Health Care Benefits For Retired Salaried Associates
Who Retired On Or After January 1, 1992

Effective January 1, 2009
This booklet describes the Medical Benefits Program, which includes Prescription Drug benefits, and the Dental Benefit Plan. The program covers salaried retirees who are eligible for medical benefits who retired on or after January 1, 1992:

The Plans cover salaried Associates who, at the time of retirement were not represented by a collective bargaining unit, and who have retired from locations designated by The Goodyear Tire & Rubber Company as covered locations which are on file with the Plan Administrator.

This booklet is the “Summary Plan Description” required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). Key features are summarized in everyday language in this booklet. This Summary Plan Description hereby incorporates the benefit booklet of providers and together with their contracts comprises the Plan documents.

There is another version of this Summary Plan Description (“SPD”) that covers other salaried retirees who retired prior to January 1, 1992.

In all cases, your rights and benefits, and those of your dependents and beneficiaries, are governed by the terms and conditions of the Plans as in effect from time to time. The Company, through its authorized representatives, reserves the right to modify or terminate any or all of the Plans at any time.

If you have any questions or if you need any additional information about your benefits, please contact the Goodyear Benefits Solution Center @ (800) 334 9395.
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General Provisions

To be eligible for coverage under the Plans, you must have retired on or after January 1, 1992 from a location designated by the Company, and meet the eligibility provisions. The list of such locations is on file and is available from the Plan Administrator. Following is a general description of provisions applicable to the Plans, as in effect January 1, 2009.

Retiree Medical Eligibility

The following section applies to those associates who:

- Were a Goodyear associate and age 40 or older on January 1, 2003, or
- Were a Goodyear associate and under the age of 40 on January 1, 2003, and have 30 years of continuous service when they exit the Company.

If you were an associate and over age 40 on January 1, 2003, in order to qualify for retiree medical benefits, you must retire from active service (that is commence your pension effective as of the first of the month following your last day of continuous service) with either 30 or more years of service, or be at least age 55 with 10 or more years of service at retirement, or if you were hired after age 60, at the time you attain 5 years of service, under the Pension Plan. If you do not meet any of these requirements, you are not eligible for retiree medical coverage. If you were an associate that was under age 40 on January 1, 2003, you must have 30 years of continuous service when you retire from the Company.

If you meet one of the conditions above, you will be eligible for retiree medical coverage subject to the Rule of 95, as described below.

If you retire and are eligible for and receiving a monthly pension, or have received a lump sum distribution under the Salaried Pension Plan, you may be eligible for retiree medical coverage. You must file and apply for your pension benefit and retiree medical coverage while you are an active associate to commence at the time your employment terminates.

You may elect the option of “No coverage” but to be eligible at a future date you must request coverage within 30 days after your other coverage ends and provide proof of prior credible coverage.

You will be required to contribute toward the cost of your health coverage. The Company will share in the cost by providing its maximum contribution (see Maximum Company Contribution, page 11) toward the cost of health care coverage if you retire with 95 or more points. Points are based on your years of attained age and your years of attained continuous service, following pension rules for age and service, added together, at the time of retirement. For example, if you retire at age 62 with 29 full years of continuous service; you will have a total of 91 points.

If you retire with less than 95 age and continuous service points, the Company contribution will be reduced by 2% for every point less than 95. You will be required to make payment in advance based on the Company’s annual estimate of health care contributions. Failure to make the required payment will result in cancellation of your coverage.

If you retire with 30 or more years of continuous service at any age, you will receive 95 points at retirement.

If you meet the eligibility requirements for retiree medical coverage under this section and become eligible for long-term disability benefits on or after January 1, 1996 and have eight or more years of continuous service on the date your disability began, you will have 95 points. You will receive an additional 15 points to be added to your total at the time of your retirement if, on January 1, 1996, you were:

- Age 50 or older and had 10 or more years of service; or
- Any age and had 20 or more years of service;

When you retire you will be notified of the medical options available to you. Currently, the Company medical plans offered to eligible retirees are national programs offered through Blue Cross / Blue Shield.

A participant who became Medicare eligible on or after January 1, 2008 is no longer eligible for coverage under the Medical Plan for Salaried Retirees. If a retiree becomes Medicare eligible before their dependent, the dependent will continue to be eligible until such time they reach Medicare eligibility.

The Company reserves the right to modify or terminate any or all of the plans at any time. If you choose “no coverage”, you will not receive prescription drug benefits, since the prescription drug benefit is part of the medical plan. You will pay the price tags that are in effect for retirees and adjusted each year.
Eligible Dependents

Eligible dependents are those individuals who were on your Company record (even if not in coverage) as of January 1, 2006 or upon your retirement if later:

- Your wife or husband.
- Your unmarried children under age 19.
- Your unmarried children 19 years or older provided they are dependent on you for a majority of their financial support and upon attainment of age 19, are full-time students. Eligibility as a full-time student terminates upon ceasing to be a full-time student or attaining age 27, if earlier. Coverage for an unmarried full-time student will be extended for 90 days following termination of status as a full-time student provided no other group medical coverage of any kind is in effect on such student.

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

- Your unmarried children 19 years or older provided they are dependent on you for a majority of their financial support and upon attainment of age 19, are mentally or physically incapable of self-support as determined by the Company. Eligibility terminates when the dependent is no longer mentally or physically incapable of self-support.

Eligibility is also extended for a full-time student who becomes disabled after age 19, up to age 27.

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

The word “child” in addition to your natural children includes such stepchildren, foster children or other children (all unmarried) who live with you and depend upon you for support and maintenance.

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

- Effective January 1, 2006 a salaried retiree is not permitted to add new eligible dependents to their coverage even with a “change in status”.

The dependents listed on your Company record (whether or not enrolled in coverage) will remain eligible, but you are not eligible to add dependents who would otherwise be eligible for coverage after January 1, 2006.

- If you or one of your eligible dependents elect to enroll in Medicare Part D or a Medicare Advantage Plan as of January 1, 2006 or later, you or that dependent will not be eligible for the Medical Benefit Plan for Retired Salaried Employees while enrolled in the Medicare Part D or Medicare Advantage Plan.

- If you opt out of the Company’s retiree health care coverage (medical, prescription drug and/or dental), you will not be permitted to re-enroll unless you show evidence of prior credible coverage. In other words, you will not be permitted an annual election—you will only be able to re-enroll in the Company’s retiree medical plan by showing proof that you had other coverage and that it ended, and if you notify the Goodyear Benefits Solution Center within 31 days of the loss of the other coverage. Prior credible coverage means another employer sponsored plan or Medicare Advantage plan is available to you or to your spouse but prior credible coverage does not encompass only enrollment in Medicare Part A and Part B without a supplemental plan.

- If you work as an active associate of another employer after you retire from the Company, and you have elected coverage under the Retiree Medical Plan for Salaried Retirees, you and your dependents must enroll in any medical/prescription drug coverage available to you as an active employee. The coverage of the retiree as an active associate will be primary, whether or not the salaried retiree actually enrolled for the active coverage.

- If you or a dependent is not Medicare eligible by January 1, 2008, you will not be eligible for coverage under Goodyear’s Medical Plan when you become Medicare eligible.
**Qualified Medical Child Support Orders**

If a court orders you in divorce or legal separation procedures to provide medical coverage to a child who you will no longer have custody of, you should contact the Plan Administrator to obtain, without charge, a copy of such procedures for a Qualified Medical Child Support Order (QMCSO).

**Your Health Care Choice**

Medical benefits for retired associates and their eligible dependents are provided through Anthem Blue Cross/Blue Shield. There are two Blue Cross/Blue Shield National Preferred Provider Organization (PPO) options available. You will receive information about the two different options during the annual open enrollment period if you are in coverage. Upon enrollment into one of the plans, you will receive a separate booklet from Blue Cross/Blue Shield describing in detail the plan benefits, including applicable deductibles and co-payments.

Your 2011 Options are:

- **$500/$1000 Option**—This National option has a $500/$1000 family deductible and 20% In-network co-payment. Deductible and co-payments are higher if you are out of network.

- **$1500/$3000 Option**—This National option has $1500/$3000 family deductible and 20% In-network co-payment. Deductible and co-payments are higher if you are out of network.

- **“NO” coverage Option**—If you have medical coverage from another source, such as your spouse’s medical plan, you may choose the “No Coverage” option. If you choose no coverage, you are also opting out of prescription drug coverage since this is part of your medical coverage.

Each option offers a different level of benefit and has different deductibles. When you make your choices each year, you will need to look at these factors and the premiums associated with each option and determine your needs, coverage you may have available elsewhere (through a spouse’s plan, for example).

Each year you will be given an opportunity to change your medical plan option, unless you opt out of coverage. If you opt out of coverage, in order to re-enroll in the Medical Plan you must provide proof to the Goodyear Benefits Solution Center of prior credible coverage. Please contact the Goodyear Benefits Solution Center at (800) 334-9395.

**The “No Coverage” Option**

If you have medical coverage from another source, such as your spouse’s medical plan, you may choose the “No Coverage” option. If you choose no coverage, you are also opting out of prescription drug coverage since this is a part of your medical coverage.

If you elect “No Coverage” for 2006 or later, you will only be able to re-enroll in the Medical Benefits Program for Retired Salaried Employees if you provide proof of prior credible coverage to the Goodyear Benefits Solution Center. If you have any questions regarding how to do this, please contact the Goodyear Benefits Solution Center at (800) 334-9395.

**Medical Appeals**

If you are denied a medical benefit under the Plan, you may file an appeal. The medical claims and appeals procedure has been delegated to the specific providers under the medical options of the Retired Salaried Benefit Plan. You may refer to the Summary Plan Description of the medical provider for their specific claims and appeals procedure (or) you may call their customer service number listed on your medical identification card to request another copy of their claims and appeals procedure.

**Your Cost for Coverage**

The contribution that you will be required to pay will depend upon your effective date of retirement, whether you or your dependents are Medicare eligible and whether the “Rule of 95” applies to you.

Payment for your medical coverage is due monthly. You can pay for it each month through a deduction from your monthly benefit payment from your Company Pension if eligible or directly from your savings or checking account at your bank, by contacting the Benefits Solutions Center at (800) 334-9395.

If your pension benefit does not cover the full cost of your medical coverage or you are not receiving a monthly Pension payment, you must mail the balance due for the monthly contribution each month in advance by check or bank debit. You must mail the
required monthly contribution monthly in advance by the 15th of the month prior to the month of coverage by check payable to:

The Goodyear Tire & Rubber Company in care of Benefit Operations,
P.O. Box 403365
Atlanta, GA 30384-3365

Note: There are no partial month premium payment refunds (i.e. premiums received for a month’s coverage is non-refundable).

Changing Your Benefit Plan Election

Your medical selection, once made, remains in effect for a full Plan year (January 1–December 31).

However, you can change some of your choices during the year if you have an eligible change in status and notify the Goodyear Benefits Solution Center at (800) 334-9395 within 31 days of the change. Events that trigger “changes in status” are governed by Internal Revenue Service regulations, and are defined as:

• An annulment, legal separation or divorce.
• A dependent child reaching an age where he or she is no longer eligible for benefit coverage, or re-qualifies as being eligible for benefit coverage.
• The death of your spouse or dependent child.
• A change in your, your spouse’s or dependent’s employment status, including work schedule, that causes a change in eligibility for benefits for you or your dependents.
• A change in the place of residence or work for you, your spouse or dependent.

If a change in status occurs, you will be permitted to change some of your elections, provided that:

• The change results in you, your spouse or dependent gaining or losing eligibility for coverage, and
• Your new elections are consistent with that gain or loss of coverage.

If you do have a change in family status, if consistent you can:

• Change your medical option and drop dependents covered.
• Change your dental dependents covered.

Note: If you fail to notify the Plan within 31 days, you may not be able to make changes to your coverage, or add/drop dependents.

If your spouse has or acquires other medical coverage, you must notify the Company by contacting the Goodyear Benefits Solution Center to request a Coordination of Benefits form.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends and provide proof of prior credible coverage.

Retiree Benefit Reviews to Continue

As with all of its benefit programs, the Company will periodically review coverages to determine if appropriate adjustments are needed. Monthly contributions may be adjusted for coverage in the future. If so, you will have an opportunity to change your medical election at that time.

Continuation of Coverage (This section applies to medical and dental benefits)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the Company offer you and/or your dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the Plan would otherwise end (“Qualifying Events”). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.
Who Is Covered

Retiree
If you are a retiree of the Company covered under the Plan, you may choose this continuation coverage if you lose your coverage because the Company files for bankruptcy under Chapter 11 of the Federal Bankruptcy Code.

Spouses of Retirees
If you are the spouse of a retiree covered by the Plan, you are a “Qualified Beneficiary” and have the right to choose continuation coverage yourself if you lose group health coverage under this Plan for any of the following four reasons:
• the death of your spouse.
• divorce or legal separation from your spouse.
• your spouse becoming entitled to Medicare.
• the commencement of certain bankruptcy proceedings, since your spouse is retired.

Dependent Children
A dependent child of an associate covered by the Plan also is a “Qualified Beneficiary” and has the right to continuation coverage if group health coverage under the Plan is lost for any of the following five reasons:
• the death of a parent.
• parents’ divorce or legal separation.
• a parent becoming entitled to Medicare.
• the dependent ceasing to be a “dependent child” under the Plan.
• a proceeding in a bankruptcy reorganization case, since your parent is retired.

A child born to, or placed for adoption with, the retiree during a period of continuation coverage also is a Qualified Beneficiary.

Separate Elections
If there is a choice among types of coverage under the plan, each of you who are eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation of coverage even if the retiree does not make that election. Similarly, a spouse or dependent child may elect a different coverage from the coverage that the retiree elects.

Your Responsibilities under the Law
Under the law, the retiree or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan, within 60 days of the date of the event. In addition, the associate or a family member must inform the Plan Administrator of a determination by the Social Security Administration that the retiree or covered family member was disabled during the 60-day period after the associate’s termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. (See “Special rules for disability,” below.) If, during continued coverage, the Social Security Administration determines that the retiree or family member is no longer disabled, the individual must inform the Plan Administrator of this re-determination within 30 days of the date it is made.

Employer’s Responsibilities under the Law
The Company as Plan Administrator must notify you and your dependents within 44 days of a loss of coverage because of a death, termination of employment, reduction in hours or a bankruptcy that you have the right to choose continuation coverage. Under the law, you have a maximum of 60 days from the qualifying event (which is the date of the event which causes loss of coverage) to inform the Plan Administrator that you want continuation coverage.

Choosing Continuation Coverage
If you do not choose continuation, coverage within the time period described above, your group health insurance coverage will end. If you choose continuation coverage, the Company is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Associates or family...
members. This means that if the coverage for similarly situated Associates or family members is modified, your coverage will be modified. (“Similarly situated” refers to current Associates or their dependents who have not had a qualifying event.)

**How Long will Coverage Last?**

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. Such events may extend an 18-month continuation period to 36 months, but in no event will coverage extend beyond 36 months from the date of the event that originally made the associate or a qualified beneficiary eligible to elect coverage. You should notify the Plan Administrator if a second qualifying event occurs during your continuation coverage period.

**Special Rules for Disability**

If the associate or covered family member is disabled at any time during the first 60 days of continuation coverage, the continuation coverage period is 29 months for all family members, even those who are not disabled. The Social Security Administration must determine the disability that extends the continuation coverage period. The associate or family member must inform the Plan Administrator within 60 days of the date of disability determination and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the associate or family member is no longer disabled, the individual must inform the Plan Administrator of this predetermination within 30 days of the date it is made. If an associate or family member is disabled and another qualifying event (other than bankruptcy of the Company) occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

**Special Rule for Retirees**

In the case of a Retiree or an individual who was a covered surviving spouse of a Retiree on the day before the filing of a Title 11 bankruptcy proceeding by the Company, coverage may continue until death and, in the case of the spouse or dependent child of a Retiree, 36 months after the date of death of a Retiree.

**Continuation Coverage May be Cut Short**

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Company no longer provides group health coverage to any of its Associates.
- The premium for continuation coverage is not paid in a timely manner (within the applicable grace period).
- The individual becomes covered under another group health plan after making their COBRA election (whether or not as an associate) that does not contain any exclusion or limitation with respect to any preexisting condition of the individual (other than an exclusion or limitation that, after July 1, 1997, does not apply to, or is satisfied by, the individual under the provisions of the Health Insurance Portability and Accountability Act of 1996).
- The individual becomes entitled to Medicare.
- Coverage has been extended for up to 29 months due to disability (see “Special rules for disability”) and there has been a final determination that the individual is no longer disabled.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. (The law also says that, at the end of the 18-, 29-, or 36-month continuation coverage period, you must be allowed to enroll in any individual conversion health plan provided under the Plan). Once your continuation coverage terminates for any reason, it cannot be reinstated.

This notice is a summary of the law and therefore is general in nature. The law itself and the actual Plan provisions must be consulted with regard to the application of these provisions in any particular circumstance. If you have any questions about the
law, please contact the Plan Administrator who has delegated this to:  
Goodyear Benefits Solution Center  
P O Box 52040  
Phoenix, AZ 85072-2040  
(800) 334-9395  

Also, if you have changed marital status, or you or your spouse have changed address please notify the Goodyear Benefits Solutions Center at (800) 334-9395.

**Health Insurance Portability and Accountability Act (HIPAA)**

Under HIPAA, a certificate of group health plan coverage is provided with your COBRA notification for evidence of your prior health coverage with the Company. You may need to furnish this certificate if you become eligible for another group health plan that excludes coverage for certain medical conditions that you have before you enrolled (pre-existing conditions). This certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the six-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the Plan Administrator to see if you need to provide this certificate. You may also need this certificate to purchase, for yourself or your dependents, a personal health insurance policy that does not exclude coverage for pre-existing conditions.

The Plan also provides an annual notice that the prescription drug coverage under this Plan is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. You can use the notice (and request another copy of the notice) provided by the Plan to show such prior coverage if required upon future enrollment in Medicare prescription drug coverage.

**Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations**

HIPAA - Privacy Regulations became effective April 14, 2003 containing provisions designed to protect the privacy of certain individually identifiable health information. The Plan has been amended as specified by the Act and is hereby incorporated by reference as part of the plan document. A copy of the amendment may be obtained free of charge by written request to the Plan Administrator.

Prior to the April 14, 2003 effective date of the Privacy Regulations, current associates were issued a Notice of Privacy Practices. Thereafter, newly hired associates receive the notice during their initial orientation into the Company. This notice sets forth the rules and obligations regarding the disclosure of your health information and details about a number of individual rights you have as a plan participant under the Act.

The Company as the Plan Sponsor of Associate Group Health Plans and in the administration of associate benefits has always made it a practice to protect an individual’s private health information. The Notice of Privacy Practices is in the back of this booklet for your reference.

**Working Spouse Provision**

The “Working Spouse” provision is designed to require other employers to pay their “fair share” of the health care costs. The provision also includes employee’s dependent children that are working and who have access to health care coverage through their employer. This provision takes effect when an employee has a spouse and/or dependent children that work for an employer on a full-time basis (32 hours or more) and are eligible for that employer’s group sponsored health care plan.

If your spouse is a USW or URW hourly retiree and a participant in the Retirees of The Goodyear Tire & Rubber Company Health Care Trust (VEBA), the Working Spouse Rule does apply. Your spouse will be required to enroll in the retiree medical coverage available to them, and The Goodyear Tire & Rubber Company will only pay as secondary.

**Coordination of Benefits Notice**

If your spouse has access to employer sponsored coverage. They are required to enroll in their employer’s plan and there will be no reimbursement from the Company beginning in January 1, 2008.
**How Does it Work**

When a spouse or a dependent is working or retired and is eligible to be covered by another employer sponsored group hospital, surgical, medical or prescription drug program and the associate is eligible for the Company's health care coverage, medical claims of the working or retired spouse or dependent will be coordinated whether or not the spouse enrolls in that coverage.

If the retiree’s spouse or dependent elects not to enroll in their own employer sponsored group health care coverage, coordination of benefits will still apply. This means that Goodyear will only pay benefits on the working or retired spouse or dependent as a secondary payer after applying the coordination of benefits provision on the basis of what the spouse’s or dependent’s employer group health care plan would have paid if coverage had been elected.

Like Goodyear, most employers that offer health care benefits have an open enrollment process each fall for the upcoming benefit year. Therefore, associates with full-time working or retired spouses or dependent children that have access to health care coverage with their employer need to have their spouse or dependent children take action during their open enrollments periods.

**Additional Information on the “Working Spouse” provision**

- If medical and prescription drug coverage are offered to the spouse and dependent as separate elections, they should enroll in both.
- Dependents are not required to enroll in dental and vision if they are separate elections.
- The “Working Spouse” does not apply to Medicare or to independent insurance policies purchased by the spouse or dependent.
- "Employer–sponsored” coverage means that the employer or former employer contributes some portion of the cost of the coverage.
- Most Comparable: If more than one plan is available to the spouse through his or her employer, he or she should enroll for the plan that is most comparable to the Goodyear plans after looking at premium, co-payments, coinsurance, deductibles, etc. If only one plan is offered to the dependent and the cost is under $200 per month, the “Working Spouse” provision will apply to that plan.

In summary, the key elements of the “Working Spouse” provision are:

- Associates that have full time working spouses or dependent children or a spouse that is retired that have access to employer sponsored group health care coverage must update their records each year during Annual Enrollment, or if a change occurs during the year at the time of the change.
- Full time is defined as a work schedule of 32 or more hours per week.
- Retiree is defined as a person that has retired from an employer and is eligible for the former employer’s group health care plan.
- If an associate’s spouse or dependent elects not to enroll in their own employer sponsored group health care coverage, Goodyear will pay as if the other coverage was taken.

**Non-Duplication of Benefits**

You or your dependents may have other group medical insurance in addition to coverage under this Plan -- through your spouse's employer, for example. If so, the Plan will coordinate medical benefit payments with the other plan. This coordination is designed to guard against duplicate or over insurance.

When benefits are coordinated, benefits will be equal to the amount payable under this Plan minus the amount paid by the other plan. However, the amount payable can never be more than what the Company’s Plan would have paid in the absence of any other plan.

In those cases where your dependent is eligible to be covered by another Company-sponsored or other employer-sponsored flexible benefits plan as an active employee, if coverage was available and not elected, medical benefits under the Plan will be payable as if such coverage was elected for purposes of coordination of benefits.

Non-duplication does not apply to individual or private insurance plans.
**Which Plan Pays First**

Under non-duplication rules, the plan that pays benefits first is called the primary plan. The plan that pays next is secondary. If there are, more than two plans providing coverage, non-duplication rules help decide the order of any additional payments.

A plan without non-duplication or coordination of benefits rules is always primary -- that means it always pays benefits first. If all plans have non-duplication or coordination of benefits rules, benefits are paid according to the following:

- A plan covering a patient as an associate or retiree pays before a plan covering that patient as a dependent.
- A plan covering a patient as an active associate pays before a plan covering that patient as a retiree.
- For dependent children, the plan covering the parent whose birthdates (month and day only) occurs earlier in the calendar year pays benefits first. For example, let’s say the father was born on June 15, and the mother’s birth date is March 1. The mother’s plan would pay first, because her birthday comes earlier in the year.

This rule applies only if both plans have primary plan rules based on birth date. If one of the plans does not use the birthday rule, the father’s plan pays first.

- If both parents have the same birthday, the plan that has covered the dependent child longest pays first.
- If you are legally separated or divorced, special coordination rules apply to your children. If a court decree says that one parent must pay for a child’s health care, the plan of that parent pays first. Otherwise, benefits are paid in the following order:
  - The plan of the parent with custody of the child;
  - The plan of the stepparent who is married to the parent with custody of the child; or
  - The plan of the parent who does not have custody of the child.

Coverage for medical benefits for an active associate will normally be primary over Medicare and any other federal, state, or government-sponsored hospital, surgical, medical, prescription drug, or vision care program.

For associates working beyond age 65, Medicare will become primary at retirement.

If you, your surviving spouse, or eligible dependents, are eligible to receive Medicare, each such person’s medical benefits under the Company’s Plan will be coordinated with Medicare whether or not such person has actually enrolled for coverage under Part B of Medicare. This means that if you fail to sign up for Part B when first eligible prior to January 1, 2008, the Company will not pay claims that would otherwise be covered by Part B as primary coverage under the Company’s Medical Plan.

**If you are employed following your retirement from the Company, and if you have access to medical and/or prescription drug coverage through your employer, you and your dependents are required to take that coverage. You may still elect coverage under the Goodyear Medical Benefit Program, but your coverage with your current employer will be primary over the Company’s retiree program for you and your dependents.**

**Non-Duplication of Benefits with Medicare**

When you retire if you were eligible for Medicare prior to January 1, 2008, Medicare Parts A and B will always be considered as a primary program. Benefits for you or your eligible dependents under the Plan will be coordinated with Medicare and will become payable immediately after Medicare has satisfied its payment obligation.

If you, your surviving spouse or eligible dependents are eligible for primary coverage under Medicare, prior to January 1, 2008, each person’s benefits under the Company’s Medical Plan will be coordinated with Medicare whether or not such person has actually enrolled for coverage under Part B of Medicare. If you or your spouse becomes Medicare eligible on or after January 1, 2008 you are no longer eligible for coverage in the Medical Plan for Salaried Retirees when you become Medicare eligible.

**Right of Recovery and Subrogation**

If you receive health care benefits from the Plan, and you also recover money (by settlement or otherwise) from a third party (including any insurance company) for an injury or illness relating to those same health care expenses, the Plan has the right to reimbursement of amounts paid as benefits. For example, this could occur if you have a car accident and receive medical
benefits from the Plan and a settlement from the insurance company. In addition, the Plan can pursue and join in all rights and claims that you may have against that third party to recover the expenses it paid and has first priority to claims against third parties and the right to any full or partial recovery even if you are not made whole. This does not apply to any individual policies issued to you or a dependent, unless such coverage is primary under the Plan’s non-duplication of benefits rules.

The Plan’s subrogation and reimbursement rights:

• Extend to any money you receive because of the injury or illness from any person, corporation or other source, and

• Entitle the Plan to recover all expenses it paid because of the injury or illness, even if the total amount you receive from other sources does not fully compensate you for the damage you suffered as a result of the injury or illness (i.e. you are not made whole by the recovery). Under these circumstances, the Plan shall agree to a reasonable fair sharing of all recoveries.

If you recover any money, directly or indirectly, the Plan has first priority for repayment and the right to any full recovery or any partial recovery of the benefits it provided to you even if you are not made whole, but the Plan will pay a portion of the reasonable legal fees and expenses incurred by you and/or your dependent in obtaining such recovery from the third party. If money is recovered from more than one party, the same rule shall apply to the amount recovered from each party.

When you accept benefits under the Plan, you agree that you will do nothing to interfere or compromise the Plan’s subrogation or reimbursement rights.

The Plan reserves the right to examine the facts of each case to determine a reasonable fair sharing of all recoveries from all parties involved.

You must:

• Provide the Plan with written notice in advance of any action that you or your representatives are considering that might adversely affect the Plan’s rights, such as a settlement with any third party; and

• Until the Plan is fully reimbursed, obtain the Plan’s consent before you reach a settlement

• Plan is fully reimbursed, obtain the Plan’s consent before you reach a settlement of any claim or action against a third party that you claim to be legally responsible to you based upon your injury or illness.

The Plan is not obligated to provide you any representation, legal or otherwise, in your attempts to recover from a third party.

In addition, if the Plan determines that benefits have been paid in error or obtained fraudulently, the Plan has the right to re-cover such amounts from the participant.

Note that some state laws govern subrogation in different ways. The Plan is covered by Federal law; state laws on subrogation do not apply.

**Right to Recover Overpayment**

In the event of any overpayment of benefits, the Plan will have the right to recover the overpayment from you or from a provider, in the discretion of the Plan Administrator. If you receive a benefit greater than allowed, in accordance with the provisions of the Plan, you (or the provider) will be requested to refund the overpayment.

**Discontinuation of Medicare Part B Reimbursement**

Effective January 1, 2008, the Medicare Part B reimbursement for retirees, spouses and survivors was discontinued.
**Payment of Premiums**

If health care premiums are not being taken out of your pension check, you must mail the required monthly contributions in advance by the 15th of the month prior to the month of coverage by check payable to:

The Goodyear Tire & Rubber Company
P.O. Box 403365
Atlanta, GA 30384-3365

You may also arrange for your premiums to be debited from your bank account. If you are interested in this option, please contact the Goodyear Benefits Solution Center at (800) 334-9395.

**Non-Payment of Premiums**

Retirees eligible for benefits are responsible for required premium contributions. Failure to make the required premium contribution for any benefit elected that requires a contributory premium will result in a notification of non-payment for the benefit(s). If payment is not received in the specified time given on the notice, the benefit(s) will be cancelled for non-payment.

**Limit on Company Cost for Retiree Medical Plan**

For purposes of conforming with the Financial Accounting Standards Board (FASB) accounting requirements and rising health care costs, the Company has established a required maximum average annual Company contribution per retired employee for medical coverage. The limitation is imposed on a plan wide basis by adjusting each year the required premium contributions of each retiree. For the purposes of this section, retired employee is defined to mean each retiree (including surviving spouses) and their dependent(s) eligible for retiree healthcare coverage. A member is defined to be an individual retiree, surviving spouse or dependent.

Effective January 1, 2008 Goodyear reduced the maximum Company contribution for post-1992 retirees for retiree healthcare and for administrative reasons, changed the maximum contribution to a per adult basis. The updated maximum Company contributions are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Pre-Medicare</th>
<th>Medicare (Age 65+)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Per Adult</strong></td>
<td>$3,000</td>
<td>$1,000*</td>
</tr>
<tr>
<td><strong>Family (2 Adults)</strong></td>
<td>$6,000</td>
<td>$2,000*</td>
</tr>
</tbody>
</table>

*NOTE: Eligible retirees on Medicare also continue to receive the value of Medicare Part D (prescription drugs).

If coverage for you and your spouse is “split,” that is, one is eligible for Medicare and one is not, the 2008 maximum amount on Goodyear’s contributions will be $4,000: $3,000 + $1,000. Family coverage will still include eligible dependents. These maximum contribution amounts are used to calculate Goodyear’s total contribution for the non-Medicare and Medicare retiree groups.

Reminder to former participants of Goodyear Relief – if you become eligible for another group medical plan, (other than Medicare) you are no longer eligible for medical coverage under the Medical Plan for Retired Salaried Employees.

The Company reserves the right to modify or terminate any or all of the plans at any time.

**Women’s Health and Cancer Rights Act of 1998**

The Company complies with the provisions of the Women’s Health and Cancer Rights Act of 1998. It requires all health plans that cover a mastectomy to cover reconstructive surgery following a mastectomy.

When you receive covered benefits for a mastectomy and decide to have breast reconstruction, based on consultation with your attending physician, the Company’s Plan will cover:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymph edemas.

This coverage is subject to the same deductibles and co-payments as other covered services under the Plan.

This regulation applies to all health care plans for both active and retired employees. If you have any questions about this surgery, please call your health care provider. The contact number is on the back of your current medical card.
**Mental Health Parity Act**

In accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Goodyear’s Medical plans have removed any limits on Inpatient and Outpatient services for Behavioral Health and Chemical Dependency to the extent otherwise covered under the plans offered through Anthem, Summa, and UHC. These services may be subject to pre-certification, utilization management and medical review.

**Michelle’s law**

Goodyear’s Medical plans are compliant with “Michelle’s Law”, an amendment to ERISA (Sec. 714, PHS Act Secs. 2707 and 2753, and Code Sec. 9813). The law allows college students who have to take time off from school for medical reasons to be allowed to keep their medical insurance benefits under the parent’ health insurance. Group health plans cannot terminate coverage of a dependent child due to a medically necessary leave of absence before the date that is the earlier of: (1) the date that is one year after the first day of the medically necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. The student has to be full-time until the first day of the leave. The child’s leave has to be certified as medically necessary.

**Newborn’s and Mothers’ Health Protection Act of 1996 (NMHPA)**

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).
Prescription Drug Coverage For You
And Your Family

If you are eligible and elect medical coverage, it will include prescription drug coverage through Medco Health Solutions a network of pharmacies and Medco Order pharmacy.

The prescription drug program has tiered level of coverage. The following table shows the different levels of coverage:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Generic</td>
</tr>
<tr>
<td>2</td>
<td>Preferred Brands</td>
</tr>
<tr>
<td>3</td>
<td>Non-Preferred Brands</td>
</tr>
<tr>
<td>4</td>
<td>4th Tier Drug Levels</td>
</tr>
</tbody>
</table>

Definitions you need to understand:
Generics
A generic drug is the chemical equivalent of a brand name drug. Generic drugs are subject to the same Food and Drug Administration standards for quality strength and purity as their brand name counterparts. About half of all drugs on the market today have a generic equivalent. In essence, the difference between a brand name drug and its generic equivalent is the manufacturer and price. Generic drugs cost less because they do not have the sales, advertising and development costs employed with brand name drugs.

Brand Name Drugs
The brand name is the product name chose by the manufacturer under which a drug is advertised and sold.

Preferred or Formulary Drugs
There are many medications providing the same clinical result, but vary in side effects, strength and cost. A drug formulary is a list of prescription drugs that are clinically more effective and/or cost effective for treating certain medical conditions. The medications on the Medco formulary are reviewed and approved by Medco’s National Pharmacy and Therapeutics Committee, made up of independent physicians and pharmacists. The committee recommends policies for the evaluation, selection and use of medications. The formulary helps encourage doctors to consider cost in addition to clinical effectiveness when prescribing medications.

Non-Preferred and Non-Formulary Drugs
These are brand name drugs not as clinically and/or cost effective as the drugs included on the formulary. Many times when a generic is not available, there may be more than one brand name drug that can be used to treat a condition and at least one of those brand names is on the approved formulary list.

Please note the formulary does change slightly from time to time and it is available on the Medco Website at www.medco.com. If you do not have online access, you may call Medco at 866-544-3698.

In-Network Retail Co-payment
If you use a Medco network retail pharmacy, you will receive up to a 30-day supply. The Mandatory Generic (“Hard Mac”) Program applies to this benefit. You can get information on Medco’s participating pharmacies by logging on their Website at www.medco.com. If you do not have online access, you may call Medco at 866-544-3698.

Non-Network Retail Pharmacy
The co-payments for prescriptions obtained from a non-network pharmacy are the same as in-network except, you must pay any difference between the network price and the non-network pharmacy’s cash price. You will be responsible for paying for the prescription and filing a claim with Medco for reimbursement. The Mandatory Generic Program applies to this benefit.

Mail Order
You may also elect to use the Medco Mail-Order program. Please refer to the previous page for the co-payments applying to you. You will be able to obtain up to a 90-day supply at mail order. The Mandatory Generic Program applies to this benefit.

Specialty Drugs
Patients that typically have serious medical conditions, including but not limited to rheumatoid arthritis, renal failure, hemophilia, multiple sclerosis, hepatitis and AIDS/HIV, use specialty drugs. These drugs can have very serious side effects, and their use requires frequent dosage adjustments and monitoring. In addition, many of these medications require special handling, such as refrigeration. The costs of these medications are often over $1,500 a
month. Due to the frequent dosage adjustments and to avoid wasted medication, all patients will be limited to a 30-day supply.

The co-payment for specialty drugs on the formulary will be 10% of the discounted cost of the medication, and the co-payment for non-formulary specialty drugs will be 10% of the discounted price plus $10 for each prescription. There will be a maximum “out-of-pocket” for all specialty drug co-payments of $1,000 per patient per calendar year.

These medications must be filled at Medco’s specialty Mail Order, Accredo only.

Accredo is an experienced leader in the specialty pharmacy industry. Accredo provides specialty medications and support to individuals with chronic illnesses requiring cost therapies. Accredo has been in the specialty pharmaceutical business since 1989. They are dedicated to the delivery of extraordinary care. You will have access to a team of specialists including pharmacists, nurse clinicians, social patient care coordinators, and reimbursement specialists who will work closely with you and help you throughout your course of therapy.

If you have questions or would like more information on the services Accredo provides, you may contact Accredo at the toll-free number, (866) 544-3698.

Below is a chart summarizing your prescription drug coverage based on your medical plan election. All prescriptions for drugs in the 4th tier are subject to the co-payment schedule as follows:

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Co-payment Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic GERD drugs</td>
<td>50%</td>
</tr>
<tr>
<td>Name Brand GERD drugs</td>
<td>100%</td>
</tr>
<tr>
<td>All non-sedating antihistamines requiring a prescription</td>
<td>100%</td>
</tr>
<tr>
<td>ED, Nail Fungus and Contraceptives for the Retiree that are on the formulary</td>
<td>50%</td>
</tr>
<tr>
<td>ED, Nail Fungus and Contraceptives for the Retiree that are NOT on the formulary</td>
<td>100%</td>
</tr>
</tbody>
</table>

**4th TIER**

Certain categories of prescribed drugs that are heavily advertised and frequently over-utilized by the population are being placed on a 4th Tier. Often times these categories or classes of drugs are considered “lifestyle” medications and may have lower cost alternatives including generics and over-the-counter medications. These prescribed drugs fall in the following categories:

- Gastro Esophageal Reflux Disease (GERD) Erectile Dysfunction (ED) - only covered when proven to be medically necessary
- Prescription Medications for Nail Fungus.
The prescription drug plan covers contraceptive prescriptions for the retiree only.

Mandatory Generic Program ("HARD MAC") if your physician request a Brand Name when a Generic is available, you will have to pay the co-payment PLUS the difference in the cost between the Generic and the Brand Name.

Changes to the 4th Tier effective January 1, 2009

Non-sedating antihistamines will no longer be covered under the prescription drug coverage.

Generics used for treatment of GERD will be subject to a 50% co-payment. All brands within this therapeutic class will be subject to a co-payment of 100% of the discounted price.

To Make the Most of Your Prescription Drug Benefits You Should

- Ask your doctor if there is an over-the-counter medication that may be appropriate instead of using a brand. Although over-the-counter alternatives are not covered under the Plan, you may find that the daily cost of these alternatives is actually less expensive than your co-pay.

- Ask your doctor if there is a Generic available and appropriate for your medical condition. Your doctor can write your prescription to allow for generic substitution. All 50 states have laws allowing your pharmacist with your doctor’s approval to dispense generic drugs for prescriptions written for the brand name drug.

- If no Generic is available, check to see if there is a Preferred Brand Name equivalent rather than a Non-Preferred Brand. This will also help you maintain lower prescription drug costs for you and your families until generic substitutions become available.

- Make sure your doctor does not indicate “DAW” (Dispense as Written) on your prescription, even if no Generic is available at that time. If “DAW” is written on the prescription, when the Generic becomes available (that is, comes off the manufacturer’s patent), you will be required to pay the difference in cost as well as the applicable Preferred Brand or Non-Preferred Brand co-pay. The pharmacist is required by law to fill the prescription as written.

- If it is a maintenance medication that you will be taking for some time, you should consider mail order, as you will be able to obtain a 90-day supply instead of a 30-day supply. Mail Order saves money for you and the Company.

- Take the list of formulary drugs when you visit your doctor so that your doctor can consider the cost when medications are prescribed.

- Remember, as always, if you have any questions, ask your doctor or pharmacist.

How to File a Prescription Drug Benefit Claim

Participating Pharmacy

If you or a dependent incur expenses for covered prescription drugs, present your Plan Identification Card to your Participating Pharmacy who will file your claim directly with Medco. You will only be responsible for the co-payment.

Non-Participating Pharmacy

If you purchase a prescription from a Non-Participating Pharmacy, you must pay the full cost of the prescription, complete the prescription drug claim form and send the claim with the detailed pharmacy receipt attached, to Medco for reimbursement. Claim forms are available from your Human Resources Department or HR Connect. If no claim form is available, make sure the receipt contains all of the information required for processing; the name and NCPDP number of the pharmacy, full name of person for whom the prescription was written, date of service, day’s supply and description of the drug - including the National Drug Code - and price. This information is needed to obtain reimbursement for your eligible expenses once you have secured a non-participating claim form. The amount of reimbursement will be equal to the amount that the Plan would have been paid if you had used a Participating Pharmacy and not necessarily the actual charge.

Mail Order Prescription Service

When you need medication that needs to be taken for a period of time or on a regular basis and you wish to use the Mail Order Prescription Service through Medco’s Mail-Order pharmacy, Medco by Mail. Ask your physician to provide a written prescription for up to a 90-day supply. If you are currently taking medication, you must obtain a new written prescription from your physician.
Complete the Medco Prescription Drug Reimbursement Form. Be sure to answer all the questions, and make certain you include on the form your Social Security number. Send the completed form, and your original prescriptions to:
Medco Health Solutions Inc.
PO Box 14711
Lexington, KY 40512

Medco will process your order and return your prescriptions to you via First Class Mail. Included with your prescription will be instructions and a personalized reorder form. This reorder form can be used when ordering future prescriptions or refills of your present prescription. Refills can also be requested on-line at www.medco.com or through the Medco’s toll free number.

Any inquiries may be made to Medco through their website at www.medco.com or by using the following toll-free number (866) 544-3698.

Appealing a Denied Claim For Prescription Drug Coverage

First Level Appeals
In the event your request for coverage of a prescription benefit claim is denied, you (or your authorized representative) have the right to appeal the determination in writing. Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the notice of the initial coverage decision.
Your request for appeal should include:
• The patient’s name, member ID and phone number.
• The prescription drug for which the benefit coverage has been denied.
• The reason you believe the claim should be paid.
• Any documentation or other written information to support your request for claim payment.

Requests for review of denied claims should be sent to:
Medco Health Solutions of Irving
ATTN: Coverage Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

Second Level Appeals
If you are not satisfied with the first level appeal decision of the Claims Administrator, you (or your authorized representative) have the right to request a second level appeal from the Claims Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of the first level appeal decision.

Requests for second level review of denied claims should be sent to:
Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063
ATTN: Second Level Appeals

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second level appeal is denied. See “One Year Limit to File a Legal Action” below.

Appeal Process
You will be provided written or electronic notification of decision on your appeal as follows:
• For all appeals other than member submitted paper claims including those relating to Participating Pharmacy and Medco By Mail Claims (as defined in How to File a Claim for Prescription Drug Coverage), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
• For appeals relating to Non-Participating Pharmacy Claims (also called member submitted paper claims), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.
For procedures associated with urgent claims, see Urgent Claim Appeals That Require Immediate Action below.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

We have delegated to the appropriate Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator’s decisions are final and binding. Please note that the Claims Administrator’s decision is based only on whether or not Benefits are available under the Plan. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

**Urgent Claim Appeals That Require Immediate Action**

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. You have the right to request an urgent appeal of an adverse benefit determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call (800) 753-2851 or send a written request to:

Medco Health Solutions of Irving  
Attn: Urgent Appeals  
8111 Royal Ridge Parkway  
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

**Right to File a Legal Action**

If your second level appeal is denied, you have the right to file suit in federal court under Section 502(a) of ERISA.

**Retiree Benefit Medco Identification Cards**

Upon enrollment you will receive a Plan Identification Card and a separate identification card from Anthem BCBS (medical) or Medco (prescription drug).

You should review all the information on the Plan Identification Cards to make sure they are accurate. If you determine that any of this information is not correct, you should report it to the Goodyear Benefit Solution Center immediately.
**Dental Protection For You and Your Family**

The dental plan is designed to emphasize preventive treatment detecting and treating smaller dental problems before they get larger. Basically, the way the Plan pays benefits depends on the type of service you or a covered family member receives.

The embedded dental coverage was discontinued as of January 1, 2008. If you do not elect contributory dental coverage you will not have coverage for oral surgery, endodontic or periodontal type dental services.

If you opt out of coverage you are only eligible to re-enroll if you opted out because of other coverage. In other words, you will not be permitted to re-enroll unless you show that you have been in continuous coverage while not enrolled in Goodyear’s plan. You must notify the Goodyear Benefits Solution Center within 31 days of the loss of other coverage.

If you elect dental coverage, your coverage will be administered through Delta Dental Plan. Effective in 2008, enhanced benefits are available when you have treatment from a participating Delta Dental PPO dentist. See the chart below for how it works.

<table>
<thead>
<tr>
<th>What is the payment based on?</th>
<th>PPO Dentist</th>
<th>Premier Dentist</th>
<th>Non-Participating Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The submitted fee or the amount in your dentist’s Local PPO Fee Schedule¹, whichever is less.</td>
<td>The submitted fee or the Maximum Approved Fee², whichever is less.</td>
<td>The submitted fee or the Non-participating Dentist Fee³, whichever is less.</td>
</tr>
</tbody>
</table>

**Special things to consider**

**Participating Dentists:**
- Will submit claim forms for you.
- Cannot balance bill you.
- Will only charge your co-payment and deductible (if applicable) up front.
- Added benefits for:
  - posterior resin fillings.
  - Simple restorations covered at 80%.
  - Implants covered.
- Annual maximum increase to $1,500 from $1,200.

**Premier Dentists:**
- Will submit claim forms for you.
- Cannot balance bill you.
- Will only charge your co-payment and deductible (if applicable) up front.
- No change in benefits (same as in 2007 and prior).
- Annual maximum $1,200.

**Non-Participating Dentists:**
- May have you submit your own claim information.
- Will bill you the total difference between what was charged and what was paid.
- May charge the full amount up front.
- No change in benefits (same as in 2007 and prior).
- Annual maximum $1,200.

**Payment Examples**

<table>
<thead>
<tr>
<th>Submitted Fee: $100.00</th>
<th>Submitted Fee: $100.00</th>
<th>Submitted Fee: $100.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO Fee Schedule¹ amount: $70.00</td>
<td>Maximum Approved Fee²: Amount: $90.00</td>
<td>Non-Participating Dentist Fee³: Amount: $85.00</td>
</tr>
<tr>
<td>Delta Dental pays 80% of the PPO Fee Schedule: $56.00</td>
<td>Delta Dental pays 50% of the Maximum Approved Fee: $45.00</td>
<td>Delta Dental pays 50% of the Non-Participating Dentist Fee: $42.50</td>
</tr>
<tr>
<td>You pay: $14.00</td>
<td>You pay: $45.00</td>
<td>You pay: $57.50</td>
</tr>
</tbody>
</table>

The PPO dentist cannot charge you the $30 difference between the PPO Fee Schedule¹ amount and the submitted fee.

Because the dentist does not participate, you are responsible for the difference between Delta’s payment and the submitted fee.

---

1. A PPO Dentist is one that has agreed to the PPO Fee Schedule, which is lower than the Maximum Approved Fee used for a dentist who participates in the Delta Dental Premier.
2. Maximum Approved Fee is the maximum amount for a specific procedure determined by Delta Dental in the Premier program.
3. Non-participating Dentist Fee is the maximum fee allowed when the dentist does not participate in either Delta Dental network.
If your dentist does not participate in the PPO, there will be no change to your benefits.

- The plan pays 100% of charges for preventative and diagnostic expenses, like regular exams, X-rays, sealants and teeth cleaning.
- The plan pays 85% of charges for root canal work, gum treatment and oral surgery.
- The plan pays 50% of charges for restorative (fillings and crowns) and prosthodontic (dentures and bridges) services, plus orthodontia for your dependent children under age 19.
- The plan will pay up to $1,200 in dental benefits for each covered individual per year. The lifetime limit for orthodontia is $1,500 per child.

If you obtain services through a Participating Dentist, you will only be responsible for co-payment amounts. You will not be responsible for additional fees charged. Reimbursement for non-participating dentists will be at a lower fee schedule. You may call your dentist, call Delta to see if the dentist is a participant in the network or go to www.deltadentaloh.com and click on Dentist Search under “Looking for a Dentist?”

To contact Delta Dental call, (800) 524-0149, the customer service hours are 7:30 a.m. to 8:00 p.m. EST.
**How Dental Coverage Works**

The Plan is designed to emphasize preventive treatment detecting and treating smaller dental problems before they get larger. Basically, the way the Plan pays benefits depends on the type of service you or a covered family member receives.

<table>
<thead>
<tr>
<th>Dental Plan Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
</tr>
<tr>
<td><strong>Predetermination</strong></td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
</tr>
<tr>
<td><strong>Basic Dental Services</strong></td>
</tr>
<tr>
<td><strong>Restorative and Prosthodontic</strong></td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
</tr>
</tbody>
</table>
**Diagnostic and Preventive Services**

You are encouraged to see your dentist for preventive dental care to make sure you stay healthy, and to reduce the risk of more serious and costly dental treatment. The Plan will pay 100% of the maximum approved fee for the following services if obtained through a participating dentist. If not obtained through a participating dentist, the payment will be less:

<table>
<thead>
<tr>
<th>Service</th>
<th>What's Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams and X-rays</td>
<td>Routine oral examinations</td>
</tr>
<tr>
<td>Dental Prophylaxis</td>
<td>Cleaning of teeth and, for dependent children, topical application of fluoride, space maintainers and dental sealants. Routine cleanings are eligible for benefits only twice during a calendar year. Local applications of fluoride and space maintainers are eligible services only for dependent children under age 19. Dental sealants are eligible for benefits once every three years for dependent children under age 15. Coverage for sealants will be for specific teeth in accordance with accepted standards of dental practice.</td>
</tr>
</tbody>
</table>

**Basic Dental Services**

The plan will pay 85% of the maximum approved fee for the following services if obtained through a participating dentist. If not obtained through a participating dentist, the payment will be less:

<table>
<thead>
<tr>
<th>Service</th>
<th>What's Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endodontics</td>
<td>Treatment of the nerve canal in a tooth (e.g., pulp capping, root canal therapy).</td>
</tr>
<tr>
<td>Periodontic</td>
<td>Treatment of diseases of the gums, and bone-related diseases of the supporting structures of the teeth (e.g., sub gingival curettage, osseous surgery, periodontal scaling).</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Surgical procedures, including simple extractions and removal of impacted wisdom teeth (e.g., excision of tumors, cysts, bone tissue, reduction of dislocation, and surgical correction of temporomandibular joint (TMJ or TMD) dysfunctions are subject to consultant review. Prior to surgery to correct a dysfunction with the temporomandibular joint benefits will be paid for appliance therapy that is intended to correct the condition without surgery. If the appliance therapy does not correct the condition, and surgery to correct the condition is subsequently necessary, the benefits previously paid for the appliance therapy will be deducted from the total payable for the surgical procedure which includes any benefits payable for post-surgery therapy. Benefits include local anesthesia, or general anesthesia (when medically necessary), and routine post-operative care.</td>
</tr>
<tr>
<td>Accidental Injuries</td>
<td>Treatment of accidental injuries to sound natural teeth rendered within 12 months of the date of the accident.</td>
</tr>
</tbody>
</table>
**Restorative and Prosthodontic Services**

The Plan will pay 50% of the maximum approved fee for the following services if obtained through a participating dentist. For simple restorations (fillings), the plan will pay 80% of the maximum approved fee if performed by a PPO Dentist. If not obtained through a participating dentist, the payment will be less:

<table>
<thead>
<tr>
<th>Service</th>
<th>What’s Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restorative</strong></td>
<td>Fillings, using silver or resin (tooth-colored) materials, including fillings placed after a nerve is removed from a tooth. Cast restorations, crowns, caps and jackets, are covered when fillings cannot restore teeth satisfactorily.</td>
</tr>
<tr>
<td><strong>Prosthodontic</strong></td>
<td>Installation and replacement of fixed bridgework, partial dentures and complete dentures. Replacement of an existing partial denture or fixed bridgework is a covered benefit only if the existing denture or bridge is at least five years old and cannot be made serviceable. Endosteal implants are a covered benefit when rendered by a PPO participating dentist only. Benefits will not be payable for the fittings of bridges and crowns that were ordered while you or your dependents were not covered under the Plan, or that were ordered while you were covered, but are finally installed or delivered more than 60 days after termination of coverage.</td>
</tr>
<tr>
<td><strong>Orthodontic</strong></td>
<td>Treatment for the prevention and correction of irregularities of the teeth and malocclusion (teeth straightening) is a benefit for dependent children under age 19. The maximum payment allowable for orthodontics is limited to a lifetime benefit of $1,500 for each eligible dependent child under age 19. Your dentist must file a treatment plan with Delta before treatment begins. Payment will be based on the usual, customary and reasonable fee for the procedure. Benefits will be paid as services are performed on a quarterly basis. Benefits cannot be prepaid to the dentist, nor will the benefits be paid in a $1,500 lump sum.</td>
</tr>
</tbody>
</table>
**Maximum Approved Fee**

A system used by Delta Dental to determine the approved fee for a given procedure for a given Delta Dental Premier Dentist. A fee meets Maximum Approved Fee requirements if it is the lowest of:

- Submitted Amount.
- The lowest fee regularly charged, offered or received by an individual Dentist for a dental service, irrespective of the Dentist’s contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region and/or specialty, under normal circumstance.

Delta Dental may also approve a fee under unusual circumstances.

Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for the Covered Service. In all cases, Delta Dental will make the final determination about what is the Maximum Approved Fee for the Covered Service.

**Ineligible Expenses, Exclusions, Limitations and When Benefits Will Not be Paid**

- Under some circumstances, the Plan will not pay benefits. These situations include:
  - Services performed solely for cosmetic reasons or for correction of congenital or developmental malformations, or dentistry for aesthetic reasons.
  - Replacement of a lost, missing or stolen appliance of any type or replacement or repair of orthodontic appliances.
  - Replacement of a bridge, crown, or denture within five years after the date it was originally installed unless:
    - Such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or
    - The bridge, crown, or denture, while in the mouth, has been damaged beyond repair because of an injury received while a person is insured for these benefits.
  - Any replacement of a bridge, crown, or denture that is or can be made usable according to common dental standards.
  - Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
    - Change vertical dimension;
    - Stabilize periodontal involved teeth; or
    - Alter, restore, or maintain occlusion.
  - Replace tooth structure loss resulting from attrition, abrasion, or erosion
  - Orthodontic services or supplies for any person other than a dependent child under age 19.
  - Porcelain, porcelain substrate, and cast restorations are not payable for Children under age 12. Porcelain fused to metal and porcelain crowns on posterior teeth - the Plan will pay only the applicable amount that it would have paid for a full metal crown.
  - Porcelain/ceramic onlays, the Plan will pay only the applicable amount that it would have paid for a metallic onlay. Porcelain/ceramic inlays— the Plan will pay only the applicable amount that it would have paid for an amalgam or composite resin restoration (depending on the tooth being restored).
  - Benefits for root planning by the same Dentist or dental office are payable once in any two-year period. Periodontal surgery, including subgingival curettage, by the same Dentist or dental office is payable once in any three-year period.
  - Bite registrations; precision or semi-precision attachments; or splinting.
  - Veneers of any type.
  - Preventative control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments etc).
  - Services for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature as determined by the standards of generally accepted dental practice.
  - Services that are deemed medical services.
- Charges for hospitalization, laboratory test, and histopathological examinations.
- Services due to or resulting from an injury or illness from any employment (other than for this Company) for wage or profit or covered under any Workers’ Compensation or similar law.
- Charges made by a hospital owned or operated by the United States government.
- Charges that you are not legally required to pay.
- Charges that would not have been made if you had no insurance.
- Charges that exceed the usual, customary and reasonable fee.
- Charges for unnecessary care, treatment, or surgery as determined by the standards of generally accepted dental practice.
- Charges if you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program other than Medicaid.
- Services due to or resulting from experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Charges for hospitalization laboratory tests, and histopathological examinations.
- Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications, and relative analgesia.

For more information on benefits not payable, contact Delta Dental.

**Fraud**

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help lower the costs by calling Delta Dental’s toll-free hotline number, (800) 524-0147. You do not need to identify yourself. Only Anti-Fraud calls can be accepted on this line.

**Non-Duplication of Benefits**

You or your dependents may have other group dental coverage in addition to this Plan -- through your spouse’s employer, for example. If so, the Dental Plan will coordinate benefit payments with the other plan. This coordination is designed to guard against duplicate or excess dental benefit payments.

Under non-duplication of benefits, the benefits will be equal to the amount payable under this Plan minus the amount paid by the other plan. However, the amount payable can never be more than what the Company’s Plan would have paid in the absence of any other plan.

Non-duplication does not apply to individual or private insurance plans.

**Which Plan Pays First**

Under non-duplication rules, the plan that pays benefits first is called the primary plan. The plan that pays next is secondary. If there are more than two plans providing coverage, non-duplication rules help decide the order of any additional payments.

A plan without non-duplication or coordination of benefits rules is always primary -- that means it always pays benefits first. If all plans have non-duplication or coordination of benefits rules, benefits are paid according to the following:

- A plan covering a patient as an associate or retiree pays before a plan covering that patient as a dependent.
- A plan covering a patient as an active associate pays before a plan covering that patient as a retiree.

For dependent children, the plan covering the parent whose birth date (month and day only) occurs earlier in the calendar year pays benefits first. For example, let’s say the father was born on June 15, and the mother’s birth date is March 1. The mother’s plan would pay first, because her birthday comes earlier in the year.
This rule applies only if both plans have primary plan rules based on birth date. If one of the plans does not use the birthday rule, the father’s plan pays first for the dependent children.

- If both parents have the same birth date, the plan that has covered the patient longest pays first.
- If you are legally separated or divorced, special coordination rules apply to your children. If a court decree says that one parent must pay for a child’s health care, the plan of that parent pays first. Otherwise, benefits are paid in the following order:
  - The plan of the parent with custody of the child;
  - The plan of the stepparent who is married to the parent with custody of the child; or
  - The plan of the parent who does not have custody of the child.

**Duration of Coverage**

If you stop paying any required monthly payments for coverage, coverage under the Contributory Dental Plan will end.

If your death occurs while your dependents are covered for benefits under the Dental Plan, coverage will be continued for your spouse and dependent children for up to 90 days, upon payment of the applicable premiums.

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**How to File a Dental Care Benefit Claim**

If you have dental coverage, your Participating Dentist will file your claim for you. However, if you go to a Non Participating Dentist you may have to file your own claim. To submit your dental claim:

1. Complete your portion on the standard dental claim form. (You may obtain this form from Delta’s website, www.deltadentaloh.com or Delta’s Customer Service Center.) Be sure to enter your Social Security number.

2. Sign the space where it says subscriber.

3. Attach your dentist’s itemized bill. The bill must show the patient’s name, relationship to you, date and nature of service. Or, take your claim form to your dentist’s office and ask your dentist to complete the dentist’s portion.

4. Send the itemized bill and claim form directly to:
   Delta Dental
   P. O. Box 9085
   Farmington Hills, MI 48333-9085
   Telephone Number: (800) 524-0149

5. Normally, your Participating Dentist will receive a check from Delta Dental for the amount of benefits payable within three weeks from the date the claim was submitted. You will receive an “Explanation of Benefits” (EOB) statement advising you of the amount of benefits paid to your dentist. You will be responsible for your co-payment. If, after 30 days, you have not heard from Delta Dental, contact them at:
   Delta Dental
   P.O. Box 30416
   Lansing, MI 48909-7916
   Telephone Number: (800) 524-0149

If you go to a Non Participating Dentist, you will receive a check for the amount of benefits payable and a claim payment statement. If after 30 days, you have not heard from Delta Dental, contact them at:

   Delta Dental
   P.O. Box 30416
   Lansing, MI 48909-7916
   Telephone Number: (800) 524-0149

In the meantime, do not wait for the payment, but pay your dentist promptly.
**Major Dental Services**

Major dental services should be planned and scheduled. To assist you and your dentist in such planning, the Plan provides for a Predetermination.

**Predetermination**

You can request a Predetermination for any proposed services—regardless of the expenses you expect. However, predetermination of benefits is strongly suggested for all temporomandibular joint (TMJ) or temporomandibular dysfunction (TMD) procedures in excess of $250. This applies even if you go to a Participating Dentist. You must make sure that your dentist requests such predetermination. This predetermination will provide an understanding of any financial obligation before the treatment begins. Predetermination is strongly recommended for other services in excess of $200.

You are urged to ask your dentist to submit the proposed course of treatment for a Predetermination. By using the Predetermination procedure, you will understand both your own financial obligations and the amount payable under the Plan before treatment begins.

**To obtain a Predetermination:**

1. Complete your portion of the standard dental claim form. You may obtain this form directly from your Delta Dental. Be sure to enter your Social Security number.

2. Ask your dentist to complete the dentist’s portion and forward the form directly to:
   
   Delta Dental  
   P.O. Box 9085  
   Farmington Hills, MI 48333-9085  
   Telephone Number: (800) 524-0149

   The Predetermination Notice will be sent to your dentist promptly, with a copy to you, usually well before your next appointment.

3. Discuss the Predetermination with your dentist during your next appointment. Based on the Delta Dental estimate, your dentist may suggest alternate methods of treatment.

4. After the work is completed, your dentist must return the Predetermination Notice to Delta Dental, indicating the actual dates the services were performed. Delta Dental will send you an Explanation of Benefits statement advising you of the amount of benefits paid to your dentist. You will be responsible to pay your dentist your co-payment amount. If you have not received notification of payment within 30 days after the dentist submits the form, you should write to Delta Dental at:

   Delta Dental  
   P.O. Box 30416  
   Lansing, MI 48909-7916  
   Telephone Number: (800) 524-0149

**Claims Appeal Procedure**

Delta Dental will notify you or your authorized representative if you receive an adverse benefit determination after your claim is filed. An adverse benefit determination is any denial, reduction, or termination of the benefit for which you filed a claim, or a failure to provide or to make payment (in whole or in part) of the benefit you sought. This includes any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational or was not medically necessary or appropriate. If Delta Dental informs you that the Plan will pay the benefit you sought but will not pay the total amount of expenses incurred, and you must make a Co-payment to satisfy the balance, you may also treat that as an adverse benefit determination.

If you receive notice of an adverse benefit determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can take the following steps:

- First, you or your Dentist should contact the Delta Dental Customer and Claims Services department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly.

- You may also mail your inquiry to the Customer and Claims Services department at P.O. Box 30416, Lansing, Michigan, 48909-7916. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim.
• This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow Delta Dental to correct this error quickly.

Whether or not you have asked Delta Dental informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal review of your claim, send your request in writing to:

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

Please include your name and address, the Subscriber’s Social Security number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim. Instead, he will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director’s decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director’s adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

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

Upon enrollment you will receive a Plan Identification from Delta Dental.
Important Information Regarding Health Care and Dental Benefits

The following information is provided in compliance with the Employee Retirement Income Security Act (ERISA).

Plan Identification

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type</th>
<th>Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefits for Salaried Associates at Designated Locations*</td>
<td>Group Health Plan</td>
<td>550</td>
</tr>
<tr>
<td>Dental Benefit Plan for Salaried Associates at Designated Locations</td>
<td>Dental Benefit Plan</td>
<td>522</td>
</tr>
</tbody>
</table>

* Includes Prescription Drug Plan

Plan Administrator

The Goodyear Tire & Rubber Company is the plan administrator and the named fiduciary for the benefit plans described in this booklet. The administrator’s address and other pertinent data are as follows:

- The Goodyear Tire & Rubber Company
  - 1144 East Market Street
  - Akron, Ohio 44316
  - Telephone No: (330) 796-2121
  - ERISA Employer Identification No. 34-0253240

The Company, which shall be the “administrator” of the Plans described in this booklet for purposes of ERISA and the “plan administrator” for purposes of the Internal Revenue Code, shall be responsible for the general administration of the Plans. Goodyear self-administers these benefits. However, if an alternative health care plan option is selected, the respective alternative health care provider will perform the claims administration.

Agent for Service of Legal Process

The Secretary of The Goodyear Tire & Rubber Company is the agent for service of legal process at the above address.

Plan Year

January 1 through December 31.

Self-Insured Plans

The medical plans, the prescription drug benefits and the Dental Plan described in this booklet are self-insured and paid directly by The Goodyear Tire & Rubber Company from its general assets, and retiree contributions.

YOUR RIGHTS UNDER ERISA

As a participant in The Goodyear Tire & Rubber Company Health Care Benefits Plan for Retired Salaried Associates who retire on or after January 1, 1992, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA).

ERISA provides that all participants of the Plans shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
• Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people, who operate your plan called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of your and other Plan participants and beneficiaries. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part your must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to one hundred and ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in state or federal court, provided you have followed the plan’s claim procedures in a timely fashion. Please refer to the SPD for more information on how to properly complete the claims procedure process. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the Plan Fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim or suit is frivolous.

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