

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Part I Annual Report Identification Information

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A This return/report is for: a multiemployer plan; a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or a single-employer plan; a DFE (specify) _____

B This return/report is: the first return/report; the final return/report; an amended return/report; a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here.

D Check box if filing under: Form 5558; automatic extension; the DFVC program; special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>RETIRES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
	1c Effective date of plan <u>08/25/2008</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>RETIRES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST</u> <u>60 BLVD. OF THE ALLIES, 5TH FLOOR</u> <u>PITTSBURGH, PA 15222-1219</u>	2b Employer Identification Number (EIN) <u>26-6330284</u>
	2c Plan Sponsor's telephone number <u>412-201-2242</u>
	2d Business code (see instructions) <u>326200</u>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>09/27/2016</u>	<u>THOMAS F. DUZAK</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
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4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: a Sponsor's name	4b EIN 4c PN
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5 Total number of participants at the beginning of the plan year	5	18705
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).		
a(1) Total number of active participants at the beginning of the plan year.....	6a(1)	0
a(2) Total number of active participants at the end of the plan year	6a(2)	0
b Retired or separated participants receiving benefits.....	6b	19352
c Other retired or separated participants entitled to future benefits.....	6c	0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d	19352
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e	
f Total. Add lines 6d and 6e	6f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
 4A 4D 4E

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <u>2</u> A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
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11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2015</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

<p>A Name of plan <u>RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>26-6330284</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL PLAN OF OHIO

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>31-0685339</u>	<u>54402</u>	<u>0001011</u>	<u>29057</u>	<u>01/01/2015</u>	<u>12/31/2015</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid <u>0</u>	(b) Total amount of fees paid <u>0</u>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.....
Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

6b	
6c	
6d	

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

(5) Other (specify below).....
▶

(6) Total additions

d Total of balance and additions (add lines **7b** and **7c(6)**)

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

(2) Administration charge made by carrier

(3) Transferred to separate account

(4) Other (specify below).....
▶

(5) Total deductions

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**).....

7b	
7c(1)	
7c(2)	
7c(3)	
7c(4)	
7c(5)	
7c(6)	
7d	
7e(1)	
7e(2)	
7e(3)	
7e(4)	
7e(5)	
7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	1838189
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)	
	(4) Earned ((1) + (2) - (3)).....	9a(4)	1838189
b	Benefit charges (1) Claims paid.....	9b(1)	1631975
	(2) Increase (decrease) in claim reserves.....	9b(2)	
	(3) Incurred claims (add (1) and (2)).....	9b(3)	1631975
	(4) Claims charged.....	9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions.....	9c(1)(A)	
	(B) Administrative service or other fees.....	9c(1)(B)	184487
	(C) Other specific acquisition costs.....	9c(1)(C)	
	(D) Other expenses.....	9c(1)(D)	
	(E) Taxes.....	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges.....	9c(1)(G)	
	(H) Total retention.....	9c(1)(H)	184487
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	9d(1)	
	(2) Claim reserves.....	9d(2)	
	(3) Other reserves.....	9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p style="text-align: center;">▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p style="font-size: x-small;">OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2015</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

<p>A Name of plan <u>RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN</u></p>	<p>B Three-digit plan number (PN) ▶</p>	<p><u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>26-6330284</u></p>	

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
HIGHMARK INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>23-1294723</u>	<u>54771</u>	<u>124218</u>	<u>4617</u>	<u>01/01/2015</u>	<u>12/31/2015</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid <u>0</u>	(b) Total amount of fees paid <u>0</u>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) deposit administration (2) immediate participation guarantee
(3) guaranteed investment (4) other ▶

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received.....	9a(1)		
(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	
b Benefit charges (1) Claims paid.....	9b(1)		
(2) Increase (decrease) in claim reserves.....	9b(2)		
(3) Incurred claims (add (1) and (2)).....		9b(3)	
(4) Claims charged.....		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions.....	9c(1)(A)		
(B) Administrative service or other fees.....	9c(1)(B)		
(C) Other specific acquisition costs.....	9c(1)(C)		
(D) Other expenses.....	9c(1)(D)		
(E) Taxes.....	9c(1)(E)		
(F) Charges for risks or other contingencies.....	9c(1)(F)		
(G) Other retention charges.....	9c(1)(G)		
(H) Total retention.....		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a		8506831
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs ▶

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE C
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2015

This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A Name of plan
RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST

D Employer Identification Number (EIN)
26-6330284

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

HIGHMARK

56-2526063

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	4245336	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CVS CAREMARK

05-0304626

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	1606680	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CDS ADMINISTRATORS, INC.

25-1352803

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	1102764	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

STATE STREET GLOBAL ADVISORS

04-1867445

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 19 51 52 68	NONE	326832	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

LOOMIS SAYLES

04-3200030

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	321273	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

MEKETA INVESTMENT GROUP, INC.

04-2659023

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50 70	NONE	277356	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

WELLINGTON TRUST

27-2594633

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	194745	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

BUCK CONSULTANTS, LLC

13-3954297

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 50	NONE	142547	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

BOND BEEBE

52-1044197

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	69258	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

CALLISTER NEBEKER & MCCULLOUGH

87-0304195

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	55573	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

JP MORGAN

13-4994650

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 50	NONE	41806	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

CONSOLIDATED GRAPHICS COMMUNICATION

1901 MAYVIEW ROAD
BRIDGEVILLE, PA 15017

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	40851	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

THOMAS F. DUZAK

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	37938	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

TERESA GHILARDUCCI

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	34689	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

HAZEL BROADNAX

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	31833	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

S. TED NELSON

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	31833	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

SCOTT M. SPENCER

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	31833	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

JEFFREY LEWIS

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	31833	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

ALAN REUTHER

3813 JOCELYN ST NW
WASHINGTON, DC 20015

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	30000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

WILLIAM IVEY

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	29374	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

SIMONE L. ROCKSTROH

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	29374	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)

PAUL WHITEHEAD

26-6330284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	PLAN FIDUCIARY	21317	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

**SCHEDULE D
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2015

This Form is Open to Public Inspection.

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A Name of plan <u>RETIREEES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN</u>	B Three-digit plan number (PN) ▶ <u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>RETIREEES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST</u>	D Employer Identification Number (EIN) <u>26-6330284</u>

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: <u>PASSIVE EMERGING MARKETS</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>27-6784056-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>42945679</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>CREDIT 3-10 YEAR INDEX</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>54-6535997-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>48939823</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EAFE INDEX</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>04-6832069-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>61362897</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EMERGING MARKETS INDEX NL</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>75-6661332-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>16221233</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>PASSIVE BOND MARKET INDEX</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>04-6903137-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>79797752</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>REIT INDEX</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>04-6903137-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>16258410</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>RUSSELL 3000 INDEX</u>	b Name of sponsor of entity listed in (a): <u>STATE STREET BANK AND TRUST COMPANY</u>	
c EIN-PN <u>04-3393595-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>58993474</u>

a Name of MTIA, CCT, PSA, or 103-12 IE: THE LOOMIS SAYLES SENIOR LOAN FUND

b Name of sponsor of entity listed in (a): LOOMIS SAYLES AND COMPANY, L.P.

c EIN-PN <u>82-0542784-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>68312988</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: U.S. HIGH YIELD BOND INDX

b Name of sponsor of entity listed in (a): STATE STREET BANK AND TRUST COMPANY

c EIN-PN <u>04-3508891-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>63754710</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: U.S. TIPS INDX NL QP CTF

b Name of sponsor of entity listed in (a): STATE STREET BANK AND TRUST COMPANY

c EIN-PN <u>02-6138231-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>205532824</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: WTC-CTF EMERGING LOCAL DEBT

b Name of sponsor of entity listed in (a): WELLINGTON TRUST COMPANY, NA

c EIN-PN <u>27-2594633-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: U.S. SHORT TERM GOVERNMENT/CREDIT B

b Name of sponsor of entity listed in (a): STATE STREET BANK AND TRUST COMPANY

c EIN-PN <u>27-6934633-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>78199160</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2015 This Form is Open to Public Inspection
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For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A Name of plan <u>RETIRES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN</u>	B Three-digit plan number (PN) ▶ <u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>RETIRES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE TRUST</u>	D Employer Identification Number (EIN) <u>26-6330284</u>

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	8052	1423716
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	39980696	40217011
(2) Participant contributions	2098768	1894544
(3) Other.....	16376888	12194599
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	192880	0
(2) U.S. Government securities.....		
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred		
(B) All other.....		
(4) Corporate stocks (other than employer securities):		
(A) Preferred		
(B) Common		
(5) Partnership/joint venture interests		
(6) Real estate (other than employer real property)		
(7) Loans (other than to participants)		
(8) Participant loans		
(9) Value of interest in common/collective trusts.....	754434843	672005962
(10) Value of interest in pooled separate accounts.....		
(11) Value of interest in master trust investment accounts		
(12) Value of interest in 103-12 investment entities	66316818	68312988
(13) Value of interest in registered investment companies (e.g., mutual funds).....	6547005	12308804
(14) Value of funds held in insurance company general account (unallocated contracts).....		
(15) Other		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	885955950	808357624

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h	11224447	10663388
i Acquisition indebtedness	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	11224447	10663388

Net Assets

l Net assets (subtract line 1k from line 1f).....	1l	874731503	797694236
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Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	55997700	
(B) Participants	2a(1)(B)	29421101	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		85418801
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	12678	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		
(2) Dividends: (A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	413	
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate.....	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	-14442915
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	596170
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds).....	2b(10)	
c Other income.....	2c	42278777
d Total income. Add all income amounts in column (b) and enter total.....	2d	113863924

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	12651577
(2) To insurance carriers for the provision of benefits	2e(2)	168987350
(3) Other	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	181638927
f Corrective distributions (see instructions)	2f	
g Certain deemed distributions of participant loans (see instructions).....	2g	
h Interest expense.....	2h	
i Administrative expenses: (1) Professional fees	2i(1)	595822
(2) Contract administrator fees.....	2i(2)	1097492
(3) Investment advisory and management fees	2i(3)	563382
(4) Other	2i(4)	7005568
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)	9262264
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j	190901191

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	-77037267
l Transfers of assets:		
(1) To this plan.....	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unqualified **(2)** Qualified **(3)** Disclaimer **(4)** Adverse

b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? Yes No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: BOND BEEBE, P.C

(2) EIN: 52-1044197

d The opinion of an independent qualified public accountant is **not attached** because:

(1) This form is filed for a CCT, PSA, or MTIA. **(2)** It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

	Yes	No	N/A	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X		
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.).....		X		

	Yes	No	N/A	Amount
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X		
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X		
e Was this plan covered by a fidelity bond?	X			500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X		
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X		
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X			
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	X			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X		
l Has the plan failed to provide any benefit when due under the plan?		X		
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)				
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.				
o Did the plan trust incur unrelated business taxable income?				
p Were in-service distributions made during the plan year?				

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?
 If "Yes," enter the amount of any plan assets that reverted to the employer this year. Yes No Amount:

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (see ERISA section 4021)? Yes No Not determined

Part V Trust Information

6a Name of trust	6b Trust's EIN
6c Name of trustee or custodian	6d Trustee's or custodian's telephone number

***Retirees of The Goodyear Tire & Rubber Company
Health Care Plan and Trust***

Financial Statements

For the Years Ended December 31, 2015 and 2014

**RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY
HEALTH CARE PLAN AND TRUST
TABLE OF CONTENTS
FOR THE YEARS ENDED DECEMBER 31, 2015 AND 2014**

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REPORT OF INDEPENDENT AUDITORS

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

Report on the Financial Statements

We have audited the accompanying financial statements of Retirees of The Goodyear Tire & Rubber Company Health Care Plan and Trust, which comprise the statements of net assets available for benefits as of December 31, 2015 and 2014 and the related statements of changes in net assets available for benefits for the for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

The Plan's management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of Retirees of The Goodyear Tire & Rubber Company Health Care Plan and Trust as of December 31, 2015 and 2014, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.



A Professional Corporation
Bethesda, MD
September 22, 2016

RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN AND TRUST
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2015 AND 2014

	2015	2014
ASSETS		
Investments - at fair value	\$ 752,627,754	\$ 827,491,546
Receivables		
Employer contributions	40,217,011	39,980,696
Participants' contributions	1,894,544	2,098,768
Prescription rebates	12,072,155	16,249,397
	54,183,710	58,328,861
Other assets		
Cash - operating funds	1,423,716	8,052
Prepayments	122,444	127,491
	1,546,160	135,543
TOTAL ASSETS	808,357,624	885,955,950
LIABILITIES		
Accounts payable and accrued expenses	10,663,388	11,224,447
NET ASSETS AVAILABLE FOR BENEFITS	\$ 797,694,236	\$ 874,731,503

**RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN AND TRUST
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEARS ENDED DECEMBER 31, 2015 AND 2014**

	<u>2015</u>	<u>2014</u>
ADDITIONS		
Contributions		
Employer		
Profit sharing deferrals	\$ 35,000,000	\$ 35,000,000
COLA deferrals	20,997,700	20,411,555
	<u>55,997,700</u>	<u>55,411,555</u>
Participants	29,421,101	29,004,326
	<u>85,418,801</u>	<u>84,415,881</u>
Investment income		
Net appreciation (depreciation) in fair value of investments	(16,110,494)	23,435,432
Interest and dividends	2,276,839	3,300,737
	<u>(13,833,655)</u>	<u>26,736,169</u>
Investment expenses	(563,382)	(665,836)
	<u>(14,397,037)</u>	<u>26,070,333</u>
Other income		
Prescription drug rebates	16,368,634	12,573,797
Subsidies	25,910,143	24,706,911
	<u>42,278,777</u>	<u>37,280,708</u>
TOTAL ADDITIONS	<u>113,300,541</u>	<u>147,766,922</u>
DEDUCTIONS		
Benefits paid		
Retired participants		
Prescription benefits	94,185,653	86,116,230
Medical benefits	74,801,697	80,897,052
Medicare Part B reimbursement	12,651,577	13,088,239
	<u>181,638,927</u>	<u>180,101,521</u>
Administrative expenses		
Actuarial and benefit consulting fees	172,661	124,347
Benefits administrative fees	6,450,676	6,707,764
VEBA administrator fees	1,096,529	1,122,891
Audit and accounting services	69,258	50,485
Trustee/Bank fees	11,587	28,123
Governance expenses	304,573	326,064
Insurance	214,543	237,971
Investment consulting	277,356	276,329
Legal fees	55,574	21,055
Printing and postage	46,124	41,430
	<u>8,698,881</u>	<u>8,936,459</u>
TOTAL DEDUCTIONS	<u>190,337,808</u>	<u>189,037,980</u>
NET DECREASE	(77,037,267)	(41,271,058)
NET ASSETS AVAILABLE FOR BENEFITS AT BEGINNING OF YEAR	<u>874,731,503</u>	<u>916,002,561</u>
NET ASSETS AVAILABLE FOR BENEFITS AT END OF YEAR	<u>\$ 797,694,236</u>	<u>\$ 874,731,503</u>

**RETIREES OF THE GOODYEAR TIRE & RUBBER COMPANY HEALTH CARE PLAN AND TRUST
NOTES TO FINANCIAL STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2015 AND 2014**

NOTE 1: DESCRIPTION OF THE PLAN

The following description of the Retirees of The Goodyear Tire & Rubber Company Health Care Plan (the Plan) and Trust provides only general information. Participants should refer to the Trust Agreement and Summary Plan Description for a more complete description of the Plan's provisions.

A. General

The Plan was established by the Committee for The Goodyear Tire & Rubber Company Health Care Trust (the Committee) pursuant to the Settlement Agreement between The Goodyear Tire & Rubber Company (Goodyear), the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, CLC (USW) and representatives of plaintiff class members in *Redington et al. v. The Goodyear Tire & Rubber Company*, Civ. Act. No.5:07-cv-1999 (N.D. Ohio). The Settlement Agreement dated October 29, 2007, was approved by the Federal District Court on August 22, 2008, and the Trust Agreement became effective August 25, 2008. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan provides certain health benefits to current and future USW-represented Goodyear retirees, surviving spouses and other spouses and dependents who may be entitled to such benefits through their relationship with the retirees and surviving spouses, as may be determined from time to time by the Committee.

B. Administration of the Trust

The administration of the Goodyear Tire & Rubber Company Health Care Trust is the responsibility of the Committee. The Plan's trustee is JP Morgan Chase Bank, N.A.

C. Benefits

The Plan provides health benefits (hospital, vision, medical, surgical, dental, Medicare Part B reimbursement and prescription drug) to retirees and surviving spouses, and to their covered dependents.

D. Funding Policy

The Plan is funded as follows:

Initial Contribution

Pursuant to the Settlement Agreement, The Goodyear Tire & Rubber Company agreed to contribute \$1 billion to the Trust. This amount was increased by cost of living allowance (COLA) deferrals and offset by premium charges in excess of specified premium Caps and a contribution to the EPD Trust (currently known as Retirees of Veyance Technologies, Inc. Health Care Trust). On August 27, 2008, the Plan received \$984,641,760.

Profit Sharing Deferrals

The Trust is entitled to receive annual variable cash contributions representing a portion of profit sharing amounts earned by USW-represented active employees pursuant to the 2013 collective bargaining agreement (CBA) between Goodyear and the USW, up to a maximum cap as stated in the applicable CBA and is set to expire on July 29, 2017. The CBA provides for profit sharing deferrals for the years beginning January 1, 2014 and forward, subject to an annual maximum cap of \$35,000,000. For the years ending December 31, 2015 and 2014, the annual maximum cap of \$35,000,000 was reached both years.

COLA Deferrals

During the term of the 2013 CBA, the Trust is entitled to receive contributions representing a portion of the amount of COLA adjustments to which USW-represented active employees are entitled under the CBA. For the years ending December 31, 2015 and 2014 there were deferrals of \$20,997,700 and \$20,411,555, respectively.

NOTE 1: DESCRIPTION OF THE PLAN - continued

Participant Contributions

Contributions by retirees are determined by the Committee, subject to certain restrictions contained in the Settlement Agreement and vary based on year of retirement and family status. For the years ending December 31, 2015 and 2014, there were contributions of \$29,421,101 and \$29,004,326, respectively.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

The financial statements have been prepared using the accrual basis of accounting, in accordance with accounting principles generally accepted in the United States of America.

B. Accounting Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions which affect the reported amounts of assets, liabilities, benefit obligations and changes therein, IBNR, claims payable and disclosure of contingent assets and liabilities. Actual results may differ from these estimates.

C. Valuation of Investments and Income Recognition

Investments are presented at fair value, determined as follows:

- Commingled funds are valued at net asset value (NAV) per share. The NAV is based on the fair value of the underlying investments held by the fund less its liabilities. The NAV is used as a practical expedient. This practical expedient would not be used when it is determined to be probable that the fund will sell the investment for an amount different than reported.
- Short-term investments are valued at cost, which approximates fair value.

Purchases and sales of securities are reflected on a trade-date basis. Interest income is recorded on the accrual basis. Dividend income is recognized as of the ex-dividend date.

In accordance with the policy of stating investments at fair value, net appreciation or depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the period.

D. Employer Contributions Receivable

Contributions are accrued based upon analysis of employer remittance reports and subsequent cash receipts. Management believes all amounts accrued to be collectible; accordingly, no provision for uncollectible amounts have been recorded.

E. Claims Payable and Amounts Incurred but Not Paid

Amounts currently payable to or for participants, beneficiaries and dependents represent actual and estimated amounts paid or payable after year end for all reported claims for benefits occurring during the respective accounting periods, and other miscellaneous benefits related to services performed in those respective periods. These amounts are reported as part of the postretirement benefit obligation.

NOTE 2: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - continued

F. Postretirement Benefit Obligations

Postretirement benefit obligations represent the total actuarial present value of those estimated future benefits that are attributed to employee service rendered through December 31. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired employees, their beneficiaries and dependents and (2) active employees, their beneficiaries and dependents after retirement. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to the employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by the Plan's actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

G. Transitional Reinsurance Program

Section 1341 of the Affordable Care Act established a transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Marketplaces. For the years ended December 31, 2015 and December 31, 2014, required contributions to the program were \$44 and \$63, respectively, per covered life. Accounting standards require that this contribution, known as the transitional reinsurance fee, be accrued as a liability at the beginning of the calendar year along with an offsetting deferred charge. The deferred charge is recognized as expense ratably through the year as coverage occurs. For the years ended December 31, 2015 and December 31, 2014, the transitional reinsurance fee expense was \$325,292 and \$523,026, respectively. The fees are included in Benefits administrative fees on the statements of changes in net assets available for benefits.

H. Recognition of Benefits

Benefits are recognized when paid, except for Medicare Part B reimbursements, which are recognized in the period the benefit is earned by the participant.

I. Subsequent Events

In preparing these financial statements, management of the Plan has evaluated events and transactions that occurred after December 31, 2015 for potential recognition or disclosure in the financial statements. These events and transactions were evaluated through September 22, 2016, the date that the financial statements were available to be issued.

NOTE 3: RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

Actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term could materially affect the amounts reported and disclosed in the financial statements.

NOTES TO FINANCIAL STATEMENTS

NOTE 4: FAIR VALUE MEASUREMENTS

Generally accepted accounting principles define fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, establish a fair value reporting hierarchy and define three broad levels of inputs (the assumptions that market participants would use in pricing the asset or liability) as noted below:

Level 1

Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.

Level 2

Inputs are quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active or inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3

Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Specific detail on valuation methodology is presented in Note 2. There have been no changes in the valuation methodology used at December 31, 2015 and 2014.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the end of the reporting period. For the years ended December 31, 2015 and 2014, there were no transfers into or out of levels 1, 2 or 3.

As of December 31, 2015 and 2014, assets measured at fair value on a recurring basis are summarized by level within the fair value hierarchy as follows:

	2015			Total Fair Value
	Level 1	Level 2	Level 3	
Short-term investments	\$ -	\$ 12,308,804	\$ -	\$ 12,308,804
Total investments in the fair value hierarchy	<u>\$ -</u>	<u>\$ 12,308,804</u>	<u>\$ -</u>	12,308,804
Investments measured at net asset value				<u>740,318,950</u>
Total investments - fair value				<u>\$ 752,627,754</u>
	2014			
	Level 1	Level 2	Level 3	Total Fair Value
Short-term investments	\$ -	\$ 6,739,885	\$ -	\$ 6,739,885
Total investments in the fair value hierarchy	<u>\$ -</u>	<u>\$ 6,739,885</u>	<u>\$ -</u>	6,739,885
Investments measured at net asset value				<u>820,751,661</u>
Total investments - fair value				<u>\$ 827,491,546</u>

NOTES TO FINANCIAL STATEMENTS

NOTE 4: FAIR VALUE MEASUREMENTS - continued

The fair values of the following investments have been determined using the NAV per unit of the investment as of December 31, 2015 and 2014:

	<u>2015</u>	<u>2014</u>
Commingled funds	<u>\$ 740,318,950</u>	<u>\$ 820,751,661</u>

These commingled funds are managed by two different advisors, State Street and Loomis Sayles. There are no restrictions on these funds and there are no unfunded commitments. The investments held by State Street have daily redemptions with a 2 day trade date notice and the liquidation of the funds will occur 3 days after the trade date. State Street requests notice 15 days in advance of the trade date for all contributions or redemptions that are of significant size, as determined by State Street. All investments held by Loomis Sayles can be redeemed on the first and 15th of each month with a 15 day notification.

NOTE 5: POSTRETIREMENT BENEFIT OBLIGATIONS

As of December 31, 2015 and 2014, the actuarial present value of accumulated plan benefits is as follows:

	<u>2015</u>	<u>2014</u>
Postretirement benefit obligations		
Basic		
Retired participants	\$ 2,083,101,659	\$ 2,803,722,267
Other participants fully eligible for benefits	298,955,755	400,052,524
Participants not yet fully eligible for benefits	<u>589,535,877</u>	<u>830,867,014</u>
Total benefit obligations	<u>\$ 2,971,593,291</u>	<u>\$ 4,034,641,805</u>

Information regarding the changes in benefit obligations for the years ended December 31, 2015 and 2014 is shown below:

Balance at beginning of year	<u>\$ 4,034,641,805</u>	<u>\$ 3,047,620,118</u>
Increase (decrease) during year attributable to		
Service and interest costs	238,631,355	200,095,634
Actuarial assumption (gain)/loss	(346,095,367)	877,888,248
Expected benefits paid	(140,579,463)	(134,806,788)
Actuarial experience (gain)/loss	<u>(815,005,039)</u>	<u>43,844,593</u>
	<u>(1,063,048,514)</u>	<u>987,021,687</u>
Total benefit obligations	<u>\$ 2,971,593,291</u>	<u>\$ 4,034,641,805</u>

The Plan had a deficiency of net assets over benefit obligations at December 31, 2015 and 2014 related primarily to the postretirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current bargaining agreements. However, the obligation of the Plan is to provide benefits only to the extent of the assets available in the Trust. If the deficiency is not funded through future increases in the collectively bargained contribution rates, the Committee has the authority to reduce benefits (See Note 8).

The postretirement benefit obligation of the Plan is reflected net of projected retiree contributions of \$65 per month for households in which the retiree is eligible for Medicare, \$130 per month for households in which the retiree is not eligible for Medicare.

NOTES TO FINANCIAL STATEMENTS

NOTE 5: POSTRETIREMENT BENEFIT OBLIGATIONS - continued

The weighted-average health care cost-trend rate assumptions have a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 2015 and 2014 to \$304,765,306 and \$4,787,107,166, respectively.

The following were significant assumptions used in the valuations as of December 31, 2015 and 2014:

	2015	2014
Discount rate	4.50%	4.00%
Mortality rates	RPH-2014 headcount-weighted mortality table with fully generational projection using the Buck-modified scale MP-2015.	RP-2000 combined mortality table with fully generational projection using scale BB.

Representative values of the assumed annual rates of retirement at December 31, 2015 and 2014 are as follows:

<u>Age</u>	<u>Assumed to Retire During the Year</u>	
	<u>Less than 30 Years of Service</u>	<u>30 or More Years of Service</u>
50 - 54	0.0 %	5.0 %
55 - 58	2.0 %	8.0 %
59	2.0 %	10.0 %
60	4.0 %	12.0 %
61	6.0 %	31.0 %
62	45.0 %	45.0 %
63	45.0 %	45.0 %
64	55.0 %	55.0 %
65 and older	100.0 %	100.0 %

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

NOTE 6: TAX STATUS

The Internal Revenue Service has determined and informed the Trust by a letter dated June 30, 2009, that the Plan and related trust are designed in accordance with applicable sections of the Internal Revenue Code (the IRC). The Trust is exempt from federal income taxation under Section 501(a) of the Internal Revenue Code, as described at Section 501(c)(9). The Plan has been amended since receiving the letter, however the Committee believes that the Trust is designed and is currently being operated in compliance with the applicable provisions of the IRC.

Generally accepted accounting principles require management to evaluate tax positions taken and recognize a tax liability if the Trust has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Management has evaluated the tax positions taken by the Trust and concluded that as of December 31, 2015 there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 7: PRIORITIES UPON TERMINATION

It is the intent of the Committee to continue the Plan in effect so long as the Trust has assets; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Committee Members. In the event of termination, the Committee Members shall first satisfy the obligations of the Plan to the extent of the assets in the Trust. Termination shall not permit any part of the Plan to be used for, or diverted to, purposes other than the exclusive benefit of the participants.

NOTE 8: RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In May 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2015-07 "Disclosures for Investments in Certain Entities That Calculate Net Asset Value per Share (or Its Equivalent)" (ASU 2015-07) which removes the requirement to present certain investments for which the practical expedient is used to measure fair value at net asset value within the fair value hierarchy table. Instead, an entity is required to include those investments as a reconciling item so that the total fair value of investments in the disclosure is consistent with the total investment balance on the statements of net assets available for benefits. ASU 2015-07 further requires retrospective application to all prior periods presented in the year of adoption. The amendments in ASU 2015-07 are effective for reporting periods beginning after December 15, 2016, but early adoption is permitted. Management has elected early adoption of ASU 2015-07 and the changes in the presentation created by this ASU are reflected in these financial statements.

In July 2015, the FASB issued Accounting Standards Update 2015-12 "Plan Accounting: Defined Benefit Pension Plans (Topic 960), Defined Contribution Plans (Topic 962), Health and Welfare Benefit Plans (Topic 965)" (ASU 2015-12). The amendments to generally accepted accounting principles in Part I and Part III of ASU 2015-12 are not applicable to the Plan. Part II of ASU 2015-12 amends prior reporting standards and permits disaggregation of investments measured at fair value only by general type, either on the financial statements or in the notes. Part II of this ASU also eliminates the requirement to disclose the net appreciation (depreciation) in fair value of investments by general type and the requirement to disclose individual investments that represent 5% or more of net assets available for benefits. ASU 2015-12 requires retrospective application to all prior periods presented in the year of adoption. The amendments in ASU 2015-12 are effective for reporting periods beginning after December 15, 2015, but early adoption is permitted. Management has elected early adoption of ASU 2015-12 and the changes in presentation created by this ASU are reflected in these financial statements.

The adoption of ASU 2015-07 and ASU 2015-12 had no effect on the net assets available for benefits or the changes in net assets available for benefits for the years ended December 31, 2015 and 2014.

**REPORT OF INDEPENDENT AUDITORS ON SUPPLEMENTAL INFORMATION REQUIRED BY THE
DEPARTMENT OF LABOR'S RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE UNDER
THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

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

We have audited the financial statements of Retirees of The Goodyear Tire & Rubber Company Health Care Plan and Trust as of and for the year ended December 31, 2015, and our report thereon dated September 22, 2016 which expressed an unmodified opinion on those financial statements, appears on page 1. Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.



A Professional Corporation
Bethesda, MD
September 22, 2016

Retirees of The Goodyear Tire & Rubber Company
Health Care Plan
EIN 26-6330284
Plan number 501
Plan Year Ended December 31, 2015

Form 5500, Schedule H, Part IV, Line 4i
Schedule of Assets (Held at End of Year)

(a)	(b)	(c)	(d)	(e)
Identity of issue, borrower, lessor, or similar party		Description of investment including maturity date, rate of interest, collateral, par, or maturity value	Cost	Current Value
Common Collective Trusts				
		Credit 3-10 Year Index NL Ctf	4,006,863 shares	41,681,716
		MSCI EAFE Index NL Ctf	3,723,477 shares	49,845,121
		MSCI Emerging Markets Index NL Ct	820,746 shares	16,727,527
		Passive Bond Market Index NL Ctf	5,372,139 shares	73,771,972
		Reit NL Index Ctf	421,486 shares	4,991,746
		Russell 3000 Index NL Ctf	3,461,449 shares	29,916,573
		U.S. High Yield Bond Indx	6,179,578 shares	49,464,484
		U.S. Tips Indz NL QP CTF	15,240,458 shares	181,811,357
		Short Term Govt/Credit CMLI	7,570,835 shares	77,496,521
		Passive Emerging Markets Local Curr NL Strategy	5,609,415 shares	44,339,661
			<u>570,046,678</u>	<u>672,005,962</u>
103-12 Investment Entities				
		The Loomis Sayles Senior Loan Fund	60,400,000 shares	60,400,000
Registered Investment Companies				
		JPMorgan U.S. Treasury Plus Money Market	12,308,804 shares	12,308,804
			<u>\$ 642,755,482</u>	<u>\$ 752,627,754</u>

Retirees of The Goodyear Tire & Rubber Company
Health Care Plan
EIN 26-6330284
Plan Number 501
Plan Year Ended December 31, 2015

Form 5500, Schedule H, Part IV, Line 4j
Schedule of Reportable Transactions

Identity of party involved (a)	Description of asset (b)	Purchase price (c)	Selling price (d)	Lease rental (e)	Expense incurred with transaction (f)	Cost of asset (g)	Current value of asset on transaction date (h)	Net gain or (loss) (i)
Single transactions:								
JPMorgan	US Treasury Plus Money Market Fund	N/A	44,339,661	N/A	N/A	44,339,661	44,339,661	-
Series of transactions:								
JPMorgan	US Treasury Plus Money Market Fund	165,595,921	N/A	N/A	N/A	165,595,921	165,595,921	0
		N/A	159,834,491	N/A	N/A	159,834,491	159,834,491	0
State Street Global Advisors	Passive Emerging Markets	44,339,661	N/A	N/A	N/A	44,339,661	44,339,661	0
Wellington Trust	WTC-CTF Emerging Local Debt	3,662,442	N/A	N/A	N/A	3,662,442	3,662,442	0
			61,424,999	N/A	N/A	44,524,637	44,524,637	16,900,362

**Retirees of the Goodyear Tire & Rubber Company
Health Care Plan
EIN 26-6330284
Plan No. 501
Plan Year Ended December 31, 2015**

**Form 5500, Schedule H, Part III
Financial Statements used to formulate IQPA's opinion**

The entire report has been attached to the Accountant's Opinion

**Retirees of the Goodyear Tire & Rubber Company
Health Care Plan
EIN 26-6330284
Plan No. 501
Plan Year Ended December 31, 2015**

**Form 5500, Schedule H, Part IV, Line 4i
Schedule of Assets (Held at Year End)**

See attachment to the Accountant's Audit Report attached at Accountant's Opinion

**Retirees of the Goodyear Tire & Rubber Company
Health Care Plan
EIN 26-6330284
Plan No. 501
Plan Year Ended December 31, 2015**

**Form 5500, Schedule H, Part IV, Line 4j
Schedule of Reportable Transactions**

See attachment to the Accountant's Audit Report attached at Accountant's Opinion

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2015</div> This Form is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2015 or fiscal plan year beginning	01/01/2015 and ending 12/31/2015
A This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
C If the plan is a collectively-bargained plan, check here.....	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description)

Part II Basic Plan Information —enter all requested information							
1a Name of plan Retirees of The Goodyear Tire & Rubber Company Health Care Plan	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">08/25/2008</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan	08/25/2008		
1b Three-digit plan number (PN) ▶	501						
1c Effective date of plan	08/25/2008						
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Retirees of The Goodyear Tire & Rubber Company Health Care Trust 60 Blvd. of the Allies, 5th Floor Pittsburgh PA 15222-1219	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">26-6330284</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">(412) 201-2242</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">326200</td> </tr> </table>	2b Employer Identification Number (EIN)	26-6330284	2c Plan Sponsor's telephone number	(412) 201-2242	2d Business code (see instructions)	326200
2b Employer Identification Number (EIN)	26-6330284						
2c Plan Sponsor's telephone number	(412) 201-2242						
2d Business code (see instructions)	326200						

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		09/26/2016	Thomas F. Duzak
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2015)
v. 150123

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN
	3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN
a Sponsor's name	4c PN
5 Total number of participants at the beginning of the plan year	5 18,705
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).	
a(1) Total number of active participants at the beginning of the plan year	6a(1) 0
a(2) Total number of active participants at the end of the plan year	6a(2) 0
b Retired or separated participants receiving benefits	6b 19,352
c Other retired or separated participants entitled to future benefits.....	6c 0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 19,352
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	6e
f Total. Add lines 6d and 6e	6f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....	6g
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4D 4E

<p>9a Plan funding arrangement (check all that apply)</p> <p>(1) <input type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>	<p>9b Plan benefit arrangement (check all that apply)</p> <p>(1) <input checked="" type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<p>a Pension Schedules</p> <p>(1) <input type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p>	<p>b General Schedules</p> <p>(1) <input checked="" type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information – Small Plan)</p> <p>(3) <input checked="" type="checkbox"/> <u>2</u> A (Insurance Information)</p> <p>(4) <input checked="" type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p>
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