Yokohama

Retiree Health Reimbursement Arrangement

Summary Plan Description

Contents

Introduction

The Yokohama Retiree Health Reimbursement Arrangement (the "HRA Plan") is provided by Yokohama at no cost to eligible participants. It provides funds you can use to reimburse yourself, tax free, for qualfying medical, prescription drug, dental and vision premiums, and for certain medical, dental, and vision out-of-pocket expenses.

Yokohama Coorporation intends for the HRA Plan to qualify as a "health reimbursement arrangement" as that term is defiend under IRS Notice 2002-45 and a "medical reimbursement arrangement" under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended. This HRA Plan is also intended to be exempt from the Affordable Care Act as a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2). The HRA Plan will be interpreted at all times in a manner consistent with this intent.

This booklet is your Summary Plan Description (SPD). It has been developed to help you learn about and understand your benefits under the HRA Plan. The Plan Administrator is responsible for the administration of the HRA Plan. The Plan Administrator has the discretionary authority and the responsibility to, among other things, interpret the HRA Plan provisions, and to exercise discretion where necessary or appropriate in the interpretation, administration, and determination of eligibility for benefits under the HRA Plan. Although this HRA Plan has been summarized in everyday language, this booklet does not replace the legal documents governing the HRA Plan. This SPD describes the HRA Plan benefits in effect as of April 1, 2017.

If there are any differences between this information and the official HRA Plan document, the HRA Plan document governs.

Please keep in mind that although Yokohoma Corporation intends to continue this plan in its present form, Yokohoma Corporation reserves the right, by action of the appropriate representative, to amend, modify, suspend, or terminate, in whole or in part, the plan at any time. These modifications or terminations may be made for any reasons Yokohoma Corporation or its representatives deem appropriate, or as a result of changes in the laws that govern the plan.

Nothing in this booklet says or implies that benefits will remain unchanged in future years.

Please retain this SPD for your records. If you have any questions after reading this booklet, please contact:
Mercer Marketplace
P.O. Box 14401
Des Moines, IA 50306-3401
Phone: (866) 609-4809
Secure Fax: (857) 362-2999 (secure fax)
HRA@Mercer.com

Eligibility

Eligible retirees, spouses and domestic partners, as described below, are referred to herein as "participants".

Eligible Retirees

To be considered an eligible retiree for purpose of this HRA Plan, you must meet all of the eligibility requirements described below.

210 – Salaried, All Others (Yokohama and Mohawk)

- You are at least 55 years of age with a minimum of 10 years of service
- You were hired into a Mohawk facility prior to 1/1/1993

240 – Salem, Salaried (Old Mohawk)

- You are at least 55 years of age with a minimum of 10 years of service
- You were hired prior to 1/1/1993

250 – Salaried & SAS

- You are at least 55 years of age with a minimum of 10 years of service
- You retired on or after 8/1/1991

510 – Friend, Salaried & Hourly

- You are at least 62 years of age with a minimum of 20 years of service
- You retired on or after 8/1/1991

720 – Guntersville, Salaried

- You are at least 55 years of age with a minimum of 10 years of service
- You retired after 8/1/1991

720 – Guntersville, Hourly

- You are at least 55 years of age with a minimum of 10 years of service
- You retired after 3/1/1992

870 – SAS Rubber

- You are at least 55 years of age with a minimum of 15 years of service, or at least 65 years of age with a minimum of 20 years of service

- You retired after 3/1/1992

In addition, for all groups identified above, the following additional requirements must be met in order to be considered an eligible retiree for purposes of this HRA Plan:

- You were enrolled in Yokohama's retiree medical plan on 3/31/2017, and enrolled in Medicare and a medical plan available through Mercer Marketplace 365 on 4/1/2017 or when first becoming eligible for Medicare, or
- You were eligible to enroll in Yokohama's retiree medical plan on or after 4/1/2016, were retired, but did not enroll in Yokohama's plan but have established your HRA with Mercer Marketplace 365 effective 4/1/2017 and are enrolled in Medicare, or
- You were an active employee on 4/1/2017 and enroll in a medical plan available through Mercer Marketplace 365 upon retirement and eligible for Medicare at your first opportunity to enroll.

Eligible Spouse

To be considered an eligible spouse for purposes of this HRA Plan, your spouse must meet certain eligibility requirements, as described below.

- Your legal spouse is at least 65 years of age;
- Your legal spouse was covered under Yokohama's retiree medical plan on 3/31/17 or when the eligible employee retired if at a later date; and
- Your legal spouse has enrolled in a medical plan available through Marketplace 365 on 4/1/2017 or within 63 days of the date your spouse became eligible to enroll in Medicare Part A or Part B.

Eligible Domestic Partner

To be considered an eligible domestic partner for purposes of this HRA Plan, your domestic partner must be your same or opposite sex domestic partner who meets all of the requirements on the Declaration of Domestic Partnership Form. You and your domestic partner must submit an accurate and completed Declaration of Domestic Partnership Form, and meet all of the requirements listed on this form. Continued eligibility for your domestic partner depends on the continuing accuracy of this form. Domestic Partner eligibility ends on the date a domestic partner no longer meets all of the requirements listed on the form. Further, you domestic partner must meet the additional eligibility requirements, as described below.

- Your domestic partner is at least 65 years of age;
- Your domestic partner was covered under Yokohama's retiree medical plan on 3/31/17 or when the eligible employee retired if at a later date; and
- Your domestic partner has enrolled in a medical plan available through Marketplace 365 on 4/1/2017 or within 63 days of the date your spouse became eligible to enroll in Medicare Part A or Part B.

Other Dependents

Other dependents may not enroll or participate in this HRA Plan. However, you may use your HRA account

for reimbursement of your dependent's eligible expenses. Dependents whose eligible expenses can be reimbursed from your HRA account include:

- Your legally married spouse, whether or the same or opposite sex;
- Your children until the end of the year in which they turn age 26, regardless of student status, whether they are married or live with you and regardless of whether you provide any support,
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support,
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit) which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.)

When Participation Begins

Retiree

You may participate in the HRA Plan the first day of the month of your 65th birthday. However, if your birthday falls on the first day of the month, you will be eligible to begin participation one month earlier.

Spouse and Domestic Partner

When you retire, your eligible spouse or domestic partner may participate in the HRA the first day of the month of his/her 65th birthday. If your spouse's or domestic partner's birthday falls on the first day of the month, he or she will be eligible to begin participation one month earlier.

If your spouse or domestic partner does not enroll when initially eligible, such spouse or domestic partner will not be eligible to enroll as of a later date.

When Participation Ends

Retiree

Your participation in the HRA Plan ends on the earliest of the following dates:

- Your death;
- The date you are rehired as an active employee of Yokohama;
- The date you discontinue your medical coverage through Mercer Marketplace;
- The date you commit fraud or misrepresentation on the HRA Plan;
- The date the HRA Plan is amended, resulting in your ineligibility for HRA participation;
- The date the HRA is terminated.

If you die before your spouse or your domestic partner, your HRA will be forfeited at the time of your death. If your surviving spouse or domestic partner is age 65 or over and otherwise eligible to participate in the HRA Plan, he or she will continue to receive contributions to their HRA as long as he or she remains eligible to participate in this HRA Plan.

If your surviving spouse or domestic partner is under age 65 at the time of your death, your HRA will be forfeited at the time of your death. However, when your eligible surviving spouse or domestic partner turns age 65, he or she may become eligible for their own HRA so long as he or she otherwise satisfies the eligibility requirements to participate in this HRA Plan. .

If you are participating in the HRA upon your death and you do not have a surviving spouse or domestic partner, your HRA will be forfeited. However, your estate or representative may submit claims for reimbursement of eligible health care expenses incurred during your participation in the HRA. Claims must be submitted by March 31st following your death.

Spouse, Domestic Partner and Children

Your spouse's or your domestic partner's and your eligible children's participation in this HRA Plan ends on the earliest of the following dates:

- Upon death;
- The date you divorce or end your domestic partnership;
- The date you discontinue medical coverage through Mercer Marketplace;
- The date he/she commits fraud or misrepresentation on the Plan;
- The date the HRA is amended, resulting in in the spouse's/domestic partner's ineligibility to participate in the HRA plan; or
- The date the HRA is terminated.

Funding of the HRA Plan and Your Benefit Dollars

All funds placed into your HRA account are owned by Yokohama. Funding is provided periodically and in amounts determined at the discretion of Yokohama into a hypothetical tax-free account reflecting a bookkeeping concept. There are not assets actually set aside for the exclusive purpose of providing benefits to the participants or that are protected from the Company's creditors. Under federal law, you are not permitted to make any contributions to your HRA account, whether made on a pre-tax or after-tax basis.

Yokohama determines the monthly contribution amount each year to be placed into your HRA account to be used for eligible medical expenses. To the extent that your spouse or domestic partner is eligible to participate in this HRA Plan, you and such spouse/domestic partner will have a separate HRA account and each account will receive a separate monthly contribution amount, the amount of which will be determined by Yokohama. There is no maximum dollar amount that can be contributed to your HRA.

Carryover

Unused HRA Plan account balances carryover to the following year as long as you remain eligible for the HRA Plan.

Eligible Reimbursements

You may use your HRA for reimbursement of certain eligible expenses, provided the expense:

- Has been incurred by you, your spouse, or your eligible tax dependent;
- Is not reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement;
- Does not exceed your HRA account balance;
- Is incurred while you are participating in the HRA; and
- Is considered to be tax-deductible under Internal Revenue Code Section 213.

Further, any medical care expense that is attributable to a deduction allowed under Internal Revenue Code Section 213 that has been claimed for any prior taxable year is not reimbursable from the HRA.

Eligible Expenses

Premium Expenses

The HRA Account may be used to pay for premium expenses to cover medical related premium payments. The types of premium expenses can include:

- Medical Supplement Policy premiums;
- Medicare Part C/Medicare Advantage premiums;
- Medicare Part D premiums;
- Medicare Part B premiums
- Medical plan premiums
- Dental plan premiums
- Vision plan premiums

Other Out-Of-Pocket Expenses

The HRA Plan allows you to be reimbursed for your eligible out-of-pocket medical, dental, and vision expenses to the degree that funds are available. Eligible out-of-pocket expenses include copayments, deductibles and coinsurance payments. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the HRA Account include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person’s general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

Over-the-counter medications (except insulin) are no longer eligible for reimbursement without a prescription. You will need a doctor's prescription indicating that the medications are medically necessary in order to be reimbursed from the HRA Account. Insulin may continue to be reimbursed without a prescription. You may still submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

Below is a partial list of expenses eligible for reimbursement under the HRA Account:

- Medical Expenses
  - Deductibles
  - Copayments
  - Charges for routine check-ups, physical examinations, and tests connected with routine exams
  - Charges over the "reasonable and customary" limits
  - Expenses not covered by the medical plan due to exclusion by the insurance company
  - Drugs requiring a doctor's written prescription that are not covered by insurance
  - Over-the-counter drugs, if obtained with a prescription, and only as permitted under applicable law or regulation. Certain other over-the-counter items such as bandages, crutches, and other supplies will be reimbursable without a prescription, but only to the extent applicable regulations permit
  - Insulin (which may be reimbursed without a prescription)
  - Smoking cessation programs and related medicines
  - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
  - Other selected expenses not covered by the medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches).
- Dental Expenses
  - Deductibles
  - Copayments
  - Expenses that exceed the maximum annual amount allowed by your dental plan
  - Charges over the "reasonable and customary" limits
  - Orthodontia treatments that are not strictly cosmetic
- Vision and Hearing Expenses
  - Vision examinations and treatment not covered by insurance plan
  - Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
  - Cost of hearing exams, aids and batteries
- Transportation - Amounts paid for transportation for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

Ineligible Expenses

Below is a partial list of expenses ***not*** eligible for reimbursement under the HRA Account:

- Over-the-Counter drugs or items without a prescription unless specifically permitted under applicable law or regulation
- Cosmetic Procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- Expenses Related to General Health - Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Plan Administrator.

Requesting Reimbursement From Your HRA Account

Filing a Claim

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Claims can be submitted on a daily basis and reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator (as identified below).

All claims for a Plan Year must be submitted to the Claims Administrator by March 31st after the end of the year in which such claim was incurred. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator, even if there are funds in your HRA Account.

To be reimbursed for an eligible expense, submit a reimbursement form, called a One Time Expense form, for the eligible medical or premium expense incurred. Proof of the paid premium or eligible medical expense must be included. Proof of premium documentation should include the participant's name, billing period date and premium amount, and can be in the form of a welcome letter, an invoice or account statement summary, a declaration page or an Annual Notice of Change. For other eligible medical expenses, proof may be in the form of an Explanation of Benefits (EOB) from an insurance carrier or a statement or invoice from a health care provider or pharmacy.

Claims may be submitted directly through the website portal, emailed, faxed or sent through the mail to the appropriate contact information listed below.

The Claims Administrator for the HRA Account is Mercer Marketplace.

You may contact the Claims Administrator by phone at (866) 609-4809 or in writing at:

Mercer Marketplace
P.O. Box 14401
Des Moines, IA 50306-3401
(857) 362-2999 (secure fax)
HRA@Mercer.com

COBRA

Under federal law, eligible dependents may lose coverage due to a COBRA qualifying event such as a divorce, death or a child ceasing to be an eligible dependent.

Eligible dependents are required to notify the Plan Administrator in writing of a qualifying event within 60 days of the event or they will lose the right to continue coverage under the Plan. If an eligible dependent elects to continue coverage, he/she is entitled to the level of coverage the Plan in effect immediately preceding the qualifying event.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of the qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he/she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he/she becomes covered under another group health plan; or
- The employer ceases to provide any group health plan.

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Claims Denials and Appeals

This section provides general information about the claims and appeals procedure applicable to the HRA Plan under ERISA.

Claim-Related Definitions

"Claim" is any request for plan benefits made in accordance with the plan's claims-filing procedures..

"Adverse Benefit Determination" is a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review; and
- A service being characterized as experimental or investigational or not medically necessary or appropriate.

Initial Claim Determination

The HRA Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the HRA Plan has to evaluate and respond to a claim begins on the date the HRA Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator. The timeframes on the following pages apply to the claims that you may make under the Plan.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

	The HRA Plan
Time frame for Providing Notice	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.
Extensions	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*
Period for Claimant to Complete Claim	You have at least 45 days to provide any missing information.
Other Related Notices	N/A

*15 extension period is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing and should be filed with the Plan Administrator as listed on page 20.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described on page 17. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

The time periods for providing notice of the benefit determination on review are described in the following chart.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan.

Time Frames for Appeals Process

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	The HRA Plan
Period for Filing Appeal	You have at least 180 days.
Time frame for Providing Notice of Benefit Determination on Review	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.
Extensions	None.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, Benefit Booklets, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Benefit Booklets 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, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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 (if any) 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 medical child support 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 is 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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.

Administrative Information

Below is key information you need to know about your benefit plans:

Plan Name	Yokohama Retiree Health Reimbursement Arrangement Plan
Plan Number	515
Plan Sponsor	Yokohama 1500 Indiana Street Salem, VA 24153
Employer Identification Number	95-2624417
Plan Administrator	Yokohama 1500 Indiana Street Salem, VA 24153 1-800-423-4544
Agent for Service of Legal Process	Plan Administrator
Plan Year	January 1 through December 31 ; Short plan year starting on April 1, 2017 and ending on December 31, 2017
Plan Type	Retiree Health Reimbursement Account

Source of Contributions	Yokohama pays 100% of the cost of the Health Reimbursement Account. Yokohama, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time.

Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

Yokohama reserves the right to amend the HRA Plan in whole or in part or to completely discontinue the Plan at any time.

Any amendment, termination or other action by Yokohama will be done in accordance with Yokohama's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Yokohama, the Plan shall terminate unless the Plan is continued by a successor to Yokohama.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Yokohama to the extent permitted under applicable law.

Plan Administration

Yokohama is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD or in the Plan document. Yokohama has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of retirees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Yokohama will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor Yokohama will be liable in any manner for any determination made in good faith.

Yokohama may designate other organizations or persons to carry out specific fiduciary responsibilities for Yokohama in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Yokohama will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

HIPAA

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Yokohama Retiree Health Reimbursement Arrangement. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Yokohama Retiree Health Reimbursement Arrangement (referred to as "the Plan" in this notice, unless specified otherwise).

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Yokohama as an employer — that's the way the HIPAA rules work. Different policies may apply to other Yokohama programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Yokohama

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Yokohama for plan administration purposes. Yokohama may need your health information to administer benefits under the Plan. Yokohama agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The Manager of Benefits and the Director of Human Resources are the only employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Yokohama, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Yokohama, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Yokohama information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Yokohama cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Yokohama from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement),

or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan

(unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on April 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this

notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via first class mail.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact the Privacy Officer, as described below.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact Brenda Fleming at 1-800-423-4544.