

Goodyear Retiree Health Care Trust
Reference Code 17B9715

Freedom Blue PPO
Your 2017 Benefits at a Glance

| | In-Network | Out-of-Network |
|---|--|---|
| Plan Deductible | \$500 | |
| Plan Coinsurance (Member Cost Sharing) | 5% | 10% |
| In Network Out-of-Pocket Maximum (does not include Part D Drugs) | \$3,000 | |
| Combined In and Out of Network Out-of-Pocket Maximum (does not include Part D Drugs) | \$6,000 | |
| 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. |

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| | 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 17FB9715 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 Health Care Trust 199715 | |
|---|--|------------------------------------|
| General Provisions | Freedom Blue PPO In-Network | Freedom Blue PPO Out-of-Network |
| Plan Deductible | \$500 | |
| Plan Coinsurance (Member Cost Sharing) | 5% | 10% |
| In Network Out-of-Pocket Maximum (does not include Part D Drugs) | \$3,000 | |
| Combined In and Out-of-Network Out-of-Pocket Maximum (does not include Part D Drugs) | \$6,000 | |
| Benefit Category | | |
| Freedom Blue PPO Employer Group Plan | | |

IMPORTANT INFORMATION

| | |
|--|---|
| Premium and Other Important Information | <p>You may pay a premium each month to your retiree/employer group/trust fund. In addition, you keep paying your Medicare Part B premium.</p> <p>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.</p> |
| 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. |
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| Benefit Category | Freedom Blue PPO Employer Group Plan |
|--|--|
| <p>Ambulance Services (medically necessary ambulance services)</p> | <p>In-Network You pay cost sharing of \$0.</p> <p>Out-of-Network Emergency - You pay cost sharing of \$0. Non-Emergency - You pay cost sharing of 10%.</p> |
| <p>Chiropractic Care¹</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>Authorization rules may apply</p> <p>In-Network You pay cost sharing of \$20.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Dental Services¹</p> | <p>Preventive dental services (such as cleaning) not covered.</p> <p>Authorization rules may apply for Medicare-covered accidental dental services.</p> |
| <p>Diabetes Supplies and Services¹ (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)</p> | <p>Authorization rules may apply.</p> <p>In-Network Diabetes self-management training: You pay nothing You pay 5% coinsurance.</p> <p>If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |

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| Benefit Category | Freedom Blue PPO Employer Group Plan |
|---|---|
| <p>Diagnostic Tests, Lab, Radiology Services (Such as MRIs and CT Scans), and X-rays</p> | <p>Authorization rules may apply.</p> <p>Costs for these services may vary based on place of service.</p> <p>In-Network You pay 5% for the following:</p> <ul style="list-style-type: none"> • Lab services • Diagnostic procedures and tests • X-rays • Diagnostic radiology services (not including X-rays) • Therapeutic radiology services <p>If the doctor provides you additional services, separate doctor office visit cost sharing may apply.</p> <p>Out-of-Network You pay 10% coinsurance for out-of-network diagnostic procedures, tests and lab services.</p> <p>You pay 10% coinsurance for out-of-network therapeutic and diagnostic radiology services.</p> <p>You pay 10% coinsurance for each out-of-network outpatient x-ray.</p> |
| <p>Doctor Office Visits</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>In-Network Primary care physician visit: \$25</p> <p>Specialist visit: \$35</p> <p>Out-of-Network Primary care physician visit: 10% coinsurance</p> <p>Specialist visit: 10% coinsurance</p> |

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|---|--|
| <p>Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p> <p>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.</p> | <p>Authorization rules may apply.</p> <p>In-Network You pay 5% coinsurance.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p> | <p>You pay a \$65 copay for each emergency room visit.</p> <p>Worldwide coverage for emergency and urgently needed care.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, your copay is waived for the emergency room visit.</p> |
| <p>Foot Care (<i>podiatry services</i>)</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>In-Network Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: \$35</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Hearing Services</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>In-Network Exam to diagnose and treat hearing and balance issues: \$35</p> <p>Routine hearing exam (for up to 1 every year): \$35</p> <p>Hearing aid fitting/evaluation (for hearing aids every 3 calendar years): \$500</p> <p>Out-of-Network You pay 10% coinsurance.</p> |

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|---|--|
| <p>Home Health Care¹</p> | <p>Authorization rules may apply.</p> <p>In-Network You pay cost sharing of 5%.</p> <p>Out-of-Network You pay cost sharing of 10%.</p> |
| <p>Mental Health Care¹</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>Authorization rules may apply.</p> <p>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.</p> <p>Our plan covers 90 days for an inpatient hospital stay.</p> <p>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.</p> <p>You pay a cost sharing of 5% for each stay at a network hospital.</p> <p>Outpatient group therapy visit: \$35 Outpatient individual therapy visit: \$35</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Outpatient Prescription Drugs</p> | <p>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.</p> <p>You pay 10% of the cost for Part B drugs out-of-network.</p> <p>Part B Drugs are not available at retail pharmacies.</p> <p>Drugs covered under Medicare Part D Part D prescription drugs are not covered by the Freedom Blue PPO plan.</p> |

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|---|---|
| <p>Outpatient Rehabilitation Services¹ (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>Authorization rules may apply.</p> <p>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.</p> <p>In-Network You pay a \$25 cost sharing for occupational therapy visits.</p> <p>You pay a \$25 cost sharing for physical therapy and/or speech and language pathology visits.</p> <p>Out-of-Network You pay 10% for out-of-network occupational therapy visits.</p> <p>You pay 10% for out-of-network physical therapy and/or speech and language pathology visits.</p> |
| <p>Outpatient Substance Abuse Care¹</p> | <p>Authorization rules may apply.</p> <p>In-Network You pay cost sharing of \$35.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Outpatient Surgery¹</p> | <p>In-Network You pay cost sharing of 5%.</p> <p>Authorization rules may apply.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Over-the-Counter Items</p> | <p>Not covered</p> |
| <p>Prosthetic Devices¹ (includes braces, artificial limbs and eyes, etc.)</p> <p>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.</p> | <p>Authorization rules may apply.</p> <p>In-Network You pay 5% coinsurance.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |

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|---|---|
| <p>Renal Dialysis</p> | <p>In-Network You pay nothing.</p> <p>Out-of-Network You pay 10% coinsurance.</p> |
| <p>Transportation (Routine)</p> <p>Cost sharing is not applied to the deductible or out of pocket maximums.</p> | <p>In-Network You pay \$0 cost sharing per trip.</p> <p>Out-of-Network You pay 50% of the cost for out-of-network transportation services.</p> |
| <p>Urgent Care (This is not emergency care)</p> | <p>You pay a \$35 copay.</p> |
| <p>Routine Vision</p> <p>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.</p> <p>Office visit copays do not apply to the annual deductible.</p> | <p>In-Network Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): \$35</p> <p>Routine eye exam (for up to 1 every year): You pay nothing.</p> <p>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.</p> <p>\$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.</p> <p>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.</p> <p>Out-of-Network You pay 10% coinsurance for routine out-of-network eye exams.</p> <p>\$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.</p> <p>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.</p> |

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| Benefit Category | Freedom Blue PPO Employer Group Plan |
|--|--|
| Wellness/Education and Other Supplemental Benefits & Services | <p>The plan covers the following supplemental education/wellness programs: SilverSneakers Membership/Fitness Classes</p> <p>Out-of-Network You pay 50% of the cost for out-of-network health/wellness services after a \$500 deductible.</p> |
| Preventive Services | <p>In-Network You pay nothing</p> <p>Out-of-Network You pay nothing</p> <p>Our plan covers many preventive services, including:</p> <ul style="list-style-type: none"> • 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 <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p> |
| Hospice | <p>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.</p> |

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|---|---|
| INPATIENT CARE | |
| <p>Inpatient Hospital Care¹ (includes Substance Abuse and Rehabilitation Services)</p> | <p>In-Network</p> <p>You pay cost sharing of 5% for each stay at a network hospital.</p> <p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Authorization rules may apply</p> <p>Out-of-Network</p> <p>You pay 10% coinsurance for each stay at an out-of-network hospital.</p> |
| <p>Inpatient Mental Health Care</p> | <p>For inpatient mental health care, see the "Mental Health Care" section of this booklet.</p> |
| <p>Skilled Nursing Facility (SNF)¹ (in a Medicare-certified skilled nursing facility)</p> | <p>Authorization rules may apply.</p> <p>In-Network</p> <p>You pay cost sharing of 5% per admission.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network</p> <p>You pay 10% coinsurance, days 1-100.</p> |

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