# RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN

SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2016

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

To All Goodyear Retiree Health Care Plan Participants:

The Retirees of the Goodyear Tire & Rubber Company Health Care Trust is pleased to furnish you with this Summary Plan Description describing the benefits available to Goodyear Retiree Health Care Plan Participants under The Retirees of the Goodyear Tire & Rubber Company Health Care Plan ("Goodyear Retiree Health Care Plan" or "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
- Benefit Coverage and Exclusions
- Plan Administration
- Your Rights under ERISA

This Summary Plan Description contains provisions that generally apply to all Goodyear Retiree Health Care Plan 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, whether you are eligible for Medicare and your family status.

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

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

Sincerely,

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

TABLE OF CONTENTS

## INTRODUCTION

The Retirees of the Goodyear Tire & Rubber Company Health Care Trust (the "Trust") is a fund that provides post-retirement health care benefits for current and future eligible Retirees (and their eligible spouses and Dependents) of the Goodyear Tire & Rubber Company ("Goodyear") and Goodyear Dunlop Tires North America, Ltd., the former Dunlop Tire Corporation ("Dunlop"). Currently, the Trust provides medical, prescription drug and dental coverage, as well as some limited Medicare premium reimbursement benefits.

The Trust is an independent organization. The Trust is **not** managed or operated by Goodyear, Dunlop or the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW").

Under a Settlement Agreement with Goodyear that the court approved on August 22, 2008, a Committee ("Committee") was created to oversee and operate the program of health benefits provided by the Trust. (The Settlement Agreement, The Goodyear Tire & Rubber Company Health Care Trust and related documents are collectively referred to in the rest of this Summary Plan Description as the "Settlement Agreement.") The Committee is the sponsor and named fiduciary of the program of health care benefits. The program's official name is the Retirees of the Goodyear Tire & Rubber Company Health Care Plan ("Plan"). The Committee consists of nine members who were appointed according to the Settlement Agreement.

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

In the event of a conflict between this Summary Plan Description and the actual Plan document (including the Benefits Exhibits to the Plan), the Settlement Agreement or a Health Services or Insurance Contract, the actual Plan document, the Settlement Agreement or the Health Services or Insurance Contract will control.

## STATEMENT OF ERISA LEGAL RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to the following:

### Receive Information About Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500) and the most recent Summary Plan Description. With the exception of the Summary Plan Description, the Plan Administrator may

make a reasonable charge for the copies.You may also receive a summary of the Trust'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 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 benefits booklets for more information about your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

If your claim for a Plan 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 copies of Plan documents or the latest annual report from the Trust 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 Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's benefit decision or lack thereof concerning the qualified status of the domestic relations order or a medical child support order, you may file suit in a Federal court.

If the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If the court finds your claim is frivolous, the court may order you to pay these costs and fees.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have 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 area office

of the U.S. Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain information about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or by accessing the Employee Benefits Security Administration website at www.dol.gov/ebsa.

## GENERAL INFORMATION

The following important information is provided to help you understand your legal rights under the Plan. The Plan has specific conditions that you must meet to be eligible to receive benefits. 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 Plan ceases to provide benefits.

Subject to any limitations contained in the Settlement Agreement, the Plan 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 under the Plan.

### Questions About Health Benefits

There are three 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 currently provided by Highmark Blue Cross and Blue Shield ("Highmark"). Prescription drug benefits are currently provided by CVS/Caremark. Limited dental care benefits are 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, whether prior approval is required, you should first consult the applicable benefit section included in this Summary Plan Description.

If you still need assistance, contact the benefit provider using the phone number provided in this booklet, on the back of your identification card, on the Trust's website or in any other materials you have received from the Trust. If you need help with your benefits, including eligibility for benefits or required contributions, call the Goodyear Retiree Health Care Trust Administration 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 Administrator**

Goodyear Retiree Health Care Trust Administration Office
60 Boulevard of the Allies, Fifth Floor
Pittsburgh, PA 15222
(866)694-6477

**Plan Number**

501

**Employer Identification Number (EIN) of the Plan**

26-6330284

**Plan Effective Date**

August 22, 2008, and amended effective January 1, 2010 and January 1, 2016

**Plan Administrator and Named Fiduciary**

The Committee is the named fiduciary of the Plan and the Plan Administrator. The Committee's official name is The Retirees of The Goodyear Tire & Rubber Company Health Care Trust Committee. As Plan Administrator,the Committee has discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefit determination. Such interpretations and determinations are final and binding.

**Agent for Service of Legal Process**

Thomas F. Duzak, Chair of the Committee, is the agent for service of process at the address for the Plan Administrator listed above.

**Type of Plan**

Health and Welfare Benefit Plan offering group health plan options.

**Type of Administration of the Plan**

The Plan is managed on behalf of the Plan Administrator by CDS Administrators, Inc. ("CDS"). Claims are processed by various benefit providers. The Plan Administrator determines benefit eligibility.

**Funding and Source of Contributions for the Plan**

The Plan benefits provided to you under the Trust are both self-funded and insured benefits. That is, depending on your choice of benefit options, the Plan will pay benefits from the Trust or benefits will be paid by the insurance company that provides your benefits through the Trust. The initial funding of the Trust included a payment to the Trust made by Goodyear pursuant to the Settlement Agreement. Additional

contributions are currently being made by Goodyear on behalf of active employees covered under certain collective bargaining agreements between Goodyear and the USW. These additional payments to the Trust may or may not continue to be paid, depending of the outcome of collective bargaining between Goodyear and the USW. The Committee determines contributions charged to participants based upon the Trust's projected income and expenses.

**Plan Year**

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

## DESCRIPTION OF GOODYEAR RETIREE HEALTH CARE PLAN BENEFITS

**Medical Benefits**. Hospital, medical and physician services benefits available under the Plan are explained in more detail in the Medical Benefits attachments.

**Prescription Drug Benefits**. Prescription drug benefits available under the Plan are explained in more detail in the Prescription Drug Benefits attachments.

**Dental Benefits**.Dental benefits available under the Plan are explained in more detail in the Dental Benefits attachment.

## PLAN BENEFIT OPTIONS

**Medical Benefit Options**

The Plan may offer different types of medical benefits coverage, including a Medicare Advantage PPO Option, non-Medicare PPO Options or other benefit options. See the attached benefit exhibits for the currently available benefit coverage options.

The Plan may also offer prescription drug benefits through Medicare and non-Medicare benefit options, and limited dental coverage. See the attached benefits exhibits for these coverage options.

Certain rules govern your eligibility for each option:

- The National PPO benefit option is available to all Retirees, but Retirees who have fewer than 95 "points" will be required to pay a higher monthly contribution (refer to "**Cost of the Plan**" below for an explanation of "points").

- The National Catastrophic PPO benefit option is available only to Retirees who have less than 95 points.

- Only Retirees (or their Surviving Spouse or Dependents) who reside in the United States and are eligible for Medicare Parts A and B are eligible for the Medicare Advantage (Freedom Blue) PPO benefit option.

- Prescription drug benefits are available to all Retirees that elect medical benefits regardless of the medical benefits option elected. However, because the prescription drug coverage available to Medicare-eligible Retirees and their Dependents qualifies as a Medicare Part D plan, any persons who are enrolled in another Medicare Part D plan cannot also enroll in this Plan's prescription drug benefit.

- Dental benefits are only available to Retirees and their Spouse or Dependents that are enrolled in one of the Plan's medical benefit options.

With regard to available benefits, the following general rules apply:

- Some options provide greater medical or prescription drug coverage, but may require larger contributions than more limited options that cost less.

- A Retiree may enroll or change coverage options only during open enrollment each year if the Retiree is eligible for more than one type of coverage or more than one benefit, or during a special enrollment period discussed below.

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 for medical benefits in this Plan.

Additional information about each of the Plan's benefit options are attached to this booklet. Please refer to them for a more detailed explanation of specific eligibility requirements, benefit coverages, exclusions and limitations.

**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 Plan 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 cannot participate in such program and will lose eligibility for the Plan. If contributions are not made using direct debit payments from your checking or savings account or Goodyear pension deduction payments, the Plan Administrator will assess a $10 per-check check processing fee.

***Points*** -- Initially, the cost of the Plan's benefit options to you is determined by your age and service credits (or "points") which are computed by Goodyear and reported to the Trust Administration Office, along with your pension eligibility status. If you have questions about your age and service credits, you should contact Goodyear or Dunlop. As noted above, the Committee, in its sole discretion, may change the contribution amount that you are required to make, regardless of your number of points.

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 continuous service completed. Total points equal the sum of the number of age and continuous service points that you have at the time of retirement.

An Employee who retires with 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 or more years of continuous service will receive an additional 30 points at retirement.

An Employee who does not preferentially hire at another Goodyear facility 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 fewer than 30 years of continuous service; or

(ii) any age and had 20 or more years but less than 30 years of continuous service.

In order to receive a higher level of Plan benefits, Retirees who have fewer than 95 points at the time of retirement will be required to contribute an additional amount beyond the contribution that they would pay if they had 95 points.

The amount that the Retiree contributes toward the total cost of Plan coverage will be increased by $10 ($20 for a non-Medicare eligible Retiree) per month for every point less than 95 if a Retiree chooses to enroll in most medical benefit options. Retirees will be required to pay in advance each month their portion of the monthly contribution amount as established by the Committee annually.

Enrollment in certain benefit plan options may not require a contribution of an additional amount based upon the number of points.

**Who is Eligible for Coverage**

Eligibility for coverage is determined by the Committee. The rules for coverage are set forth below. If, after reading these rules, you still have questions regarding whether you are eligible to receive benefit coverage, you should call the Trust Administration 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 Trust. This means the following individuals are eligible for benefits from the Trust:

- Current Retirees are all individuals who separated from service with Goodyear or Dunlop on or before January 1, 2007, if, as of their separation date, they 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 Dunlop and the USW as in effect on January 1, 2007 ("Original Plan"). The Original Plan also incorporated the requirements for commencing a monthly pension benefit under the 1950 Pension Plan of The Goodyear Tire & Rubber Company, the Dunlop Huntsville 1970 Pension Plan, or the Dunlop 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).

- Eligible Retirees are all individuals other than Current Retirees, who:

  ---As of the day before their separation from service from Goodyear or Dunlop, 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 Dunlop 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 that addressed the eligibility requirements of employees covered under those agreements and that 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. You may request a copy of the Settlement Agreement from the Plan Office.

  ---Were Active Employees and who upon retirement, are identified by Goodyear or Dunlop as being eligible for the Plan. 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.

- A Surviving Spouse is a spouse of a deceased Retiree. If at least one of the conditions in A AND the condition in B are satisfied, a Surviving Spouse is entitled to benefits under the Plan under the same conditions and amounts that the Surviving Spouse was entitled to as a Dependent immediately prior to the death of the Retiree.

  A. On the day before the Retiree's death the Retiree was

     - an Active Employee who satisfied the applicable eligibility requirements under the Original Plan;

     - a Current Retiree; or

- an Eligible Retiree.

B. The spouse had been in a legally recognized marriage with the deceased Retiree for at least 12 consecutive months immediately preceding the Retiree's death.

A Surviving Spouse of an Active Employee will not become eligible for coverage until the first day of the seventh month after the death of the Active Employee spouse. Coverage for a Surviving Spouse and any Dependent children of a Surviving Spouse terminates on the Surviving Spouse's death or, if earlier, when the Surviving Spouse remarries.

- The term "Surviving Spouse" also means a surviving Dependent to the same extent that the 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).

If there is no Surviving Spouse, coverage will continue for a surviving Dependent, provided the 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 receive benefits under the Plan.

**Dependent Eligibility**

Only Dependents who meet the conditions for eligibility receive benefits under the Plan. Dependents are:

- Your lawful spouse (including a common-law spouse pursuant to applicable state law);
- A never-married child under age 19;
- A never-married child 19 years or older, provided the child is your Dependent and upon attainment of age 19 is a full-time student at an accredited high school or post-secondary institution.

Eligibility as a full-time student terminates upon ceasing to be a full-time student or attaining age 25. 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.

If an otherwise eligible full-time student who is covered under the Plan:

-is attending a post-secondary educational institution on the last day immediately preceding a medically necessary leave of absence or medically required reduction in academic hours; and

-the student ceases to become eligible for coverage because of the medically necessary leave of absence or reduction in academic hours; then,

the student 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 the student's Dependent status, such as the parent's termination of coverage or the student exceeding the Plan's age limit. COBRA coverage will be offered at the earlier of the expiration of the 12 month extension or the loss of coverage due to the independent event.

In the event a full-time student over age 19 ceases to be a full-time student, he or she may again be deemed to be an eligible Dependent as a full-time student if he or she otherwise meets the requirements of this section and re-qualifies as a full-time student within 24 months following the date he or she ceased to be a full-time student.

In order to qualify as a full-time student an eligible Dependent child must attend on a full-time basis (12 undergraduate credits or 9 graduate credits) an accredited school, college or similar institution providing a high school or post-secondary education in a course of study leading to a high school diploma, an Associate degree, a Bachelor's degree or a higher degree. Certain leaves due to medical conditions may allow retention of full-time status even if not currently enrolled as such. Full-time status may also be regained upon re-enrollment that occurs within certain limits.

- A never-married child 19 years or older, provided the child is your Dependent and prior to attainment of age 19 the child was mentally or physically incapable of self-support as determined by the Plan 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, but only up to age 25.

The word "child" means any of:

- a natural child,
- an adopted child, and
- a stepchild or a child for whom you are appointed as legal guardian, but only when such child lives with you and depends on you for support and maintenance and qualifies as a Dependent on your income tax return.

The Plan will cover a child for whom a Qualified Medical Child Support Order (QMCSO) has been served upon the Plan, provided that the Order must first be submitted to the Trust Administration Office to determine if it qualifies as a QMCSO and if it affects the child's eligibility for benefits under the Plan. You may obtain from the Plan Administrator, without charge, a copy of the Plan's procedures governing QMCSOs.

If you acquire a Dependent child other than by birth, legal adoption or marriage, the Dependent child will not become eligible until three months have elapsed from the date the child is legally appointed as your Dependent child.

The term "unmarried child" means a child who has never been married. When a Dependent child becomes married, even though the marriage may later be dissolved for any reason, the child ceases to be an eligible Dependent forever.

To be eligible for Dependent coverage, proof that a Dependent meets the above criteria is required. Eligibility for a Dependent child is verified by submitting proof of financial dependency, full time residence and other documentation according to the following chart. The Plan may require annual submission of documentation where necessary.

| Category | Financial Dependency | Full-time Residence | Required Documents |
|---|---|---|---|
| Natural child under age 19 | No | No | Birth certificate |
| Adopted child under age 19 | No | No | Birth certificate and certificate of adoption |
| Student child** age 19 to 25 | Yes | No | Birth certificate or certificate of adoption, school verification of full-time enrollment, Federal tax return |
| Disabled child** over age 19 | Yes | No | Birth certificate or certificate of adoption, disability forms, Federal tax return and child's Federal tax return, if employed |
| Step child | Yes | Yes* | Birth certificate, Federal tax return, affidavit of full-time residency and verification of child's home address |
| Child under legal guardianship | Yes | Yes* | Birth certificate, legal guardianship papers, Federal tax return, affidavit of full-time residency and verification of child's home address |

* In the case of a divorce, the requirement for full-time residence with the Retiree may be waived if the divorce decree indicates that the Retiree is not responsible for physical custody. However, the child must still be claimed on the Retiree's Federal tax return to be eligible.

** Includes an adopted child

## ENROLLING IN THE PLAN

To enroll in the Plan, you will be asked to fill out an enrollment form for the Plan with information about yourself and your eligible Dependents. If applicable, you also will be asked to choose which type of coverage(s) you desire. After you enroll in the Plan, you will be responsible for informing the Plan of any changes in your personal situation that may affect your Plan coverage. **You must report to the Plan within 31 days any changes in: your employee status; your marital status; the number of Dependents or the eligibility status of Dependents; your Medicare status; or your residence location.**

### 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 annual open enrollment period, with coverage becoming effective on January 1st of the next calendar year.

You may also qualify for "delayed participation" if you submit evidence to the 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 that provides substantially equal or better coverage than the Plan.

You must 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.

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

## DURATION OF COVERAGE UNDER THE PLAN

### When Coverage Begins

<u>Retiree</u>

You will begin participating in the Plan on 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.

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

If you are a disability Retiree, you commence coverage under the Plan on the later of:

- the date of retirement from Goodyear or Dunlop due to disability; or
- the date your coverage ends under the medical benefits program sponsored by Goodyear or Dunlop.

If the coverage commencement date under the above is retroactive, and if you elect to commence participation in the Plan as of that date or any other date that is not a current date, you must make all required Plan contributions owing from the Plan coverage commencement date to the enrollment date in order to enroll. The Plan's Claims Administrator will also coordinate with the appropriate insurance companies to reprocess any claims incurred after the applicable enrollment date.

If the retroactive Plan coverage date creates an immediate significant delinquent contribution balance for any disability Retiree, the Plan may consider individual circumstances for possible relief from the full advance payment rule.

Dependents

When you become eligible for Retiree coverage, you will be given the opportunity to enroll your Dependents. Your Dependents are generally eligible for Plan benefits on the date your coverage begins, provided

- you are eligible to receive Plan benefits;
- each of your enrolled Dependents meets the Plan's definition of a Dependent;
- you have made proper application for enrollment; and
- coverage for your Dependents under a plan maintained by Goodyear or Dunlop has terminated.

**When Coverage Ends**

Your coverage under the Plan will terminate on the earliest of the following:

- the last day of the month in which you no longer meet the conditions for eligibility;
- the last day of the month of which your death occurs; or
- 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:

- on the same date that your coverage terminates;
- up to three months after 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 in the section above on Dependent Eligibility) provided no other group medical coverage is in effect on such student;
- 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;
- on the last day of the month in which a Dependent ceases to meet the definition of Dependent;
- the subsequent remarriage of a Surviving Spouse;
- the date the Plan is terminated, or
- the date specified in any Plan amendment that eliminates coverage for your Dependents.

**It is important that you understand that the 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 Health Care Trust 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.**

**Loss of Coverage for Failure to Pay Contributions**

In addition to the events described in the previous section, your coverage (and that of your Dependents) will terminate on the last day of the month preceding the month for which you fail to make all required contributions. If your coverage, including coverage for your Dependents, terminates because of your failure to pay required contributions when due, your loss of coverage will continue for the rest of the plan year in which coverage is terminated. Loss of coverage may continue permanently, unless you are permitted to re-enroll in the Plan as described in this section. To re-enroll you must also satisfy all conditions for re-enrollment.

Loss of coverage due to failure to pay required contributions, even when you might otherwise continue to be eligible, is a serious consequence. Therefore, the Plan will terminate coverage for this reason only after the Plan has sent written notice(s) to you and offered you the option to bring all delinquent payment amounts current. However, if you do not comply with the payment requirements explained in the notice(s) and bring all delinquent premium payments current within the specified period, your health care coverage and that of your Dependents will be terminated retroactively effective the last day of the last month for which you were fully current on all required premium payments. To the extent permitted by law, all quarterly Medicare Part B reimbursement benefits will also be retroactively terminated until your right to further coverage under the Plan has been reinstated or you have re-enrolled.

The Plan permits a participant who has lost coverage because of non-payment of contributions a one-time right to re-enroll in the Plan. This right will be offered to you during the next annual open enrollment period starting after the date on which your coverage was terminated due to non-payment of contributions. If the date your coverage is terminated is after the date the Plan's annual open enrollment period has started, you will not be able to re-enroll until the open enrollment period in the following plan year.

If termination of coverage has occurred due to non-payment of required contributions, the Plan will maintain a record of the delinquent contributions owed for the period beginning on the retroactive termination date through the date the Plan acted to suspend coverage. In order to exercise your one-time re-enrollment right, you must first repay to the Plan all delinquent contributions that accrued during that period, that is, from the retroactive termination date through the date the Plan acted to suspend coverage.

If you choose to re-enroll, only claims incurred after the effective date of your re-enrollment will be covered by the Plan. If you do not satisfy the delinquent premium repayment obligation at the time of your re-enrollment, that is, repay all delinquent contributions from the retroactive termination date through the date the Plan acted to suspend coverage, you will NOT be allowed to re-enroll in the Plan.

**If you (and your Dependents) have previously lost coverage due to non-payment of contributions, you have re-enrolled in the Plan under the one-time re-enrollment option, and you again lose coverage due to non-payment of contributions, your coverage will be permanently terminated and you will not be allowed to re-enroll in the future.**

The Committee has established an administrative policy that adopts and implements procedures to carry out enforcement of these rules. You may obtain a copy of the policy at any time by contacting the Trust Administration office. The Plan termination rules are also subject to all appeal rights granted under the Plan.

**Loss of Coverage for Failure to Timely Submit Claims**

Failing to promptly submit claims to the Claims Administrator, or to appeal denied claims, may forfeit your claim to benefits. See the section on "*Claim Review and Appeal Procedures*" below for an explanation of applicable deadlines for submitting claims and appealing denied claims.

**Recovery of Benefit Payments**

Regardless of any other Plan provision, the Plan reserves the right to recover from you any benefit amounts that are paid in error or in excess of the amount actually owed under the Plan or paid with respect to claims incurred or services provided after coverage has terminated (whether for you or a Dependent). If you have lost coverage due to failure to pay contributions and you do not re-enroll in the Plan or you are not eligible to re-enroll, you are obligated to repay to the Plan all benefit amounts you or any health care service provider received from the Plan for claims incurred after your coverage termination date. Your obligation to repay and the Plan's right of recovery are equitable remedies enforceable by the Plan in the form of an equitable lien by agreement. The Plan's equitable lien right extends to all amounts paid from the Plan, without regard to when payment occurs or may have previously occurred. All benefit payments from the Plan to or on behalf of you or your Dependents, regardless of when paid,

are subject to the right of the Plan to enforce its equitable lien rights and obtain recovery of ineligible benefit payment amounts.

**Changes in Membership Status**

In order for there to be consistent coverage for you and your Dependents, you must keep the Trust Administration Office informed about any address changes and any changes in family status (births, adoptions, deaths, marriages, divorces, etc.). A change in family status may affect your coverage. The Committee has the right under the Plan to request information and documentation from you to support or establish any claimed family status.

Your newborn child may be automatically covered under the Plan for a maximum of 31 days from the moment of birth. To be a covered Dependent beyond the 31-day period, the newborn child must be enrolled as your Dependent under the Plan before the 31-day period expires. If you acquire a new Dependent due to a marriage, birth or adoption, you may enroll such Dependent(s) within 31 days after such event. You must notify the Plan Administrator within 60 days of any death, divorce, legal separation or loss of Dependent status. **Failure to enroll or provide such notice may cause you or your Dependents to lose COBRA rights or eligibility to participate in the Plan**.

**Medicare**

If you or a Dependent is entitled to Medicare benefits 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 co-insurance amounts not covered by Medicare, provided that the services are eligible for coverage under the Plan. Contact your benefit option provider for specific details, or see the Coordination of Benefits provisions below.

Medicare deductible and co-insurance amounts will not be covered by the Plan if the services are not covered under the Plan, even if they are covered under Medicare.

**Plan Amendment**

The Committee, subject to certain restrictions contained in the Settlement Agreement, has the power and authority to amend or terminate this 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." **Failure to pay required contributions is NOT 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 Trust Administration 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 because of divorce or legal separation from the Retiree. A covered spouse who has been married to a covered Retiree for at least 12 months prior to the covered Retiree's death will also 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**

Divorce or legal separation of the Retiree and spouse or a Dependent child losing eligibility for coverage as a Dependent child are qualifying events that you or the qualifying beneficiary must notify the Plan of, within 60 days after the qualifying event occurs. You may contact the Trust Administration Office by calling (866) 694-6477 or writing to the Goodyear Retiree Health Care Trust, 60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222. ***Failure to provide such notice may jeopardize eligibility for COBRA coverage.***

**How COBRA Coverage is 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. Contributions for COBRA coverage will be described in the COBRA material sent to you. Failure to timely pay those contributions will terminate your COBRA coverage.

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 lasts for up to a total of 36 months.

**If You Have Questions**

Address any questions concerning your COBRA continuation coverage rights and options to the Goodyear Retiree Health Care Plan, 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 Plan, 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**

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

## COORDINATION OF BENEFITS

The Plan contains a coordination of benefits provision, commonly called a "COB" provision. The COB provision is used when you or your Dependents are eligible for benefit payments under more than one group health plan, including Medicare. The object of a coordination of benefits provision is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments. See the attached benefits booklets for details about how each benefit coordinates with any other plans.

## REIMBURSEMENT OF BENEFIT PAYMENTS AND SUBROGATION

You may be required to reimburse the Trust up to the full amount paid by the Trust for monies paid to you or on your behalf by someone else because of injuries or illness you have sustained. In some circumstances, the Plan may have the right to pursue directly another person who is, or may be considered, liable for your injury, sickness or other condition and for which the Trust has advanced benefit payments. That right is called "subrogation." The following is only a summary of the Plan's right to reimbursement and right of subrogation. A more detailed description of the Plan's rights is found in the Plan document and in the Trust Agreement. The following provisions supersede any conflicting provisions in the attached benefits booklets.

**Reimbursement**

If you or your Dependent recovers damages, whether by settlement, court award, verdict or otherwise, for an injury, sickness or other condition caused by another person, or if you or your Dependent may obtain a recovery in the future, the Plan does not cover either the reasonable value of the services to treat the injury or illness or the actual treatment of the injury or illness. These benefits are specifically excluded under the Plan.

However, if the Plan does advance payment for such an injury, sickness or other condition, then you and your Dependent are required to promptly reimburse the Plan for all money or other property received from any settlement, award, arbitration proceeding, or verdict, whether paid in a lump sum or otherwise. The reimbursement obligation extends to the reasonable value of all medical benefits advanced or provided by the Plan and is payable by you, your Dependent or your legal representatives, estate or heirs. Reimbursement is required even if:

- you or your Dependent has not been fully compensated, or "made-whole" for the loss;
- you or your Dependent or someone else has admitted liability for payment or have agreed or been found to have some degree of fault under comparative negligence or any other legal theory;

- the recovery is for an occupational illness or injury; or

- the recovery is called anything other than a recovery for medical expenses incurred.

If there is a recovery, the Plan has a first priority right and lien over any other party or person to receive reimbursement of the benefit payments it has advanced. Reimbursement to the Plan can come from a recovery received from any source, including uninsured and underinsured motorist coverage, no-fault insurance, medical payment coverage (auto, homeowners or otherwise), any workers' compensation settlement, any compromises or awards, any other group insurance (including student plans), as well as a direct recovery from any liable party.

If requested by the Plan or its representative, you or your Dependent may be required to sign and deliver any documents needed to protect the Plan's priority or reimbursement right, or to assign benefits. Whenever you or your Dependent accepts a benefit payment advanced by the Plan that is subject to reimbursement, your acceptance is deemed an agreement that any recovery you or Dependent receives is held for the benefit of the Plan under its reimbursement provisions. You also agree to cooperate with the Plan and take reasonable actions, as requested, to assist the Plan making a full recovery. You or your Dependent may not take any action that would adversely affect the Plan's right of reimbursement.

Recoveries for injuries, sickness or other conditions are often only obtained after legal proceedings have been brought. The Plan is not responsible for legal fees and expenses associated with such proceedings unless the Plan has so agreed in writing. This means that no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan and any so-called fund doctrine, common fund doctrine, attorney's fund doctrine or other similar legal claim or theory may not be applied to avoid the Plan's recovery right.

If the Plan does not recover all amounts owed, it may offset future benefit payments until a full recovery has been obtained.

**Subrogation**

Whenever the Trust advances benefit payments in connection with an injury, illness or other condition, the Plan is "subrogated" to all of the rights of the injured person for whom the benefit payments were made. This means the Plan may pursue claims for recovery of amounts paid against any party liable for the person's injury or illness.

The Plan may assert its right independently of any other claims that may be brought by any other person, including the injured person. However, the Plan is not obligated in any way to pursue a claim. It may do so in its sole discretion.

If the Plan elects to pursue a claim, the injured person who has benefitted from the Trust's benefit payments is obligated to cooperate with the Plan and its representatives in order to protect the Trust's rights. Cooperation means providing the Plan with relevant information as requested, signing and delivering requested documents, avoiding any action that would adversely affect the Plan's rights and obtaining the Trust's consent before releasing any party from liability for payment of medical expenses. If the Injured Participant fails to cooperate with

the Plan, the Trust may reduce future benefits payable under the Plan until the value of benefits advanced by the Trust have been fully recovered.

If the Plan asserts its subrogation right, it has a first priority right of recovery and lien that must be satisfied in full before any other claim. However, legal costs incurred by the Plan in subrogation matters will be paid by the Trust.

## CLAIM REVIEW AND APPEAL PROCEDURES

As a Participant in the Plan, you have the right to appeal decisions to deny or limit Plan benefits. You may also file an appeal to address concerns regarding eligibility (your or a Dependent's right to participate in the Trust), confidentiality or privacy. Appeals of denied claims should be filed as described in the procedures set forth below, which supersede any conflicting appeals procedures described in the benefit booklets.

The type of claim determines the way you appeal or ask for review of a denied or partially denied claim under the Plan. If the claim concerns health care benefits, the claims procedures and appeal rights are explained in the next section titled "*Appeals of Decisions Concerning Eligibility, Coordination of Benefits or other Plan Rules*."

Examples of appeals of health benefit decisions would be situations where the Plan denies your claim in whole or in part because the treatment is not medically necessary or is not a covered benefit or treatment under the Plan. Other examples might be a situation where the Plan denies part of a claim because the amount charged by the hospital or physician is greater than the amount the Plan has agreed to pay or a prescribed drug is not one that the Plan covers.

If your claim involves eligibility to participate in the Plan or the application of other Plan rules, these claims and appeals procedures are explained in the section titled "*Other Claims and Appeals*." You must submit these claims to the Goodyear Retiree Health Care Trust Administration Office. Final review of appeals from these claim denials is conducted by the Trust's Claims and Appeals Subcommittee.

Examples of claims and appeals that must be submitted to the Trust Administration Office or the Trust's Claims and Appeals Subcommittee would be a denial of a claim because a Dependent no longer meets the definition of Dependent under the Plan or the refusal to allow a Surviving Spouse to continue to receive benefits under the Plan because he/she has remarried.

If you want to make a claim or appeal a claim denial and you have a question as to whether your claim involves health benefits or another type of claim, you may review the applicable benefit summary attached to this booklet or contact the Plan Administration Office.

### Health Benefit Claims and Appeals

All Health Benefit Claims are reviewed and considered by the appropriate Claims Administrator, currently Highmark Blue Cross Blue Shield for medical services, CVS/Caremark for drugs and prescriptions and Delta Dental for dental services. Additional information about submitting claims is located in each benefit option booklet attached to this Summary.

A Health Benefit Claim may be filed with the Claims Administrator on a form approved by the Claims Administrator for that purpose or it may be submitted on your behalf by a health care provider. A Health Benefit Claim is any claim for benefits from the Plan by a Participant based upon or resulting from the receipt or expected receipt of a medical treatment, service or product in connection with a specific medical condition or symptom. **Generally, the Claims Administrator must receive the claim within one year of the date of service for the claim to be eligible for payment.** Check your benefit booklet for more information about claims submission deadlines.

Before approving a claim the Claims Administrator may require you, or the medical, dental or prescription provider to submit information about the claim and to complete documents or forms deemed reasonably necessary for the proper administration of Health Benefit Claims under the Plan. The payment of a benefit under the Plan upon submission of a claim may be secondary to and payable only if not paid by another plan, insurer or government program or agency.

**Health Benefit Claim Types and Processing Times**

Different time frames may apply to processing a Health Benefit Claim, depending on the kind of Claim submitted. There are four kinds of Health Benefit Claims. They are:

- An *urgent care* claim. This is a claim for medical care when delay in processing could seriously jeopardize life, health or ability to regain maximum function or, if not immediately addressed, could subject the claimant to severe pain, as determined by your physician.

- A *pre-service* claim. This is a claim for approval of a benefit that the Plan wholly or partly conditions on approval before receipt of the service.

- A *post-service* claim. This is a claim for approval of a benefit that is not an urgent care claim and or is not conditioned upon receipt of prior approval.

- A *concurrent care decision* claim. This is a claim concerning the continuation or extension of approved benefits or services provided over time.

When a claim is submitted, a decision on the claim must be made no later than:

- 72 hours for an urgent care claim, or sooner based upon medical circumstances;

- 15 days for a pre-service claim, or sooner based upon medical circumstances;

- 30 days for a post-service claim, if the determination is adverse;

- 24 hours for a concurrent care decision claim.

Time periods for decisions begin when the claim is filed, even if all information necessary to review the claim is incomplete. However, the Plan's time to respond will be extended because of missing information, until it is provided following the notice of extension. In the case of an

urgent care claim, the Plan has 24 hours to request any missing information and you or the health care provider has 48 hours to provide it. In the case of pre-service or post-service claims, the Plan has 5 days for pre-service and 30 days for post-service claims to request any missing information. You or your medical care provider has 45 days to provide it. Decisions on pre-service and post-service claims may be extended by 15 days for reasons beyond the Plan's control.

**Appeals of Decisions Regarding Health Benefit Claims**

If a Health Benefit Claim is denied in whole or in part, you or your authorized representative will receive a written verification of the denial explaining the reason for the denial. The denial will also reference any Plan provisions, guidelines or the like that the decision maker relied upon in denying the Health Benefit Claim or will advise you how to obtain copies. All copies are free of charge, upon request. If the denial of the Health Benefit Claim involves a determination as to "medical necessity," "experimental treatment" or similar matters, the denial will include an explanation of the clinical judgment applied or will advise you how to get such an explanation, free upon request, and will identify the name of the medical professionals consulted as part of the claims process. The denial will also indicate if there is any additional material or information the decision maker needs to make the claim application acceptable and the reasons why such additional information or material may be necessary.

Any documents relevant to your claim that are created or received by the Plan during claims review or the appeals process are available to you upon request, free of charge. If the claim is denied, you are also entitled to review all documents, records and other information relevant to the Health Benefit Claim, whether or not they were relied on by the decision maker reviewing the Health Benefit Claim.

**Level 1 and 2 Appeals**

If a Medical Benefits Claim is denied, you have up to 180 days from the date of the denial to appeal the decision. The Plan must respond to a Level 1 or Level 2 appeal request by no later than the following times:

- urgent care claim – 72 hours;
- pre-service claim – 15 days each for a level 1 or level 2 appeal;
- post-service claim – 30 days each for a level 1 or level 2 appeal.

Level 1 appeals are reviewed by Highmark Blue Cross Blue Shield for medical services, CVS/Caremark for pharmaceutical products and Delta Dental for dental claims. Level 2 Appeals are reviewed by Claims and Appeals Subcommittee of the Committee, appointed for that purpose, or at the discretion of the Committee, by the entire Committee.

All reviews of Level 1 and 2 appeals will be made by someone who was not involved in making the initial Medical Benefits Claim denial decision, and who is not a subordinate of the original decision maker. A review on appeal will be an original review. That is, the review will not give any weight to the initial denial, and will take into account all information submitted, regardless whether it was submitted or considered in the initial decision denying the Medical Benefits Claim.

In deciding an appeal of a denial decision based wholly or partly on medical judgment (such as decisions about whether a particular medical procedure or service is experimental, investigational or not medically necessary or appropriate), the person(s) reviewing the decision on appeal must consult with a qualified health care professional who was not consulted in connection with the initial adverse decision that is the subject of the appeal.

**You are required to complete both the Level 1 and Level 2 appeals of a Medical Benefits Claim denial before you may file a lawsuit for benefits under ERISA**. No fees or costs are imposed upon you by the Plan for filing or appealing any claim for benefits. If you complete the Plan's appeal process, you may file a civil suit seeking a judgment overturning the Plan's denial of the claim. **You must file such a lawsuit within two years of the date of the final denial on appeal**.

You must follow the appeals process, including any time limits, if you wish to appeal a claim that has been denied in full or in part. If you have questions, you may call the Trust Administration Office at (866) 694-6477.

**Appeals of Decisions Concerning Eligibility, Coordination of Benefits or other Plan Rules**

The initial decision concerning eligibility or application of Plan rules is made by CDS, the Goodyear Retiree Health Care Trust Administration manager. Generally, this initial decision happens when you or a Dependent are denied participation in the Plan or is denied coverage (in whole or in part) for a service because of eligibility requirements or some other Plan rule. If you have a question about why your claim was denied for one of these reasons, you should contact the Trust Administration 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. The review by the Trust Administration Office is a Level 1 review. One appeal from the Level 1 review is allowed (Level 2). Level 2 appeals are considered by the 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 seeking an appeal on your behalf, the Trust Administration Office must obtain a signed Designation of Representation Form from you before the Trust Administration Office or the Claims and Appeals Subcommittee can begin processing your claim or appeal. A Designation of Representation Form can be obtained by calling the Trust Office at (866) 694-6477, or by visiting the Trust website at *www.goodyearretireetrust.com*.

Once an appeal (Level 1 or Level 2) has been filed in writing as described below, the Trust Administration 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, fax, 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 reviews described below, the Plan requires you to submit all requests for appeal in writing. Written appeal requests, including a detailed description of the claim and all relevant information, should be sent to: Appeals, Goodyear Retiree Health Care Trust, 60 Boulevard of the Allies, Fifth Floor, Pittsburgh PA 15222. If you wish, you may fax your appeal to (412) 224-4465 or send an email to GRTrust@cdsadmin.com

**Level 1 Appeal**

The Trust Administration Office will review the materials supplied to it and provide a written response not later than 90 calendar 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; refer to the specific Plan provision, rule or guideline on which the determination is based; describe any additional material or information necessary for you to perfect the claim; explain why the information is necessary and describe 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 Trust's Claims and Appeals Subcommittee. Level 2 Appeals will be resolved by the Subcommittee not later than 60 calendar days from the date that your Level 2 Appeal was received by the Goodyear Retiree Health Care Trust Office, unless the Claims and Appeals Subcommittee determines that special circumstances require additional time. In that event, you will be notified prior to the end of the initial review period of the extension, which will not be longer than an additional 60 days.

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 haven't already been provided a copy of any rule or guideline upon which the determination is based, you be will provided one.

**You are required to complete the two appeals of a non-medical Claim denial before you may file a civil suit for benefits under ERISA**. No fees or costs are imposed upon you by the Plan for filing or appealing any claim for benefits. If you complete the Trust's appeal process you may file a civil suit seeking a judgment overturning the Trust's denial of the claim. You must file such a lawsuit **within two years of the date of the final denial on appeal**.

The Trust's Claims and Appeals Subcommittee has complete discretion and the 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 Plan. Decisions of the 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 Claims and Appeals Subcommittee is challenged in court, it is the intention of the Plan that the decision be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the 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

Occasionally, the Committee or a benefits provider may need additional information from you. When you enroll in the Plan, you must agree to furnish the Committee or a benefits provider with all information 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 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 Trust maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Goodyear Retiree Health Care Trust Administration Office. This summary is not intended and cannot be construed as the Trust'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 Trust 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 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 Health Care Trust Administration Office.

## SPECIAL MEDICARE PART B REIMBURSEMENT BENEFIT

### Eligibility

A Retiree or eligible Surviving Spouse and their eligible Dependents who are eligible and enrolled for health care benefits under the Plan will be eligible for a Special Medicare Part-B Reimbursement Benefit when first eligible to enroll in Part B of Medicare with Medicare as

primary coverage, provided the individual enrolls and continues to be enrolled in Part B of Medicare.

**Amount of Benefit**

The amount of the Special Medicare Benefit will be equal to the lesser of:

- the standard monthly premium for Part B of Medicare that is paid by persons who enroll in Medicare coverage; or

- $50.

The Special Medicare Benefit does not include any additional premiums, such as those charged for delinquent enrollment.

**Payment of the Benefit**

Payment of the benefit will commence on the first day of the month following eligibility as explained above with payments made following the completion of each calendar quarter. Payment continues so long as an individual continues to be enrolled for health care benefits under the Plan and continues to be enrolled for Medicare Part B coverage. The Special Medicare Benefit is paid by the Plan through electronic funds transfer ("EFT") only. You must arrange for and have an account that accepts EFT payments in order to receive benefit payments. Also, the Special Medicare Benefit will not be paid to an eligible Dependent who is also eligible for the Special Medicare Benefit as an employee of Goodyear or Dunlop, a Retiree or a Surviving Spouse or when the Dependent receives reimbursement from any other employer for the Medicare Part B premium.