Goodyear Retiree Healthcare Trust
Reference Code 17FB8289

Freedom Blue PPO
Your 2017 Benefits at a Glance

	In-Network	Out-of-Network
Plan Deductible	$150	
Plan Coinsurance (Member Cost Sharing)	5%	10%
In Network Out-of-Pocket Maximum (does not include Part D Drugs)	$1,500	
Combined In and Out of Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,000	
Doctor Office Visit	$25 PCP, $35 Specialist cost sharing	10% coinsurance
Preventive Testing/Screenings	Covered in Full	Covered in Full
Diagnostic Testing including Lab, X-Rays and Advanced Imaging (costs for these services may vary based on place of service)	5% cost sharing	10% coinsurance
Outpatient Surgery	5% cost sharing	10% coinsurance
Ambulance	$0 cost sharing	10% coinsurance
Emergency Room	$65 cost sharing	$65 cost sharing
Inpatient Hospital Stay	5% per stay	10% coinsurance
Skilled Nursing Facility (days 1-100 per benefit period)	5% per day	10% coinsurance
Outpatient Drugs (Medicare Part B)	5% cost sharing	10% coinsurance
Durable Medical Equipment	5% coinsurance	10% coinsurance
Routine Vision (covered every calendar year)	Standard eyeglass lenses and frames or contact lenses are covered in full. A $100 benefit maximum applies to non-standard frames or specialty contact lenses.	You have a $100 benefit maximum for out-of-network specialty frames or specialty contact lenses.

	In-Network	Out-of-Network
Hearing Aids (covered every three calendar years)	$500 coverage	

Questions? Call 1-866-456-7739(TTY Users, call 711) 7 days a week between 8 a.m. - 8 p.m. EST

Reference Code 17FB8289 Please have this number ready when you call.

Please see *Summary of Benefits* for detailed information.

*Plan drugs may be covered in special circumstances, for instance, illness while traveling outside the plan's service area where there is no network pharmacy.

2017 Summary of Benefits Employer Group Plan

	Goodyear Retiree Healthcare Trust 178289	
General Provisions	**Freedom Blue PPO In-Network**	**Freedom Blue PPO Out-of-Network**
Plan Deductible	$150	
Plan Coinsurance (Member Cost Sharing)	5%	10%
In Network Out-of-Pocket Maximum (does not include Part D Drugs)	$1,500	
Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs)	$3,000	

Benefit Category	**Freedom Blue PPO Employer Group Plan**
IMPORTANT INFORMATION	
Premium and Other Important Information	You may pay a premium each month to your retiree/employer group/trust fund. In addition, you keep paying your Medicare Part B premium. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
Covered Medical and Hospital Benefits **Note:** Services with a 1 may require prior authorization.	
OUTPATIENT CARE AND SERVICES	
Acupuncture	This plan does not cover acupuncture and other alternative therapies.

Benefit Category	Freedom Blue PPO Employer Group Plan
Ambulance Services (medically necessary ambulance services)	**In-Network** You pay cost sharing of $0. **Out-of-Network** Emergency - You pay cost sharing of $0. Non-Emergency - You pay cost sharing of 10%.
Chiropractic Care[1] Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	**Authorization rules may apply** **In-Network** You pay cost sharing of $20. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part). **Out-of-Network** You pay 10% coinsurance.
Dental Services[1]	Preventive dental services (such as cleaning) not covered. Authorization rules may apply for Medicare-covered accidental dental services.
Diabetes Supplies and Services[1] (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	Authorization rules may apply. **In-Network** Diabetes self-management training: You pay nothing You pay 5% coinsurance. If the doctor provides you additional services, separate doctor office visit cost sharing may apply. **Out-of-Network** You pay 10% coinsurance.

Benefit Category	Freedom Blue PPO Employer Group Plan
Diagnostic Tests, Lab, Radiology Services (Such as MRIs and CT Scans), and X-rays	Authorization rules may apply. Costs for these services may vary based on place of service. **In-Network** You pay 5% for the following: • Lab services • Diagnostic procedures and tests • X-rays • Diagnostic radiology services (not including X-rays) • Therapeutic radiology services If the doctor provides you additional services, separate doctor office visit cost sharing may apply. **Out-of-Network** You pay 10% coinsurance for out-of-network diagnostic procedures, tests and lab services. You pay 10% coinsurance for out-of-network therapeutic and diagnostic radiology services. You pay 10% coinsurance for each out-of-network outpatient x-ray.
Doctor Office Visits Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	**In-Network** Primary care physician visit: $25 Specialist visit: $35 **Out-of-Network** Primary care physician visit: 10% coinsurance Specialist visit: 10% coinsurance

Benefit Category	Freedom Blue PPO Employer Group Plan
Durable Medical Equipment (includes wheelchairs, oxygen, etc.) Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.	Authorization rules may apply. **In-Network** You pay 5% coinsurance. **Out-of-Network** You pay 10% coinsurance.
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	You pay a $65 copay for each emergency room visit. **Worldwide coverage for emergency and urgently needed care.** If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.
Foot Care *(podiatry services)* Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	**In-Network** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 **Out-of-Network** You pay 10% coinsurance.
Hearing Services Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	**In-Network** Exam to diagnose and treat hearing and balance issues: $35 Routine hearing exam (for up to 1 every year): $35 Hearing aid fitting/evaluation (for hearing aids every 3 calendar years): $500 **Out-of-Network** You pay 10% coinsurance.

Benefit Category	Freedom Blue PPO Employer Group Plan
Home Health Care[1]	Authorization rules may apply. **In-Network** You pay cost sharing of 5%. **Out-of-Network** You pay cost sharing of 10%.
Mental Health Care[1] Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	Authorization rules may apply. **In-Network** Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. You pay a cost sharing of 5% for each stay at a network hospital. Outpatient group therapy visit: $35 Outpatient individual therapy visit: $35 **Out-of-Network** You pay 10% coinsurance.
Outpatient Prescription Drugs	**Drugs covered under Medicare Part B** **See Section 1 for more Information on Medicare Part B Drugs** You pay 5% of the cost for the Part-B covered chemotherapy drugs and other Part B-covered drugs. You pay 10% of the cost for Part B drugs out-of-network. Part B Drugs are not available at retail pharmacies. **Drugs covered under Medicare Part D** Part D prescription drugs are not covered by the Freedom Blue PPO plan.

Benefit Category	Freedom Blue PPO Employer Group Plan
Outpatient Rehabilitation Services[1] (Occupational Therapy, Physical Therapy, Speech and Language Therapy) Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	Authorization rules may apply. Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. **In-Network** You pay a $25 cost sharing for occupational therapy visits. You pay a $25 cost sharing for physical therapy and/or speech and language pathology visits. **Out-of-Network** You pay 10% for out-of-network occupational therapy visits. You pay 10% for out-of-network physical therapy and/or speech and language pathology visits.
Outpatient Substance Abuse Care[1]	Authorization rules may apply. **In-Network** You pay cost sharing of $35. **Out-of-Network** You pay 10% coinsurance.
Outpatient Surgery[1]	**In-Network** You pay cost sharing of 5%. Authorization rules may apply. **Out-of-Network** You pay 10% coinsurance.
Over-the-Counter Items	Not covered
Prosthetic Devices[1] (includes braces, artificial limbs and eyes, etc.) Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.	Authorization rules may apply. **In-Network** You pay 5% coinsurance. **Out-of-Network** You pay 10% coinsurance.

Benefit Category	Freedom Blue PPO Employer Group Plan
Renal Dialysis	**In-Network** You pay nothing. **Out-of-Network** You pay 10% coinsurance.
Transportation (Routine) Cost sharing is not applied to the deductible or out of pocket maximums.	**In-Network** You pay $0 cost sharing per trip. **Out-of-Network** You pay 50% of the cost for out-of-network transportation services.
Urgent Care (This is **not** emergency care)	You pay a $35 copay.
Routine Vision Office visit copays do apply to the in-network out-of-pocket maximum; however, you will continue to pay office visit copays until you reach the combined in and out-of-network maximum. Office visit copays do not apply to the annual deductible.	**In-Network** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $35 Routine eye exam (for up to 1 every year): You pay nothing. **Eye Wear** Limited to one pair of eyeglass frames with eyeglass lenses or contact lenses every calendar year. Davis Vision Fashion Collection eyeglass frames, standard eyeglass lenses and standard contact lenses are covered in full. $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye. A $100 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses. **Out-of-Network** You pay 10% coinsurance for routine out-of-network eye exams. $200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye. A $100 benefit maximum is available towards the purchase of non-Davis Vision Collection eyeglass frames, eyeglass lenses, or towards the purchase of Non-Collection Contact Lenses.

Benefit Category	Freedom Blue PPO Employer Group Plan
Wellness/Education and Other Supplemental Benefits & Services	The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes **Out-of-Network** You pay 50% of the cost for out-of-network health/wellness services after a $500 deductible.
Preventive Services	**In-Network** You pay nothing **Out-of-Network** You pay nothing Our plan covers many preventive services, including: • Abdominal Aortic Aneurysm Screening • Alcohol misuse counseling • Bone Mass Measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes Screening • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccine, including Flu shots,Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.

Benefit Category	Freedom Blue PPO Employer Group Plan
INPATIENT CARE	
Inpatient Hospital Care[1] (includes Substance Abuse and Rehabilitation Services)	**In-Network** You pay cost sharing of 5% for each stay at a network hospital. Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply **Out-of-Network** You pay 10% coinsurance for each stay at an out-of-network hospital.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1] (in a Medicare-certified skilled nursing facility)	Authorization rules may apply. **In-Network** You pay cost sharing of 5% per admission. Plan covers up to 100 days each benefit period. No prior hospital stay is required. **Out-of-Network** You pay 10% coinsurance, days 1-100.