BRIDGESTONE AMERICAS, INC.

Summary Plan Description

BARGAINING EMPLOYEES
Akron, Ohio
Russellville, Arkansas
Bloomington, Illinois
Des Moines, Iowa
LaVergne, Tennessee
Warren County, Tennessee

Note: Does not apply to LaVergne Maintenance and Bloomington Plumber and Pipefitter employees

Contract effective August 2013

Revised January 2014

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Introduction

This Summary Plan Description ("SPD") describes the benefit programs provided for in the Pension and Insurance Agreement (the "P&I Agreement"), effective August 2013, entered into by Bridgestone Americas Tire Operations, LLC (referred to in this SPD as "BATO") and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, AFL-CIO, CLC (the "Union").

The benefit programs are provided for eligible employees of BATO who are employed at its manufacturing plants at the following locations and represented by the following Locals of the Union: Akron, Ohio, Local Union No. 7L; Des Moines, Iowa, Local Union No. 310L; Russellville, Arkansas, Local Union No. 884L; LaVergne, Tennessee, Local Union No. 1055L; Warren County, Tennessee, Local Union No. 1155L; and Bloomington, Illinois, Local Union No. 787L.

This SPD describes the main features of the benefit programs provided for in the P&I Agreement for eligible employees, eligible dependents and beneficiaries. While this SPD summarizes the terms of the benefit programs as accurately as possible, it does not take the place of the official Plan documents for each benefit program. If there is any discrepancy, the provisions of the official Plan documents will govern the rights and benefits of employees, dependents and beneficiaries to the extent permitted by law. The terms "you" and "your" as used in this SPD refer to eligible employees of BATO covered under the benefit programs. The term "Bridgestone" or "Company" as used in this SPD refers to Bridgestone Americas, Inc., the parent company of BATO.

Periodically, additional benefit plan materials will be made available to you (via mail and/or via Bridgestone's intranet and/or internet sites, at least one of which you have access to), including benefit newsletters and annual enrollment materials. These documents serve as Summaries of Material Modifications (SMMs) and will describe important information about your benefits. These materials will modify and/or supplement the information described in this SPD. Be sure to keep SMMs with this SPD for your reference.

The following benefit programs are described in this SPD. Not all benefit programs are available to all employee groups and to be eligible for benefits under a particular program you must meet the specific eligibility requirements of that program. Many of the benefit programs are not provided after retirement.

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Care Benefits
- Employee Assistance Program
- Flexible Spending Accounts
- Non-Occupational Accident and Sickness Benefits
- Life Insurance and Survivor Income Benefits

- Accidental Death and Dismemberment Insurance
- Savings Plan Benefits
- Pension Benefits

Please read this document carefully and familiarize yourself with the eligibility requirements. Please also review the benefits provided under these plans and the procedures for filing benefit claims.

Eligibility and Participation

Some plans described in this SPD may have special eligibility requirements and eligibility waiting periods may differ based on the benefit offered and your hire date. Any special eligibility rules will be outlined in the applicable section(s) of this SPD.

Employees

Generally, you are eligible for coverage under the health and welfare plans if you are classified as a full-time hourly employee (not temporary, project-based or part-time work), actively at work, and have the specified amount of credited service for your classification and/or location. A complete list of the other employers participating in the plans may be obtained by participants and beneficiaries upon written request to the Pension and Benefits Department.

Employees are generally eligible for coverage after completing 31 days of credited service on a full-time basis with BATO. However, production employees hired after October 1, 2005 and maintenance employees hired after July 27, 2013 (together referred to in this SPD as "New Hires") are generally eligible for coverage after completing 90 days of credited service on a full-time basis with BATO. If eligibility rules are different than indicated above, it will be noted in the applicable section(s) of this SPD.

If you are not actively at work on a full-time basis for BATO when benefits would otherwise become effective, the effective date of coverage will be the first day when you are actively at work. However, this rule does not apply to the medical plan and will not exclude employees who are on vacation, on leave of absence for union activities, working less than their standard shift or temporarily disabled from coverage.

You must enroll in accordance with required procedures established by the Plan Administrator and must submit any required documentation (which may include an enrollment/change form, a copy of a marriage certificate or birth certificate) through myHR, the Bridgestone intranet portal, within 31 days of your initial eligibility date. If you do not enroll within 31 days of your eligibility date, you will not have the opportunity to enroll again until the next annual open enrollment period unless you experience a change in status (as described in this SPD).

Retirees

Post-retirement benefits are not available to all employees. Certain retiree groups are eligible for coverage under some, but not all, of the benefit programs provided to active employees. The eligibility criteria for post-retirement benefits are highlighted in the *When You Retire* section.

Dependents

Dependents are only eligible for coverage under a benefit plan if you are a participant in the plan.

You may elect to cover the following dependents under the plans:

- Your legal spouse,
- Your child under age 26,

- An unmarried (i.e., never married) child who is age 26 or older, who is your biological child, legally adopted child, or stepchild and who is physically or mentally incapable of self-support. The child must have been a covered dependent under the Plan before turning age 19, and the incapacity must have occurred before reaching age 19,

- An organ donor, when the recipient is covered under this plan, will be covered as though he or she were a covered dependent child of the recipient, but only for eligible charges in connection with the procedure to remove the organ from the donor,

- Dependent children who are hired as a New Hire may be covered as dependents until they become eligible for the New Hire medical plan or reach age 27, whichever comes first.

A "Child" means your biological child, legally adopted child, stepchild, or an eligible dependent child for whom you are obligated to provide health coverage under an order deemed to be a Qualified Medical Child Support Order ("QMCSO").

Foster children, grandchildren or other children not listed as covered dependents are not eligible for coverage. However, those foster children, grandchildren or other children of employees who were covered dependents under the plan on or before December 20, 1996, will continue to be covered dependents until they no longer meet dependent eligibility requirements.

If both you and your spouse are employed by the Company and are eligible for medical coverage, eligible dependent children can be covered as dependents of the employee that is enrolled for coverage. This assignment of dependents will not deprive eligible children of coverage because of death or termination of the subscribing parent; dependents may be re-enrolled under the other parent.

Fraud or an intentional misrepresentation of an individual as an eligible dependent may trigger a rescission.

Special Rules for Dependent Coverage

If you have a newborn child or legally adopt a child, you must notify the HR Shared Services within 31 days of the child's birth or legal adoption for coverage under the plan.

A newborn child is covered from the moment of birth or date of legal adoption as long as you enroll the child for coverage during a special enrollment period of 31 days from the date of birth or legal adoption.

Your premiums for your newly acquired child will become effective on the effective date of coverage. If you do not enroll the child within the 31 days, coverage will not be provided for that child. You may enroll that child during the next annual open enrollment period.

A few reminders:

- Only eligible employees and dependents may be covered under the plans. It is a Federal crime to receive benefits that you are not entitled to by falsely claiming to be an eligible employee or an eligible dependent under the plans,

- You cannot be covered as both an employee and an eligible dependent under the plans,

- Any statement regarding your health, age, coverage under another health plan or other information provided to obtain benefits in writing and signed by you, may be used to contest benefits received under the plans,

- Falsifying information in order to obtain benefits is grounds for denial of benefits and disciplinary action.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability

SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Enrollment

Initial Enrollment

You and your eligible dependents are eligible to enroll in the health and welfare plans within 31 days of your initial eligibility date (the date you become eligible for coverage as described in the *Eligibility and Participation* section or other applicable sections of this SPD). If you and your eligible dependents do not enroll for certain benefits when initially eligible, you may not be able to enroll until the following annual open enrollment period offered by Bridgestone or during an enrollment period provided due to a change in status (including a special enrollment event).

You may enroll dependents by completing and signing the current enrollment/change form indicating your eligible dependents. You are required to provide copies of supporting documents (for example, a marriage or birth certificate) when you enroll dependents. If you are an active employee and later acquire dependents through marriage, birth or adoption, a new enrollment form must be completed and submitted within 31 days of the event.

Whenever there is an increase or decrease in the number of your eligible dependents, you should immediately notify your Human Resources representative or through myHR so your records reflect the correct coverage. To make changes, you must complete a new enrollment/change form.

Annual Open Enrollment

Bridgestone conducts an annual open enrollment period during the fall of each year. During open enrollment, you make your enrollment decisions under the plan for the upcoming plan year. If you are a late enrollee, you may enroll in the healthcare program during the annual open enrollment period. If you are already a participant in the plans, you may make any changes to your coverage (for example, add or delete eligible dependent coverage) or plans for any reason during the annual open enrollment period.

Your new coverage elections will be effective on January 1st of the new calendar year.

Working Spouse Rule

The working spouse rule only applies to medical coverage. If the spouse of an employee is eligible for medical coverage under another group insurance plan(s) (such as through another employer or a retirement plan) and the premium is $50 or less per month for single coverage, the working spouse cannot have primary coverage under the Bridgestone medical plan. He or she may be covered under the Bridgestone plan for secondary coverage only and should enroll in one of his/her other available medical plans for primary coverage. If the working spouse does not enroll in one of the other available plans under which they are eligible, the medical benefits provided to that individual under the Bridgestone medical plan will be reduced. The Bridgestone medical plan will apply its coordination of benefits provisions as if the working spouse was enrolled for coverage under the other available plan.

This plan will continue to provide primary coverage to the spouse and any dependent children until the earliest date the spouse can enroll into the other plan. This date must be certified in writing by the Plan Administrator. If the other plan contains a pre-existing condition limitation

clause, this plan will continue to be primary for that medical condition until the other plan assumes liability.

When a claim is received by the plan, the spouse may be required to complete and return a questionnaire as instructed in order to receive benefits.

If the monthly premium is over $50 for single coverage under all other available plans, the spouse may have primary coverage under the Bridgestone plan.

No Duplicate Coverage

You may not be covered by the plan as both an employee and an eligible dependent at the same time. Also, an eligible dependent may not be concurrently covered by more than one Bridgestone employee. In such cases, employees have the choice of enrolling separately for their respective coverage or one employee can enroll and claim the other as an eligible dependent.

Cost

You may be required to share with BATO the cost for benefit coverage. If the contribution rates (premiums) for the benefit coverages are not included in this SPD, please refer to your annual open enrollment materials and/or other Summaries of Material Modification documents for current rates.

The cost for your coverage for any dependents you cover is automatically deducted from your paycheck each pay period. Applicable benefit premiums are made on a pre-tax basis to the extent permitted by IRS rules, and there are certain benefits that are only available on a post-tax basis. If you are off work, you will be billed directly.

Under IRS Code Section 125, pre-tax means the money you contribute for such benefits under the plan is not subject to Federal income Social Security (FICA) taxes, and most state taxes.

Active Employee Premiums
Weekly premiums for medical coverage, effective January 1, 2014 are shown below. Premiums will be increased by 10% over the premium in effect the previous year for 2015, 2016, and 2017:

Weekly Medical Premiums for the HIP Medical Plan Effective January 1, 2014	
Employee Only coverage	$15.02
Employee + Spouse	$27.97
Employee +Child(ren)	$29.25
Family [Employee + Spouse and Child(ren)]	$47.38

Weekly premiums for dental coverage for 2014 are shown below and are subject to change thereafter in accordance with the collective bargaining agreement.

Weekly Dental Premiums Bargaining Employees With 5 or More Years of Service	
Employee Only coverage	$4.72
Family coverage	$12.10

Weekly premiums for vision coverage for 2014 are shown below.

Weekly Vision Premiums	
Employee Only coverage	$0.70
Employee + Spouse	$1.60
Employee +Child(ren)	$1.60
Family [Employee + Spouse and Child(ren)]	$2.80

Change in Election of Coverage

Once you and your eligible dependents have enrolled in a plan, the benefit coverage(s) that you elect will remain in effect for the entire plan year. You may only make a change in your plan coverage each year during the annual open enrollment period or if you have a change in status (including a special enrollment event as described below).

Change in Status

If one or more of the following changes in status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, your change in status. Occurrences that qualify as a change in status include the events described below as well as any other events that the Plan Administrator determines are permitted under IRS rules.

- A change in your legal marital status (marriage, legal separation, annulment, divorce or death of your spouse),
- Birth of a child, legal adoption, or placement of a child for adoption,
- Death of your spouse or dependent child,
- Any change in the employment status of you, your spouse, or your eligible dependent that affects benefit eligibility under a cafeteria plan (including this plan) or other employee benefit plan for you, your spouse, or your eligible dependents, including any of the following: terminating or beginning employment, a strike or lockout, a start of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment or any other similar change which makes the individual become (or stop being) eligible for a particular benefit,
- You are complying with the Working Spouse Rule provision,

- An event that causes your eligible dependent to satisfy or not satisfy an eligibility requirement for a particular benefit,

- A judgment, decree or order from a custody change, divorce, legal separation or annulment that orders coverage of your eligible dependent child under the plan or requires that another individual (such as your former spouse) cover the child and the other individual in fact does provide this coverage, or

- You or an eligible dependent become entitled to Medicare or Medicaid, or lose eligibility for such coverage.

If you want to change your election based on a change in status, you must request the change by completing and returning an enrollment/change form to HR Shared Services no later than 31 days after the change in status event occurs. You must also be able to support that the change is on account of and corresponds with the change in status. The Plan Administrator (in its sole discretion) will determine whether a requested change is consistent with the change in status event.

Special Enrollment Rights for the Medical Plan

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to enroll in the medical plan at times other than the annual open enrollment period or following a change in status. You (and/or your dependents) have special enrollment rights if any of the following occurs:

- A person becomes your dependent through marriage, birth, or adoption or placement for adoption.

- You or your eligible dependent(s) declined medical coverage under the plan, you certify in writing that the reason for declining coverage is because you and/or your eligible dependent(s) had other coverage at the time coverage under the plan was offered to you and you and/or your eligible dependent(s) lose such other coverage, provided the other coverage ends for one of the following reasons:

  - The coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or

  - The coverage was not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, death, termination of employment, or reduction in hours) or employer contributions toward the other coverage ends.

- Termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility.

- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP towards coverage under the medical plan.

Deadline for Special Enrollment

When your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage ends as a result of loss of eligibility, you must contact Human Resources within 60

days of termination. If you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you must contact Human Resources within 60 days of determination of subsidy eligibility. For any other special enrollment event, you must request enrollment by completing and returning an enrollment/change form no later than 31 days after the special enrollment event occurs.

If HR Shared Services does not receive your completed enrollment/change form by the deadline, you and your eligible dependents will lose the special enrollment right for that event.

Coverage Change Effective Date

If you make a change in your election due to one of the above events and complete all the appropriate enrollment materials within the specified timeframes, your new coverage election will be effective retroactive to the date of the event with respect to birth, adoption or placement for adoption. For all other events, the new coverage election will be effective as soon as administratively practicable after your enrollment materials are received.

Termination and Extension of Benefits

When Coverage Ends

Your coverage under the plans will end for you and/or your eligible dependents on the earlier of the following dates unless you and/or your eligible dependents are eligible for COBRA continuation coverage and elect the coverage in a timely fashion:

- The day on which your employment terminates for any reason,
- The day on which you are no longer an eligible employee,
- The date the plan or benefit program under the plan terminates or is modified to eliminate any benefits for your classification,
- The first day of the coverage period that you do not pay the required premium in a timely manner,
- The date of your scheduled return after a leave if you do not return to work on that date, or
- The date your employment would have terminated if you had not taken leave.

In certain cases, when you are on leave of absence, you can continue your coverage for a limited time.

Your dependents' coverage will end on the earlier of the following dates:

- The date your coverage as an active employee terminates,
- The first day of the coverage period that you do not pay the required premium for eligible dependent coverage,
- The date when the dependent no longer meets the plan’s definition of an eligible dependent,
- The date when the eligible dependent becomes a full-time member of the armed forces of any country, or
- The date the benefit program under which your eligible dependent is covered is terminated or is amended to exclude coverage for you or your dependent.

Under COBRA, you may be eligible to elect continuation of your medical (and dental and healthcare flexible spending account) coverage temporarily for yourself or any eligible dependent covered on the day prior to the day your benefits ended.

Rescission

Coverage can be rescinded (retroactively terminated) in cases of fraud or intentional misrepresentation of a material fact.

When Employment Terminates

Except as otherwise provided below, upon your termination of employment with BATO and its affiliated companies:

1. Medical, dental and vision benefits will terminate immediately except as follows:

    a. Coverage for you or any of your dependents will be extended for three months following termination to cover a hospital confinement or surgery resulting from a continuous total disability that began while the coverage was in effect.

    b. If there is a permanent or partial plant closure, coverage may continue for a maximum of 30 months (24 months upon payment of the applicable monthly premium and 6 months upon payment of the monthly group rate determined in advance by BATO) from the date of the closure of the plant.

2. Coverage for non-occupational accident and sickness benefits terminates immediately.

3. Coverage for basic life insurance, accidental death and dismemberment insurance, optional contributory life, survivor income benefits, and supplemental life insurance terminates immediately, except as follows:

    a. If you should die within 31 days following the termination of coverage, your basic life insurance will be paid.

    b. Conversion - When your insurance terminates, you have 31 days to convert any of the life insurance programs you participate in to an individual policy by applying promptly to MetLife and paying the appropriate premiums. No physical examination is necessary.

    c. If there is a permanent or partial plant closure, basic life insurance, AD&D and survivor income benefits will continue for 27 months.

4. Pre-tax contributions to the flexible spending accounts will terminate on the date that your employment with BATO and its affiliated companies terminates or the date that you are no longer a regular full-time employee. However, you may continue to make contributions to your Healthcare FSA on a post-tax basis through the end of the calendar year and, if you do so, you may request reimbursement for certain eligible out-of-pocket expenses incurred during that period.

During an Authorized Leave of Absence

If you take a leave of absence approved by your employer, you may continue certain benefit coverages during the leave as specified by the Leave of Absence policy. To continue benefits during the leave, you must continue to comply with all applicable leave of absence provisions and pay all applicable premium payments for coverage on a timely basis.

If you are on unpaid leave or your paid leave does not cover your benefit premiums, you must pay all applicable premiums on an after-tax basis. If you know the length of your leave of absence in advance, you have the option of pre-paying your regular benefit premiums on a pre-tax basis before taking your leave or you will be billed on the first of each month for that current month's coverage.

Coverage may continue as follows during an authorized leave of absence provided the employee makes any applicable premium payments required of active employees:

1. Medical, dental and vision benefits for you and your dependents will continue:

    a. During an authorized leave of absence for active duty military service for up to 24 months to the extent that benefits are not provided by the Federal or any state government. For the final 18 months of the period the cost of coverage is will be at the COBRA rate for the medical plan.

    b. During all other authorized leaves, for up to a maximum of 90 days.

2. Coverage for non-occupational accident and sickness benefits will continue for up to 90 days during certain approved leaves (other than for military service).

3. Coverage for your basic life insurance and accidental death and dismemberment insurance will be continued while on a leave of absence granted by BATO.

4. Supplemental life insurance coverage will continue if you arrange to continue premium payments while absent from work.

5. Group universal life insurance will continue if you arrange to continue premium payments while absent from work.

6. Pre-tax contributions to the flexible spending accounts will terminate when you no longer receive pay from BATO and its affiliated companies. However, you may continue to make contributions to your Healthcare FSA on a post-tax basis for the remainder of the year and any applicable COBRA period and, if you do so, you may request reimbursement for certain eligible out-of-pocket expenses incurred during that period.

Coverage may continue as follows during an absence due to injury or sickness:

1. Medical, dental, and vision benefit coverage for you and your dependents will continue during the period in which you accumulate seniority.

2. Coverage for non-occupational accident and sickness benefits will continue during the period you accumulate seniority.

3. Coverage for basic life insurance and accidental death and dismemberment Insurance will continue during the period in which you accumulate service seniority.

4. Supplemental life insurance and group universal life coverage will continue if you arrange to continue the premium payments while absent from work.

5. Pre-tax contributions to the flexible spending accounts will terminate upon the date that you are no longer receiving pay from BATO and its affiliated companies. However, you may

continue to make contributions to your Healthcare FSA on a post-tax basis for the remainder of the year and any applicable COBRA period and you may request reimbursement for certain eligible out-of-pocket expenses incurred after your change in status.

During Absence Due to Layoff

In addition, coverage may continue as follows while you are on layoff if you have more than one year of credited service at the time of layoff:

1. Medical, dental and vision benefits for you and your dependents will continue for a period ranging from three to twelve months depending on your amount of continuous service with BATO and its affiliated companies. You may extend coverage for the balance of the first 24 consecutive months following layoff by paying of the monthly group premium in advance.

2. Non-occupational accident and sickness benefits will continue for 90 days.

3. Basic life, AD&D and survivor income benefits will continue for up to 90 days. If you arrange to make premium payments (three months in advance) to continue this coverage, you can extend this coverage for up to two years from the date of layoff.

   Reinstatement of Medical, Dental and Vision Benefits When You Return to Work After Layoff

   a. If you declined to continue medical, dental and/or vision benefits while you were laid-off, these benefits can be reinstated the day you return to work with premium deductions resuming immediately.

   b. If you elected to continue your medical, dental and/or vision benefits while you were laid-off and all premiums are paid up to date, the direct billing of the premium will end the day you return to work with premium deductions resuming immediately.

   c. If you elected to continue your medical, dental, and/or vision benefits while you were laid-off but you did not pay any or all payments and your coverage was cancelled, you can either make all back payments by check and have premium deductions resume immediately, or you can wait until the next open enrollment period to enroll for coverage.

If You Die as an Active Employee

Coverage will continue for your surviving spouse and eligible dependents as follows:

Medical, dental and vision coverage will be extended for your surviving spouse and/or eligible dependent children if you die and were covered under the applicable plans on your date of death. Coverage will be extended for up to 36 months by paying the monthly premium in advance, which, for the first three months is the premium in effect immediately before you died, and for the additional 33 months will be the COBRA rate (as described below). Coverage will not be extended under the active plan as described in this paragraph if the spouse and/or eligible children elect coverage under the USW retiree plan. The retiree medical plan is a separate medical plan from the one described in this SPD. Any required monthly premiums for that plan must be paid in order to keep the coverage in force.

Extended Medical Benefits Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Company provide extended medical, dental and vision benefits and healthcare flexible spending account coverage to:

- terminating employees (except employees who are terminated for gross misconduct),
- employees whose coverage terminates because of a reduction in hours worked, and dependents who lose coverage because of the qualifying event, or because of:

    (1) death of the employee,

    (2) divorce or legal separation from the employee,

    (3) the employee becoming eligible for Medicare, or

    (4) reaching the limiting age by adult children.

The coverage will be the same as that provided to active plan participants who are similarly situated to the employee or dependent.

The maximum period of time that coverage can be extended under COBRA is 18 months for employees who lose coverage because of termination of employment or reduction in hours and 36 months for dependents who lose coverage. If the Social Security Administration determines within the first 18 months of COBRA coverage that an employee or dependent was disabled at the time of the employee's termination of employment or reduction in hours, or at any time during the first 60 days of COBRA continuation coverage, the employee or dependent will have the right to continue coverage for an additional 11 months, for a total of 29 months. Continued coverage will end before the expiration of the applicable 18, 29 or 36 month period if the employee or dependent fails to make the premium payment or if he or she becomes covered by another group plan or Medicare.

Individuals entitled to elect continued coverage will have the opportunity to do so within 60 days of the notification of continuation rights. The employee and/or dependents must notify the Company if the employee is divorced or legally separated or if a dependent child is no longer eligible for coverage. Individuals electing continued coverage because of COBRA will be required to pay the COBRA premium rate, which is 102% of the cost to the Company for such coverage (and, in the case of an employee or dependent who becomes disabled, 150% of such cost for the 19th through 29th months of coverage); provided that the actual amount payable for such coverage will be subject to any subsidy provided by the American Recovery and Reinvestment Act of 2009.

The COBRA continuation provision will be integrated with other Bridgestone policies concerning coverage continuation.

It is very important to keep in mind that Bridgestone must have complete and accurate information in order for you to receive the maximum benefit from your employee benefits programs. Please be sure to report changes in family status and address to your Human Resources or labor relations representative (if applicable) or the Benefits Administration Department as soon as possible.

Family and Medical Leave Act (FMLA)

If you have worked for BATO or its affiliated companies for at least 1,250 hours over the previous 12-month period and have at least 12 months of service, you may be eligible for up to 12 weeks of unpaid leave within a 12-month period under the Family and Medical Leave Act. You may be eligible for FMLA leave due to one of the following reasons:

- Birth and care of your newborn or newly adopted child,
- To care for your spouse, child or parent who has a serious health condition, or
- Your own serious health condition (when you are unable to perform your job).

During FMLA leave, your health coverage will continue on the same basis as if you had continued working (i.e. as an active employee). In addition, you may be eligible to continue other benefits as determined by the Plan Administrator in accordance with FMLA. You must continue to make all applicable premium payments for coverage on a timely basis during your FMLA leave either through paycheck deductions or self-payment. The employer will designate a disability leave or occupational injury leave as FMLA leave so that the leave periods run concurrently. BATO will comply with any special leave provisions that apply to certain states.

If you are on FMLA leave during annual open enrollment, you will be sent an enrollment packet to elect coverage for the coming year. While you are on FMLA leave, you will also be permitted to make election changes due to change in status or special enrollment events that occur while you are on a FMLA leave, to the same extent as if you were an active employee. You must complete an enrollment/change form and return it to the Benefits Administration Department within the required period as described above. If you do not make your request within the required period, you may not make any election changes until the next annual open enrollment period.

During FMLA leave, your health coverage will continue on the same basis as if you had continued working (i.e. as an active employee). In addition, you may be eligible to continue other benefits as determined by the Plan Administrator in accordance with FMLA. You must continue to make all applicable premium payments for coverage on a timely basis during your FMLA leave either through paycheck deductions or self-payment. The employer will designate a disability leave or occupational injury leave as FMLA leave so that the leave periods run concurrently. BATO will comply with any special leave provisions that apply to certain states.

FMLA now includes when a spouse, child or parent is called to active duty in support of a contingency operation (12 weeks leave) or if a spouse, child, parent or next of kin who is a covered service member incurs a serious injury or illness (26 weeks leave).

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as amended, you are entitled to continue certain health coverages while on military leave. For more information regarding benefit coverages which you may continue during leaves of absence or maintaining your health coverage after you are no longer eligible under the plans, please refer to the official Plan documents or contact your Human Resources or labor relations representative.

If you are absent from work because you have been involuntarily activated from the ready reserve of National Guard, you may elect to continue (medical, dental and vision) coverage under this plan during this absence, and you will be treated as not having terminated your employment for this purpose, for a period not more than one year from the last day worked.

How the Medical Plan Options Work

The medical plan covers a broad range of medically necessary services available for USW and other union-represented employees indicated. Below is a brief description of the medical coverage currently available.

Health Incentive Plan (HIP) - You are eligible for the HIP medical plan if you were a production employee hired on or before October 1, 2005 or are a maintenance employee hired before July 27, 2013. The HIP medical plan offers you a choice whenever you need medical care. If you use in-network doctors, you will generally receive a higher level of benefits. If you use out-of-network doctors, your level of benefits will generally be lower. When you are covered by the HIP, the company responsible for claims administration will be either UnitedHealthcare (UHC) or BlueCross BlueShield of Tennessee (BCBST), depending on the state where you live. The HIP plan design is the same regardless of which company administers the HIP.

USW PPO Plan (PPO) - You are eligible for the USW PPO medical plan if you are a New Hire (a production employee hired after October 1, 2005 or a maintenance employee hired on or after July 27, 2013). This medical plan offers you a choice whenever you need medical care. If you use in-network doctors, you will generally receive a higher level of benefits. If you use out-of-network doctors, your level of benefits will generally be lower. When you enroll in the PPO, the company responsible for claims administration will be either UnitedHealthcare (UHC) or BlueCross BlueShield of Tennessee (BCBST), depending on the state where you live. The PPO plan design is the same regardless of which company administers the medical plan.

How the HIP and PPO Plans Work

UnitedHealthcare (UHC) and BlueCross BlueShield of Tennessee (BCBST) are the medical claims administrators and are assigned by state. Depending on the state you live in, your coverage will be administered by either UnitedHealthcare or BlueCross BlueShield of Tennessee.

In-Network and Out-of-Network Providers

When you seek medical care, you decide if you want to use doctors, hospitals and other healthcare facilities that participate in a network of contracted providers through the medical claims administrator or to receive your care from any other qualified doctor, hospital or facility. If you choose in-network doctors and facilities, you generally receive a higher level of benefits and pay less out of your pocket. If you use out-of-network doctors or facilities, you will generally receive a lower level of benefits and pay more out-of-pocket expenses.

If the medical network does not have a participating doctor that can provide medically necessary services, the medical carrier may authorize you to see an out-of-network doctor, and cover the services at the in-network level of benefits. Also, if you receive services from an out-of-network doctor or other healthcare professional while being treated at an in-network hospital through no fault of your own (for example, the radiologist who reads your x-ray), the claims administrator may authorize the services to be paid at the in-network level of benefits.

If you go to the emergency room at a non-network hospital for a true emergency (treatment for a sudden, unexpected and life-threatening illness or injury), benefits will be paid at the in-network level of benefits.

Out-of-network benefits are paid based on “reasonable and customary” (R&C) charges. R&C is based on the usual fee charged for such services; the prevailing range of fees in the area charged by most doctors and unusual circumstances or complications requiring additional time, skill or experience. Expenses over the R&C amount are not covered.

Hospital, Surgical and Medical Benefits

To receive the maximum benefit from the medical plan, it is important that you get your non-emergency care from in-network doctors.

Benefits for Services of a Network Provider

The medical plans provide a different level of benefits depending on whether or not you use the services of a participating doctor. Generally, benefits will be paid at a higher level if you use in-network services, although there may be additional plan requirements. If you select a network doctor, he or she will file your claim for you. Benefits will be paid, as applicable, directly to your doctor. You may use any qualified non-network doctor or facility, but you may have to file the claim yourself.

Co-insurance

Co-insurance is a percentage of the cost of certain covered medical expenses, over and above the deductible and co-payment, that you are responsible for paying.

Co-payments

A co-payment is a fixed dollar amount (or fixed percentage) paid by the patient to your doctor at the time of service. You are responsible for co-payments for medical care and will not be reimbursed for any co-payments. In addition, co-payments do not apply toward your deductible or annual out-of-pocket maximum amount.

Annual Deductibles

The annual medical plan deductible is the amount you must pay each calendar year before benefits are paid toward your medical expenses. Services are subject to the annual deductible amounts unless specified otherwise.

> **Individual Deductible:** The individual deductible is met when the covered medical expenses of a covered individual incurred during each calendar year under the medical plan equal the deductible amount shown in the schedule of medical benefits.
>
> **Family Deductible:** One covered member *cannot* satisfy the entire family deductible. The maximum amount of expenses any one family member can incur that will go toward the family deductible is the individual deductible amount. Once the combined medical expenses that were applied to the individual deductibles equal the family deductible amount, the family deductible will be considered as having been met for the calendar year.

Expenses including, but not limited to, medical co-payments and deductibles for routine vision care, prescription drugs, and dental care, and expenses in excess of reasonable and customary fees do not apply toward the satisfaction of the annual medical deductibles.

Out-of-network deductible expenses will not apply toward the satisfaction of the in-network deductible expenses and in-network deductible expenses do not apply toward satisfying the out-of-network deductible expenses.

Out-of-Pocket Expenses

An out-of-pocket expense is the portion of eligible expenses that you are responsible for paying. Co-payments, non-covered services, charges above the reasonable and customary fees and pre-certification penalties do not apply toward the satisfaction of the out-of-pocket maximums. In addition, out-of-network out-of-pocket expenses do not apply toward the satisfaction of the in-network out-of-pocket maximum, and in-network out-of-pocket expenses do not apply toward satisfaction of out-of-network out-of-pocket maximums.

Annual Out-of-Pocket Maximum (Stop-Loss Benefit)

The annual out-of-pocket maximum (stop-loss) amount is the maximum amount that an individual or family* will have to pay out-of-pocket in a calendar year for covered services. Once you meet the applicable out-of-pocket maximum, the employer then pays 100% for all eligible medical expenses. Expenses that apply toward the out-of-pocket maximum are the deductible amounts and the employee coinsurance for covered medical and surgical expenses. Co-payments do not apply toward the out-of-pocket maximum.

* The family out-of-pocket maximum is calculated by adding your out-of-pocket expenses for all qualified items for all of the covered members of your family.

Following are examples of other expenses that do not apply to the annual out-of-pocket maximum amount:

- Expenses in excess of fee schedule or reasonable and customary fees,
- Expenses incurred for services or items excluded or not covered by this plan,
- Expenses beyond limitations of covered services,
- Penalties imposed because of failure to comply with hospital certification requirements and/or case management requirements,
- Any co-payment, including co-payments for office visits, wellness care, mental health/substance abuse benefits; prescription drug benefits; vision and dental benefits; and other out-of-pocket costs for these plans.

Healthcare Cost Containment Provisions

PLEASE READ THIS SECTION CAREFULLY. FAILURE TO FOLLOW THESE PROVISIONS MAY RESULT IN FINANCIAL PENALTIES OR A REDUCTION IN BENEFITS.

The medical plan contains the following healthcare cost control features that require that certain medical treatment be reviewed and approved by the medical carrier before you receive the treatment.

The healthcare cost controls are:

- Pre-admission Certification,

- Continued Hospital Stay Review,
- Prospective Procedure Review.

Your benefits will be reduced if you do not follow these requirements. Be sure that you or your doctor contact the medical carrier for pre-approval of certain medical care as described below. Refer to the phone numbers on the back of your UnitedHealthcare or BlueCross BlueShield medical identification cards.

Pre-admission Certification

1. **Before you are admitted to the hospital**
   Whenever a non-emergency hospital admission is recommended or required, you or your doctor must call for pre-certification in advance.

   For emergency admissions, the medical carrier must be notified within 48 hours of admission or on the first business day following a weekend or holiday admission. If you are admitted for less than 48 hours, notification is not required.

2. **Pre-admission testing**
   Pre-admission testing must take place on an outpatient basis before you are admitted to a hospital for a non-emergency surgical procedure.

Continued Stay Review

Once you are admitted, the medical carrier will continue to review your progress by working with your doctor to determine how long you should stay and whether you require mandatory case management.

Prospective Procedure Review

The prospective procedure review program requires that you get approval from the medical carrier before certain diagnostic procedures are performed. You or your doctor must call for separate approval before you receive the following inpatient or outpatient diagnostic procedures:

- Magnetic Resonance Imaging (MRI), and
- Computerized Axial Tomography (CAT) Scans.

Penalties for Not Complying with Cost Containment Requirements for Out-of-Network Services Listed

If you use out-of-network doctors for services that require certification and you do not obtain authorization, or the carrier does not approve services under the healthcare cost containment provisions, the expenses you incur that have not been certified or approved will not be considered covered services and will result in out-of-pocket expenses to you.

The maximum penalty in any calendar year will be $250 per person for each time you do not get the required approval, unless the care is on an emergency basis or during a hospital confinement for another primary unrelated medical condition. This penalty does not apply toward the in-network or out-of-network deductible and out-of-pocket maximum, whether or not you have met the in-network or out-of-network deductible or out-of-pocket provision during the calendar year.

If you are admitted to the hospital for non-emergency treatment on a Friday or Saturday without getting the admission approved, you will be subject to the penalty.

If it is determined that there was reasonable cause for not complying with the cost containment controls, the claim will be paid as if it had been in compliance with the controls.

Pre-certification does not guarantee that the doctor or facility is approved as a network provider, nor does pre-certification guarantee your coverage. For example, if you are not eligible for coverage at the time the services are provided or if the services are not covered under the medical plan, benefits will not be paid.

Covered Expenses

Medical services must be eligible for payment as described in this SPD, and must be:

- For off-the-job injuries and illnesses (Workers' Compensation covers job-related injuries and conditions),
- Performed or approved by a licensed doctor. A doctor whose services these plans cover is an M.D. (medical doctor), D.O. (osteopath) or D.D.S. (dental surgeon). Other providers, such as Nurse Practitioners and Physician Assistants, may be covered for certain services, providing that a) the provider is properly licensed by his or her state, b) the service being billed is considered to be within the scope of the provider's license, and c) the service is covered by the benefit plan for the member that received the service,
- For medical care that is medically necessary. **Important:** Any healthcare service, treatment, or supply is only a covered benefit if it is medically necessary. The fact that a physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a sickness, injury, mental illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a covered health service under the Plan.

Medically Necessary: healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by the medical claims administrators or its designee, within its sole discretion. The services must be:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The medical claims administrators reserve the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, will be within the medical claims administrators' sole discretion.

Covered Expenses of the Health Incentive Plan and USW PPO Plan

Abortions

Benefits payable for abortions only apply to (a) abortions that are medically necessary; that is, when the life of the mother is endangered if the pregnancy continued and (b) medical complications arising from an abortion.

Ambulance Service

Benefits are paid for necessary ambulance transportation charges from the place of serious injury or onset of severe, sudden illness, to a local hospital. Transfer by ambulance when recommended (in writing) by a physician between two hospitals/extended care facilities or between home and a hospital or extended care facility will be covered. Charges for other than transportation or for travel beyond a local area hospital that is adequately equipped to provide the necessary care will not be covered.

Audiological Testing

Coverage is provided for testing by an audiologist upon the written recommendation of a doctor.

Cardiac and Pulmonary Rehabilitation - Phase II

Benefits for cardiac rehabilitation and pulmonary rehabilitation are determined by medical necessity up to a maximum of 60 visits per condition per calendar year. Eligibility will be determined upon review of a letter from your physician and other documentation, which must be submitted for a predetermination of benefits.

Chiropractic Services

Benefits are payable for chiropractic services for manipulations or adjustments for the treatment of neuromusculoskeletal conditions by a licensed Chiropractor (D.C.) or a Doctor of Osteopathy (D.O.). Benefits will also be provided for x-rays made during visits to a Chiropractor when necessary for the diagnosis and analysis of neuromusculoskeletal conditions.

Benefits are payable for eligible expenses, after the annual deductible, for up to 30 visits per calendar year.

Diagnostic Laboratory and X-Rays

Charges directly connected with x-rays, fluoroscopy and laboratory tests for diagnostic purposes will be paid whether performed in a hospital, doctor's office, clinic or ambulatory care facility.

Included are charges for such medical tests as basal metabolism, electrocardiographs and electroencephalograms. Services must be performed or authorized by a doctor (M.D., D.O., D.D.S. or D.S.C.). Routine x-rays taken by a doctor of dental surgery (D.D.S.) in connection with a surgery not covered under the medical plan are not payable.

Doctor Visits

Certain office visits and certain doctor visits (M.D. or D.O.) when you are in the hospital are considered covered expenses.

Durable Medical Equipment and Supplies

Benefits are payable for the purchase or rental of necessary medical equipment, including oxygen and equipment for its administration, surgical dressings, casts, splints, trusses, braces, crutches, wheelchairs, hospital beds, iron lungs, hypodermic needles, syringes, certain support garments, and similar items if their use is certified by the attending physician as medically necessary and, for purchases, the cost to rent the equipment for the period of use is more than the cost to purchase. If the purchase price of equipment is over $500, prior approval is required. The Company reserves the right to limit coverage under the plan of certain types of equipment to one item of such equipment per lifetime.

Benefits are also payable for blood and blood plasma, artificial limbs, larynx and eyes.

Emergency Care

Coverage applies to treatment due to accidental, serious injury or sudden serious illness wherever performed.

Home Health Care

Home health care benefits are used in place of benefits for hospital or nursing home confinement. The services must be provided by a home health care agency and all services must be recommended by a physician in lieu of inpatient confinement. Home health care is available for 100 days per calendar year and encompasses professional services and medical supplies as described below.

Professional Services

- Nursing care,
- Home health care aide,
- Physical, occupational, respiratory and speech therapy,
- Nutrition counseling,
- Medical social services by a licensed social worker (provided the services are part of the treatment).

Medical Supplies

- Miscellaneous supplies,
- Prosthetic and orthopedic appliances,

- Rental or purchase of durable medical equipment,
- Prescription drugs and medicines (including insulin and other diabetic supplies).

Hospice Care

Benefits will be provided at the in-network coverage level for terminally ill patients for care furnished by any formal hospice program if the care is recommended by the attending physician and included in the patient's treatment plan.

Benefits include:

- Inpatient care for acute intervention, medical crisis or pain management,
- Up to $500 of bereavement support for the patient's immediate family within three months following the patient's death,
- Covered services and supplies include nursing care, home health care services, respiratory and inhalation therapy, medical social services, individual and family counseling, and respite care.

Inpatient Hospital Expenses

Benefits will be paid for expenses resulting from a hospital confinement. Benefits will be paid for up to 730 days for each confinement and apply to:

- Semiprivate room and board,
- Intensive, cardiac, contagious or isolation care,
- Administration of anesthetics, laboratory work, x-rays, operating rooms, medicines, dressings, splints, drugs and other necessary services and supplies,
- Charges made by hospital-approved medical employees, technicians and physicians for the use of hospital equipment,
- Charges by non-hospital employees for use of hospital equipment when service is not generally available by hospital employees.

Maternity Care

Maternity care is covered for pregnancies of female employees, wives of employees, and female dependents covered under the medical plan. In addition to the traditional hospital, expenses in connection with birthing centers, home births and services of midwives are covered.

Prenatal office visits are covered, after the applicable co-payment, when charged separately by an in-network doctor.

Expenses for routine well-patient newborn care while hospitalized will be processed as part of the mother's claim during the joint confinement of the mother and baby in the same hospital. A separate deductible for the newborn’s claim expenses will only be charged if the newborn receives treatment or care for a covered condition, remains hospitalized after the mother’s discharge, or the newborn child and mother are confined in separate hospitals.

Mother and baby will be confined for a minimum of 48 hours for a normal birth or 96 hours for a cesarean birth, unless the mother and doctor determine that a shorter confinement is satisfactory.

Mental Health and Substance Abuse

All services for mental health, alcohol or substance/drug abuse must be approved by the medical carrier. Refer to the telephone number on your medical identification card for behavioral health contact information.

> *Nervous and mental disorder* means a condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant features. Nervous and mental disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.
>
> *Substance abuse* means significant and ongoing abuse if and/or dependency upon alcohol and/or drugs which has resulted in family, work, legal or health problems.

Covered expenses include charges made by a:

- Hospital, on its own behalf, for bed and board and other necessary services and supplies; except that for any day of hospital confinement, covered expenses will not include that portion of charges for bed and board which is more than the allowed number of days for in-network care or the dollar limits for out-of-network care shown in the schedule,
- Licensed ambulance service for expenses to or from the nearest hospital where the needed medical care and treatment, can be provided,
- Hospital, on its own behalf, for medical care and treatment received as an outpatient,
- Facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis,
- Facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis,
- Physician, psychologist or an individual who has master of social work (MSW) credentials for professional services.

Nursing Care

Benefits are payable for private duty nursing care performed by a registered graduate nurse or licensed practical nurse, other than a close relative or a nurse who ordinarily resides in the patient's home.

Benefits will also be payable for charges made by an approved visiting nurse service for medical treatment at home by a registered nurse or licensed physical therapist within 21 days following hospitalization of at least three days and for the same cause which required the confinement.

Private duty nursing care and visiting nurse service treatment must be ordered in writing by the attending doctor. The doctor must certify that, in the absence of this care, hospital confinement would be required.

Oral Surgery Benefits

Benefits will be payable for eligible charges, including local and general anesthesia charges for procedures performed by a Doctor of Dental Surgery (D.D.S.) or Doctor of Medicine (M.D.) described in the Schedule of Oral Surgical Procedures, including treatment of a fractured jaw or of accidental injuries to natural teeth within 12 months of the accident (including replacement of such natural teeth within such period).

Organ Transplants - Centers of Excellence

A person in need of an organ transplant will be required to use a “Center of Excellence” which is contracted with the carrier in order to receive the in-network level of benefits. Centers of Excellence are facilities that specialize in organ transplants.

The medical carrier will coordinate treatment with the case manager. The case manager will coordinate admission requirements, specialty referrals, hospital billing, transport and lodging of the patient and one adult (or two adults if the patient is a minor under the age of 18).

Outpatient Surgery

Certain surgeries must be performed on an outpatient basis for benefits to apply.

Physical Therapy

Coverage applies to charges for up to 60 treatments in a calendar year for physical therapy provided by a licensed physical therapist upon the written recommendation of a physician.

Podiatrist and Chiropodist Benefits

Coverage also applies to procedures performed by a podiatrist (D.P.M.) or chiropodist (D.S.C.).

Post-Hospital Confinement and Extended Care Facilities

Post-hospital convalescence benefits are available for care by a covered approved convalescent extended care facility.

Benefits apply if you have been confined in a hospital for at least three days and within 21 days following such hospital stay you are confined in an extended care facility. The services must be approved in writing by the attending doctor. The doctor must certify that the care is medically necessary and that, in the absence of extended care facility confinement, you would require inpatient hospital care.

Benefits will be paid for up to 100 days per calendar year, for charges for room and board and necessary services and supplies.

A covered extended care facility is an institution approved under Title XVIII (Health Insurance for the Aged) of the Social Security Act or extended care facilities approved by the Joint Commission on accreditation of hospitals. In no event will any institution, or part thereof, which is used principally as a rest facility, a facility for the aged or a facility for the care of alcoholics or drug abuse patients be included for coverage.

Preventive Care Services

Charges for preventive care services provided on an outpatient basis are covered as required by applicable law if performed in-network.

Preventive care services provided on an outpatient basis include medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF),
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,
- For infants, children and adolescents, preventive care and screenings according to the Health Resources and Services Administration guidelines,
- For women, additional preventive care and screenings according to the Health Resources and Services Administration guidelines.

To read more about recommendations regarding preventive care services as outlined by the USPSTF, visit: www.uspreventiveservicestaskforce.org/recommendations.htm.

Radiation Therapy and Chemotherapy

Charges for x-ray, radium and radioactive isotopic therapy and for chemotherapy are covered wherever performed.

Reconstructive Surgery after Mastectomy

A participant who is receiving benefits under a BSAH medical plan in connection with a mastectomy will have coverage provided in a manner determined to be medically necessary in consultation with the attending physician and the patient. The coverage includes:

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

The plan’s regular deductibles, coinsurance and out-of-pocket maximum provisions apply to the above services.

Speech Therapy

Benefits will be provided for up to 60 treatments in a calendar year for restorative or rehabilitative speech therapy or speech therapy to correct speech impairment due to a structural, physiological or neurological disorder as certified by a physician. Treatment must be provided by a qualified speech therapist to restore speech loss or correct impairment upon the written recommendation of a physician.

Sterilizations

Surgical sterilizations including vasectomies and tubal ligations are covered.

Surgery and Anesthesia Benefits

Benefits are payable for necessary surgeries, including certain oral surgeries, regardless of where performed. Second surgical opinions are not mandatory, but are a covered expense in connection with a non-emergency surgical procedure.

In-network benefits are payable at 90% (subject to annual deductibles) of the maximum allowable charge for surgeries performed in a hospital or outpatient surgical facility. Co-payments apply according to the place of service.

Non-network benefits are payable at 70% of the "reasonable and customary" fees after the deductible is met. Determination of "reasonable and customary" charges for out-of-network surgery and anesthesia takes into consideration the usual fee the doctor most frequently charges most of his or her patients for such a service, the prevailing range of fees in the area charged by most doctors, and unusual circumstances or complications requiring additional time, skill or experience.

General anesthesia is a covered expense when administered by a doctor or a registered nurse anesthetist for covered surgeries. However, benefits do not apply for charges for the administration of local infiltration anesthetics or for anesthetics administered by the operating surgeon, the assistant surgeon or any person compensated by the hospital or other institution.

Wellness Benefits

Wellness care must be obtained from in-network doctors; no wellness benefits are payable when rendered by out-of-network doctors. The medical carriers follow guidelines established by the nationally recognized U.S. Preventive Services Task Force to determine what constitutes a preventive care service that is required to be covered by applicable law. See “Preventive Care Services” above for additional information.

Exclusions and Expenses Not Eligible Under the Medical Plan

Please refer to the *Medical Plan Exclusions and Limitations* section.

Coordination of Benefits

Please refer to the *Coordination of Benefits* section for an explanation of the coordination of medical benefits.

Claims

The HIP program is administered by either BlueCross BlueShield of Tennessee (BCBST) or UnitedHealthcare (UHC), depending on your state of residence.

For inquiries about claims, participating doctors and facilities, or coverage issues:

BCBST –800-841-7434 or **www.bcbst.com**. Group #82020. Submit claims to BlueCross BlueShield, 1 Cameron Hill Circle, Chattanooga, TN 37402.

UHC –800-341-1695 or **www.uhc.com**. Group #712560. Submit claims to UnitedHealthcare, PO Box 740800, Atlanta, GA 30374-0800

Note: See the *Claims and Appeals Procedures* section for detailed information about your rights as a plan member.

Medical Schedules of Benefits

SCHEDULE OF BENEFITS		
Health Incentive Plan **In-network and out-of-network services are subject to annual plan deductibles unless noted otherwise**		
Service	**In Network**	**Out of Network**
Coinsurance Levels	90% for most services	70% for most services
Individual Deductible	$250	$500
Family Deductible	$500	$1,000
Individual Out-of-Pocket Maximum (stop-loss)	$2,000	$4,000
Family Out-of-Pocket Maximum (stop-loss)	$4,000	$8,000
Physician's Office Visit	$30 co-pay per visit	70%
Specialist Office Visit	$40 co-pay per visit	70%
Preventive Care Includes preventive services as government-mandated and follow U.S. Preventive Task Force guidelines	100% Office visit co-pay applies to wellness services that do not qualify as government-mandated services	Not Covered
Well Child Care up to age 18 for routine preventive care	100%	Not Covered
Immunizations up to age 18	100%; office visit co-pay applies to the extent allowed by law	Not Covered
Inpatient Hospital and Professional Services	90%	70%
Outpatient Surgery, Surgical Outpatient Hospital or Treatment Facility	90%	70%
Outpatient Surgery - Physician’s Office	100% after applicable office visit co-pay	70%
Non-Surgical Outpatient Hospital or Treatment Facility	90%	70%
Urgent Care	$50 co-pay, then 100%; not subject to deductible	$50 co-pay, then 100%; not subject to deductible
Emergency Room	$200 co-pay, then 100%; not subject to deductible	$200 co-pay, then 100%; not subject to deductible
Skilled Nursing Facilities 100 days per year	90%	70%
Allergy Shots	Applicable office visit co-pay	70%
Non-preventative diagnostic procedures such as x-rays, lab, mammograms	90%	70%

SCHEDULE OF BENEFITS		
Health Incentive Plan **In-network and out-of-network services are subject to annual plan deductibles unless noted otherwise**		
Service	**In Network**	**Out of Network**
MRI/CAT prior authorization required when performed on outpatient basis	90%	70% $250 pre-cert penalty per failure to comply
Chiropractic Care 30 visits per calendar year	90%	90%
Physical Therapy 60 visits per year	90%	70%
Hearing Tests	90%	90%
Speech Therapy 60 visits	90%	70%
Cardiac Rehabilitation Phase II – 60 days per year	90%	70%
Home Health Care 100 days per year	90%	70%
Hospice Care	90%	90%
Delivery of baby	90%	70%
Abortion (non-elective)	90%	70%
Infertility Treatment (Office visits, tests & counseling, diagnosis & treatment to correct infertility. Excludes drugs, in vitro, GIFT, ZIFT and Artificial Insemination)	90% after applicable office visit co-pay	70%
Organ Transplants	90% at in-network Centers of Excellence	Not Covered
Medical Supplies and Durable Medical Equipment	90%	70%
Ambulance	90%	90%
Oral Surgery	90%	90%
Artificial limbs, larynx and eyes	90%	90%
Mental Health/Substance Abuse Outpatient Inpatient	 100% after $30 co-pay for group therapy; $30 co-pay for individual therapy 90%	70%

SCHEDULE OF BENEFITS		
USW PPO Plan **After Completion of 90 Days of Credited Service** **In-network and out-of-network services are subject to annual plan deductibles unless noted otherwise**		
Service	**In Network**	**Out of Network**
Coinsurance Levels	80% for most services	60% for most services
Individual Deductible	$500	$1,000
Family Deductible	$1,000	$2,000
Individual Out-of-Pocket Maximum (stop-loss)	$3,000	$5,000
Family Out-of-Pocket Maximum (stop-loss)	$6,000	$10,000
Physician's Office Visit	$30 co-pay per visit	60%
Specialist Office Visit	$40 co-pay per visit	60%
Preventive Care Includes preventive services as government-mandated and follow U.S. Preventive Task Force guidelines	100% Office visit co-pay applies to wellness services that do not qualify as government-mandated services	Not Covered
Well Child Care up to age 18 for routine preventive care	100%	Not Covered
Immunizations up to age 18	100%; office visit co-pay applies to the extent allowed by law	Not Covered
Inpatient Hospital and Professional Services	80%	60%
Outpatient Surgery, Surgical Outpatient Hospital or Treatment Facility	80%	60%
Outpatient Surgery Physician's Office	100% after applicable office visit co-pay	60%
Urgent Care	$50 co-pay, then 100%; not subject to deductible	$50 co-pay, then 100%; not subject to deductible
Emergency Room	$200 co-pay, then 100%; not subject to deductible	$200 co-pay, then 100%; not subject to deductible
Skilled Nursing Facilities 100 days per calendar year	80%	60%
Allergy Shots	Applicable office visit co-pay	60%
Non-preventative diagnostic procedures such as x-rays, lab, mammograms	80%	60%

SCHEDULE OF BENEFITS		
USW PPO Plan **After Completion of 90 Days of Credited Service** **In-network and out-of-network services are subject to annual plan deductibles unless noted otherwise**		
Service	**In Network**	**Out of Network**
MRI/CAT prior authorization required when performed on outpatient basis.	80%	60% $250 pre-cert penalty per failure
Chiropractic Care 30 visits per calendar year	80%	80%
Physical Therapy 60 visits per year	80%	60%
Hearing Tests	80%	80%
Speech Therapy 60 visits	80%	60%
Cardiac Rehabilitation – Phase II 60 days per year	80%	60%
Home Health Care 100 days per year	80%	60%
Hospice Care	80%	80%
Delivery of baby	80%	60%
Abortion (non-elective)	80%	60%
Infertility Treatment (Office visits, tests & counseling, diagnosis & treatment to correct infertility. Excludes drugs, in vitro, GIFT, ZIFT and Artificial Insemination)	80% after applicable office visit co-pay	60%
Organ Transplants	80% at in-network Centers of Excellence	Not Covered
Medical Supplies and Durable Medical Equipment (over $500 requires prior approval)	80%	60%
Ambulance	80%	80%
Oral Surgery	80%	80%
Artificial limbs, larynx and eyes	80%	80%
Mental Health/Substance Abuse Outpatient Inpatient	 100% after $30 co-pay for group therapy; $30 co-pay for individual therapy 80%	60%

Prescription Drug Benefits

You are eligible for prescription drug benefits when you enroll in the medical plan. Express Scripts, Inc. (ESI), formerly called Medco, administers the prescription drug program.

After you are enrolled for medical coverage, you will receive information from Express Scripts, including a description of how the prescription drug plan works, an identification card and claim forms.

Prescriptions may be purchased at retail pharmacies or through the mail-order service.

Benefits are payable as described in the Schedule of Benefits.

Using the Prescription Drug Benefit at Retail Pharmacies

In-Network Retail Pharmacies

When you have your prescription(s) filled at a participating retail pharmacy, you must show your prescription drug ID card and pay the applicable co-payment.

You can get information about participating pharmacies in your location and claims payment status information by calling 800-455-6904 or visiting the website at: **www.express-scripts.com.**

Out-of-Network Pharmacies

If you have your prescription medication(s) filled at a non-participating retail pharmacy, the amount paid by the plan is generally lower. See the prescription drug Schedule of Benefits for coverage levels. All other prescription drug provisions apply.

Retail Refill Allowance

You may receive up to three fills at a retail pharmacy for your maintenance (ongoing) medications for the regular retail co-payment amount. After the third fill, if you have your maintenance medication filled at a retail pharmacy instead of using the mail-order service, you will be charged double the retail co-payment. Certain narcotics that cannot be shipped by mail are not subject to this limitation. You may want to check with Express Scripts if you have a narcotic prescription to make sure it can be filled through mail-order

Using the Prescription Drug Benefit at Mail-Order

A mail order prescription drug program is available as an alternative for obtaining prescribed medications at a retail drug store and for prescriptions for more than a 30-day supply. You may get up to a 90-day supply through the mail-order program.

You are encouraged to have your maintenance medications filled through the mail order program. Maintenance drugs are those drugs you take on an ongoing basis for a chronic condition or illness, such as high cholesterol, high blood pressure, etc. Maintenance drugs are subject to the Retail Refill Allowance provision above.

If the mail-order service is not used when required, the benefit paid will only be up to the amount that would have been paid under the mail-order program.

To use the mail order service, mail a written prescription from your doctor to Express Scripts using the mail order form along with the applicable co-payment for each prescription. The prescription is then reviewed and filled by pharmacists and returned to you by mail, along with a new mail order envelope. Your doctor's office may be able to fax the prescription to Express Scripts as well.

You can inquire about mail-order or the status of your claim by calling 800-282-2881.

Diabetic Supplies

Benefits for diabetic supplies (syringes, needles, and test tapes) are payable through both retail and mail order after the appropriate co-payment or co-insurance.

Covered Prescription Drugs

- Injectiable insulin, or any Prescription Legend Drug* that requires a prescription.
- A compound medication that has at least one ingredient that is a Prescription Legend Drug*.
- Generic oral contraceptives that are a "preventive health service" as defined under the Patient Protection and Affordable Care Act (PPACA), or a brand equivalent if no generic oral contraceptive is effective and safe for the participant.
- Any other drug that requires a prescription under state law.

*Prescription Legend Drug means any medical substance that has a label that states "Caution: Federal Law prohibits dispensing without a prescription" as required under the federal Food, Drug and Cosmetic Act.

Exclusions

No benefits are payable for:

- A medical condition or injury for which you or your dependent is entitled to receive reimbursement under any Workers' Compensation law or is entitled to benefits from any municipal, state, federal, or other governmental program of any sort.
- Contraceptive medications or devices, or any therapeutic device or appliance (e.g., support garments and other non-medicinal substances), unless specifically indicated as covered.
- The administration of any medication.

- More than a 90-day supply of any medication, for any refill over the number of refills specified by the physician, or for any refill dispensed after one year from the physician's order.
- Sexual dysfunction drugs.
- Non-FDA approved drugs.
- Medications for which the customary and usual charge is less than the applicable copayment drugs (does not apply to New Hires in HIP plan).

Prescription Drug Schedule of Benefits

SCHEDULE OF BENEFITS		
Prescription Drug for the HIP and USW PPO Plans		
Annual Deductible	$150 Individual/$300 Family*	
Applicable Copayments	**Retail (30-day supply)**	**Mail-Order (90-day supply)**
Generic Drugs	$12	$30
Preferred Brand Drugs	Higher of $20 or 20%	Higher of $50 or 20%
Non-Preferred Brand Drugs	Higher of $40 or 40% Maximum per-prescription co-pay $100	Higher of $100 or 40% Maximum per-prescription co-pay $200
4th Tier Prescription Drugs – Gastro-esophageal and non-sedating antihistamines	50% co-payment (Retail and Mail-Order)	
Non-covered drugs (drugs not included in the formulary)	You pay full cost	
Out of Network Coverage	In-network co-payments or co-insurance, whichever is higher; must pay in full and submit a paper claim for reimbursement	
* *This is a separate deductible from the medical plan annual deductible.*		

Prescription Drug Notes:

- *If a brand name drug is dispensed when a generic is available, you are required to pay the applicable co-payment plus the cost difference between the brand name drug and the generic drug.*
- *Prescription drug requirements in excess of an initial 30-day supply, up to and including a 90-day supply, must be filled through the mail order service or the benefit will be reduced.*
- *You are encouraged to fill your maintenance (ongoing) medications through the mail-order service. You can get up to three fills at a retail pharmacy, after which you will pay double the retail co-pay if you continue to have your prescriptions filled at retail instead of through mail order.*

Amounts paid for drugs not included in the formulary do not count toward the annual deductible.

Prior Authorization

Formulary

Express Scripts utilizes a national panel of physicians and pharmacists to continually review and compare prescription drugs to ensure its drug formulary includes proven medications to treat every condition. The plan does not cover (is not included in the formulary) certain specified brand name drugs. However, the formulary includes one or more safe and effective drug alternatives for each of these drugs. You, your doctor, or your pharmacist may request a coverage review. See “The Coverage Review Process” section that follows.

Coverage Management Programs

Bridgestone is committed to providing you with a cost-effective prescription drug plan. With this goal in mind, we have incorporated a suite of coverage programs designed to help ensure that your prescription plan provides you with the coverage you need while keeping costs low for both you and Bridgestone. Express Scripts administers these programs.

Prior Authorization

Some medications are not covered without prior authorization from the prescription drug carrier. Medications may fall under one or more of the following prior authorization programs.

Traditional Prior Authorization

With traditional prior authorization, you must obtain pre-approval through a coverage review (see the section on “*The Coverage Review Process*”). A coverage review determines whether your use of the medication qualifies for coverage under your prescription plan’s authorization rules.

Smart Prior Authorization

For some medications, Express Scripts uses an automated process called Smart Rules™ to determine whether you qualify for coverage. Using factors that we have on file, such as your medical history, drug history, age, and gender, Smart Rules can often eliminate the need for a coverage review.

The Coverage Review Process

You, your doctor or your pharmacist may initiate the review process for any coverage program that the prescription drug program has, by calling Express Scripts at 800-455-6904.

Your doctor will be sent a Coverage Management Review Fax Form to fill out and send back to Express Scripts at the fax number indicated on the form. When you use the mail order service, Express Scripts will call your doctor for you to start the coverage review process. Express Scripts will send you and your doctor a letter confirming whether or not coverage is approved (usually within two business days of receiving the necessary information).

If coverage is approved, you will pay your normal co-payment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request the appeal is included in the letter that you receive.

If you have any questions, unsure what coverage programs your plan has, please visit Express Scripts online at **www.express-scripts.com** or call Member Services at 800-455-6904.

Medical Plan Exclusions and Limitations

Medical Plan Exclusions and Limitations

There are certain standard expenses and charges that are not covered by the medical plan, as described in the medical plan portion of this Summary Plan Description. No benefits will be payable for charges related to or in connection with the following expenses.

1. Non-compliance with pre-certification requirements for out-of-network services as described in the Healthcare Cost Containm*ent* section.

2. An accident or sickness arising out of, or in the course of, any employment for wage or profit, or disease covered by a Worker's Compensation Act or similar legislation.

3. Remedying a condition by means of cosmetic surgery (i) except for cosmetic surgery to remedy congenital conditions where such surgery is therapeutic, as well as cosmetic, or (ii) unless such condition is the result of accidental bodily injuries sustained while a covered individual or such surgery qualifies as reconstructive surgery, and both the surgery and the reconstructive surgery are essential and medically necessary.

4. Unless required by applicable law, charges incurred during confinement in a hospital owned or operated by the United States Government or any other agency thereof, charges for services, treatments, or supplies furnished by or for the United States Government or any agency thereof, and charges incurred during confinement in a hospital owned or operated by a state, province, or political subdivision unless there is an unconditional requirement to pay these last mentioned charges without regard to any rights against others, contractual or otherwise, or for work that is furnished or paid for because of service in the armed forces of any government.

5. Illnesses or injuries due to any act of war, including, but not limited to, any war declared or undeclared, and armed aggression resisted by the armed forces of any country, combination of countries or international organization, if the act occurs while the employee or eligible dependent is a covered individual.

6. Charges for services or supplies in excess of reasonable and customary fees therefore or in excess of such charges as would have been made in the absence of this plan, will not be covered.

7. Charges for medical examinations for "check up" purposes when not related to or necessary for the treatment of an illness, unless otherwise provided in this SPD or required to be covered by law.

8. In the case of a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of the network manager that results in the facilities, personnel, or financial resources of the network manager being unavailable to provide or arrange for the provision of a basic or supplemental health service or benefit in accordance with this plan, the benefits provided under the plan will be limited to the services and supplies that the network manager actually provides.

9. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

10. Benefits payable for abortions only apply to (a) abortions that are medically necessary; that is, where the life of the other would be endangered if the pregnancy continued and (b) medical complications arising from an abortion.

11. Mouth Conditions. Charges for physician services in connection with mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue, unless the charges are for treatment in connection with eligible dental surgical procedures.

12. Doctor services and shoes, in connection with weak, strained or flat feet, any instability or imbalance of the foot, or any metatarsalgia or bunion, unless the charges are for an open cutting operation or services provided by a Doctor of Medicine or a Doctor of Osteopathy.

13. Doctor services in connection with corns, calluses or toenails.

14. Expenses for confinement in any institution or any part of an institution that is not a hospital, convalescent extended care facility or hospice facility.

15. Intentionally self-inflicted injury or charges incurred for medical care resulting from the commission of or the attempt to commit a serious crime unless caused by a mental condition or domestic violence.

16. Completing claim forms or for missed appointments.

17. Personal comfort, convenience or entertainment items such as television or telephone use while hospitalized.

18. Custodial care, domestic services, or for care performed by non-professional medical personnel.

19. Charges for sterilization reversal procedures.

20. Artificial insemination, in-vitro fertilization, embryo transplants, gamete intrafallopian tube transfers, cost for sperm preparation or storage for artificial insemination or any surgical procedures to promote fertility.

21. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants) anorgasmia, and premature ejaculation.

22. Gender change, including hormonal therapy.

23. Hearing aids and examinations for the fitting of hearing aids; for the purpose of this exclusion, hearing aids shall include any service, procedure or device designed or intended to restore or enhance the patient’s ability to hear (including, but not limited to, audiant bone conductor, electro-magnetic and/or surgically implanted devices).

24. Radial keratotomy or other similar procedures to correct refractive vision errors.

25. Eyeglasses, contact lenses or examinations for prescription and fitting thereof other than as provided immediately following cataract surgery.

26. Counseling or behavior modification guidance relating to such things as smoking, weight control, etc.

27. Transportation by other than a professional ambulance service or hospital-based ambulance service.

28. Non-medical social services, recreational therapy, educational testing or services, or daily living training.

29. Private duty nursing care while confined in a hospital or nursing home.

30. Shoes of any type.

31. Stair glides, stair climbing equipment, ramps, elevators, air conditioners, purifiers or humidifiers.

32. Durable medical equipment while confined in a skilled nursing facility that is included in the daily room fee.

33. Membership costs or fees associated with health clubs and weight loss clinics.

34. Cardiac and pulmonary rehabilitation Phase III.

35. Routine newborn care of a well baby; well child care; or school physicals, unless specifically described as covered under the plan.

36. Elective abortions.

37. Any charges which the person is not legally obligated to pay and charges for services which would not have been made if no insurance existed or for which there is no cost to the person receiving them.

38. Clinical and investigational trials, experimental procedures, drugs and substances.

39. Artificial heart, lung, liver or pancreas or any other artificial organ or any associated expense.

40. Replacement of external prostheses due to wear and tear, growth, loss, theft or destruction; or for any biomechanical external prosthetic devices.

41. Separate and additional charges by a facility for wheelchairs and other medical equipment and supplies that are normally included in the daily charge to patients for all care, services and supplies.

42. Any expense that is not medically necessary.

43. Any expense not consistent with the standards of good medical practice that are generally accepted by the medical-scientific community in the United States.

44. Any expense not consistent with the symptoms or diagnosis of the condition for which services or supplies are rendered.

45. Any expense provided solely for the convenience of the patient or the provider.

46. Any expense not necessary for the diagnosis or correction of a condition that is threatening to the life, health or physical well-being of the covered person, or the source of extreme physical discomfort.

47. Plan provisions limiting benefits because of other insurance. Refer to the *Coordination of Benefits* section for further information.

48. State taxes charged for medical expenses that are the responsibility of the member, such as, but not limited to, deductible and co-insurance.

Dental Benefit Plan

The dental plan, which is administered by Delta Dental Plan of Tennessee, is a Preferred Provider Organization (PPO) designed to give you comprehensive benefits based on whether you use in-network or out-of-network dental providers. Employee premiums are required for coverage under the dental plan.

Two Delta Dental networks are available:

- The *Delta Premier PPO Network* is a large network with over 106,000 participating dentists nationwide. Premier Network dentists have agreed to a fee contract with Delta Dental to provide quality services at discounted rates.

- The *Delta Preferred PPO Network* is a network of over 40,000 participating dentists located in most areas of the country. Preferred Network dentists have also agreed to discounted fee agreements with Delta Dental. In many cases, the fees charged by the Preferred Network dentists will be lower than those charged by the Premier Network dentists.

Dental office visits and services are subject to a $20 co-payment. Applicable coinsurance and deductibles still apply.

- The *co-payment is waived* when you receive services from dental providers in Delta Dental's PPO (Preferred Provider) Network.

- You *will* have to pay the $20 co-pay when you receive services from a dentist in the Delta Dental Premier Network or a non-participating (out-of-network) provider. Coinsurance and deductibles still apply.

Participating providers will not bill you for amounts above what was paid to them by the dental plan. You are responsible for any applicable coinsurance and deductibles.

You may locate participating providers by calling Delta Dental at 800-223-3104, ext. 249 (or 615-255-3175 within the Nashville calling area) or by visiting the Delta Dental website at **www.DeltaDentalTN.com** and selecting either the Premier or Preferred network.

You may also choose to receive services from dentists who are not contracted with Delta Dental. The $20 co-pay also applies to services received from non-participating providers. Claims for non-participating providers are paid according to the prevailing fee in the geographic area and you may be billed for any amount beyond what is paid by Delta.

Eligibility

Employees and dependents as described in the *Eligibility and Participation* section of this SPD are eligible to participate in the dental plan.

Cost

Weekly premiums for dental coverage for 2014 are shown below and are subject to change thereafter.

Individual coverage $4.72
Family coverage..... $12.10

Covered Expenses, Limitations and Exclusions of the Dental Plan

Benefits are payable as shown in the Schedule of Dental Benefits.

Covered Expenses (limitations may apply)

- Two oral exams and cleanings in any calendar year.
- Following periodontal surgical procedures, the dental plan will pay for up to four maintenance procedures in two years.
- Full mouth x-rays once every three years, unless special need is shown.
- One set of bite-wing x-rays in a calendar year.
- One topical application of fluoride if under 19 years of age.
- Optional services (services that are more expensive than an alternative procedure that meets professional standards, e.g., an inlay when an amalgam filling would restore the tooth) but only up to the cost of the alternative procedure.
- If you transfer from one dentist to another during the course of treatment, benefits will be limited to the amount that would have been paid if only one dentist had provided the service.
- One restoration on any one surface of a tooth.
- Root canal treatment, including charges for x-rays and temporary restorations, limited to once in a five-year period.
- One periodontal surgical procedure per quadrant.
- Sealants (on unrestored, non-cavity biting surface of the maxillary and mandibular permanent first and second molars) for dependents under age 14, limited to one sealant application per tooth per lifetime.
- Composite fillings on the outside surfaces of the bicuspid teeth; amalgam filling in molar teeth and chewing surfaces of bicuspid teeth.
- Complete or partial dentures, including necessary adjustment within a six-month period; payment for a reline or rebase of a partial or complete denture is limited to once in a three-year period.
- Implants (artificial materials implanted into or on bone or gums) or their removal except for evidence-based dental benefit coverage.

- Orthodontia services, limited to dependent children up to age 19.

Evidence-Based Benefits

Your dental coverage also provides for evidence-based dental benefits. This coverage, based on scientific research, is meant to help improve the oral health of people with specific high-risk health conditions. Evidence-based benefits include:

- Coverage for endosteal implants (implants placed directly into bone like natural tooth roots).
- Additional dental cleanings (up to four cleanings per year) for:
  - Diabetics and pregnant women with periodontal disease,
  - Individuals with renal failure or on dialysis,
  - Individuals with suppressed immune systems, and
  - Head and neck radiation patients.

You must contact Delta Dental directly for approval before receiving evidence-based benefits.

Exclusions

- Root planing, curettage and osseous surgery for dependents under age 14.
- Treatment of injuries or illness covered by Workers' Compensation or employer liability laws.
- Services received without cost from any federal, state or local agency. This exclusion does not apply if prohibited by law.
- Topical application of fluoride if 19 years of age or older.
- Adult prophylaxis for a member under 14 years of age.
- Space maintainer for a member more than 14 years of age.
- Cosmetic surgery or procedures for purely cosmetic reasons.
- The replacement, by the same dentist, of amalgam or composite restorations within 12 months of the initial replacement.
- Services for congenital (hereditary) or developmental malformations. Malformations include, but are not limited to, cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth).
- Treatment to restore tooth structure lost from wear.
- Replacement of crowns, cast restorations, bridges or dentures received in the previous five years.
- Crown or cast restoration on a tooth that can be restored with an amalgam, composite, or plastic restoration.

- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or to stabilize the teeth.
- Any single procedure started before being covered under the dental plan.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in that facility.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
- Services by a dentist beyond the scope of his or her license.
- Dental services provided at no cost to you.
- Dental services for charges that are more than what would have been charged and actually collected if no coverage existed.
- A posterior bridge where a partial denture is constructed in the same arch.
- Temporary partial dentures if no anterior teeth are missing.
- Porcelain, gold or veneer crowns for children under age 12.
- Fixed bridges or cast partials for children under age 16.
- Stainless steel crowns if over age 12.
- Orthodontia treatment that began before the person is eligible under the dental plan or for dependents age 19 or older.
- Repair or replacement of orthodontic appliances.
- Any graft using synthetic materials.
- General anesthesia or intravenous sedation other than by a dentist properly licensed to administer general anesthesia in connection with covered oral surgical procedures.
- Missed appointments.
- Charges for completing claim forms or filing claims.
- Treatment of dental diseases or injuries resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government.
- Periodontal splinting (stabilization of mobile teeth).
- Appliances, restorations and procedures to alter vertical dimension.
- Services other than those specifically covered in the dental plan.

- Expenses covered under the Medical Plan or another medical benefits plan sponsored by the Company.
- Claims filed after 12 months from date of service.
- Prescription drugs.
- Treatment for desensitizing teeth, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

Payment, Claims, Predetermination and Other Provisions

Payment

Payment for services provided by a participating dentist is made directly to the provider. Payment for services provided by a non-participating dentist is made to you unless you assign benefit payments to the provider. Orthodontic benefits are paid monthly.

Claims

Delta Dental will give you or your dentist, on request, a standard claim form to make a claim for benefits. To make a claim, you and your dentist must both sign the completed form (you must sign if the patient is a minor) and send it to Delta Dental at the address shown on the claim form.

Claims must be filed within 12 months after treatment is completed for which benefits are payable. Any claim filed after this period will be denied.

Note: See the *Claims and Appeals Procedures* section for detailed information about your rights as a plan member.

Predetermination

Your dentist may submit a claim form before treatment showing the services to be provided for a predetermination of services. You should get a predetermination for expenses over $300.

Dental Schedule of Benefits

SCHEDULE OF BENEFITS	
DENTAL	
Calendar Year Maximum	**$1,500**
Annual Deductible *(applies to Basic and Major Services only)*	**$50 per person**
Co-Pay *(applies to services received from Premier network dentists and/or non-participating dentists. Co-pay is waived for services rendered by PPO network providers.)*	**$20 per visit**
Service	**Plan Payment***
Diagnostic and Preventive Services ▪ oral examination (2 exams during any calendar year) ▪ x-rays (covered as required but not more frequently than: 1 set of bite-wing x-rays during any calendar year; full mouth x-rays once every 3 years) ▪ prophylaxis (cleaning or periodic maintenance limit of 2 during any calendar year) ▪ fluoride treatment (covered not more than once in any calendar year for persons to age 19) ▪ space maintainers to age 14	**100%**
Basic Services ▪ oral surgery (surgical extractions) ▪ restorative (fillings) ▪ periodontics (treatment of gums and bones supporting teeth) ▪ endodontics (root canal therapy) ▪ general anesthesia (when medically necessary and administered in connection with oral surgery) ▪ simple extractions	**80%**
Major Services ▪ crowns ▪ bridges ▪ partial dentures ▪ full dentures ▪ implants	**60%**
Orthodontia ▪ Straightening of teeth for dependent children to age 19	**50% up to $1,000 lifetime maximum**
* *Payable benefits are based on the Maximum Plan Allowance (MPA). The MPA is based on fees charged in your geographic area. You are not responsible for charges over the MPA if you go to a participating dentist. You are responsible for charges over Maximum Plan Allowance if you go to a non-participating dentist.*	

Vision Benefits

The vision plan, administered by EyeMed Vision Care (EyeMed), provides coverage for eye examinations, lenses, frames and contact lenses for active employees and their eligible dependents. You may enroll for coverage after you have completed 31 days of continuous service (91 days of continuous service for New Hires).

Each covered person can get an eye examination once every 24 months and one set of eyeglasses or contact lenses once every 24 months.

Cost

Weekly premiums for vision coverage for 2014 are shown below.

Weekly Vision Premiums	
Individual coverage	$0.70
Employee + spouse	$1.60
Employee + child(ren)	$1.60
Family coverage	$2.80

Choosing a Provider

The EyeMed network panel of participating providers for Bridgestone is the Access network. When looking for a provider, select the Access network on EyeMed's website at **www.eyemedvisioncare.com**. You can also request a list of providers by calling the toll-free number for EyeMed at 866-723-0513.

You can get your vision care from either in-network (participating) providers or from out-of-network providers. If you receive services from an out-of-network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Schedule of Benefits minus the in-network co-pay amounts for vision exam and ophthalmic materials. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts, and send to: EyeMed Vision Care, Attn: OON Claims, P.O. Box 8504, Mason, Ohio 45040-7111. For your convenience, an EyeMed out-of-network claim form is available at **www.eyemedvisioncare.com** or by calling EyeMed's Customer Care Center at 866-723-0513.

Additional Purchases and Out-of-Pocket Discount

Under the plan, each covered person may receive benefits for either eyeglasses (frames and lenses) or contact lenses as outlined in the Schedule of Benefits. In addition to this coverage, EyeMed Vision Care provides a discount on products and services once your funded benefit has been used. The discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses

- 20% off items not covered by the plan at network providers.

Discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed providers' professional services, contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount policy.

The following services and supplies are not covered under the plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing,
- Aniseikonic lenses,
- Medical and/or surgical treatment of the eye, eyes or supporting structure,
- Corrective eyewear required by an employer as a condition of employment and safety eyewear,
- Services provided as a result of any Workers' Compensation law,
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount),
- Two pair of glasses instead of bifocals,
- Services or materials provided by any other group benefit plan providing vision care,
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of the order,
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available,
- Discounts on frames where the manufacturer prohibits discounts, including, but not limited to: Bvlgari, Cartier, Chanel, Gold & Wood, Maui Jim, and Pro Design,
- Applicable taxes,
- Visual Display Terminal (VDT) exam.

Claims

For claims address and other administration information, please refer to the *Plan Administration Summary section* in the back of this SPD.

Vision Schedule of Benefits

SCHEDULE OF BENEFITS		
VISION		
Vision Care Services *(once every 24 consecutive months unless noted otherwise)*	**Member Cost**	**Out-of-Network Reimbursement**
Exam with dilation, as necessary	$5 co-pay	Up to $60
Frames	80% of balance over plan allowance of $80	Up to $70
Standard Plastic Lenses:[1]		
Single vision	$15 co-pay	Up to $79
Bifocal	$15 co-pay	Up to $95
Trifocal	$15 co-pay	Up to $120
Lenticular	$15 co-pay	Up to $140
Standard progressive	$80 co-pay	Up to $50
Premium progressive	$80 co-pay plus 80% of balance over plan allowance of $120	Up to $50
Lens Options:	*(Member is responsible for expenses associated with selection of the following additional lens options)*	
Tint (solid and gradient)	$15	N/A
UV coating	$15	N/A
Standard scratch-resistance	$15	N/A
Standard polycarbonate	$40	N/A
Standard anti-reflective	$45	N/A
Other add-ons and services	20% off retail price	N/A
Contact Lenses:		
Fit and follow-up		N/A
Standard	Up to $55	
Premium	10% off retail	
Conventional	85% of balance over plan allowance of $120	Up to $120
Disposables	Balance over plan allowance of $120	Up to $120
Medically Necessary	Balance over plan allowance of $350	Up to $195
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional pricing	N/A

[1] *You are entitled to one pair of standard lenses per 12-month period if (i) there is a change in prescription of .50 diopter or more in one or both eyes; or (ii) a shift in axis of astigmatism of 20 or more degrees.*

Flexible Spending Accounts (FSA)

Overview of Flexible Spending Accounts

The Healthcare and Dependent (Day)Care Flexible Spending Accounts (HCFSA and DCFSA respectively) allow you to set money aside on a pre-tax basis to reimburse yourself for eligible health care and/or dependent daycare expenses that you anticipate you will spend during the plan year. It is important to plan carefully because IRS rules require that you forfeit any unused money in your account that you do not claim for reimbursement of eligible expenses.

The administrators for the Flexible Spending Accounts are BlueCross BlueShield of Tennessee (BCBST) and UnitedHealthcare (UHC), and are assigned by state. The state where you live will determine which company will administer your FSA.

Plan Year

For purposes of the flexible spending accounts, the plan year runs from January 1 through December 31. To participate each year, you must make an election during the annual open enrollment period. You have until March 31st of the following plan year to submit claims for reimbursement of expenses incurred during the current plan year.

Eligibility

You are eligible to participate in the FSAs once you have completed 30 days of continuous service. You do not have to be enrolled in a medical plan to participate in the HCFSA or DCFSA.

Your participation will begin the first day of the month following the month HR Shared Services receives your properly completed enrollment form.

Enrollment

You may enroll into either the HCFSA or DCFSA, or both, (subject to enrollment in the appropriate medical plan option as described) when you become eligible or during the annual open enrollment period (for the upcoming plan year). IRS regulations require that you make an active election to participate each year, whether you are a current participant or not. When you enroll, you will need to specify the monthly pre-tax amount you want to set aside through payroll deduction during the year into the account(s).

Changing or Canceling Your Account

Under federal law, you may not change or stop your contributions during a plan year unless there is a qualified change in:

- Your own or your spouse's employment status or,
- Your family status.

In addition, any change in, or discontinuation of, the amount you set aside must be consistent with the qualified status change.

Qualified changes in employment status that will allow you to change or discontinue your contribution include:

- A change in your work location requiring relocation of your residence, or
- Your spouse becoming employed or unemployed, or
- A reduction or increase in hours for you or your spouse.

Qualified changes in family status that will allow you to change or discontinue your contribution include:

- Marriage,
- Divorce,
- Birth or adoption, or placement of a child for adoption,
- Death of a spouse or child, or
- An event that causes your eligible dependent to meet or no longer meet eligibility requirements for a particular benefit.

Also, a change to your HCFSA election may be allowed in the following circumstances:

- A judgment, decree or order from a custody change, divorce, legal separation or annulment orders coverage of your eligible dependent child or requires that another individual (such as your former spouse) cover the child and the other individual in fact provides such coverage, or
- You or an eligible dependent become entitled to Medicare or Medicaid or lose eligibility for such coverage.

With respect to the DCFSA, you may also change your election if you have a change in your dependent daycare provider and/or the cost for service provided by a dependent daycare provider, who is not your relative, significantly increases or decreases.

Unless there is a status change as described above, you cannot make a change in the amount you contribute during the plan year. You will be required to continue your contribution even if you are no longer participating in the medical, vision or dental plan, or dependent daycare expenses are no longer incurred.

Your request for a change in, or discontinuation of, your contribution amount must be submitted within 31 days of the qualified status change, and it must be consistent with the change in family or employment status.

You cannot be reimbursed for health care expenses from your dependent daycare expense account and you cannot be reimbursed for dependent daycare expenses from your health care expense account. Also, you cannot move money from one account into the other account.

Events Affecting Participation

If Pay Stops

If your pay stops for any reason, your contributions will stop. If you are on disability leave *with* pay due to injury or sickness, your contributions will continue.

Account Status at Termination

If pre-tax contributions to your HCFSA stop due to your termination of employment, you may elect to continue to make contributions to your Healthcare FSA on a post-tax basis through the end of the calendar year. If you continue to contribute, you will be eligible for reimbursement for expenses incurred after your termination of employment through the end of the calendar year. See the *General Provisions* section for more information about COBRA. If you do not elect to continue contributions through the end of the year, any unused funds in your FSA accounts will be forfeited according to IRS guidelines. You have until March 31 of the following year to submit claims for expenses incurred before your participation ended.

Contact Information

Visit the administrator's website — either **myuhc.com*** or **bcbst.com** — to take advantage of the following features:

- View your Explanations of Benefits
- Utilize a savings calculator for the FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA claims summary including claim transaction details.

*Reference group #742736

Healthcare Flexible Spending Account (HCFSA)

It is important that you estimate your health care expenses very carefully. Under IRS rules, you will lose any funds left in your account after the claims filing deadline. The claims period is from January 1 through December 31 of the current year. This means that you may only be reimbursed from your HCFSA for the current year for eligible expenses incurred during the current claims period.

The maximum amount you can set aside in your HCFSA is $2,500 per year. The minimum amount you can designate to contribute to your account is $120.00 per year. Your designated contribution amount is deducted on a pro-rata basis from your pay on a *pre-tax* basis.

What Your HCFSA Reimburses

Your HCFSA may be used to reimburse yourself for the following healthcare expenses, along with the deductibles, coinsurance or co-payments related to these expenses. Any reimbursement you receive through your HCFSA cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

NOTE: Dependent healthcare expenses are eligible for reimbursement under the **Healthcare FSA *NOT*** under the DCFSA. **The DCFSA is for dependent *DAYCARE* expenses only, *NOT* for a dependent's healthcare expenses.**

Below is a partial list of the types of healthcare expenses eligible for reimbursement from your HCFSA. Generally, eligible healthcare expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation). A complete listing of eligible expenses can be found by calling 800-TAXFORM (800-829-3676), by visiting your claims administrator's website, or on the IRS website at **www.irs.gov/pub/irs-pdf/p502.pdf** (Publication 502).

Eligible Medical Expenses

- Copayments, coinsurance and deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;

- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, coinsurance and deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, coinsurance and deductible amounts;
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCFSA cannot be claimed as deductions on your income tax return.

How to Get Reimbursed for Eligible HCFSA Expenses

The entire annual amount you designate to contribute to your Healthcare FSA is available for reimbursement of eligible expenses at the beginning of the plan year. All eligible expenses must be incurred between January 1 and December 31 of each year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care. You are not allowed to carry forward funds from one calendar year to the next.

Automatic Reimbursement Claim Rollover (Auto-Rollover)

Eligible medical and prescription drug expenses that you are responsible for under the medical plan options are automatically submitted to your HCFSA for reimbursement. [You may opt-out of this feature by going to myuhc.com (for UHC members) or by calling BCBST customer service (for BCBST members)]. This feature eliminates extra paperwork and makes it more convenient for you to use your HCFSA. All claims must still be verified and the claims administrator may request additional substantiation.

The auto-rollover feature does not apply to dental or vision claims.

Paper Claim Submission

If you do not use the auto-rollover feature (or the feature does not apply to the service), you will need to submit a paper form to be reimbursed from your HCFSA for the eligible expenses that have been incurred. A reimbursement form can be found on the Bridgestone self-service portal or on the administrators' websites.

To be reimbursed from your HCFSA account for covered out-of-pocket expenses, you must include proof of the expenses incurred. Proof can include:

- An Explanation of Benefits (EOB) (original or photocopy) from the medical, dental, prescription drug or vision care plan along with an itemized invoice showing type of service or supply, date of service, total cost and patient's name,
- An itemized bill, invoice or receipt (original or photocopy) showing type of service or supply, date of service, total cost, and patient's name.

When submitting paper claims to UHC, you will be reimbursed for eligible expenses as long as the amount requested is at least $25 (except for reimbursements during the last month of the plan year). Amounts below $25 will be accumulated and processed with future payments. BCBST does not impose a minimum expense amount before processing payment.

You have until March 31 of the following year to request reimbursement from the prior year's account for qualified expenses that were incurred on or before December 31 of that year.

Any unused funds remaining in your account will be forfeited according to IRS rules.

Submit your HCFSA claims for reimbursement to:

For UHC members or those in UHC-assigned states	**For BCBST members or those in BCBST-assigned states**
Include group #742736 on your claim form	
Health Care Account Service Center	BCBST Claims Service Center

PO Box 981506
El Paso, TX 79998-1506

Fax: 915-231-1709
Toll Free Fax 866-262-6354

Customer Service 800-331-0480

1 Cameron Hill Circle STE 0022
Chattanooga, TN 37402-0022

Toll Free Fax: 888-666-1221

Customer Service: 800-565-9140

Reimbursements from the account will be made only to you. Reimbursable expenses will include expenses incurred by you and your eligible dependents. You can only claim expenses that were incurred while you are a participant in the FSA.

If you receive a reimbursement in error, you will have to repay the amount you were not entitled to.

Dependent (Day)Care Flexible Spending Account (DCFSA)

It is important that you estimate your dependent daycare expenses very carefully. Under IRS rules, you will lose any funds left in your account after the claims filing deadline. All eligible expenses must be incurred between January 1 and December 31 of each year. You are not allowed to carry forward funds from one calendar year to the next.

NOTE: The DCFSA is used for dependent daycare expenses, *NOT* for dependent healthcare expenses. Dependent healthcare expenses are reimbursable under the *HCFSA*.

The minimum annual amount you can designate to contribute to your account is $120.00. The maximum amounts are shown in the table below. Your designated contribution amount will be deducted on a pro-rata basis from your pay on a *pre-tax* basis.

If you are. . .	You can contribute up to. . .
Single	$5,000 per calendar year
Married, filing jointly and your spouse earns at least $5,000 per year	$5,000 per calendar year
Married, filing jointly and your spouse earns less than $5,000 per year	Your spouse's total earnings for the year
Married, filing a joint tax return and your spouse is a student or disabled	$250 per month (up to $3,000 a year) for one dependent or $500 a month (up to $5,000 a year) for two or more dependents
Married, filing separately	$2,500 per calendar year

What Your DCFSA Reimburses

This account may be used to reimburse yourself for "employment-related expenses" as described below on a pre-tax basis.

Dependent daycare expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13, or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for him/herself and lives with you for more than one-half of the year, or
- A dependent under federal tax law who is physically or mentally incapable of caring for him/herself who lives with you for more than one-half year and for whom you provide over one-half of his/her support for that calendar year.

Employment-Related Expenses

For any of these expenses to be eligible for reimbursement, they must be incurred to allow you or your spouse to work for pay outside the home. This also includes time used in looking for a job, as well as your spouse attending school, provided he/she is a full-time student for at least five months during the calendar year.

Eligible Expenses

Eligible dependent expenses include (if not otherwise excluded), but are not limited to the following. Expenses for:

- Care at a daycare center and daycare transportation,
- Licensed nursery school fees,
- Care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent,
- Care provided by a relative who cares for your qualified dependents, as long as that relative is over age 19 and is not your dependent under federal tax law, or
- Care at a day camp that you send your eligible children to during school vacations so that you and your spouse, if married, can work or attend school full-time, or
- Care for a qualified dependent over age 13, including a spouse or adult dependent, who is physically or mentally incapable of caring for him/herself. If you are claiming reimbursement for care outside your home for this type of dependent, the dependent must spend at least eight hours each day in your home.

A complete listing of eligible expenses can be found by calling 800-TAXFORM (800-829-3676) or by visiting the IRS website: **www.irs.gov/pub/irs-pdf/p503.pdf** (Publication 503).

How to Get Reimbursed for Eligible DCFSA Expenses

To be reimbursed from your DCFSA account for covered out-of-pocket expenses, you must include proof of the services rendered. An expense is considered incurred when services are provided, not when you are billed or when you pay for care. Proof can include a bill, receipt, or invoice, and must include the following information:

- Your name,
- The nature of the expense or service,
- The amount of the expense or service,
- The name of the person for whom the expense or service was incurred,
- The name of the person or organization to whom the amount was or is to be paid,
- The date the expense or service was incurred.

The name, address, and Social Security number (or taxpayer identification number) of your day-care provider is also required. However, exceptions are available for church or charitable organizations under Section 501(c)(3) of the Internal Revenue Code.

When submitting a claim to UHC, you will be reimbursed for eligible expenses as long as the amount requested is at least $25 (except for reimbursements during the last month of the plan year). Amounts below $25 will be accumulated and processed with future payments. BCBST does not impose a minimum expense amount before processing payment.

The amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

For the DCFSA, if your employment terminates, you can continue to request reimbursement for eligible dependent daycare expenses incurred until the date your DCFSA balance is exhausted, or the end of the plan year following your employment termination, whichever comes first. The dates of service must fall within the calendar year in which the DCFSA is established.

You have until March 31 of the following year to request reimbursement from the prior year's account for qualified expenses that were incurred on or before December 31 of that year.

Any unused funds remaining in your account will be forfeited according to IRS rules.

Submit your DCFSA claims for reimbursement to:

For UHC members or those in UHC-assigned states
Include group #742736 on your claim form

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

Fax: 915-231-1709
Toll Free Fax 866-262-6354

Customer Service 800-331-0480

For BCBST members or those in BCBST-assigned states

BCBST Claims Service Center
1 Cameron Hill Circle STE 0022
Chattanooga, TN 37402-0022

Toll Free Fax: 888-666-1221

Customer Service: 800-565-9140

Reimbursements from the account will be made only to you. You can only claim expenses that were incurred while you are a participant in the FSA.

If you receive a reimbursement in error, you will have to repay the amount you were not entitled to.

Tax Facts

Dependent (Day)Care Flexible Spending Account vs. Federal Income Tax Credit

For some people, the federal income tax credit may save more money in taxes than the Dependent (Day)Care FSA. When you use the federal income tax credit, you take a credit on your federal income tax return at year-end. You cannot use expenses reimbursed through your DC FSA to claim the tax credit.

You should consult your tax advisor for help to determine whether to contribute to the Dependent (Day)Care FSA or take the income tax credit.

Claims and Appeals Procedures

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call the company that administers your FSA — either BlueCross BlueShield of TN or UnitedHealthcare — before requesting a formal appeal to try to resolve the issue over the phone. However, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- The patient's name and ID number as shown on the ID card;
- The provider's name;
- The date of medical service;
- The reason you think your claim should be paid; and
- Any documentation or other written information to support your request.

You or your dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
ATTN Appeals
P.O. Box 981512
El Paso, TX 79998-1512

BlueCross BlueShield of Tennessee
ATTN Consumer Guidance Claims 3.3
1 Cameron Hill Circle
Chattanooga TN 37402

Review of an Appeal

The administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if the administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

This plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Bridgestone Benefits Appeals Board ("Appeals Board") within 60 days from receipt of the first level appeal. Bridgestone must notify you of the benefit determination within 30 days after receiving the completed appeal (or 60 days if special circumstances exist).

When a written appeal is received regarding the denial of a Healthcare FSA expense, the Appeals Board, or its designee, will in addition provide you with the name of any medical experts the program consulted in making its original determination. The review will be conducted by a named fiduciary of the program who is not the individual, or the subordinate of the individual, who made the original adverse determination.

If the adverse determination was based, in whole or in part, on a medical judgment, the fiduciary reviewing the claim on appeal will consult with an appropriate health care professional. The medical professional will not be an individual, or a subordinate of an individual, who was consulted with in the first determination of the claim.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Bridgestone will review all claims in accordance with the rules established by the U.S. Department of Labor. The Appeals Board's decision will be final.

The table below describes the time frames in an easy to read format which you and the administrator are required to follow.

Claim Denial and Appeals	
Stage of Claim or Appeal	**Timing**
If your claim is incomplete, Administrator must notify you within:	**30 days**
You must then provide completed claim information to Administrator within:	**45 days** after receiving an extension notice*
If Administrator denies your initial claim, they must notify you of the denial:	
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal (60 days in special circumstances)
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
Bridgestone must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*The Administrator may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Notification of Determination on Review

The Board or its designee will make a determination on review and will provide written notification to you of the determination on review no later than 60 days after receiving your review request. For a DCFSA claim appeal, if, due to special circumstances, the program fiduciary cannot make a determination within 60 days after receiving your review request, up to an additional 60 days can be added to make a determination on review. If the 60 day extension is needed, you will be notified why the extension is required and the date the program expects to make a decision.

If your claim is denied on appeal, the notice of determination on review will contain the reasons for the denial, reference to the specific program provisions on which the benefit determination is based, a statement that you can receive, upon request and free of charge, reasonable access to and copies of all documents and other information related to the claim, and a statement describing your right to file a civil action under Section 502(a) of ERISA. In addition, if the notice involves an HCFSA claim for reimbursement, the notice will also include the specific internal rule, guideline, protocol, or similar criterion, if any, that was relied upon in making the adverse determination, a statement that a copy of the same is available to you free of charge upon your written request and, if a denied claim is based on medical necessity, experimental treatment, or similar limit, a statement explaining the scientific or clinical judgment of the determination and applying the terms of the program to your medical circumstances, or a statement that the explanation will be provided to you free of charge.

Employee Assistance Program (EAP)

The Employee Assistance Program is available to you as an active employee, whether or not you are enrolled in a medical plan.

The EAP is a service provided by Aetna Resources For Living (Aetna RFL), offering confidential assistance to help you deal with the challenges of daily living, such as stress, depression, substance abuse, marital or family problems. It also provides referrals to special community resources to help you deal with financial, eldercare, childcare or legal concerns. You can receive unlimited telephonic counseling and up to five face-to-face counseling sessions at no cost.

Staffed by licensed professional counselors, the EAP is the first step in getting the help you need, and Aetna RFL can help you with solutions and support for a variety of concerns including (but not limited to):

- Handling stress
- Finances
- Childcare or eldercare
- Emotional problems, such as depression or anxiety
- Marriage and family relationships
- Dealing with grief and loss

Call Aetna Resources For Living
800-678-2212 • www.rfl.com

Additional Treatment

If you need additional help with substance abuse or mental health issues after your EAP benefit ends, the EAP counselor can help coordinate your care with your medical provider.

Non-Occupational Accident and Sickness Benefits (A&S)

Eligibility for Coverage

You are automatically enrolled in this coverage after 30 days of credited service if you are a regular employee, and after one year of credited service if you are a New Hire, as long as you are actively at work on that date or the first day thereafter.

If you are re-employed with credit for prior service, your coverage will be reinstated immediately.

Benefit Amounts

If you were hired before April 26, 2007, the amount of the weekly benefits will be 18 hours times the current wage rate or the benefit shown in the following table, whichever is greater. For example, if you earn $17.00 an hour, your weekly benefit amount would be $350. (18 hours x $17 an hour equals $306, which is lower than the benefit shown in the chart below, so you would receive the benefit amount listed in the chart, which is $350.)

Average Hourly Earnings	Weekly Benefit Amount
Up to $15.99	$320
$16.00 - $18.50	$350
$18.51 - $20.99	$390
$21.00 or more	$420

The term "average hourly earnings" means the straight time average hour earnings for the employee during the most recent pay period in which he/she worked in their regular classification and is calculated by dividing the total hours worked in the total straight time earnings.

If you were hired after April 26, 2007, once you become eligible for non-occupational accident and sickness benefits, the amount of weekly benefits is calculated by multiplying 18 hours times your current wage rate.

Employees off work due to injury or illness will continue to be covered during the period they accumulate seniority. Weekly benefits will be reduced for each week beyond 21 weeks of benefits during any one continuous period of disability by the amount of:

- Pension that the employee is eligible for, and
- Any primary disability or reduced/unreduced old age benefits under Social Security that the employee is entitled to, when paid to the employee for the same week of benefits.

Benefits will be payable for an accident or sickness not covered by Workers' Compensation from the fourth day of disability, the second normal working day missed or the first day of hospitalization, whichever is later. Benefits will also be payable from the first day of disability due to outpatient surgery and for one day of outpatient testing before your hospitalization.

Benefits will be paid for the duration of the disability, up to a maximum of 52 weeks for each period of disability, with the exception of New Hires, who are eligible for 26 weeks of A&S in a rolling 52-week period and are not eligible for the 52 weeks' benefit duration, even after completing five years of service. To receive benefit payments, you must be under the care of a licensed physician. Physician assistants and nurse practitioners working under the supervision of your doctor can certify your disability and complete the claim forms.

Periods of disability due to the same cause will be considered the same period of disability unless separated by return to full-time work for at least two weeks. Periods of disability due to different causes will be considered different periods of disability if separated by return to full-time work.

Layoff and Leave of Absence

In the event of a layoff, coverage will be continued for 90 days following layoff.

During an authorized leave of absence (excluding military service), coverage will be continued for up to 90 days.

Termination of Coverage

All coverage will terminate when employment with the Company and its affiliated companies terminates, except as described in the *Layoff and Leave of Absence* section.

Life Insurance, Accidental Death & Dismemberment (AD&D) and Survivor Income Benefits

Life Insurance Provided by BATO

Basic life insurance provides a benefit payable to your designated beneficiary upon your death. Accidental death and dismemberment insurance is also provided. Your beneficiary is the person designated by you on your current enrollment form on file with Bridgestone or the Metropolitan Life Insurance Company (MetLife).

You are eligible for basic life insurance, accidental death and dismemberment (AD&D) insurance and survivor income benefits as a full-time employee after 30 days of credited service. If you are a new hire (hired after October 1, 2005), you are eligible for this benefit after 90 days of credited service.

Basic Life Insurance

The basic life insurance benefit, payable to your beneficiary, is $50,000.

Basic life insurance will be provided to retirees who retire on a normal, early or disability pension. If you retired before May 9, 2001, the basic life insurance benefit will be reduced to $3,000. The reduction takes place over a 30-month period; meaning, at the end of this 30-month period, you will have $3,000 worth of life insurance. If you retire after May 9, 2001, the amount of basic life insurance in force at retirement will be reduced to $5,000, payable in equal monthly installments.

Accidental Death and Dismemberment Insurance (AD&D)

This benefit will be paid to your beneficiary if, while insured, you suffer any of the losses described below solely as the result of accidental injury. Accidental injury is one that occurs solely through external, violent and accidental means. The accidental death and dismemberment benefit of $50,000 will be paid to your beneficiary if you die from an accidental injury either on or off the job.

No more than your amount of insurance will be paid for all losses incurred during your lifetime.

Covered Losses	Principal Sum
Loss of life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%
Loss of sight means permanent and uncorrectable loss of sign in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.	
Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of same hand	25%

Covered Losses	Principal Sum
Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.	
Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%
Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.	
Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.	
Paralysis of both arms and both legs	100%
Paralysis of both legs	50%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%
Paralysis means loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.	

Only one amount, the largest to which you are entitled, is paid for all losses resulting from one accident.

Loss of sight means total and irrecoverable loss of sight. Loss of limb means loss of hand or foot by severance, at or above the wrist or ankle. Loss also means partial loss if the resulting handicap is equivalent to the entire loss of the hand, foot, or eyesight.

The death benefits will be paid to your beneficiary, and the dismemberment benefits will be paid to you.

Seat Belt/Airbag Benefit

If you or a dependent dies in an automobile accident while wearing a seat belt or in a car equipped with airbags (properly inflated), an additional benefit equal to 10% of the coverage amount (to a maximum of $10,000) will be paid. The minimum payment is $1,000.

Exclusions

No loss is covered as an accidental death or dismemberment if it results directly or indirectly from:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity,
- Infection, other than infection occurring in an external accidental wound,
- Suicide or attempted suicide,
- Intentional self-inflicted injury,
- Service in the armed forces of any country or international authority, except the United States National Guard.
- Any incident related to:

- Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger,
- Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight,
- Parachuting or otherwise exiting from an aircraft which such aircraft is in flight, except for self-preservation,
- Travel in an aircraft or device used
  - For testing or experimental purposes,
  - By or for any military authority, or
  - For travel or designed for travel beyond the earth's atmosphere,

- Committing or attempting to commit a felony,
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is:
    - Taken or used as prescribed by a physician, or
    - An "over the counter" drug, medication or sedative taken as directed
  - Alcohol in combination with any drug, medication, or sedative, or
  - Poison, gas, or fumes,
- War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Conversion

If you are terminated or laid-off, you can convert all or part of your group life insurance to an individual policy issued by MetLife without evidence of insurability. You must apply and pay your premium within 31 days of the termination of insurance.

Survivor Income Benefits

Survivor Income Benefits include two types of benefits:

- Transition Survivor Income Benefits, and
- Bridge Survivor Income Benefits.

Transition Survivor Income Benefit

Transition Survivor Income Benefits are payable to eligible survivors for up to two years following the death of an employee.

Three kinds of survivors may be eligible to receive Transition Survivor Income Benefits:

1. Your dependent spouse, if you have been married for at least one year (Class A Survivor).

2. Your unmarried child under age 21; or at least age 21 but under age 25 if dependent upon and living with you; or over 20, if totally and permanently disabled and dependent upon and living with you (Class B Survivor).

3. Your parent for whom you provided at least 50% support during the calendar year immediately preceding your death (Class C Survivor).

If you die while employed, your spouse will receive a monthly benefit of $600 (subject to reduction as described below) for up to two years. If you have no spouse, the benefit will be paid to your child or children. If you have no spouse or children, the benefit will be payable to your parent or parents. If you have more than one child or parent, the benefit will be equally divided among children or among parents.

The Transition Benefit will not be paid to any survivor age 62 or over or who is eligible for an old age, disability, widow's or widower's unreduced Social Security benefit.

Bridge Survivor Income Benefit

Bridge Survivor Income Benefits are payable to the eligible surviving spouse of an employee who died at age 45 or older.

If you die after age 45 while employed, your spouse, if any, will be eligible to receive a monthly bridge benefit of $600 (subject to reduction as described below) beginning with the 25th month after your death, and ending if and when your spouse remarries, dies, reaches age 62 or, if younger, receives full widows’ or widowers’ insurance benefits under the federal Social Security Act. No bridge benefit is payable if the survivor receives a Mother’s Insurance Benefit under the Federal Social Security Act. If there is no spouse, no bridge benefit is payable.

Benefit Reduction

Bridge and transition benefits payable to a spouse will be reduced by the amount of the Pre-Retirement Qualified Joint and Survivor Benefit payable to the spouse under the pension plan. However, the benefits will not be reduced below $400 per month.

Optional Life Insurance

Optional Contributory Life Insurance

The optional contributory life insurance program remains in effect for those enrolled in the program as of April 22, 1991, who maintained continuous coverage. You may not change the persons covered or the amount of coverage. You can cancel your coverage at any time but cannot re-enroll for coverage. MetLife issued individual insurance certificates for those enrolled in the plan.

Your beneficiary for optional contributory life insurance is the same as for basic life insurance.

Optional contributory life insurance will end on the earliest of (1) retirement, (2) termination of employment or (3) failure to authorize or make monthly premium payments.

Optional Group Universal Life Insurance

The optional group universal life insurance program remains in effect for only those who remain enrolled in the program as of January 1, 2006. You may cancel coverage at any time but cannot re-enroll for coverage.

Supplemental Life Insurance

Supplemental life insurance provides a benefit payable upon your death or upon the death of a covered dependent.

This section of the Summary Plan Description describes the features of supplemental life insurance. All benefits are subject in every respect to the terms of the Group Policy issued by the Metropolitan Life Insurance Company (MetLife).

Employee Coverage

You may enroll within 31 days from date of eligibility without evidence of insurability. If you enroll later than 31 days from your eligibility date, you may be required to submit evidence of insurability at your own expense. When you enroll, premiums are deducted, on a post-tax basis, automatically through payroll deduction.

You may elect coverage of $25,000, or, subject to application and approval by the carrier, you may elect $50,000 or $75,000 coverage.

Benefits are payable from any cause of death while you are insured, except for suicide within the first two years (one year in North Dakota) of the effective date of coverage or benefit increase in coverage.

Dependent Coverage

You may enroll your spouse for $10,000 benefit coverage, or for either $20,000 or $30,000 subject to application and approval by the carrier. You do not need to be enrolled for supplemental life insurance to obtain coverage for your spouse.

Eligible dependent children can be enrolled for coverage if you or your spouse is enrolled for Supplemental Life Insurance and the child(ren) is at least 14 days old. The benefit amount is

$5,000. Coverage will continue until the child turns 19 years of age, or until age 25 if the child is dependent upon you for support, is a full-time student, or is mentally or physically incapacitated.

Dependents can be enrolled without evidence of insurability if enrolled within 31 days from the date they are eligible for dependent coverage. If enrolled after 31 days from their eligibility date, evidence of insurability may be required at your own expense.

Accidental Death Benefit

You can elect an Accidental Death Benefit for yourself and/or your spouse that will pay an additional benefit equal to the current Supplemental Life Insurance amount if death is due to an accident. This coverage is available until age 65.

Cost

Your premiums for supplemental life insurance are based on age and the benefits you elect.

2014 – 2017 Supplemental Life Insurance Monthly Rates for each $1,000 of Coverage *Rates Applicable to Both Employee and Spouse Coverage*		
Employee/Spouse Age	**Without Accidental Death Benefit**	**With Accidental Death Benefit**
Under age 25	$ 0.089	$ 0.114
25-29	0.097	0.123
30-24	0.104	0.130
35-39	0.129	0.155
40-44	0.196	0.224
45-49	0.302	0.329
50-54	0.517	0.545
55-59	0.840	0.867
60-64	1.462	1.489
65-69	2.159	N/A
Rates for age 70 and older are available from the carrier upon request. *Add $1.205 per month for $5,000 of coverage for all eligible children. Only one premium is required, regardless of the number of children covered.*		

Termination of Coverage

Supplemental life insurance coverage will end if you do not pay required premiums.

Claims and Appeals

You must contact MetLife directly at 866-492-6983 if you have a claim.

See the *Claims and Appeals Procedures* section for detailed information about your rights as a plan member.

Pension Plan

Eligibility and Participation

Except as otherwise provided in this section, you are eligible to participate in and accrue benefits under the pension plan while you are accumulating seniority under the applicable collective bargaining agreement if you have completed at least one year of credited service.

However, if you are a Post-2008 employee, the amount of any pension or other benefits you earned under the pension plan was frozen as of December 31, 2013. Post-2008 employees do not receive credited service for any period after December 31, 2013 for purposes of determining the amount of their pension or any other benefits payable to them. Post-2008 employees will receive credit for periods of service after that date for vesting or pension eligibility, but only with respect to their pension or other benefits earned as of December 31, 2013. The term “Post-2008 employee” means an employee whose date of hire, date of rehire or date that he or she otherwise became a member of a bargaining unit covered under the pension plan is on or after January 1, 2009, and who, as of December 31, 2013, does not have a vested right to a pension under the pension plan.

However, no employee who is hired, rehired or otherwise becomes a member of a bargaining unit on or after January 1, 2014 is eligible to participate in the pension plan.

Normal Retirement

Eligibility

You may retire and begin receiving a normal retirement pension at any time after your attainment of age 65 if you are then an active employee and were hired before age 60. If you were hired on or after age 60, you may retire and begin receiving a normal retirement pension at any time after the fifth anniversary of the date you were hired.

Amount – Master Agreement

For retirements after August 8, 2013

The monthly amount of normal retirement pension will be $58 multiplied by your years of credited service, offset by the account value of Employer contributions to your 401(k) plan.

Amount – Bloomington Agreement

For retirements after August 8, 2013

The monthly amount of normal retirement pension will be $58 multiplied by your years of credited service, reduced by $20.00 times your years of credited service with the Employer before October 4, 1987, and offset by the account value of Employer contributions to your 401(k) plan.

Amount – Warren Agreement

For retirements after August 9, 2013

The monthly amount of normal retirement pension will be $58 multiplied by your years of credited service under the Bridgestone salaried employees' retirement plan as of September 30, 2000 (provided the amount is not less than your accrued monthly pension under that plan) plus $58 times your years of credited service after September 30, 2000.

Early Retirement

Eligibility

You may retire and begin receiving an early retirement pension if you are over age 55 but under age 65 and have 10 or more years of credited service; or if you have at least 30 years of credited service, regardless of age.

Amount

The monthly amount of your early retirement pension is computed in the same manner as a normal retirement pension based on the date of your early retirement and your years of credited service at date of early retirement. If you have 30 or more years of credited service or are age 62 or over, the benefit amount will not be reduced. If you have less than 30 years of credited service and are under age 62 the benefit amount is reduced by 4/10 of 1% for each month between your early retirement pension commencement date and age 62.

Special Early Retirement

If you retire with 30 or more years of credited service and are then between the age 55 and the age you become eligible for 80% of your Social Security benefit, you may be eligible to receive an additional amount added to your monthly benefit, based on your age and credited service at retirement.

The temporary supplemental amount will be payable until you become eligible for 80% of Social Security benefits, become eligible for Social Security disability benefits, or die, whichever is earliest.

When you become eligible for 80% of Social Security benefits, or Social Security Disability benefits, your pension will be adjusted to equal the benefit amount payable under early retirement.

Disability Retirement

Eligibility

You may retire with a disability retirement pension if you have completed at least 10 years of credited service and thereafter (but before age 62) become totally and permanently disabled, through some unavoidable cause, while accumulating seniority. You must be totally disabled for at least five consecutive months to qualify. Post-2008 employees are not eligible for a disability retirement pension.

Disability pension payments cease if, before age 62, you are no longer totally and permanently disabled.

Amount

The monthly amount of your disability retirement pension is calculated in the same manner as a normal retirement pension.

Upon application for a disability retirement pension, you must also make application for a Social Security Disability benefit and take reasonable and necessary action, including a request for reconsideration if you receive an initial denial, in order to assure proper consideration of such application.

If your application for a Social Security Disability benefit is denied, you will receive an additional $1,000 a month; however, this additional amount will not be greater than the Social Security amount you would have received if your application had not been denied. If, prior to attaining age 62, you become eligible for a Social Security benefit unreduced for age, the additional monthly benefit described in this paragraph will cease.

Your disability retirement pension will cease when you become eligible for 80% of the unreduced primary Social Security benefit (at which time you will be eligible for a normal retirement pension based on the pension multiplier in effect on the date your disability pension began and your years of credited service at that date).

If you die prior to age 65, Survivor's Benefits may be applicable.

Deferred Vested Pension

Eligibility

If you terminate employment with at least five years of credited service, you will be entitled to a pension beginning at your normal retirement date. If you have at least ten years of service, you will be entitled to a reduced pension beginning at or after age 55. However, effective November 1, 2013, if the total actuarial present value of your Deferred Vested pension is $100,000 or less, you may elect to have it begin on the first day of any month within the first six months of your termination of employment. You must make your election during this same timeframe to have your Deferred Vested pension begin during this period.

You should apply for your Deferred Vested pension during the period beginning 180 days before the date on which you want the benefit to start.

Amount

The monthly amount of your Deferred Vested pension is computed in the same manner as a normal retirement pension based on your credited service at the time of your termination of employment. Pensions beginning before age 65 will be actuarially reduced.

Survivor Benefits

The Pre-Retirement Surviving Spouse Pension Benefit

The Pre-Retirement Surviving Spouse Pension Benefit can provide a lifetime monthly benefit to a qualified surviving spouse of a vested active employee who dies before retirement or a terminated vested employee who dies before his or her pension begins. You are qualified for this benefit if you have five or more years of credited service.

A spouse is qualified for the benefit if married to the employee at the time of death and for at least one year before the employee's death.

If You Die as an Active Employee Who Is Eligible for Early Retirement

The amount of the monthly benefit payable to your surviving spouse will be the same as that which would have been payable to your spouse had you elected a 50% Qualified Joint and Survivor Benefit (described below) and retired on the day before your death.

The Pre-Retirement Surviving Spouse Pension Benefit will not include any supplemental amount which would have been payable to you until age 62 under the Special early retirement Benefit provision. Any such supplemental benefits are payable only to you.

If You Die as a Vested Active Employee but Not Eligible for Early Retirement

If you die while still an active employee but before your 55th birthday and before accruing 30 years of credited service, the amount of monthly benefit payable to your surviving spouse will be the same as that which would have been payable to your spouse if you had separated from service on the date of your death, survived to the date first eligible for pension commencement, elected to begin a Deferred Vested pension with a 50% Qualified Joint and Survivor Benefit and died the following day. The monthly benefit payable to your spouse begins when you would have reached your normal retirement date. The spouse may elect that an actuarially reduced benefit begin before normal retirement date.

If You Die as a Vested Former Employee

If you die on or before your 55th birthday, the amount of monthly benefits payable to your surviving spouse will be the same as that which would have been payable to your spouse if you had survived to age 55, elected to begin a Deferred Vested pension with a 50% Qualified Joint and Survivor Benefit and died the following day. The monthly benefit payment to your spouse begins when you would have reached your normal retirement date, or at such earlier date as your spouse elects to have monthly payments begin.

If you die after reaching age 55 (and before any pension payments are to begin), the amount of monthly benefit payable to your surviving spouse will be the same as that which would have been payable to your spouse if you had elected to begin your Deferred Vested Pension with a 50% Qualified Joint and Survivor Benefit and died the following day. The monthly payment to your spouse begins the first of the following month you would have reached normal retirement age had you not died, or at such earlier date as your spouse elects to have monthly payments.

Lump Sum Payment of Survivor Benefit

A Pre-Retirement Surviving Spouse Pension Benefit will be paid in a lump sum if the present value of the Benefit is $5,000 or less. Further, effective on an after November 1, 2013, a surviving spouse may elect to receive the entire present value of the Pre-Retirement Surviving Spouse Pension Benefit in a lump sum payment if the present value of the Benefit is less than or equal to $100,000. This lump sum payment option is only available if the election is filed with the Pension Board, and the payment is made, within six months of the Employee's death.

Post-Retirement Survivors' Benefits

Post-Retirement Qualified Joint and Survivor Benefit

If you have a qualified spouse when your pension commences, your benefits will be paid as a 50% or 75% (as elected by you) Qualified Joint and Survivor Benefit with your spouse as your "joint annuitant" *unless you and your spouse elect in writing not to receive the benefit in this form and, if applicable to have the benefit paid in one of the optional forms of benefit described below. Your spouse's signature must be notarized, indicating that he or she agrees to waive the protection.* Your spouse is a qualified spouse if you were married before your retirement and remained married for at least one year. This form of benefit pays a reduced pension to you for life, but provides that monthly payments equal to 50% (or 75% if elected by you) of your reduced pension will continue after your death to your surviving spouse for the rest of his or her life. Your monthly pension is reduced effective with the date of your retirement and there is no minimum number of payments made.

Under The Five Year Term Certain Benefit, if you and your spouse (if you are married) waive the Post-Retirement Qualified Joint and Survivor Benefit, you elect no other option, and you die before you receive 60 monthly pension payments, your beneficiary will receive the remainder of the 60 payments.

If you and your spouse waive the Post-Retirement Qualified Joint and Survivor Benefit, and you are eligible for a normal or early retirement pension, you may elect one of the following payment options The provisions of the elected option determine the amount payable after your death.

Contingent Annuity Options result in a reduced pension for you, but provide that monthly payments equal to 100% or 50% of your reduced pension, as you select, will continue after your death for the rest of the life of the person you have named as your contingent annuitant. If you choose this option, there is no reduction in the monthly pension for the first 60 months.

Contingent Annuity Pop-Up Options result in a reduced pension for you, but provide that monthly payments equal to 100% or 50% of your reduced pension, as you select, will continue after your death for the rest of the life of the person you have named as your contingent annuitant. If the contingent annuitant dies before you, your pension will "pop up" to the original pension, adjusted for any cost for this option.

The Extended Years Certain Option results in a reduced pension for you, but provides that your reduced monthly payments will continue after your death for the remainder of the "period certain" following the effective date of your option. You may elect a "period certain" of 10, 15 or 20 years. The continuation of payments will be made to whomever you name as your beneficiary. If you choose this option there is no reduction in the monthly pension for the first 60 months.

Note: For disability retirement, the *Pre-Retirement* Qualified Joint and Survivor Benefit provisions are applicable until the earlier of your normal retirement age, or the cessation of your permanent and total disability. Upon attainment of normal retirement age, or retirement following the cessation of your permanent and total disability, the *Post-Retirement* Qualified Joint and Survivor Benefit provisions and the optional forms of benefit described above are applicable. In order to elect the Post-Retirement Qualified Joint and Survivor Benefit or any of the other options upon disability Retirement, you must first waive the Pre-Retirement Qualified Joint and Survivor Benefit. For disability retirement before age 55 with less than 30 years of service, the Contingent Annuitant Option or Years Certain and Life Option do not become effective until age 55. If you have 30 or more years of service, the elected option is effective upon retirement date.

Lump Sum and Optional Lump Sum Payment

Effective on and after November 1, 2013, with your spouse's consent, you may elect, before beginning your Normal, Early or Deferred Vested Pension, to receive your entire pension in the form of a single lump sum payment equal to the actuarial equivalent present value (determined at the time of payment) of your pension amount that would be payable at your normal retirement age. This lump sum option is not available to you if (a) you are eligible for and elect to receive a disability pension, (b) your pension has an actuarial equivalent present value of more than $100,000, and/or (c) your pension payment is not made within six months of your termination of employment.

If the single sum value of any benefit you are entitled to is $5,000 or less and no other special distribution or severance award is made, you will receive that benefit as a single sum.

General Provisions of the Pension Plan

Official Plan Documents

This Summary Plan Description describes only the highlights of the pension plan. Benefits under all of Bridgestone's employee benefit plans are determined under and governed by the official Plan documents, which include the Pension and Insurance Agreement applicable to collectively bargained employees. If there is any conflict between the description presented in this Summary and the official Plan documents, the Plan documents will govern. Copies of the Plan documents may be obtained, at a reasonable cost, from the Pension and Benefits Department, Bridgestone Americas, Inc., 10 East Firestone Blvd., Akron, Ohio 44317.

Application for Pension

To receive any pension or to elect an option, you must make an application in writing to the Appeals Board ("Board") on a form provided by the Board. You must also furnish any certificates and other evidence as may reasonably be required. Application must be made within the 180-day period preceding the month in which you intend to begin receiving benefits. If you are eligible for a Deferred Vested pension, you should contact the Company at least 90 days before the month you intend to begin receiving benefits.

Benefits will begin in the month after the month in which the application was completed, if you are eligible. If you do not make an application, benefits to which you are entitled will begin not later than two months after the end of the plan year in which your 65th birthday occurs (unless you work beyond age 65).

Deductions for Other Benefits

Your benefit under this plan may be reduced because of certain benefits payable after retirement under any other Company pension plan.

Recovery of Overpayments

If you receive an overpayment from the plan, the plan reserves the right to recover the overpayment by reducing future benefit payments, recovering the overpayment directly from you or taking any other means available under applicable law to recover the overpayment.

Plant Closure

In the case of a total or partial plant closure, if you have 23 or more years of credited service, or are age 55 or older and have five or more years of credited service, you will be entitled to an immediate unreduced pension based on the normal retirement benefit. If you have three or more years of credited service and are ineligible for a pension, you may receive a severance award. If you have five or more years of service, you may elect (with your spouse's consent, if you are married) a special distribution within 120 days after your employment ends.

Break In Service

For purposes of determining your eligibility for a Deferred Vested pension based on your seniority in one or more of the local plants, all your continuous service with any location of BATO or an affiliated company will be included. If you have a "break in service" (that is, you are neither accumulating seniority in one of the local plants nor working at some other location for BATO or an affiliated company) before you become eligible for a Deferred Vested pension and you return to work, your service before your "break" will count if the period of your absence is not longer than your service accumulated before your break in service or if the period of your absence is less than five years. Once you have satisfied the requirements for vesting any future accrual of benefits will also be vested.

If a retiree is rehired as an active employee, his or her pension payment will be suspended while working and then recalculated to include total qualified service upon subsequent retirement.

Post-2008 Employees do not receive credited service for any period of time after December 31, 2013 for purposes of determining the amount of any pension or other benefit payable, but will receive credit for periods of service after that date for purposes of vesting in or eligibility for a pension accrued as of December 31, 2013.

Payment to Surviving Spouse or Estate

If you retire on or after August 8, 2013, on other than a Deferred Vested pension, and then die, a death benefit of $4,500 will be paid to your surviving spouse, or to your estate if you have no surviving spouse. This benefit is in addition to any other benefits provided under the plan.

Claims and Appeals

If you (employee, former employee or spouse) believe you are entitled to receive a benefit under the pension plan, you must file a claim in writing with the Company's Pension Department. If the claim is wholly or partially denied by the Pension Department, the Pension Department will notify you in writing of such denial.

Appeals

If there is a dispute about eligibility, age, credited service or amount of pension, the dispute may be taken up as a grievance under the grievance provisions of the Collective Bargaining Agreement (“CBA”), omitting, however, all steps preceding presentation of the grievance to the Labor Relations Department of BATO. If a grievance goes to arbitration, the arbitrator has authority only to interpret and apply the provisions of the provisions of the CBA. The arbitrator will have no authority to alter, add to or subtract from any provision, and his decision will be binding.

If a dispute remains after a claim for a permanent and total disability pension is denied by the Company's Pension Department in reference to the issue of whether an employee is, or whether a former employee continues to be, permanently or totally disabled, the dispute will be resolved as follows: The claimant will be examined by a physician appointed by the Appeals Board and by a physician appointed by the local union. If the physicians disagree concerning permanent and total disability, the question will be submitted to a third physician selected by the two physicians. The medical opinion of the third physician will decide the issue and it will be binding.

Appeals Board, Employee Trust Investment Committee and Disability Committee

c/o Pension Department
Bridgestone Americas, Inc.
10 East Firestone Blvd.
Akron, Ohio 44317
(330) 379-7000

Agent for Service of Legal Process

Bridgestone Americas, Inc.
535 Marriott Drive
Nashville, TN 37214
(615) 937-1000

Severance Awards

Eligibility

You will be eligible for a Severance Award if you:

- Have three or more years of credited service;
- Are not eligible for any type of pension under the Pension Plan; *and*
- Are released from employment because you are no longer physically or mentally able to meet the requirements of your job or another job to which you might be eligible for transfer.

Amount

Severance Awards are paid in a single lump sum payment unless the amount of the Severance Award exceeds $5,000; then a monthly annuity may be elected.

Your Severance Award will be equal to the greater of:

1. $500 multiplied by your years of credited service; or
2. Your years of credited service multiplied by:
    a. 1 week's pay if you have at least 3 but less than 10 years of credited service
    b. 1¼ weeks' pay if you have at least 10 but less than 15 years of credited service
    c. 1½ weeks' pay if you have at least 15 but less than 20 years of credited service
    d. 2 weeks' pay if you have 20 or more years of credited service

Special Distribution

If you are released from employment because you are no longer physically or mentally able to meet the requirements of your job or another job to which you might be eligible for transfer and you are eligible for pension, you may choose, with the consent of your spouse, to receive a lump sum payment or an annuity if you elect it. The lump sum payment (or annuity) will be paid in lieu of your pension. The choice must be made within 30 days of the date of release from employment if layoff is not involved.

The amount of the lump sum benefit will be the greater of (1) an amount determined to be actuarially equivalent to your Deferred Vested pension or (2) the amount of the severance award that would be payable under the plan if you were not eligible for a pension but had at least three years of credited service.

If you are laid off with recall rights, you can elect the Special Distribution if (1) your layoff has continued for at least one year (except that recall to work for less than three months' will not interrupt the running of the one-year period), and (2) you were eligible for a pension. You must make your choice during the period immediately following layoff that is equal in length to the number of weeks corresponding to the maximum number of credit units you would have had to

your credit under the Supplemental Unemployment Benefits Plan, if that plan had remained in effect.

If you choose this Special Distribution, you will be considered to have terminated your employment with the Company and its affiliated companies.

Savings Plan

Savings Plan Eligibility and Participation

You are eligible to participate in the savings plan if you are an employee described in the *Introduction* section of this SPD and you have completed six months of continuous service. One year of continuous service is 12 months of employment. Periods of employment are combined on the basis that 12 months of employment equals one year and each additional 30 days equals one-twelfth of a year. Only Post-2008 employees (as defined previously) are eligible for the plan's Age and Service Employer Contributions described herein unless special provisions are made to offer eligibility in the future to other classifications of employees.

Enrollment

You must be enrolled in the savings plan for purposes of contributing to the plan, but not for purposes of having Age and Service Employer Contributions made on your behalf. You may enroll effective on the first payroll date that is as soon as administratively practicable after you become eligible to participate in the plan. However, if you do not choose to participate as of that date, you may enroll as of any payroll cycle thereafter. When you become eligible to participate in the savings plan, you will receive enrollment materials from Fidelity Investments ("Fidelity"). To enroll in the savings plan, you can call Fidelity at 1-800-293-4015 or enroll through their website at **www.401k.com**.

For purposes of eligibility to receive Age and Service Employer Contributions, an employee who is a Post-2008 employee will become a member of the savings plan when the employee satisfies the service requirement for eligibility described above.

Contributions

Your Contributions

When you enroll (or are automatically enrolled if allowed by the plan) in the savings plan, an account will be set up for you. Once enrolled, you can make regular contributions to your savings plan account, up to 100% of your eligible earnings (after applicable withholdings and deductions).

For purposes of the savings plan, the term "eligible earnings" means base salary or wages, overtime, commissions, bonuses and other forms of extra earnings from BATO up to the IRS maximum (which is $260,000 in 2014 and may change in future years). Termination pay, service awards, longevity pay, severance pay and pay received for vacation after termination of employment are not included.

The amount you elect to contribute is deducted from your pay and you can contribute on a pre-tax or a post-tax (Roth) basis, or both, up to the IRS limit ($17,500 in 2014) to your account. In addition, if you are age 50 or older, you may make catch-up contributions of up to $5,500. These are the maximum amounts specified by the IRS. (The IRS may adjust these amounts yearly.) Although you can contribute to your account on either a pre-tax or post-tax basis, or both, the annual maximum contribution amount does not change. Alone or in combination, your contributions cannot be more than the IRS limit.

Pre-Tax Contributions

You can build savings, and reduce your taxes, by contributing to the savings plan on a pre-tax basis. Since your contributions are deducted from earnings, before taxes, they are called salary deferrals. The amount of the deferral is not subject to federal income taxes and most state and municipal taxes. The deferral is subject to Social Security (FICA) tax.

Contributions and earnings accumulate in your account on a tax-free basis. You pay no income tax on your account's holdings until you receive a distribution from the plan.

Saving with pre-tax dollars will not affect your Social Security benefits or any employer provided benefits, such as life insurance, long-term disability, pension or other benefits that are based on your salary.

Post-Tax Contributions

You can also build savings, and potentially reduce your tax liability in the future, by contributing to the savings plan on a post-tax, or Roth, basis.

Contributions and earnings accumulate in your account on a tax-free basis. Under certain conditions (as described below), you can pay no income tax on your account’s holdings when you received a distribution.

A Roth Contribution Option May Benefit You

The potential benefits of a post-tax or Roth contribution depend on your personal situation but focuses mainly around your existing tax rate and your anticipated tax rate when you retire. If you are contributing on a post-tax basis, you are giving up the tax break today for the tax break in the future.

Generally, Roth contributions to the savings plan may make sense if you expect your tax rate in retirement to be higher than it was during the years you contributed. If you expect your tax rate to be lower in retirement, then traditional pre-tax 401(k) contributions may be more beneficial to you.

Remember, unlike pre-tax contributions, the designated Roth contribution will be included in your current gross income for tax purposes. Your take home pay may be less than it would be if you made pre-tax contributions.

You may benefit most from the post-tax (Roth) option if you:

- expect to be in a higher tax bracket in retirement,
- don’t expect to retire for many years, and have time to accumulate tax-free earnings under a Roth feature,
- are a highly compensated individual, would like to have a pool of tax-free money to draw on in retirement, and are not eligible for Roth IRAs due to the income limitations,
- want to leave tax-free money to your heirs.

The Pre-Tax Option May Still be Beneficial

For many participants, contributing on a pre-tax basis may still be the most beneficial type of savings. We do not know what the future holds regarding tax rates. Therefore, it is not possible to predict with certainty which type of 401(k) savings option will be right for you.

Changing or Canceling Your Contributions

You may increase or decrease your contributions or stop contributing altogether through Fidelity by calling 800-293-4015 or through their website at **www.401k.com**.

Rollover Contributions

If you are eligible to contribute to the savings plan, you may make a rollover contribution to the savings plan even if you are not contributing. If you receive a distribution from an eligible employer plan, or from an individual retirement account that held amounts rolled over from an employer plan, you may roll over all or part of that distribution to the savings plan. Distributions that are not a direct rollover may be rolled over within 60 days after receiving the distribution. To make a rollover contribution to the savings plan, contact Fidelity.

Age and Service Employer Contributions

Effective January 1, 2014, BATO will make an Age and Service Employer Contribution each payroll period on behalf of each eligible Post-2008 employee who is a member of the plan during the payroll period. All Age and Service Employer Contributions will be paid to the Plan Trustee as provided in the plan.

The Age and Service Employer Contribution will be made according to the following schedule, and is based on the employee's age and years of continuous service (as defined above) at the beginning of the payroll period, and the hours for which the employee is paid by BATO during that payroll period.

Age Plus Years of Continuous Service Equals:	Age and Service Employer Contribution per Hour Paid
Less than 30 years	$0.31 per Hour Paid
30 to 39 years	$0.48 per Hour Paid
40 to 49 years	$0.75 per Hour Paid
50 to 59 years	$0.98 per Hour Paid
60 to 69 years	$1.41 per Hour Paid
70 to 79 years	$2.01 per Hour Paid
80 or more years	$3.13 per Hour Paid

If a member in the savings plan who is a Post-2008 employee is laid off and then becomes an eligible member again, an Age and Service Employer Contribution will be made on behalf of that employee in the amount that the employee would have received if he/she had not been laid off.

If a member who is a Post-2008 employee is on authorized leave of absence due to accident or sickness or for employment with the Union during a payroll period, an Age and Service Employer Contribution will be made on behalf of that employee, but it will be based on the greater of 40 hours or the actual number of hours for which the employee was paid during that period.

Vesting

- Your contributions are immediately 100% vested.
- The Age and Service Employer Contributions are 100% vested when you have completed at least two years of continuous service or reach age 65 while employed with BATO or an affiliated company.
- Your matching employer contribution account balance is vested if you:
  - have been a participant for 3 continuous years, *or*
  - have completed 5 continuous years of service (with respect to matching employer contributions made before January 1, 2004), *or*
  - reach age 65 while employed with BATO or an affiliated company.
- If your employment terminates due to retirement or disability and you are not a Post-2008 employee, your balance will be 100% vested.
- If you die while employed by BATO or while performing qualified military service, your entire account balance will be 100% vested.

Managing Your Saving Plan Accounts

Visit Fidelity's Net Benefits website at **www.401k.com** or call Fidelity at 800-293-4015 to:

- Request an enrollment guide,
- Set up initial enrollment or change pre-tax or post-tax contributions,
- Set up or change catch-up contribution,
- Review your account status,
- Redirect the amounts going into your selected investment options,
- See fund performance history,

Request prospectuses for investment options.

Your Investment Options

Investment of Contributions

You have the right to direct the investment of all amounts held for you under the savings plan (other than additional employer contributions made for you, if any, before October, 2000). If you do not direct the investment of part or all of your account, the amounts not directed for investment will be invested in "qualified default investment alternative(s)" designated by the Investment Committee. Information about the designated default investment funds may be obtained by calling Fidelity or going to their website.

Investment Funds Offered by the Savings Plan

The Investment Committee has the discretion to select the investment funds offered by the savings plan for the investment of your and BATO's contributions.

The Investment Committee has selected both Fidelity and non-Fidelity investment funds. Each of the investment funds has a different investment objective and level of risk. You will receive information on the funds directly from Fidelity. Please review the information carefully for each fund. Fund prospectuses can be obtained from Fidelity Investments by calling 800-293-4015.

Refer to your Fidelity materials for information on the investment fund options that are currently offered under the savings plan or call Fidelity at 800-293-4015.

Changing Your Investment Elections

You may change your investment elections by contacting Fidelity at 800-293-4015 or through their website at **www.401k.com**.

Withdrawals and Distributions

All withdrawals and distributions are processed by Fidelity.

Distribution When Your Employment Terminates

When you terminate employment, you may elect to receive payment of your entire vested account balance, or you may choose to defer payment of your account balance if it is over $5,000. You may elect to receive payment of your vested account or to have your vested account rolled over into an IRA, another qualified plan or any other eligible retirement plan.

To make this election, you must contact Fidelity at 800-293-4015 or go online to process your distribution request. If you elect to receive payment, it will be made as a single sum distribution as soon as reasonably possible after your termination of employment and will be subject to federal income tax withholding at the rate of 20%.

If you do not submit a timely distribution request and the value of your account balance is:

- $5,000 or less, your account balance will automatically be paid in a direct rollover to an individual retirement account or annuity designated by the Company.

If you do not elect payment of your vested account and the value of your vested account is more than $5,000, you will continue to be able to direct the investment of your account balance in the same manner as when you were actively employed.

If you do not elect payment of your vested account by the April 1st of the year after the year in which you reach age 70 ½, and you are no longer employed by Bridgestone or any affiliate. You are required to begin taking minimum required distributions (MRD). Fidelity Investments will correspond with you on this matter.

If you terminate employment before you are 100% vested under the savings plan, the unvested portion of your account will be forfeited on the date that you receive a distribution of the vested portion of your account, or five years after you terminate employment, if earlier. If you forfeit the unvested portion of your savings plan account and are rehired after you have been gone for five years or more, your rehire will have no effect on your forfeiture. If you are rehired before you

have been gone five years, and you repay the amount of any distribution that was made to you, your account will be restored to an amount equal to at least the amount forfeited.

If you terminate employment due to retirement (and you are/were not a Post-2008 employee), military or government service, or disability, your vested account balance will be paid to you in a lump sum. If you are disabled, your distribution will be deferred until your eligible retirement date unless you elect otherwise.

Rollover Distributions

You may elect to roll over all or a portion of your distribution from the savings plan to an individual retirement account (IRA) or to an eligible employer plan. You can do this by requesting Fidelity to transfer your distribution directly to your IRA or to an eligible employer plan that accepts your rollover. If you choose this direct rollover, the payment will not be taxed in the current year and no income tax will be withheld. The payment will be taxed later when you take it out of the IRA or the employer plan.

Alternatively, you may receive a payment from the savings plan and roll it over yourself within 60 days of receiving the payment. However, in this situation, the payment to you will be subject to a 20% income tax withholding. So, if you want to roll over the full distribution, you will have to replace the 20% withheld with your own funds.

If your account under the savings plan includes post-tax (Roth) contributions, special tax rules apply to your rollover of your Roth contributions and earnings on those contributions. In general, you may roll over Roth contributions, including earnings, to a Roth IRA or to a designated Roth account in another employer plan. You should consult your tax advisor before making a rollover of your Roth contributions.

Distribution on Death

If you die, a distribution of the vested portion of your account balance will be made to your beneficiary in a single lump sum. In addition, your spouse or beneficiary may be eligible to roll over their distribution; however, certain restrictions may apply.

Withdrawals

If you retire, you may withdraw all or any portion of your vested accounts up to four times per calendar year. You may also make partial or total withdrawals of your pre-tax contributions and post-tax (Roth) contributions accounts if you are an active employee age 59 ½ or older. You may make up to four withdrawals each calendar year. Portions of your account transferred from another qualified 401(k) plan may not be subject to the above restrictions. Age and Service Employer Contributions may not be withdrawn until you terminate employment.

If you are an active employee and you have not reached age 59 ½, you may be able to make a withdrawal due to financial hardship from your pre-tax contributions or post-tax (Roth) contributions (excluding earnings on those contributions) or your rollover contributions accounts. In addition, you may be allowed to withdraw certain accounts transferred from other qualified 401(k) plans due to financial hardship. Please contact Fidelity for further details.

Current IRS regulations define financial hardship as an immediate and heavy financial need for which resources are not otherwise available. Plan rules only permit four hardship withdrawals in a calendar year. Financial hardships may include amounts needed for:

- Post-high school tuition expenses for up to twelve months for yourself, spouse, children or dependents,
- Purchase of a primary residence (excluding mortgage payments),
- Medical expenses for you, your spouse or your dependents that are not covered by insurance and that would be tax deductible,
- Payments necessary to prevent being evicted from your principal residence or foreclosure on the mortgage of that residence,
- Payments for repair of damage to your primary residence which are not covered by insurance and are related to fire, natural disaster, or other unforeseeable events,
- Funeral expenses for your deceased parent, spouse, children or dependents.

To make a withdrawal due to financial hardship, you must first have tried to satisfy your hardship by taking out all available loans from the savings plan and other employer plans. Further, you must certify to the Appeals Board that the hardship cannot be relieved by stopping your contributions to the savings plan, by the liquidation of other assets, or by other available plan distributions or commercial loans. You must satisfy those requirements to receive a hardship distribution.

Distributions While in the Military

You will be eligible to receive a distribution from the savings plan during the time you perform service in the uniformed services, and will be treated as having terminated employment for this purpose. If you receive a distribution from the plan for this reason, your pre-tax contributions and post-tax Roth contributions will be suspended for a period of 6 months beginning on the date of distribution.

Taxation of Distributions

In general, distributions or withdrawals from the savings plan are subject to income tax withholding. Federal income tax generally must be withheld at the rate of 20% on the taxable portion of distributions. Withholding is not required if you elect to have the plan transfer the distribution directly into an IRA or eligible employer plan. You should review the withdrawal and distribution information available from Fidelity and get professional tax advice if you have questions about taxability.

In addition, payments received from the savings plan may be subject to a 10% penalty tax. This additional tax applies if payments are made to you, unless you are age 59 ½ or older, you are disabled, you leave Bridgestone and its affiliates at age 55 or later, the payment is a direct rollover to an IRA or to an eligible employer plan or within 60 days from receipt of payment, or you roll over the distribution into an eligible employer plan or IRA.

If your account under the savings plan includes post-tax (Roth) contributions, there are special tax rules that apply to your Roth contributions and earnings on those contributions. If you elect to have payment of your Roth contributions, including earnings, made directly to you and the payment is a “qualified Roth distribution” the payment (including the earnings attributable to your Roth contributions) will not be included in your federal taxable income. In general, a qualified Roth distribution is a payment that occurs after the end of the period of five consecutive taxable years that begins with the first day of the first taxable year in which you made a Roth

contribution to the savings plan, and is made after you have reached age 59 ½, died or became disabled. If you receive a distribution of your Roth contributions and earnings that is not a qualified Roth distribution, the earnings will be subject to federal income taxation. Before your distribution is made you will receive further information regarding the tax treatment of distributions that include Roth contributions.

To make a withdrawal or to request a distribution you must call Fidelity. A participant or beneficiary eligible for a distribution under the savings plan should contact Fidelity at 800-293-4015.

Loans

You may apply for a loan from your savings plan account by calling Fidelity at 800-293-4015. The loan will be made from your account. The amount of the loan cannot be less than $1,000. The loan cannot be more than 50% of the amount of funds in your account or $50,000, whichever is less. You must agree to repay the loan, at a reasonable interest rate, within one to five years. Repayment is made through payroll deductions. Only one loan is allowed at any time, and loans may be repaid in whole, or in part, in advance without penalty. If you repay a loan within one year of a subsequent loan, the amount available for the subsequent loan may be limited. Your repayments of principal and interest will be reinvested into your account. You may also continue contributing to your account during the repayment period.

You may not take a loan from your Age and Service Employer Contributions account or any other additional employer contributions account.

Important loan repayment information: Failure to repay a loan will result in a tax liability for you. Under the Internal Revenue Code, the unpaid principal balance remaining on a defaulted loan will be reported to the Internal Revenue Service, Form 1099R, as gross income for you for the year(s) when the loan was in default. You also may be liable for a 10% income tax surcharge.

General Provisions of the Savings Plan

Official Plan Documents

This Summary Plan Description describes only the highlights of the savings plan. Benefits under all of Bridgestone's employee benefit plans are determined under and governed by the official Plan documents, which include the Pension and Insurance Agreement applicable to collectively bargained plans. If there is any conflict between the description presented in this SPD and the official Plan documents, the Plan documents will govern. Copies of the Plan documents may be obtained, at a reasonable cost, from the Pension and Benefits Department, Bridgestone Americas, Inc., 10 East Firestone Blvd., Akron, Ohio 44317.

Recovery of Overpayments

If you receive an overpayment from the savings plan, the plan reserves the right to recover the overpayment by reducing future benefit payments, recovering the overpayment directly from you or taking any other means available under applicable law to recover the overpayment.

Top-Heavy

A plan that primarily benefits key employees is called a top-heavy plan. Key employees are certain officers of BATO and its affiliated companies. A plan is top-heavy if more than 60% of the plan's benefits are payable on behalf of key employees.

The savings plan is not currently top-heavy and it is not anticipated that it will ever become top-heavy. However, if the savings plan would become top-heavy it would be subject to special minimum benefit requirements.

Loss of Benefits

The following circumstances will or might result in the partial or total loss of benefits under the savings plan:

- Following divorce, under a “qualified domestic relations order” you may lose a portion or all of your benefit to your former spouse or to your children.
- The value of your account balance may decrease depending upon the performance of the investment funds in which your account is invested.
- The application of special Internal Revenue Code rules may limit your benefits under the savings plan.
- If you terminate employment before you are 100% vested in your entire savings plan account, you will forfeit the unvested portion of your account.

Fees

The plan sponsor will be responsible for the internal administrative fees associated with the savings plan. The investment funds, however, have management and administrative fees that are taken out at the fund level (prior to any returns credited to your account). Information on these fees is available in the prospectus for each fund.

Assignment of Benefits, Qualified Domestic Relations Orders (QDROs)

The savings plan’s purpose is to provide benefits to you (and your beneficiaries). In general, assets held by the savings plan cannot be used for any other purpose while the plan continues. You cannot assign, transfer or attach your benefits or use them as collateral for a loan (other than a plan loan). However, the Plan must obey a “Qualified Domestic Relations Order” (QDRO), such as a divorce decree, issued by a court of law. A QDRO requires that a percentage of your benefits be paid to your spouse, former spouse, child or dependent. In order to be “qualified,” the court order has to meet certain standards set forth in the law and by the Plan Administrator. Once your account is split under a QDRO, your former spouse will be entitled to receive a distribution of his/her portion, even though you may not yet be eligible to receive a distribution. You should understand that the plan must obey the order of the court. You may obtain, without charge, a copy of the savings plan’s QDRO procedures by contacting Fidelity.

Type of Plan

The savings plan is a 401(k) defined contribution plan. Although the Plan Administrator is Bridgestone, much of the administrative duties for the plan are delegated to the Appeals Board appointed by the Board of Directors of Bridgestone. Among its other duties, the Appeals Board has the power, in its sole and absolute discretion, to: (i) determine the eligibility of and right of

any person to receive benefits under the savings plan, (ii) determine the amount of benefits payable to a participant or beneficiary under the savings plan, (iii) resolve questions and disputes arising under the savings plan, (iv) make factual findings in connection with the savings plan, and (v) interpret the provisions of the savings plan.

Fidelity Investments is the trustee under the plan and receives, holds in trust, invests and distributes all contributions and earnings under the plan in accordance with the provisions of the plan.

The benefits of the savings plan are not insured by the Pension Benefit Guaranty Corporation (PBGC) as the plan is a defined contribution plan and is therefore excluded from PBGC coverage.

Plan Amendment and Termination

Bridgestone has the right at any time to amend or terminate the plan. If the savings plan is terminated, the accounts of all participants under the savings plan, if not already fully vested, will become 100% vested and nonforfeitable. If the plan is terminated, all property held in trust by the trustee will first be used exclusively for distributions to plan participants. Upon plan termination, participants would receive distributions of their accounts as described earlier in this SPD.

Plan Administrator

Bridgestone Americas, Inc.
535 Marriott Drive
Nashville, TN 37214
(615) 937-1000

Filing a Claim for Benefits

If you wish to file a claim for benefits under the savings plan, you need to submit your request to Fidelity.

Notification of a Denied Claim

If a claim for a savings plan distribution is not allowed in full, Fidelity will notify you of the total or partial denial of your claim within 90 days after receipt of a claim (plus an additional 90 days if necessary due to special circumstances). The Appeals Board, as applicable, will notify you of the time extension and a statement of the circumstances requiring the time extension and the date of an expected benefit determination.

All notices to you of a denied claim will be in writing (or electronic format) and will include:

1. the specific reason(s) for the adverse determination,

2. reference to the specific plan provisions on which the denial is based,

3. additional material and/or information needed,

4. a description of the plan’s review procedures and the applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

Appeal of a Denied Claim

Within six months after receipt of the notice of denial, you or your authorized representative can appeal the denial of a claim by filing a written request for review of your claim with the Appeals Board, Bridgestone Americas, Inc., 535 Marriott Drive, Nashville, TN 37214.

When your written appeal is received, the Appeals Board (or a named fiduciary designated by the Appeals Board) will:

1. provide you the opportunity to submit written comments, documents, records and other information relating to the claim,

2. upon request, provide reasonable access to, and copies of, all documents and other information relevant to your claim for benefits at no charge to you,

3. ensure that all of the comments, documents, records, and other information submitted by you are considered without regard to whether the information was submitted or considered in the initial benefit determination, and

4. conduct a full and fair review of your claim.

Notification of Determination on Review

The Appeals Board or its designee will notify you of the determination on review within a reasonable time but not later than 60 days (plus an additional 60 days if the Appeals Board or its designee determines that special circumstances require extra time) after receiving your request for a review. If the Appeals Board determines that an extension of time is required, you will be notified of the extension with a description of the special circumstances requiring an extension of time and the date by which the Appeals Board or its designee expects to render a decision, and will be furnished prior to the termination of the initial 60-day period.

If your appeal is denied, the notice of determination on review will include:

1. the reason for the denial,

2. reference to the specific plan provision on which the denial was based,

3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claim,

4. the voluntary appeal procedures, and

5. a statement of your right to file a civil action under Section 502(a) of ERISA.

To the extent permitted by applicable law, the decision on review will be final and binding on all interested persons.

Coordination of Benefits

The medical Plan has a non-duplication of benefits provision. The Plan does not duplicate benefits paid by another health plan. The term “coordination of benefits,” or COB, refers to the way health care plans determine how much will be paid on a claim.

When an employee and his/her spouse or dependent(s) are covered under more than one group health plan, the COB determines the order in which a claim is paid and how much is owed by each plan. This ensures that the combined amount paid by the plans is not more than what the provider actually charges.

You must let the Claims Administrator know if you have other coverage (for example, through your spouse's employer). One of your plans will be determined to be primary according to the rules listed below. The primary plan pays its full benefits first. If this plan is deemed to be the secondary plan, the benefits paid in addition to the benefits paid under the primary plan will not be an amount more than you would have received had this plan been your only coverage. In such a case, this plan, as the secondary payer, would determine what it would have paid if it were the primary plan, and then subtract what the other plan paid from that amount. The balance, if any, will be payable as a plan benefit.

Coordination with the Working Spouse Rule for Medical Coverage

If the spouse of an employee is eligible for medical coverage under another subsidized group insurance plan(s) (such as through another employer or a retirement plan) and the premium is $50 or less per month for single coverage, the working spouse cannot have the Bridgestone plan as his/her primary coverage. He or she may be covered under the Bridgestone plan for secondary coverage only and should enroll in one of his/her other available medical plans for primary coverage. If the working spouse does not enroll in one of the other available plans he/she is eligible for, the medical benefits provided to him/her under the Bridgestone plan will be reduced. This plan will apply its coordination of benefits provisions as if the working spouse was enrolled for coverage under the other available plan and will treat this plan as the secondary plan.

If the monthly premium is over $50 for single coverage under all other available plans, the spouse may have primary coverage under the Bridgestone plan.

Primary Plan Rules

The primary plan is established by applying the rules below:

1. **Other than as a Dependent -** The benefits of a plan that covers a person as other than a dependent will be determined before the benefits of a plan that covers him/her as a dependent.

2. **Husband/Wife (Birthday Rule) -** In those cases where both husband and wife are employed, the plan of the parent whose birthday (month and day only) falls earlier in the calendar year will be considered primary, and the plan of the parent whose birthday (month and day only) falls later in the calendar year will be considered secondary, with respect to the dependent children of the husband and wife. If the husband and wife have the same

birthday (month and day only), the plan covering the parent longer is primary, and the program covering the other parent for the shorter time is secondary. When the plan of the employee's spouse does not determine primary coverage for dependent children based on birthday, the plan covering the husband as an employee will be considered as primary with respect to the husband and his dependent children. The plan covering the wife as an employee will be considered as primary with respect to the wife except that:

a. ***Divorced/Not Remarried -*** In the case where parents are separated or divorced and the parent with custody of dependent children has not remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the parent without custody.

b. ***Divorced/Remarried -*** In the case when parents are divorced and the parent with custody of dependent children has remarried, the dependent coverage of the parent with custody of the children will be primary to the dependent coverage of the stepparent. The dependent coverage of the stepparent will be primary to the dependent coverage of the parent without custody.

c. ***Court Decree -*** Notwithstanding (a) and (b) above, if there is a court decree which establishes financial responsibility for the medical care expenses with respect to dependent children, the dependent coverage of the parent with such financial responsibility will be primary.

3. **More Credited Service -** When (1), (2) or (3) above do not establish an order of benefit determination, the benefits of a plan sponsored by an employer with which an employee has more credited service will be determined before the benefits of a plan sponsored by an employer with which an employee has less credited service.

4. **Plan Silent on Duplication -** If a plan does not contain a non-duplication or coordination of benefits provision, the benefits of that plan will be determined before the benefits of the plan that contains such a provision, regardless of the order of benefit determination stated above.

5. When this plan is determined to be the primary plan, full payment of the benefits will be made without regard to the benefits of the other group plans.

6. If a dependent is entitled to coverage from another group health benefits plan, available on a non-contributory basis, this plan will coordinate benefit payments as if such dependent is in fact enrolled and covered by the other plan. This plan will not provide benefits in the absence of other coverage which was available to the claimant without cost to him/her and which would have been determined to be the primary plan.

   For purposes of other company-sponsored benefit programs, an individual will be considered "eligible to be covered" as mentioned above, whenever coverage is available even if the individual did not enroll in the coverage.

7. Coverage under this plan will be secondary with respect to newborn baby care expenses if the father’s coverage under another plan is responsible for these charges.

8. The Plan (or Claims Administrator) has the right to release to or obtain from any other organization or person any information that is necessary for the purpose of administering the coordination of benefits provisions described here.

9. If a claim is overpaid, the Plan (or Claims Administrator) will have the right to recover such overpayments from any person for, to whom, or with respect to whom such payments were made, any other insurance company or any other organization.

10. **Coordination of Benefits with Medicare -** This plan will be the primary plan for employees who are on Medicare but are actively working for the Company.

The Plan's Rights of Subrogation, Reimbursement, and Recovery

Note: The following section explains your responsibilities and the Plan's rights if you receive benefits from the Plan because of an injury or illness that is caused by a third party (or for which the third party is legally responsible) or if you receive benefits that the Plan paid in error. These provisions are necessarily legal and technical, but it is important that you read this section and understand that, by accepting benefits from the Plan, you agree to these provisions, and that you agree to repay the Plan for benefits you receive under the circumstances described below. See the "Definitions" below for explanation of various terms.

The subrogation administrator for the HIP and PPO Plans is BlueCross BlueShield of Tennessee.

The subrogation administrator for the dental plan is Delta Dental Plan of Tennessee, and the subrogation administrator for the vision plan is EyeMed Vision Care.

The terms "you" and "yours" refer to you and/or to your successors and assigns as the "benefit recipients" or "claimants" as defined below.

Each benefit recipient, as a condition of participation in and coverage under the Plan, agrees to comply with the following provisions. If you incur charges or expenses for any illness, injury or other condition, whether or not these charges are incurred before or after you become covered under the Plan, and you or another claimant have or may have a legal right to seek money or otherwise recover from a third party, then any reimbursable expenses will automatically be subject to these subrogation, reimbursement, and recovery provisions.

Definitions

"Benefit Recipient" means any individual for whom benefits are paid by the Plan. If the Benefit Recipient is a minor, the obligations of the Benefit Recipient will be the obligations of his or her parent or guardian.

"Claimant" means a Benefit Recipient and his or her successors and assigns.

"Proceeds" means any money or other property that the Claimant recovers from a Third Party, whether in tort, contract, or otherwise; and whether by judgment, lawsuit, settlement (either before or after any determination of liability), mediation, arbitration or otherwise; including any such payment made as a result of uninsured or underinsured motorist coverage, or any such other coverage, and coverage resulting from a no-fault motor vehicle insurance statute or other similar legislation. "Proceeds" includes any recovery for medical, dental, and/or vision expenses, attorney fees, costs and expenses, loss of consortium, pain and suffering, any noneconomic damages, or any other recovery of any form of damages or compensation, to the fullest extent permitted by applicable law in the appropriate jurisdiction.

"Reimbursable Expenses" means any payment of benefits made under this Plan based on an illness, injury, or other condition for which the Claimant has or may have a legal right to seek money or otherwise recover from any Third Party, less any such amounts previously reimbursed to or recovered by the Plan. "Reimbursable Expenses" includes amounts paid by the Plan for

the illness or injury and the amount of all future benefits which may become payable under the Plan that result from the illness or injury.

"Third Party" means any party from whom the Claimant has or may have a legal right to seek money or otherwise recover, including but not limited to:

- Any party or parties alleged to have caused a Benefit Recipient to suffer illness, injuries, or damages;
- The insurer or any other indemnifier of any party or parties alleged to have caused a Benefit Recipient to suffer illness, injuries, or damages;
- A guarantor of any party or parties alleged to have caused a Benefit Recipient to suffer illness, injuries, or damages;
- Any party or parties who are or may be obligated to provide benefits or payments to a Benefit Recipient, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, other insurance carriers, or third-party administrators; and
- Any party or parties who are liable for payment to a Benefit Recipient on any equitable or legal liability theory.

Right of Subrogation

You will, subject to applicable law and in consideration of the coverage provided by the Plan, assign, transfer, and subrogate to the Plan all rights, claims, interests, and rights of action against a third party, limited to the extent of reimbursable expenses.

You must inform the Plan of any claim or potential claim that you have against any third party as of the date you become covered under the Plan, or, if later, within 60 days of the act that is the source of the claim, if benefits are paid by the Plan because of this act. In all cases, you must notify the Plan before filing suit or settling any claim so the Plan may participate in the suit or settlement to protect and enforce the Plan's rights of subrogation and reimbursement.

You, subject to applicable law, authorize the Plan to sue, compromise, or settle in your name or, if the Plan elects, to enter and prosecute in your name a legal action for recovery of the reimbursable expenses against a third party. The Plan will exercise all due diligence and the action will be at the expense and under the exclusive control of the Plan. This subrogation right allows the Plan to pursue any claim that you have against any third party, whether or not you choose to pursue that claim yourself. The Plan is not obligated in any way to pursue this right independently or on your behalf. The Plan is not obligated in any way to pay you part of any recovery that the Plan may get.

Right of Reimbursement

In addition to any subrogation rights and in consideration of the coverage provided by the Plan, you agree to reimburse or repay the Plan for reimbursable expenses from any and all proceeds related to an injury, illness, or other condition that the Plan has paid benefits for.

A constructive trust will be imposed on any proceeds you recover, to the extent of the greater of: (a) reimbursable expenses or (b) proceeds you recover. You will serve as a constructive trustee over these proceeds, which will be held in trust for the sole benefit of the Plan. You will be

obligated to hold the proceeds separately and alone. Failure to hold the proceeds in trust will represent a breach of your fiduciary duty to the Plan.

The Plan also has a first priority equitable lien against any rights you may have to recover proceeds from a third party, equal to the greater of: (a) reimbursable expenses or (b) proceeds subject to your right of recovery. This equitable lien will also attach to any proceeds received by anyone (including, but not limited to, you or your attorney and/or a trust) when you exercise your right of recovery. The Plan will also be able to seek any other equitable remedy against any party that possesses or controls the proceeds, including reasonable attorneys' fees.

Right of Recovery

If the Plan Administrator makes overpayments or payments in error, the Plan Administrator, at its sole discretion, has the right to recover the payments or overpayments from anyone who received the payments, any other insurance companies, or any other organizations. If the Plan made payments based on fraudulent information you provided, the Plan will exercise all available legal rights, including its right to withhold payment on future benefits until the overpayment is recovered.

Your Obligations with Respect to the Plan's Rights

You will cooperate fully with the Plan in asserting its rights, including:

- Providing any relevant information requested by the Plan;
- Signing and returning all required documents;
- Responding to requests for information about any accident or injuries;
- Appearing at depositions and in court; and
- Getting the consent of the Plan before releasing any party from liability or payment of medical, dental, and/or vision expenses.

You will not accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval. You will not do anything to prejudice the Plan's rights of subrogation and reimbursement. The Plan's right to reimbursement will not be reduced because of your own negligence.

If you receive any proceeds, you will reimburse the Plan from the first payment, the amount of reimbursable expenses, regardless of whether the judgment, settlement, or other payment allocates any specified amount to medical, dental, and/or vision expenses paid under the Plan. This means that the rights of subrogation and reimbursement may be exercised against the first dollars received (whether a full or partial recovery) or claimed regardless of whether you have been completely compensated or made whole for your loss. Therefore, you are not entitled to receive any proceeds from a third party until the Plan has recovered all reimbursable expenses.

The Plan will not pay, and is not responsible for your attorneys' fees, court costs, experts' fees, filing fees, or any other costs or expenses of litigation (collectively, "litigation expenses"). You must pay any litigation expenses. You will not deduct any litigation expenses from the amount reimbursed to the Plan; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fee Doctrine" does not override this right, and the Plan is not required to participate in or pay litigation expenses.

If the benefit recipient is a minor or is incapacitated, the Plan has no obligation to pay any medical, dental, and/or vision benefits incurred due to an illness, injury, or other condition caused by a third party until after the benefit recipient (or his/her authorized legal representative) gets valid court recognition, approval, and enforcement of the Plan's first dollar reimbursement and subrogation rights on all recoveries as described in the plan documents. If the illness, injury, or other condition that initiates the Plan's reimbursement and subrogation rights involves the wrongful death of a benefit recipient, these provisions apply to the personal representative of the deceased benefit recipient.

You agree that any legal action or proceeding involving the Plan's rights may be brought in any court that the Plan Administrator elects. Upon receiving benefits under this Plan, you will submit to each jurisdiction, waiving whatever rights may correspond to the benefit recipient by reason of his/her present or future domicile.

Your failure to comply with these provisions will be considered a breach of fiduciary duty to the Plan and a breach of contract. If you challenge or do not cooperate with the Plan's rights under this section, the Plan may, in its sole discretion:

- Offset any future Plan benefits that may become payable to you by the amount not reimbursed;
- Obtain a court judgment against you for the amount of the advance payment that is not reimbursed, and garnish or attach your wages or earnings;
- May terminate your coverage and coverage of any other person covered by virtue of the same benefit election as you under the Plan; and
- May bring legal action against you.

You will provide the Plan with any information necessary to enforce its rights resulting from payments made under the Plan, will assist the Plan in securing and exercising these rights, and will not prejudice the Plan in any way in enforcing its rights to recover under these provisions. You will have absolutely no authority to sign a release to any third party for money that the Plan may be entitled to for reimbursement.

Interpretation of this Section

If any part of these provisions is found to be unenforceable, the remaining provisions will continue in full force and effect. In addition, if any claim is made that any part of these provisions is ambiguous or questions arise about the meaning or intent of these terms, you agree that the Plan Administrator has the sole authority and discretion to resolve all disputes involving the interpretation of these provisions.

The terms of these provisions will not diminish, waive, or exclude any common law, statutory, or equitable rights that the Plan may have under applicable law, and all of these rights in the interest of the Plan and each benefit recipient under the Plan are expressly reserved to each.

When You Retire

Healthcare Coverage

Retiree Eligibility Guidelines

You are eligible to receive healthcare benefits during retirement if you were:

1. Hired on or before May 22, 1988 (January 10, 1989 for LaVergne Production) and:

    a. Retire with 10 or more years of continuous service, and

    b. Are eligible for a pension (other than a Deferred Vested pension), or

    c. Your employment with the Employer is terminated during the month you turn age 60 or later when eligible for a Deferred Vested pension. Benefits for Deferred Vested pensioners would begin when your Deferred Vested pension starts.

2. Hired after May 22, 1988 (January 10, 1989 for LaVergne Production) and:

    a. Retire with less than 10 years of continuous service, and

        i. Are eligible for a pension (other than a Deferred Vested pension), or

    b. Retire with at least 10 years, but less than 20 years, of continuous service, and

        i. Are eligible for a pension (other than a disability pension or a Deferred Vested pension), or

    c. Retire with at least 20 years of continuous service, and

        i. Are eligible for a pension (other than Deferred Vested pension), or

        ii. Retire on a disability pension after completing at least 10 years of continuous service.

General Information

If you are an eligible retiree, your post-retirement medical benefit coverage will be provided under a separate medical plan for retirees, which is different from the medical plan described in this SPD. At the time of your retirement, you will be given a different SPD that describes the medical benefit plan that will apply to you.

As an eligible retiree or surviving spouse, the medical plan benefit program you are offered depends on whether or not you are Medicare-eligible. You will be covered under the Health Incentive Plan if you or your spouse, if applicable, are non-Medicare-eligible, and under the Comprehensive Medical Plan option if you, and your spouse if applicable, are Medicare-eligible. Medicare Advantage and Medicare Supplement programs may be offered to Medicare retirees.

If you are eligible for retiree healthcare coverage, you can elect to continue your medical benefit coverage for yourself and your current eligible dependents. Eligible dependents not covered under your coverage at the time of your retirement may be covered after your retirement date if

they, in the case of adult children, are a full-time student at an accredited school, or in the case of a spouse, can provide proof of continuous coverage during the period you were enrolled under the plan (and any other required documentation).

You can continue dental coverage during retirement if you were covered under the dental plan as an active employee on your retirement date. You cannot add new dependents to the dental plan after retirement. Vision care benefits do not continue in retirement.

You will be required to pay applicable premiums for your coverages during retirement.

When you die, your surviving spouse's coverage will continue under the retiree medical plan (which is a separate medical plan that is different from the medical plan described in this SPD) if your spouse was a covered dependent under the plan and had been married to you for at least one year immediately before your death. Your surviving spouse's coverage ends when he or she dies or remarries. A surviving dependent child who was covered for benefits before you died will continue under the retiree medical plan (which is a separate medical plan that is different from the medical plan described in this SPD) provided they continue to meet the dependent eligibility requirements. To continue coverage, your surviving spouse or dependent child must pay any premiums that you would have been required to pay for retiree coverage. No retirees, surviving spouses, their dependents or surviving dependents will be covered under the medical plan described in this SPD.

Any spouses or dependents who are active employees of Bridgestone or any affiliated company are eligible only for medical coverage under the medical plan options that are available to active employees, and are not eligible for coverage under the retiree medical plan.

Medical benefits are coordinated with coverage under Medicare Part A and Part B, regardless of whether a person eligible for Medicare has actually enrolled for Part A and Part B.

In accordance with the Financial Accounting Standard No. 106, adopted by the Company on January 1, 1993, recognizing BATO’s financial obligation for postretirement benefits, the Company capped BATO’s liability to not exceed an average of $6,000 per household. Any future cost increases above this threshold will be borne by the retiree and reflected in retiree premiums and/or plan design changes. You are subject to this provision if you retired on or after May 1, 1991, or are the surviving spouse of an employee or a retiree who died on or after this date.

Life Insurance/AD&D

Upon normal, early, or disability retirement you will continue to be insured for basic life insurance in reduced amounts; however, the accidental death and dismemberment insurance, survivor income benefits and optional contributory life insurance will terminate.

The amount of basic life insurance will be reduced immediately upon retirement to $3,000.

Supplemental Life Insurance, Optional Life Insurance and GUL

When you retire or terminate employment, you may continue your existing coverage by paying premiums on a quarterly basis directly to the program administrator.

Other Benefits

In addition to the changes to benefits mentioned above, retirees are not eligible for the following benefits:

- Non-Occupational Accident and Sickness Benefits
- Employee Assistance Program (EAP)
- Flexible Spending Accounts

Claims and Appeals Procedures

Medical, Dental and Vision Plans

Initial Benefit Determination

You or your medical provider should file your claim for benefits with the claims administrator indicating your claim for benefits and the basis of your claim.

For purposes of these claims procedures, “you” means any participant seeking a benefit under the plan or an authorized representative of a participant.

Failure to Follow Proper Procedures for Pre-Service Claims and Urgent Care Claims

If you did not follow proper procedures when filing a pre-service claim (as defined below), the claims administrator will notify you as soon as possible but not later than five days after the failure, and within 24 hours for urgent care claims (as defined below). Unless you request written notification, notification may be oral. Notification is required only if the claim is received by the person or entity customarily responsible for handling benefit matters and if the claim includes the name, medical condition or symptom, and the specific treatment, service, or product for which pre-approval is requested.

Urgent Care Claims

Urgent care claims are those claims that require notification or approval before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you do not provide sufficient information to make a determination as to whether benefits are covered, the claims administrator will notify you of the specific deficiencies within 24 hours of receipt of the claim. You will then have 48 hours to provide the necessary information. The claims administrator will notify you of the adverse or favorable benefit determination as soon as possible, but not later than 24 hours after the plan received the missing information or the end of the period provided to you to supply the necessary information, whichever is earlier.

If the claims administrator denies your request for benefits, you must appeal the adverse benefit determination no later than 180 days after receiving the adverse notification.

The claims administrator will notify you of a favorable or adverse appeal decision as soon as possible but not later than 72 hours after receiving the urgent care claim.

Concurrent Care Decisions

If the plan has approved an ongoing course of treatment to be provided over a period of time or has prescribed a number of treatments, the following rules apply to subsequent benefit determinations relating to that treatment.

Reduction Before Approved Treatment Ends. If the plan reduces or terminates the course of treatment before the end of the course previously approved, the reduction or termination will

constitute an adverse determination, and the claims administrator will notify you with sufficient time in advance of the reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Request for Extension of Ongoing Treatment. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim, your request will be decided within 24 hours, provided your request is made at least 24 hours before the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to urgent care timeframes.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service claim or pre-service claim timeframes, whichever applies.

Pre-Service Claims

Pre-service claims are those claims for benefits that require notification or approval before receiving medical care (as described earlier in this booklet). The claims administrator will notify you of the adverse or favorable benefit determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. The time period may be extended for up to an additional 15 days if such an extension is necessary due to matters beyond the control of the plan. In that case, you will be notified in writing, before the end of the initial 15 day period, of the extension, the circumstances necessitating the extension, and the date by which the plan expects to render a determination. If you filed a pre-service claim improperly, the claims administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If an extension of time is needed to process the pre-service claim (as described above) because you did not provide all of the necessary information, the claims administrator will notify you of the information needed.

The notice of missing information will specifically describe the missing information and will be combined with the notice of time extension described above. You will be given 45 days from receipt of the notice to provide the missing information. The time period for making a decision on your claim will be tolled until all of the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied.

Post-Service Claims

Post-service claims are those claims for benefits that are filed for payment of benefits after medical care has been received. The claims administrator will notify you of an adverse determination within a reasonable time, but not later than 30 days after receipt of the claim. This time period may be extended for an additional 15 days if the extension is necessary due to circumstances beyond control of the plan. The claims administrator will notify you of the circumstances requiring the time extension and the date by which the plan expects to render a determination before the end of the initial 30 day period.

If the extension is needed because you did not provide all of the necessary information, the notice will specifically describe the missing information, and you will be given 45 days from receipt of the notice to provide the missing information. The time period for making a decision

on your claim will be tolled until all of the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Notification of Initial Adverse Benefit Determination

All notices to you of adverse benefit determinations will be in writing (or in electronic format) and include:

1. The specific reason or reasons for the adverse determination,

2. Reference to the specific plan provisions on which the determination is based,

3. A description of additional material or information needed to complete the claim and an explanation of why the information is needed,

4. A description of the plan's review procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review,

5. The specific internal rule, guideline, protocol, or similar criterion, if any, that was relied upon in making the adverse determination or a statement that such a rule, guideline, protocol or criterion was relied upon and a statement that a copy of the same is available to you free of charge upon request, and

6. For claims under the medical plan, provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the claims administrator, or any new or additional rationale as soon as possible, and sufficiently in advance of the date on which the notification of determination on review is provided, to give you a reasonable opportunity to respond prior to that date.

If the notice to you is for an urgent care claim, the notice will also include a description of the expedited review process for the claim. Furthermore, notices regarding urgent care claims may be given orally if written or electronic notification is provided to you no later than 72 hours after the oral notification of your appeal.

Level One Appeal of a Denied Claim

If you wish to appeal a denied pre-service claim, post-service claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit urgent care appeals in writing; notification may be oral. When appealing your claim, your written request to the claims administrator should include:

1. The patient's name and the identification number from the issued medical identification card,

2. The date(s) of medical service(s),

3. The medical provider's name,

4. The name of the plan,

5. The reasons you believe the claim should be paid, and

6. Any documentation or other written information to support your request for claim payment.

The claims administrator will:

1. Provide you with the opportunity to submit written comments, documents, records and other information relating to the claim,

2. Upon request, provide reasonable access to, and copies of, all documents and other information relevant to your claim for benefits at no charge to you,

3. Designate a fiduciary to conduct a full and fair review of your claim who is not the individual, nor the subordinate of the individual, who made the original adverse determination and who may not give deference to the initial adverse determination,

4. Ensure that the named fiduciary considers all of the comments, documents, records and other information submitted by you without regard to whether the information was submitted or considered in the initial benefit determination.

5. For claims under the medical plan, provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by or at the direction of the claims administrator, or any new or additional rationale as soon as possible, and sufficiently in advance of the date on which the notification of determination on review is provided, to give you a reasonable opportunity to respond prior to that date.

If the adverse determination was based, in whole or in part, on a medical judgment (including determinations regarding whether a treatment or drug is experimental, investigational or not medically necessary) the named fiduciary reviewing the claim on appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. However, the medical professional will not be an individual, or a subordinate of an individual, who was consulted with in the initial benefit determination of the claim.

If the claim involves urgent care, the plan will provide for an expedited review in which a request for an expedited appeal may be submitted orally or in writing by you and all necessary information may be transmitted between the plan and you by telephone, facsimile, or another available similarly expeditious method.

Notification of Determination on Review

Urgent Care Claims

The claims administrator will notify you as soon as possible taking into account the medical exigencies but not later than 72 hours after receipt of your request for review of an adverse determination.

Pre-Service Claims

The claims administrator will notify you within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the plan receives the request for review.

Post-Service Claims

The claims administrator will notify you within a reasonable period of time, but not later than 30 days after the plan receives the request for review.

Notification of Adverse Benefit Determination on Review

If the determination on appeal is adverse to you, the notice of determination on review will contain:

1. The reasons for its denial,

2. Reference to the specific plan provisions on which the benefit determination is based,

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents and other information relevant to the claim,

4. A statement describing voluntary appeal procedures offered by the plan and your right to obtain information about the voluntary appeal process,

5. A statement describing your right to file a civil action under section 502(a) of ERISA,

6. The specific internal rule, guideline, protocol, or similar criterion, if any, that was relied upon in making the adverse determination or a statement that such a rule, guideline, protocol or criterion was relied upon and a statement that a copy of the same is available to you free of charge upon request, and

7. If a denied claim is based on medical necessity, experimental treatment, or similar limit, a statement explaining the scientific or clinical judgment of the determination and applying the terms of the plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you.

If the claim is denied upon review, the claim processor will provide you with access to and copies of documents, records and other information relevant to the claim.

Level Two Appeal of a Denied Claim

If you are not satisfied with the level one appeal decision of the claims administrator, you have the right to request a second level appeal. Your second level appeal request must be submitted within 180 days from receipt of the first level appeal decision and sent to the claims administrator.

Your request for a second level appeal should, at a minimum, include the same information as your level one appeal. (See “Level One Appeal of a Denied Claim” above.) The second level appeal will be conducted by a different committee at the claims administrator in the same manner as the first level appeal.

Notification of Determination on Review of Second Appeal

Urgent Care Claims

The claims administrator will notify you as soon as possible taking into account the medical exigencies but not later than 72 hours after receipt of your request for review of an adverse determination from the first level of appeal.

Pre-Service Claims

The claims administrator will notify you within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the plan receives the request for review of the first level appeal decision.

Post-Service Claims

The claims administrator will notify you within a reasonable period of time, but not later than 30 days after the plan receives the request for review of the first level appeal decision.

The claims administrator will ensure that the fiduciary is not the individual, nor the subordinate of the individual, who made the original adverse determination and who may not give deference to the initial adverse determination. Notification to you of an adverse benefit determination on review of a second appeal will be provided in the same manner and contain the same information as that described above in the section entitled *Notification of Adverse Benefit Determination on Review*.

Level Three Appeal of a Denied Claim

If you are not satisfied with the level two appeal decision of the claims administrator, you have the right to either file a civil action under Section 502(a) of ERISA or request a third level appeal from the Bridgestone Benefits Appeals Board. Your third level appeal request must be submitted within 180 days from receipt of the second level appeal decision and sent to Bridgestone Americas, Inc., Appeals Board, 535 Marriott Drive, Nashville, TN 37214.

Your request for a third level appeal should include the same information as your level one and/or level two appeals. (See “Level One Appeal of a Denied Claim” above.) The third level appeal will be conducted by the Appeals Board (or a named fiduciary designated by the Appeals Board) in the same manner as the first level appeal.

If you do not elect to submit a benefit dispute for the voluntary third claim appeal, the plan will not assert that you failed to exhaust your administrative remedies. If you do submit a request for a voluntary third claim appeal, any statute of limitations or other defense based on timeliness will be tolled during the time that the voluntary third claim appeal is pending. Upon request, you will be provided with sufficient information relating to the voluntary third claim appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the Appeals Board for a voluntary third claim appeal, and that information will include a statement that your decision as to whether or not to submit a benefit dispute to the voluntary third claim appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed as part of the voluntary third claim appeal. If, after exhausting, or simultaneous with, the third level of appeal, you are not satisfied with the determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on clinical reasons, the exclusions for experimental or investigational services, or unproven services. The external review program is not available if the adverse benefit determination is based on defined benefit limits or eligibility provisions. Contact the claims administrator at the telephone number on your identification card for more information.

HIPAA Notice of Privacy Practices for Personal Health Information (PHI)

This notice describes how medical information about you may be used and disclosed and how you can access to this information.

Purpose and Applicability of this Notice

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the regulations implementing HIPAA require health plans to notify participants and beneficiaries about how their protected health information may be used by the Plan and disclosed to other parties. This Notice of Privacy Practices ("Notice") applies to the benefits provided under the following plans (collectively, the "Plan") that are sponsored by Bridgestone (the "Plan Sponsor"):

1. Bridgestone Americas, Inc. Employee Group Insurance Plan

Certain benefits under the Plan may be fully insured by insurance companies. If you participate in a fully insured benefit, you will also receive a separate HIPAA Privacy Notice from the insurance company.

"Protected health information" ("PHI") means your individually identifiable health information, including demographic and genetic information, that relates to your past, present, or future physical or mental health or condition; related health care services; and payment for health care services.

This Notice describes the Plan's responsibilities with respect to PHI, how the Plan may use and disclose PHI, and your rights to access and control your PHI held by the Plan.

Responsibilities of the Plan

The Plan is required by law to make sure that your PHI is kept private, to give you this Notice of the Plan's legal duties and privacy practices related to the use and disclosure of your PHI, to notify affected individuals after a breach of unsecured PHI, to follow the terms of the Notice currently in effect, and to communicate to you any future changes to this Notice.

Uses and Disclosures of PHI without Your Authorization

The following categories describe uses and disclosures of your PHI that may be made without your authorization. Not every use or disclosure in a category is listed. However, all of the ways the Plan is permitted to use or disclose PHI will fall within one of the categories.

For Treatment: The Plan does not provide medical treatment directly, but it may disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. The Plan may disclose your PHI, as necessary, to a health care provider (such as a specialist, pharmacist, or laboratory) who is involved in your care. For example, the Plan may disclose information on drugs that you have been prescribed to a pharmacist to identify potential interactions.

For Payment: The Plan may use and disclose your PHI to pay for benefits provided by the Plan. This includes activities the Plan undertakes before it approves or pays for the health care

services recommended for you, such as determining eligibility for benefits, reviewing medical necessity, undertaking utilization review activities, and coordination of benefits with other coverage that you may have. For example, your relevant PHI may be used as part of the pre-certification process for obtaining approval for a hospital stay.

For Health Care Operations: The Plan may use and disclose your PHI for the Plan's operations, such as underwriting, conducting quality assessment and improvement activities, evaluating provider performance, and case management and care coordination. For example, the Plan may use your PHI to contact you or your doctor with information about treatment alternatives. Your PHI may also be used and disclosed for the Plan's legal and audit activities, including detecting fraud and abuse. The Plan will not use or disclose PHI that is genetic information for any purpose related to underwriting. Underwriting purposes includes eligibility for or determination of benefits under the Plan and coverage or cost changes in return for activities such as completing a health risk assessment or participating in a wellness program.

To Business Associates: The Plan may disclose your PHI to a business associate that has entered into a written agreement with the Plan to protect any PHI that it receives. Business associates provide various services to the Plan, including claims processing, data analysis, utilization review, legal, accounting, actuarial, consulting, and other management and administrative services.

To the Plan Sponsor: The Plan may disclose your PHI to the Plan Sponsor for Plan administration functions. Only authorized employees of the Plan Sponsor may use and disclose your PHI to carry out their duties to administer the Plan. Your PHI cannot be used or disclosed for employment-related purposes or to administer other benefit plans. The Plan may disclose a summary of PHI to the Plan Sponsor for purposes of modifying, amending, or terminating the plan, or obtaining premium bids with respect to the Plan. The Plan may also disclose PHI to the Plan Sponsor in connection with the enrollment or disenrollment of individuals.

To the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA privacy rule.

When Required by Law: The Plan may use or disclose your PHI if a law requires such use or disclosure. The use or disclosure will be limited to the relevant requirements of the law.

For Public Health Activities: The Plan may use or disclose your PHI to a public health authority that is responsible for collecting information to prevent, report, or control disease, injury, or disability and to conduct public health activities; to a government agency that receives reports of child abuse or neglect; and to the Food and Drug Administration ("FDA") for activities related to the safety and effectiveness of regulated products and services.

For Health Oversight Activities: The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits, investigations, and inspections. These health oversight agencies may include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

For Judicial and Administrative Proceedings: The Plan may disclose your PHI in the course of any judicial or administrative proceeding if authorized by a court order. The Plan may also

disclose your PHI in response to a subpoena or discovery request if you have been notified of the request or an order has been obtained to protect the PHI that is requested.

For Law Enforcement Purposes: The Plan may disclose your PHI in response to a request by a law enforcement official that is made through a court order, subpoena, warrant, summons, or similar process. The Plan may also disclose PHI to a law enforcement official's request for purposes of identifying or locating an individual (for example, a fugitive or missing person), about an individual who is suspected to be a victim of a crime, and about a deceased individual if there is suspicion that the death may have resulted from criminal conduct.

To Coroners, Medical Examiners, and Funeral Directors: The Plan may disclose your PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or other duties as authorized by law. The Plan may also disclose PHI as necessary for funeral directors to carry out their duties.

To Organ Procurement Organizations: The Plan may use or disclose your PHI to organ procurement organizations or other similar entities to facilitate organ, eye, or tissue donation and transplantation.

To Prevent a Serious Threat to Health or Safety: The Plan may use or disclose your PHI to prevent a serious and urgent threat to the health or safety of a person or the public if the disclosure is made to a person reasonably able to prevent or lessen the threat. The Plan may also use or disclose PHI if necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: The Plan may disclose your PHI to comply with workers' compensation laws and similar programs that provide benefits for work-related injuries or illnesses.

Others Involved in Your Health Care: The Plan may disclose limited PHI to a friend or relative that is involved with your health care or payment related to your health care, unless you object or request a restriction (in accordance with the process described below under "Right to Request Restrictions"). If you are not present or able to agree to these disclosures, then, using professional judgment, the Plan may make this disclosure if it is in your best interest.

Disclosures to You or Your Personal Representative: The Plan will disclose to you or your personal representative most of your PHI when you request access to this information. The Plan will disclose your PHI to an individual who has been designated by you as your personal representative or who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan must be given written documentation that supports and establishes the basis for the personal representation. The Plan may elect not to treat the person as your personal representative if the Plan has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person or treating such person as your personal representative could endanger you, and the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Uses and Disclosures of PHI that Require Your Authorization

The following categories describe uses and disclosures of your PHI that require your authorization.

Psychotherapy Notes: The Plan must obtain an authorization for any use or disclosure of your psychotherapy notes, unless the use or disclosure is for the purpose of defending itself in a legal proceeding that you initiated.

Marketing: The Plan must obtain an authorization for the use or disclosure of your PHI that is used for marketing purposes, unless the communication is face-to-face or is a small, promotional gift.

Sale of PHI: The Plan must obtain an authorization for any disclosure that is a sale of PHI.

Other Uses and Disclosures: Other uses and disclosures of PHI not covered by this Notice will be made only with your written authorization or that of your personal representative. If the Plan is authorized to use or disclose PHI about you, you or your personal representative may revoke that authorization, in writing, at any time, except to the extent that action has already been taken in reliance on the authorization.

Your Rights Concerning Your PHI

Right to Inspect and Copy your PHI: In most cases, you have the right to inspect and obtain a copy of your PHI that is maintained in a "designated record set" for as long as the Plan maintains the PHI. A designated record set contains medical and billing information records and any other records that the Plan uses for making decisions about you. The request must be submitted in writing to the Contact Person described at the end of this Notice. This right does not include the inspection and copying of psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

Right to Amend Your PHI: If you believe that your PHI is incorrect or incomplete, you have the right request an amendment to your PHI while it is maintained by the Plan. The request must be submitted in writing to the Contact Person described at the end of this Notice. Requests for amendment of PHI may be denied by the Plan.

Right to an Accounting of Disclosures: You have the right to request an accounting of the disclosures made by the Plan in the six years prior to the date on which the accounting is requested. The request must be submitted in writing to the Contact Person described at the end of this Notice. This accounting will not include disclosures made for the Plan's treatment, payment, and health care operations; disclosures made to you; disclosures incident to an otherwise permitted or required use or disclosure; disclosures made by your authorization; disclosures made to persons involved in your care; disclosures for national security purposes; disclosures made to law enforcement or to corrections personnel; or disclosures of de-identified PHI.

Right to Request Restrictions: You have the right to request a restriction on the Plan's use or disclosure of your PHI for treatment, payment, or health care operations; and disclosures to someone who may be involved in your care or payment for your care, like a family member or friend. The request must be submitted in writing to the Contact Person described at the end of this Notice. The Plan will not agree to restrictions on PHI uses or disclosures that are legally required, or that are necessary to administer the company's business or the Plan. The Plan must agree to a requested restriction if the disclosure is for the Plan's payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care

item or service that has been paid for in full by you or another person (other than the Plan) on your behalf.

Right to Request Confidential Communications: You have the right to request that the Plan communicate with you about PHI in a certain way or at a certain location if you indicate that communication in another manner may endanger you. For example, you can ask that the Plan only contact you at work or by mail. The request must be submitted in writing to the Contact Person described at the end of this Notice.

Right to Request Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice from the Plan upon request, even if you have previously agreed to receive the Notice electronically.

Changes to This Notice

The Plan is required to abide by the terms of this Notice currently in effect, however, **the Plan reserves the right to change the terms of this Notice at any time**. The Plan reserves the right to make the revised Notice effective for PHI it already has about you as well as any PHI that it receives in the future. You may receive a copy of any revised Notice by mail or by e-mail.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan by submitting the complaint in writing at the address listed below. You will not be penalized or subject to retaliation for filing a complaint.

Contact Information for the Plan

To exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact:

Compliance Officer
Benefits Department
Bridgestone Americas, Inc.
10 E. Firestone Blvd., Akron, Ohio 44317

Official Plan Documents

This Summary Plan Description describes only the highlights of the benefit programs. Benefits under all of the Company's employee benefit plans are determined under and governed by the official Plan documents, which include the Pension and Insurance Agreement for collectively bargained plans. If there is any conflict between the description presented here and the official Plan documents, the Plan documents will govern. Copies of the Plan documents may be obtained, at a reasonable cost, from the Pension and Benefits Department, Bridgestone Americas, Inc., 10 East Firestone Blvd., Akron, Ohio 44317.

Plan Administration

The medical, dental and vision plans, accident and sickness benefits plan, and survivor income benefits are provided through welfare plans established and funded by BATO and through required employee premiums. United Health Group, BlueCross BlueShield of Tennessee, Express Scripts, EyeMed Vision Care Plan and Delta Dental Plan of Tennessee, act as contract administrators or claims administrators for the respective healthcare plans and not as insurers or guarantors of the benefits provided by those plans. Bridgestone administers the flexible spending accounts and the short-term disability plan.

Life insurance benefits (not including survivor income benefits), accidental death and dismemberment benefits and optional life insurance plans are underwritten, insured, and administered by Metropolitan Life Insurance Company (MetLife). The insurance contracts between Bridgestone and MetLife govern the operation of the plans at all times. MetLife maintains all plan records for those benefits.

The Non-Contributory Pension Plan is a defined benefit pension plan administered by the Pension Board appointed by the Company's Board of Directors. Benefits are provided through the Bridgestone Americas, Inc. Pension Fund Master Trust. The trustee is Northern Trust Company, 50 South LaSalle Street, Chicago, Illinois 60675. The Company makes contributions to the fund in amounts determined by a qualified actuary. Assets in the pension fund are to be used only for payment of benefits to participants.

Your pension benefits under the Non-Contributory Pension Plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan’s normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov

The Employee Savings Plan for Bargaining Unit Employees is a defined contribution 401(k) plan administered by the Pension Board appointed by the Company's Board of Directors. Fidelity Investments is the trustee under the plans and receives, holds, invests and distributes the trust property in accordance with the provisions of the plans. The Savings Plan states that the Employer has the right at any time to amend or terminate the plan. In the event that the plan is terminated, all property in the trust funds would be used exclusively for distributions to plan participants. Upon plan termination, participants would receive distributions of their accounts as described earlier in this SPD.

The benefits of the savings plan are not subject to coverage by the Pension Benefit Guaranty Corporation because the plan is a defined contribution plan and is therefore excluded from PBGC coverage.

Loss of Benefits

The following circumstances, in addition to those circumstances described elsewhere in this SPD, will or might result in the partial or total loss of benefits under one or more of the plans described in this SPD:

- You do not complete the required enrollment forms when you are initially eligible to participate in the plan,
- You do not pay any required premiums,
- You or your beneficiary do not make proper, timely and complete application for any/all benefits or failure to furnish the necessary certificates or evidence that the Company may reasonably request,
- You do not meet the eligibility or vesting requirements for coverage or benefits as described in this SPD,
- The Plan, BATO or Bridgestone exercises its rights described under the *Coordination of Medical Benefits* or *Right of Reimbursement and Subrogation* sections of this SPD.

Your Protection Under ERISA

As a participant in the benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration,

- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 at no charge, and

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the pension plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The pension plan must provide the statement free of charge.

Continuing Group Health Care Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as the result of a qualifying event. You or your dependents may have to pay for this coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There will be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with 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 ends, 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 a pre-existing condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Hospital Length of Stay in Connection With Childbirth

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prudent Actions by Plan Fiduciaries

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 you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Pension Benefit Guaranty Corporation

Your pension benefits under the pension plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a Federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: 1) normal and early retirement benefits; 2) disability benefits if you become disabled before the plan terminates, and 3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: 1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates, 2) some or all of benefit increases and ne benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates, 3) benefits that are not vested because you have not worked long enough for the company, 4) benefits for which you have not met all of the requirements at the time the plan terminates, 5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater you're your monthly benefit at the plan's normal retirement age, and 6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of these benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the Federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at **http://www.pbgc.gov**.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous.

Assistance with Your Questions

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 your 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.

Hospital Stays after Childbirth

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Information

Plan Amendment and Termination

The explanation of benefits contained in this Summary Plan Description describes the benefits as they currently exist. These plans are governed by the official Plan documents, which include the Pension and Insurance Agreement (P&I) and/or the Collective Bargaining Agreement (CBA) for collectively bargained plans. Bridgestone reserves the right to amend, modify, suspend or terminate these employee benefit plans at any time and at its sole discretion notwithstanding any oral or written communication to the contrary. Included in this reserved right is the right to require premiums from participants or to modify existing premium requirements.

If any of the employee benefit plans are terminated, any claims incurred prior to the termination date, which were eligible expenses prior to the termination, would be covered by the plan.

Plan Administrator under ERISA

Bridgestone Americas, Inc.
535 Marriott Drive
Nashville, TN 37214
615-937-1000

Under ERISA, Bridgestone is the Plan Administrator of the employee benefit plans described in this Summary Plan Description. Bridgestone has appointed the Appeals Board to carry out the administration of the plans.. Among its other duties, the Appeals Board has the power, in its sole and absolute discretion, to (i) determine the eligibility of and right of any person to receive benefits under any employee benefit plan, (ii) determine the amount of benefits payable to a participant or beneficiary under any employee benefit plan, (iii) resolve questions and disputes arising under any employee benefit plan, (iv) make factual findings in connection with any employee benefit plan, and (v) interpret the provisions of any employee benefit plan.

Appeals Board and Employee Trust Investment Committee

Bridgestone Americas, Inc.
535 Marriott Drive
Nashville, TN 37214
615-937-1000

Disability Committee (for claims involving a determination of disability)

10 East Firestone Blvd.
Akron, Ohio 44317
(330) 379-6675

Type of Administration of the Plan

As described above, certain benefits provided under the plan are provided pursuant to an insurance contract with a specified insurance company, and other benefits are self-insured and administered by the Company or specified claims administrators.

Sources of Contributions to the Plan

The source of contributions for benefits under the plans is BATO and/or the participant depending on the benefit. Refer to your annual enrollment materials (and/or other Summary of Material Modification documents) for a list of the contributions required by participants for each of the benefits provided by the plan if such premiums are not incorporated as part of this SPD.

Qualified Domestic Relations Orders and Medical Child Support Orders

You may obtain, without charge from the Plan Administrator, the medical plan's procedures governing medical child support order (QMCSO) determinations, and the pension plan and savings plan procedures regarding domestic relations order (QDRO) determinations.

Agent for Service of Legal Process

Akron Legal Department
Bridgestone Americas, Inc.
10 East Firestone Blvd.
Akron, Ohio 44317
(330) 379-4437

The Plan Administrator and the plan trustees also act as agents for service of legal process for the plans.

Plan Administration Summary

Type of Benefit	Medical and Prescription Drug Benefits	Dental Benefits	Vision Benefits	Flexible Spending Accounts
Official Plan Name	Bridgestone Americas, Inc. Medical Expense Benefits Plan for Salaried Employees and Certain Hourly-Rated Employees			
Plan Sponsor and ERISA Plan Administrator	Bridgestone Americas, Inc., 535 Marriott Dr., Nashville, TN 37214			
Employer Identification No.	88-0335067			
Plan Number	505			
Plan Year for IRS Filing Purposes	January 1 through December 31			
Claims Administrator Address	BCBST 1 Cameron Hill Circle Chattanooga, TN 37402 Group #82020 UHC PO Box 740800 Atlanta, GA 30374-0800 Group #712560 Prescription Drug: Vendor: Express Scripts PO Box 790227 St. Louis, MO 63179-0227	Delta Dental Plan of Tennessee 240 Venture Circle Nashville, TN 37228-1699 Group #5712	EyeMed PO Box 8504 Mason, Ohio 45040-7111 Group #9758095	Bridgestone Americas, Inc. 10 East Firestone Blvd. Akron, Ohio 44317
Final claim appeal determinations are made by the Appeals Board				

Type of Benefit	Basic Life, Supplemental and Dependent Life Benefits, AD&D	Non-occupational Accident and Sickness Benefits	Pension Plan	Savings Plan
Official Plan Name	Bridgestone Americas, Inc. Employee Group Insurance Plan	Bridgestone Americas, Inc. Employee Group Insurance Plan	Bridgestone Americas, Inc. Non-Contributory Pension Plan	Bridgestone Americas, Inc. Employee Savings Plan for Bargaining Unit Employees
Plan Sponsor and ERISA Plan Administrator	Bridgestone Americas, Inc., 535 Marriott Dr., Nashville, TN 37214			
Employer Identification No.	88-0335067			
Plan Number	505	505	003	012
Plan Year for IRS Filing Purposes	January 1 through December 31		November 1 through October 31	January 1 through December 31
Claims Administrator Address	Metropolitan Life Insurance Co. Group Life Claims P. O. Box 6100 Scranton PA 18505		Bridgestone Benefits Appeals Board Bridgestone Americas, Inc. 535 Marriott Dr. Nashville, TN 37214	Fidelity Investments, Inc. 82 Devonshire Street Boston, MA 02109
	Final claim appeal determinations are made by the Appeals Board			