommends Predetermination before your Dentist provides any services where the total charges will exceed $200. Predetermination is not a prerequisite to payment, but it allows claims to be processed more efficiently and allows you to know what services will be covered before your Dentist provides them. You and your Dentist should review your Predetermination Notice before treatment. Once treatment is complete, the dental office will enter the dates of service on the Predetermination Notice and submit it to Delta Dental for payment. (**EXCEPTION:** Predetermination *is* required when TMD treatment will exceed $250, or no coverage will be made.)

Because the amount of your benefits is not conditioned on a Predetermination decision by Delta Dental, all claims under this Plan are Post-Service Claims. Once a claim is filed, Delta Dental will decide it within 30 days of receiving it. All claims for benefits must be filed within 12 months of the date the services were completed. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or your Dentist that the information must be received within 45 days or your claim will be denied. You will receive a copy of any notice that is sent to your Dentist. Once Delta Dental receives the requested information, it will have 15 days to decide your claim. If you or your Dentist fails to supply the requested information, Delta Dental will

have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

If you have been approved for a course of treatment and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen or extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, if your claim is denied (in whole or in part), you can seek a review of that decision before the course of treatment is scheduled to terminate.

You may also appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Human Resources department, call Delta Dental's Customer Service department, toll-free, at (800) 524-0149, or write them at P.O. Box 30416, Lansing, Michigan, 48909-7916, to request a form to fill out designating the person you wish to appoint as your representative. While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate with you directly.

Questions regarding your plan or coverage should be directed to Delta Dental's Customer Service department, toll-free, at (800) 524-0149. You may also write to Delta Dental's Customer Service department, P.O. Box 30416, Lansing, Michigan, 48909-7916. When writing to Delta Dental, please include your name, the group's name and number, the Subscriber's Member ID number, and your daytime telephone number. Questions concerning eligibility should be directed to the be addressed to the Goodyear Retiree VEBA Office at 60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222 or by calling (866) 694-6477.

V. How Payment is Made

1. If the Dentist is a PPO Dentist and a Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount;

   b. The PPO Dentist Schedule; or

   c. The Maximum Approved Fee.

   Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the PPO Dentist Schedule or the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the lesser of the PPO Schedule Amount, the Maximum Approved Fee, or the Dentist's Submitted

Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

2. If the Dentist is a PPO Dentist but is not a Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The PPO Dentist Schedule.

   Delta Dental will send payment to the PPO Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the PPO Dentist Schedule for Covered Services. The Subscriber will be responsible for the lesser of the PPO Schedule Amount or the Dentist's Submitted Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

3. If the Dentist is not a PPO Dentist but is a Premier Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Maximum Approved Fee.

   Delta Dental will send payment to the Premier Dentist, and the Subscriber will be responsible for any difference between Delta Dental's payment and the Maximum Approved Fee for Covered Services. The Subscriber will be responsible for the lesser of the Maximum Approved Fee or the Dentist's Submitted Amount for most commonly-performed noncovered services. For other noncovered services, the Subscriber will be responsible for the Dentist's Submitted Amount.

4. If the Dentist does not participate in Delta Dental PPO or Delta Dental Premier, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Nonparticipating Dentist Fee.

   Delta Dental will usually send payment to the Subscriber, who will be responsible for making payment to the Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

5. For dental services rendered by an Out-of-Country Dentist, Delta Dental will base payment on the lesser of:

   a. The Submitted Amount; or

   b. The Out-of-Country Dentist Fee.

   Delta Dental will usually send payment to the Subscriber, who will be responsible for making payment to the Dentist. The Subscriber will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

VI. Benefits

Important
Eligible people are entitled to ONLY those benefits listed in the Summary of Dental Plan Benefits.

Diagnostic Services
Services and procedures to evaluate existing conditions. These services include specialty examinations and evaluations.

X-Rays
Periapical X-rays as necessary for the diagnosis of a specific condition.

Oral Surgery Services
Extractions and dental surgery, including preoperative and postoperative care.

Endodontic Services
The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services
The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes).

Other Benefits
The Summary of Dental Plan Benefits lists any other benefits that may have been selected.

VII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the following services will be the responsibility of the Subscriber (though the Subscriber's payment obligation may be satisfied by insurance or some other arrangement for which the Subscriber is eligible):

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act; that is, Medicaid.
2. Services, as determined by Delta Dental, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.
3. Services or appliances started before a person became eligible under this Plan.

4. Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications, and relative analgesia.
5. Charges for hospitalization, laboratory tests, and histopathological examinations.
6. Charges for failure to keep a scheduled visit with the Dentist.
7. Services, as determined by Delta Dental, 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.
8. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
9. Those benefits excluded by the policies and procedures of Delta Dental, including the Processing Policies.
10. Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
11. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
12. Services that are covered under a hospital, surgical/medical, or prescription drug program.
13. Services that are not within the classes of benefits that have been selected and that are not in the contract.
14. Desensitizing medicaments.
15. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc).
16. Occlusal guards and complete occlusal adjustments.
17. Lost, missing, or stolen appliances of any type.
18. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
19. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion; or for periodontal splinting.
20. Paste-type root canal fillings on permanent teeth.
21. Replacement, repair, relines, or adjustments of occlusal guards.
22. Chemical curettage.
23. Personalization/characterization of any service or appliance.
24. Specialized implant surgical techniques.
25. Diagnostic photographs and cephalometric films.

26. Mounted case analyses.
27. The completion of claim forms.
28. Consultations, when performed in conjunction with examinations/evaluations or diagnostic procedures.
29. Local anesthesia.
30. Infection control.
31. Gingivectomy as an aid to the placement of a restoration.
32. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
33. Post-operative X-rays, when done following any completed service or procedure.
34. Periodontal charting.
35. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
36. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
37. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
38. Retreatment of a root canal by the same Dentist or dental office within 24 months of the original root canal treatment.
39. A prophylaxis or subgingival curettage, when done on the same day as root planing.
40. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
41. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The benefits for the following services are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services that exceed these limitations will be the responsibility of the Subscriber. All time limitations are measured from the last date of service in any Delta Dental record or, at the request of your group, any dental plan record:

1. Benefits for Temporomandibular Disorders (TMD) are limited to those services normally provided by a dentist to relieve oral symptoms associated with malfunctioning of the temporomandibular joint, including appliance therapy and surgical correction. This does not include services that would normally be provided under medical care. Predetermination is required when TMD treatment will exceed $250 or no coverage will be made.

2. All oral surgery services performed by a dentist are Covered Services, including IV sedation and general anesthesia when performed in conjunction with periodontic, endodontic, and oral surgery services.
3. Delta Dental's obligation for payment of benefits ends on the last day of the month in which coverage is terminated. However, Delta Dental will make payment for Covered Services provided on or before the termination date, as long as it receives a claim for those services within one year of the date of service.
4. When services in progress are interrupted and completed later by another Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each Dentist.
5. Care terminated due to the death of an eligible person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
6. Processing Policies may limit treatment.
7. Benefits for root planing by the same Dentist or dental office are payable once in any two-year period.
8. Periodontal surgery, including subgingival curettage, by the same Dentist or dental office is payable once in any three-year period.
9. A limited occlusal adjustment is not a benefit more than three times in a five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
10. Tissue conditioning is not a benefit more than twice per arch in 36 months.
11. Processing Policies may limit treatment.

VIII. Coordination of Benefits

Coordination of Benefits (COB) is used to pay health care expenses when you are covered by more than one plan. Delta Dental follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective of coordination of benefits is to make sure the combined payments of the plans are no more than your actual bills.

When you or your family members are covered by more than one plan, Delta Dental follows the Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Delta Dental pays for health care only when you follow its rules and procedures. If these rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans That Do Not Coordinate

Delta Dental will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid
- Group hospital indemnity plans that pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

How Delta Dental Pays as Primary Plan

When Delta Dental is primary, it will pay the full benefit allowed by your contract as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is secondary, its payments will be based on the amount remaining after the primary plan has paid. Delta Dental will not pay more than that amount, and it will not pay more than it would have paid as primary.

Delta Dental will pay only for health care expenses that are covered by Delta Dental.

Delta Dental will pay only if you have followed all of the procedural requirements.

Delta Dental will pay no more than the "allowable expenses" for the health care involved. If the allowable expenses are lower than the primary plan's, Delta Dental will use the primary plan's allowable expenses. This may be less than the actual bill.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The primary plan will be determined by the first of the following rules that applies:

1. **Non-coordinating Plan**

   If you have another group plan that does not coordinate benefits, it will always be primary.

2. **Employee**

   The plan that covers you as an employee (neither laid off nor retired) is always primary.

3. **Children (Parents Divorced or Separated)**

   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.
   If a court decree gives joint custody and does not mention health care, Delta Dental follows the birthday rule.

   If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. **Children and the Birthday Rule**

When your Children's health care expenses are involved, Delta Dental follows the "birthday rule." Under this rule, the plan of the parent with the first birthday in a calendar year is always primary for the Children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" that says the father's plan is always primary), Delta Dental will follow the rules of that plan.

5. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Coordination Disputes

If you believe that Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting Delta Dental. If you are still not satisfied, you may call the Ohio Department of Insurance at (614) 644-2673 or (800) 686-1526 for instructions on filing a consumer complaint.

IX. 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 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, Michigan, 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, you must send your request in writing to:

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

You must include your name and address, the Subscriber's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of 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.

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 will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. 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 the Dental Director 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 the Dental Director'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 the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his 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 the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

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.

Third Level Review

If you are dissatisfied with the decision following the second level review of your appeal, you may request to have the decision reviewed by the VEBA Claims and Appeals Subcommittee in accordance with procedures outlined in this Summary Plan Description

If you are still not satisfied, you may contact the Ohio Department of Insurance for instructions on filing a consumer complaint by calling (614) 644-2673 or (800) 686-1526. You may also write to the Consumer Services Division of the Ohio Department of Insurance, 2100 Stella Court, Columbus, Ohio, 43216-1067.

X. General Conditions

Assignment
Services and/or benefit payments to eligible people are for the personal benefit of those people and cannot be transferred or assigned, other than to the extent necessary to allow direct payments to Participating Dentists.

Subrogation and Right of Reimbursement
This provision applies when Delta Dental pays benefits for personal injuries and you have a right to recover damages from another.

Subrogation
If Delta Dental pays benefits under this Certificate and you have a right to recover damages from another, Delta Dental is subrogated to that right. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

To the extent that the Plan provides or pays benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent may have to recover from another, his or her insurer, or under his or her “Medical Payments” coverage or any “Uninsured Motorist,” “Underinsured Motorist,” or other similar coverage provisions.

Reimbursement
If you or your Eligible Dependent recovers damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.

Obligation to Assist in the Plan or Delta Dental's Reimbursement Activities
If you are involved in an automobile accident or require Covered Services that may entitle you to recover from a third party, and the Plan or Delta Dental advances payment to prevent any financial hardship to you or your family, you and your Eligible Dependents have an obligation to help the Plan and/or Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. As part of this obligation, you and your covered Eligible Dependents are required to provide the Plan and/or Delta Dental with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity and his or her insurers (if known), that may be obligated to provide payments or benefits on account of the same Covered Services for which the Plan made payments.

Eligible people are required to (a) cooperate fully in the Plan's and/or Delta Dental's exercise of their right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without notifying the Plan or Delta Dental, or not including the Plan or Delta Dental as a co-payee of any settlement amount), (c) sign any document deemed by Delta Dental or the Plan Administrator to be relevant in protecting the Plan's and Delta Dental's subrogation and reimbursement rights, and (d) provide relevant information when requested.

The term "information" here includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help the Plan and/or Delta Dental enforce their rights. Failure by an eligible person to cooperate with the Plan or Delta Dental in the exercise of these rights may result, at the discretion of Delta Dental or the Plan Administrator, in a reduction of future benefit payments available to that person under the Plan of an amount up to the aggregate amount paid by the Plan or Delta Dental that was subject to the Plan's or Delta Dental's equitable lien, but for which the Plan or Delta Dental was not reimbursed.

Obtaining and Releasing Information
While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your claims and administer your benefits. This includes allowing Delta Dental to have access to your dental records.

Dentist-Patient Relationship
Eligible people are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment
If an eligible person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under the Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. Any balance of the total fee not paid by Delta Dental is your responsibility

Late Claims Submission
Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within one year following the date the services were completed.

Change of Certificate or Contract
No agent has the authority to change any provisions in this Certificate or the provisions of the contract on which it is based. No changes to this Certificate or the underlying contract are valid unless Delta Dental approves them in writing.

Actions
No action on a legal claim arising out of or related to this Certificate will be brought until 30 days after notice of the legal claim has been given to Delta Dental. In addition, no action can be brought more than three years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

Governing Law
The group contract and/or Certificate will be governed by and interpreted under the laws of the state of Ohio.

Right of Recovery Due to Fraud
If Delta Dental pays for dental services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to the acts of the Subscriber and/or Eligible Dependent, it may recover that payment from the Subscriber and/or Eligible Dependent. Subscriber and/or Eligible Dependent authorizes Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to the Subscriber and/or Eligible Dependent. Delta Dental will provide an explanation of the payment being recovered at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for the Subscriber or an Eligible Dependent than is provided by this Certificate, that law shall control over the language of this Certificate.

Your Rights In The Event of Insolvency

Delta Dental is required by Ohio law to make the following statements in this Certificate of coverage:

As a licensed health-insuring corporation (HIC), Delta Dental is not a member of a Guarantee Fund. In the event of Delta Dental's insolvency, you are protected only to the extent that the provision in the contracts between Delta Dental and its Dentists in which providers agree not to bill members applies to the dental services you receive.

In addition, in the event of Delta Dental's discontinuance of operations, Dentists are required to provide covered dental services that are medically necessary to complete previously initiated treatment, but this is limited to the 30-day period following discontinuance of operations.

Participating Dentists are not required to continue to provide covered dental services past the occurrence of the earliest of the following events:

1. The end of the 30-day period following the filing of the liquidation order per Ohio law;
2. The end of the eligible person's contract year;
3. The date the eligible person obtains equivalent coverage;
4. The end of the eligible person's period of coverage for a contractual prepayment of premium;
5. Legal transfer of Delta Dental's obligations.

In the event of Delta Dental becoming insolvent, you may be financially responsible for dental services rendered by a Dentist or facility who is not under contract with Delta Dental, whether or not Delta Dental authorized the use of the Dentist or health care facility.

In addition, in the event of Delta Dental's discontinuance of operations, Delta Dental is required by Ohio law to submit to the Ohio Superintendent of Insurance documentation of an arrangement to provide medically necessary health care services to eligible people until the expiration of their contract year. As required by Ohio law, this arrangement to provide medically necessary health care services may be made by using any one, or any combination, of the following methods:

1. The maintenance of insolvency coverage;

2. A provision in Participating Dentists' contracts with Delta Dental, provided such provision is not solely relied upon for more than 30 days;

3. In agreement with any other health insuring corporations or insurers providing eligible people with automatic conversion rights upon the discontinuance of Delta Dental's operations; or

4. Such other methods as approved by the Ohio Superintendent of Insurance.

If any of the foregoing situations apply to you, please contact Delta Dental at (800) 524-0149.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. Only anti-fraud calls can be accepted on this line.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147

Claims, Predeterminations

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

Inquiries, Review

P.O. Box 30416
Lansing, MI 48909-7916

An Equal Opportunity Employer

Additional VEBA Benefits

Special Medicare Part B Reimbursement Benefit

(A) Eligibility

A retiree or eligible surviving spouse and their eligible dependents who are eligible for benefits under the Plan will be eligible for a Special Medicare Part-B Reimbursement Benefit upon the occurrence of any of the following: (i) retirement if the retirement is on or after age 65; (ii) the attainment of age 65 if retirement is before age 65; or (iii) if earlier, when first eligible to enroll in Part B of Medicare with Medicare as primary coverage; provided that in each case the individual enrolls and continues to be enrolled in Part B of Medicare.

(B) Amount of Benefit

The amount of the Special Medicare Benefit will be equal to the lesser of (a) the standard monthly premium for Part B of Medicare that is paid by persons who enroll in Medicare coverage or (b) $50.00, but does not include any additional premiums such as those charged for delinquent enrollment.

(C) Payment of the Benefit

Payment of the Benefit will commence on the first day of the month following eligibility as explained above. Payment continues so long as an individual continues to be covered for benefits under the Plan and continues to be enrolled for Medicare Part B coverage. The Special Medicare Benefit will not be paid to an eligible dependent, (a) who is also eligible for the Special Medicare Benefit as an employee of Goodyear, a retiree or a surviving spouse or, (b) when such dependent receives reimbursement from an employer for the Medicare Part B premium.

This benefit is not taxable income as it is reimbursement to the retiree for a Medical premium paid.

(D) Coordination With Plan Contributions

The Special Medicare Benefit may be provided in full or in part by offsetting any monthly contributions charged to eligible individuals to participate in the Plan.

Working Spouse COB Benefit

Note: Effective January 1, 2010 this Working Spouse COB Reimbursement benefit applies only to the Pre 1991 Retiree Class as defined in the Settlement Agreement.

(A) If a Retiree, the spouse of a Retiree or the dependent of a Retiree (including the Surviving Spouse or a surviving dependent of a deceased Retiree) is covered or is eligible to be covered except in those cases where contributions for coverage are required (except as provided in paragraph (C) below) by another employer-sponsored group hospital, surgical, medical, dental or prescription drug program, the payment allowable under the Plan will be coordinated with the payments payable under such other group program whether or not such person has actually enrolled for coverage in that program.

(B) For purposes of employer-sponsored flexible benefits programs an individual will be considered "eligible to be covered" as mentioned above and paragraph (C) below whenever hospital-surgical-medical coverage was available and such coverage was not elected.

(C) When the spouse of a Retiree or the dependent of a Retiree (not including the Surviving Spouse or a surviving dependent of a Retiree) is eligible to be covered by another employer-sponsored group hospital, surgical, medical or prescription drug program and the Retiree is eligible for coverage under this Plan, the Plan will reimburse, on a quarterly basis, 50% of the spouse's or dependent's contribution for "single only" coverage from an employer-sponsored plan for the most comparable coverage as available under this Plan. The maximum contribution amount for such coverage by the spouse or dependent that will be considered for the 50% reimbursement is limited to $200 per month. For spousal or dependent contributions in excess of $200 per month, at its discretion, the Committee will make a determination whether to reimburse all or a portion of the excess contribution over the maximum. If the Committee's determination is to limit the reimbursement to $100 per month, the spouse or dependent will not be required to take that coverage.

(D) The spouse of the Retiree or the dependent of the Retiree will be considered to be covered under such other employer-sponsored group hospital, surgical, medical or prescription drug program (except as noted in the previous paragraph) whether or not they are actually enrolled. The payment allowable under this Plan will be coordinated with the payments that would have been payable under such other group program.

(E) Any amounts paid under this Section as a Working Spouse COB Benefit shall be subject to federal laws governing treatment of such payments as income to the recipient, and reporting of such payments to the Internal Revenue Service.