

COOPER
TIRE & RUBBER COMPANY
Benefits Enrollment
Guide 2010



Be { Fit
Engaged
Cooper

Welcome...

to the 2010 Cooper Health & Well-Being Program. Cooper is pleased to offer this comprehensive benefit program to you and your family.



Table of Contents

Getting Started

| | |
|---|---|
| Active Enrollment _____ | 2 |
| Employee's Hired on or after 1/1/2009 _____ | 2 |

Eligibility

| | |
|--|---|
| Employee Eligibility _____ | 3 |
| Your Dependents _____ | 3 |
| When Your Eligibility Terminates _____ | 4 |
| Changing Your Coverage _____ | 4 |
| About the Program _____ | 4 |

Coordination of Benefits

| | |
|--|---|
| Married Employees Both Working at Cooper _____ | 5 |
| Birth Date Rule _____ | 5 |
| Divorced/Separated Parents _____ | 6 |
| Primary/Secondary Plans _____ | 6 |
| Non-Duplication of Benefits _____ | 6 |

How to Enroll

| | |
|---|---|
| Steps for Enrolling _____ | 7 |
| Personalized Enrollment Worksheet _____ | 8 |
| Things to Consider _____ | 9 |

Managing the Cost of Your Benefits

| | |
|---|-------|
| Your Benefit Options _____ | 10 |
| Medical/Prescription Drug Plans _____ | 11-16 |
| Dental Plan _____ | 17-18 |
| Vision Plan _____ | 19-20 |
| Spending Account Updates _____ | 21 |
| Health Care Spending Account (HCSA) _____ | 22 |

Worksheets & Examples

| | |
|---|-------|
| Health Savings Account (HSA) _____ | 23 |
| Health Care Spending Account (HCSA) _____ | 24-25 |

Getting Started

This Enrollment Guide provides information about the plans within Cooper's 2010 Health & Well-Being Program, as well as instructions on how to enroll. Cooper has implemented Blue Cross Blue Shield (Anthem), a national network provider.



Active Enrollment

All eligible employees must actively enroll for 2010 Health & Well-Being benefits. You must actively enroll for all medical and insurance coverages, including dental and vision. **Remember, if you do not enroll, you will not receive benefit coverage for 2010.**

Employee's Hired on or after 1/1/2009

Employee's hired on or after 1/1/2009 and who are eligible for Medical/ Prescription Drug coverage effective on or after 4/1/2009 are eligible for the Consumer Choice option only. Please note that as you go through the open enrollment process, your only choices under the Medical/ prescription Drug coverage will be Employee Only, Employee + One or Employee + Family.

To enroll in the Health & Well-Being Program, access the Web anytime between October 5 - October 25 at **<https://hrms.sequent.biz>** or call the Benefits Call Center toll-free at **1-888-474-1148** weekdays between 11 a.m. and 7 p.m. EST.

**IMPORTANT
NOTE TO NEW
COOPER PEOPLE:**

You must enroll to receive benefits for 2010. To cover your currently eligible dependents, you must also enter all dependent information for 2010.

Before the Open Enrollment session, be sure to read “Your Dependents” section to determine if they are eligible for coverage under Cooper’s Health & Well-Being program.

Eligibility

Employee Eligibility

All U.S.-based and expatriate full-time Cooper people are eligible to participate in Cooper’s Health & Well-Being Program.

Your Dependents

Eligible dependents include the following:

- Your legally acknowledged spouse
- Children who are wholly dependent upon you for support and maintenance in accordance with the tax code, including:
 - Your unmarried children under 19 years old
 - Your unmarried children to age 25 who are full-time students in an accredited school. Full-time students are eligible for benefits until midnight on the day of their 25th birthday
 - Stepchildren, legally adopted children and children over whom you have legal guardianship, as long as they reside with you in a normal parent/child relationship (eligibility is subject to the appropriate legal documentation)
 - A child for whom you are required to provide health care coverage under a Qualified Medical Support Order
 - A child who is physically or mentally incapable of self support and is 19 years or older. Coverage is subject to a physician’s written certification, as well as your own coverage remaining in effect

Coverage for your children added to the plan due to birth or adoption will begin as of the date of birth or adoption.

Coverage for a spouse or dependent children) added or deleted due to a qualifying status change will be effective as of the date of the qualifying event, provided that you notify Cooper within 31 days of the qualifying event. If you do not notify Cooper within 31 days of the qualifying event, you must wait until the next open enrollment period to add or delete these dependents.

When Your Eligibility Terminates

For a thorough description of when eligibility terminates, please refer to Paragraph 11.14 Termination of Insurance, in the Pension & Insurance Program Agreement.

Changing Your Coverage

The benefits you choose are in effect for the entire year, unless you experience a qualified status change. If you want to change coverage in the event of a qualified status change, you must change your benefit choices within 31 days of the event. Changes to your coverage must be consistent with the particular change in status you experience.

You experience a qualified status change if:

- You gain or lose a dependent (for example through birth, adoption, marriage, divorce, death);
- Your spouse or dependent is no longer eligible, or is newly eligible, for coverage under Cooper's benefits program;
- Your spouse's or dependent's eligibility for benefits through his or her employer changes;
- Your employment status changes from benefits eligible to ineligible, or vice versa.
- You or your dependent becomes entitled to Medicare or Medicaid.

About The Program

This Enrollment Guide provides a summary of the Cooper Health & Well-Being Program. Program provisions described here are governed by the benefit contracts and plans. In the event of a conflict between the Enrollment Guide and the respective benefit contracts and plans, the respective benefits contracts and plans shall govern. Nothing in this or any other benefits document or oral representation should be construed as an employment contract or a guarantee of benefits. *The plan is typically amended annually and the Company will discuss changes with the Union prior to the change being implemented.*

The logo features the word "Be" in a large, bold, sans-serif font. To its right, a large curly bracket groups the words "Fit", "Engaged", and "Cooper" stacked vertically in a smaller, sans-serif font.

Status Changes:

If you experience a qualified status change you cannot change the current option, only the level of coverage (i.e.: move from Employee Only to Employee + one).

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Coordination of Benefits

Married Employees Both Working at Cooper

To ensure consistency in how our plans are administered, you cannot be covered as both an employee and a dependent under the Health & Well-Being Program. If you are married to another Cooper person who is eligible for this program, the following guidelines have been established to be as fair as possible.

For the Medical/Prescription Drug Plan, if you have no additional dependents (i.e., children), you and your spouse must each enroll in employee only coverage. If you and your spouse have dependent children, the employee with the earlier calendar year birth date is responsible for covering your entire family (i.e., you must select the employee + two or more coverage level), and your spouse must select No Coverage.

These guidelines ensure that all Cooper people are treated the same and that a family unit does not have to incur additional expenses (e.g., higher deductibles and copays) simply because both adults are employed at Cooper.

Birth Date Rule

When more than one plan covers the same child as a dependent of natural parents who are not divorced or separated, the primary plan is the plan of the parent whose birth date (month and day) falls earlier in the year. The secondary plan is the plan of the parent whose birth date falls (month and day) later in the year. If both parents have the same birth date, the plan that has covered the parent longer is the primary plan. The plan that has covered the parent the shorter time will be the secondary plan.

Divorced/Separated Parents

If the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is the primary plan. Otherwise, if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for that child are determined in the following order:



1 the plan of the parent with custody of the child

2 the plan of the step-parent with custody

3 the plan of the parent without custody of the child

Primary/Secondary Plans

The medical/prescription plan that covers a person as an employee – rather than as a dependent – is always considered to be the primary plan. The plan that covers the person as a dependent is the secondary plan. When a Cooper person’s spouse is also employed full-time, and the spouse’s employer makes any contribution to the cost of the medical/prescription plan, the spouse must enroll in his or her medical plan. Cooper’s medical plan will be secondary to the spouse’s medical plan with respect to coverage for the spouse.

Non-Duplication of Benefits

If another plan is primary, the Cooper plan will pay secondary benefits only up to an amount which, when added to the primary plan payment, equals the amount Cooper would have paid as the sole plan.

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How to Enroll

Steps for Enrolling

To enroll, follow these step-by-step instructions:

- Thoroughly read your Enrollment Guide to understand your options and plan provisions.
- Take into account other sources of coverage when making your benefit choices.
- Gather the Social Security numbers and dates of birth you'll need (those of your dependents if you are enrolling them for the first time).
- Calculate previous years' *health* care expenses and anticipated expenses for 2010.
- Use your Personalized Enrollment Worksheet (PEW) to determine your benefit choices and calculate costs.
- Make your enrollment choices.
- Submit your completed form to your local HR representative.

Personalized Enrollment Worksheet

A Personalized Enrollment Worksheet (PEW) will be provided to help you organize your 2010 coverage choices. This worksheet is for your use, to fill out and use as a reference during the enrollment process.

Your Personalized Enrollment Worksheet (PEW) includes the following sections:

- 1 Personal information**
Review this information to ensure accuracy. Call your local Human Resources representative if this information is incorrect.
- 2 Dependent information**
Complete this section before enrolling for easy reference.
- 3 Benefit plan options and associated per-pay-period price tags**
This information helps you plan your choices and costs. These sections list your plan options and coverage levels/amounts, along with the associated price tags.
- 4 Effect on pay worksheet**
This table is provided to help you determine pre-tax and after-tax price tags and the net effect on your pay.

IMPORTANT NOTE:

Your Personalized Enrollment Worksheet (PEW) must be completed and provided to your local HR representative.

To enroll in the Health & Well-Being Program, access the Web anytime between October 5 - October 25 at <https://hrms.sequent.biz> or call the Benefits Call Center toll-free at **1-888-474-1148** weekdays between 11 a.m. and 7 p.m. EST.

Things to Consider

When making your benefit plan choices, ask yourself:

- 1** Which plan coverage option will best meet my needs and those of my family?
- 2** What were my previous years' health needs? Do I expect these needs to change in 2010?
- 3** Do I expect special health needs for 2010 that will be better met with higher levels of coverage?
- 4** How often do I and my family members visit a doctor? A dentist? Other health care providers?
- 5** Is this my only option for medical coverage, or can I receive medical coverage from another source?

Note:

Employees hired on or after 1/1/2009 and who are eligible for Medical/ Prescription Drug Coverage effective on or after 4/1/2009 are eligible for the Consumer Choice option only.

Managing the Cost of Your Benefits

Your Benefit Options

Cooper understands that managing the cost of benefits can be challenging.

The Health Savings Account (HSA) and Health Care Spending Account (HCSA) can help you manage rising benefit costs.

The Health & Well-Being Program described in this guide includes the following plans:

- Medical/Prescription Drug
- Health Savings Account (HSA)
Note: Only available with the Consumer Choice option
- Dental
- Vision
- Health Care Spending Account (HCSA)
Note: Only available with the Traditional PPO option or if you opt out of medical coverage.



IMPORTANT MESSAGE

If you choose the Consumer Choice option, you will need to establish your Health Savings Account (HSA) with The Principal Financial Group in order to receive the Company contribution (\$250 for Employee only coverage or \$750 for Family coverage) and to deposit your payroll deductions. The Company cannot establish it for you. The effective date of the account will be 01/01/2010. You will need to have your driver's license available when establishing your account, along with information on your beneficiaries.

If you established an HSA account with Principal Financial Group in 2009, and it is still an active account, you will not need to go through this process again.

The web address for the application is:

<https://secure02.principal.com/bank/apps/naohsa/index.do?sponsor=HSA0001292>

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Catch up Feature

Similar to the 401(k) catch-up offered to employees aged 55-plus, the HSA provides these employees with an opportunity to make additional contributions to save for medical costs during retirement.

If you are 55 years or older as of January 2010 or if you will turn 55 during the year, you can contribute an additional \$1,000 to your HSA account.

Coordinated Coverage

Employees cannot enroll in Cooper's HSA if they are receiving coordinated coverage under their spouses' health care plan (at a different company) unless that plan is also HSA qualified. If you are receiving coverage under your spouse's health care plan, contact your spouse's company to determine if that plan is HSA qualified.

Medical/Prescription Drug Plans

Your PEW will list the medical plan choices available to you.

Consumer Choice

The Consumer Choice option is designed for individuals who infrequently see doctors but who want health care protection in the event of a major illness or injury and/or who want to participate in the Health Savings Account (HSA).

The Consumer Choice option is the least expensive of the options and you have the choice of In or Out-of-Network benefits. However, the deductibles are higher and there are higher out-of-pocket maximums. In addition, there are no co-pays for your prescription drug costs - those are applied to your deductible and are covered at 80 percent after you've met your deductibles. Please see chart on page 15 for details

If you choose the Consumer Choice option you must participate in a Health Savings Account (HSA). You will not be eligible for the Health Care Spending Account (HCSA)

Health Savings Account (HSA)

A Health Savings Account (HSA) allows active employees to pay for their current medical expenses and save for future medical expenses, including those incurred during retirement.

You may use your HSA account to pay for your **medical expenses** or pay for **dental** and **vision expenses** or when purchasing **prescription drugs** and certain over-the-counter drugs.

How HSAs work

Once you have selected the Consumer Choice option, you must select the amount you want to contribute to the Health Savings Account. You must contribute a minimum annual goal amount of \$260.00.

For 2010, **Cooper will contribute \$250 for employee only and \$750 for employee plus one or more into your HSA account. The HSA annual maximum no longer is tied to the deductible. Therefore the maximum contributions allowed are:**

| | | | | |
|---------------------|-------------|-----------------------|---------------|--------------------|
| Cooper contribution | <i>plus</i> | Employee contribution | <i>equals</i> | HSA annual maximum |
| \$250 | - | \$2,800 | = | \$3,050 |
| | | <i>or</i> | | |
| \$750 | - | \$5,400 | = | \$6,150 |

When enrolling, you will be asked to certify that you are eligible to participate in an HSA. One question that will be asked is whether or not the Consumer Choice plan is a qualified high deductible health plan (HDHP). The answer is "yes". Our plan meets the federal requirements of an HDHP.

Although you may use your HSA account to pay for your **medical expenses** at the time of service, it is advisable to wait until you've received your Explanation of Benefits from Health Design Plus to confirm your cost. You can also use your HSA account to pay for **dental** and **vision** expenses or when purchasing **prescription drugs** and certain over-the-counter drugs. Just like a regular checking account, you may only write checks up to the amount of the current balance in the account.

Any funds you do not use will be **carried over** from year to year and can be used up through retirement. Each year you will have the option to continue with the Health Savings option and continue to contribute to the account. Even if you stop contributing to the account, you can continue to use the HSA to pay for eligible expenses until the account is depleted.

A **service fee** of \$3.00 plus tax per month will be imposed by Principal Bank on the account.

If you maintain a balance of \$3,000, the monthly maintenance fee will be waived.

Your Principal HSA checking account is designed to help you accumulate funds on a tax favored basis and easily make withdrawals to pay your deductible or other qualified medical expenses.

As an increased benefit to Cooper Tire employees with the Principle HSA, Principle is increasing the number of free withdrawals per monthly statement cycle from six free withdrawals per monthly statement cycle to twelve free withdrawals per monthly statement cycle. Withdrawals over twelve per monthly statement cycle will be assessed a \$10.00 per item excess transaction fee.

Once you have elected to enroll in the Consumer Choice Plan, you will be required to set up your Health Savings Account with Principle Bank online at the following address, if you do not have an active 2009 account.

<https://secure02.principle.com/bank/apps/naohsa/index.do?sponsor=HSA0001292>

For those of you who are using the HSA for retirement savings, you may move it into a mutual fund or CD platform for a better return and no monthly fee. Minimum investment is \$1000. For checking account and CD interest rates, please refer to the following address at the Principal Financial Group:

<https://secure02.principal.com/bank/apps/rates/index.do>

The deadline for setting up your HSA with Principal is November 20, 2009. If you do not set up your account by this date, you will not be eligible to receive the Cooper contribution.

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When choosing your Medical/Prescription Drug Plan option, ask yourself:

- What medical expenses did I have in previous years? How many of these expenses will I have again this year?
- How often am I – and/or my dependents – likely to visit a doctor?
- Do I have special health needs that will be better met with a certain level of coverage?
- Is this my only option for medical coverage, or can I receive medical coverage through another source?
- How much of my medical expenses, not covered by the Medical/Prescription Drug Plan, can be reimbursed through my Health Care Spending Account?

Preferred Provider Organization (PPO)

Both the Consumer Choice and Traditional PPO options offer the same services and procedures but differ in how you share costs. With both of the PPO options, you have a choice every time you seek care. The Consumer Choice offers higher deductibles, higher out-of-pocket costs and higher copays than the Traditional PPO, but you will pay less for your coverage.

- **In-network providers** participate in an established network, providing services to participants at negotiated, discounted rates. When you receive services from this pre-selected group of providers, you pay less out of your pocket.
- **Out-of-network providers** do not participate in an established network. When you obtain services from out-of-network providers, charges and coinsurance will likely be higher. You pay more out of your pocket, but you have more providers from which to choose.

Medical/Prescription Drug Price Tags

| Medical/Prescription Drug | | Weekly Deduction (Tobacco User) | Weekly Deduction (Non-Tobacco User) |
|---------------------------|-------------------|------------------------------------|--|
| Consumer Choice | Employee Only | \$ 20.83 | \$ 6.23 |
| | Employee + one | \$ 27.34 | \$ 12.74 |
| | Employee + family | \$ 33.84 | \$ 19.25 |
| *Traditional PPO | Employee Only | \$ 33.84 | \$ 19.25 |
| | Employee + one | \$ 53.37 | \$ 38.78 |
| | Employee + family | \$ 72.90 | \$ 58.31 |

***Traditional PPO is not available to employees hired on or after 1/1/2009**

Tobacco Cessation Credit

As part of our emphasis on health and well-being, Cooper is encouraging employees who use tobacco to “kick the habit” by offering free tobacco cessation programs. In 2010, you will have the opportunity to reduce your cost of healthcare by \$14.60 per week if:

- You do not currently use tobacco, or
- You currently use tobacco but intend to quit and enroll in the cessation program for 2010. The cost of the health care will be reduced after completion of the 6-month tobacco cessation program.

Cooper Tire will continue to cover tobacco cessation programs and prescription drugs in 2010 for those employees who currently use tobacco and intend to quit. Look for more information about this program in the next few months. In the meantime, when you enroll for benefits, you will be asked whether you currently use tobacco, currently use tobacco and intend to quit, or you do not use tobacco at all.

Wellness counts include (Will reduce the price tags above)

- (1) On-site health evaluations including a blood pressure check and blood test;
- (2) Test results and health information available on line and mailed to your home; and
- (3) Access to health coaches by phone.

Participants will receive a \$250 discount on the cost of your health care premiums in 2010.

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| | Consumer Choice | | Traditional PPO Option | |
|--|---------------------------------|---------------------------------|---------------------------------|----------------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| | Available at all locations | | Where a network is available | |
| Calendar Year Deductible | \$1,300/ \$2,600** | \$2,600/ \$4,200 | \$500/ \$1,000 | \$900/ \$1,800 |
| Coinsurance | Covered at 80% after deductible | Covered at 60% after deductible | Covered at 80% after deductible | Covered at 60% after deductible |
| Maximum Out-of-Pocket Limits (included deductible) | \$3,500/ \$7,000** | \$5,000 \$10,000 | \$2,300/ \$4,600 | \$4,550/ \$9,100 |
| Office Visit Copay Primary Care Specialist | Covered at 80% after deductible | Covered at 60% after deductible | \$25 copay* \$35 copay | Covered at* 60% after deductible |
| Urgent Care Copay* | Covered at 80% after deductible | Covered at 60% after deductible | \$40 copay | Covered at 60% after deductible |
| Emergency Room Copay | Covered at 80% after deductible | Covered at 60% after deductible | \$100 copay* | Covered at 60% after* deductible |
| Hospital Copay Inpatient | Covered at 80% after deductible | Covered at 60% after deductible | \$250 copay* | Covered at 60% after deductible |
| Routine Adult Physical Exam Primary Care Specialist | 100% for preventive | 60% after deductible | \$25 copay \$35 copay | Covered at 60% after deductible |
| Adult Preventive Testing | Covered at 100% | 60% after deductible | Covered at 100% | Covered at 60% after deductible |
| Inpatient Mental Health | Covered at 80% after deductible | Covered at 60% after deductible | \$250 copay | Covered at 60% after deductible |
| Inpatient Substance Abuse Benefits | Covered at 80% after deductible | Covered at 60% after deductible | \$250 copay | Covered at 60% after deductible |

* Copays do not apply toward the deductible or the maximum out-of-pocket limits under the Traditional PPO option.

** Under HSA, individual deductible and Maximum Out-of-Pocket Limits are embedded in the family deductible and maximum Out-of-Pocket if participant chooses family coverage. In other words, if the individual choose the family coverage, the individual must meet the \$2,600 Calendar Year Deductible and the \$7,000 maximum Out-Of-Pocket.

***Cost of Outpatient Mental Health/Substance Abuse does not accumulate toward Maximum Out-of-Pocket Limits

Traditional PPO is not available to employees hired on or after 1/1/2009

| | Consumer Choice | | Traditional PPO Option | |
|---|--|---------------------------------|---|---------------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Prescription Drugs- Participating Pharmacy (30-day supply only; no refills)* | 100% for Preventive drugs Otherwise, 80% after deductible | 60% after deductible | <i>Generic</i> 10% (\$10 minimum, \$25 max) <i>Preferred Brand</i> : 20%(\$25 minimum, \$100 max) <i>Non-Preferred Brand</i> : 20% (\$60 minimum) <i>Specialty *Non-Preferred Brand</i> 20% (\$250 max) | |
| Prescription Drugs - Mail (90-day supply)* | 100% for Preventive drugs Covered at 80% after deductible | 60% after deductible | <i>Generic</i> \$30 copay <i>Preferred Brand</i> : 20% (\$65 min, \$250 max) <i>Non-Preferred Brand</i> : 20% (\$125 minimum) Specialty: 20% (\$750 max) | |
| Outpatient Mental Health/ Substance Abuse | Covered at 80% after deductible | Covered at 60% after deductible | \$35 copay | Covered at 60% after deductible |
| Lifetime Maximum | \$2 million per person | | \$2 million per person | |

When purchasing prescriptions, if a generic option is available but you choose a brand, you must pay the generic copay plus the cost difference between the brand and generic drugs. This also applies if a generic is available but your doctor has indicated dispense as written (DAW) on the prescription.

Cooper's prescription benefit manager, Medco, maintains a list of "preferred" drugs that often are more cost effective than other brand drugs. For the Cooper plan, that copay is reflected as the Preferred Brand. Employees who purchase a Non-Preferred Brand will be charged a higher copay. Additionally, the Preferred Brand list is accessible by all doctors across the country for reference. Please notify your doctor he/she should reference Medco's Preferred Brand list when prescribing for you.

Note: Non-preferred drugs are no longer covered by the plan unless the member obtains approval through a coverage review.

Traditional PPO is not available to employees hired on or after 1/1/2009

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When choosing your Dental Plan option, ask yourself:

- What level of dental care did I receive in previous years? What do I expect to need during the next two years?
- Is this my only option for dental coverage, or can I receive dental coverage through another source?
- What amount of my dental care expenses, not covered by the Dental Plan, can be reimbursed through my Health Care Spending Account or Health Savings Account?

Dental Plan Options

Note: These options only apply to employees hired on or after 1/1/09.

In choosing your Dental Plan coverage, you may choose between the No Coverage option, the Basic Dental option, or the Premium Dental option. The dental coverage you choose will remain in effect for two years, although the cost for the coverage can change during that time.

If you enrolled for dental coverage during last years enrollment, your coverage will automatically continue for the remainder of your two-year term, extending through 2010.

You must have coverage on yourself, as an employee, to have a dependent in the Dental Plan.

Your Dental Plan options are summarized in the following chart:

| | Basic | Premium |
|---------------------------|--|---|
| Calendar Year Deductible | Single \$50/ Family \$150 (does not apply to preventive) | Single \$25/ Family \$75 (does not apply to preventive) |
| Coinsurance % | | |
| • Preventive | Covered at 80% | Covered at 100% |
| • Basic | Covered at 50% after deductible | Covered at 80% after deductible |
| • Major | Covered at 50% after deductible | Covered at 50% after deductible |
| Annual Maximum | \$750 per person | \$1,500 per person |
| Orthodontics (Child only) | | |
| • Coinsurance | Covered at 50% after deductible | Covered at 50% after deductible |
| • Lifetime Maximum | \$750 | \$1,500 |
| Election | 2-year enrollment commitment | |

Dental Plan Price Tags

| Dental Plan | | 2010 Annual Employee Cost | Weekly Deduction |
|----------------|-------------------|---------------------------|------------------|
| Basic | Employee Only | \$ 69 | \$1.33 |
| | Employee + one | \$236 | \$4.54 |
| | Employee + family | \$471 | \$9.06 |
| Premium | Employee Only | \$201 | \$ 3.87 |
| | Employee + one | \$552 | \$10.62 |
| | Employee + family | \$943 | \$18.13 |

Note: the premiums listed above apply only to the employees hired on or after 1/1/2009.

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When choosing your Vision Plan option, ask yourself:

- What level of vision care did I receive in previous years? What do I expect to need during the next year?
- Is this my only option for vision coverage, or can I receive vision coverage through another source?
- What amount of my vision care expenses, not covered by the Vision Plan, can be reimbursed through my Health Care Spending Account?

Vision Plan

The Vision Plan covers eye care expenses for you and your eligible, enrolled family members. You can choose coverage or No Coverage. As with a Medical PPO, you can receive services from in-network or out-of-network providers. The cost of services will be lower if you use in-network providers. Whatever vision coverage you choose will remain in effect for two years, although the cost of coverage can change during that time.

If you enrolled for vision coverage during last year's enrollment, your coverage will automatically continue for the remainder of your two-year term, extending through 2010.

You must have coverage on yourself, as an employee, to enroll a dependent in the Vision Plan.

Your Vision Plan options are summarized in the chart on the adjacent page.

Note

Frequency refers to the number of times the benefit can be used in a given period, while **election** refers to the duration of your enrollment decision.

Paid in full refers to Vision Plan services for lenses and frames available according to a pre-determined list. You will be responsible for expenses from services that exceed the amounts on the pre-determined list.

| | In-Network | Out-of-Network |
|-----------------|---|---|
| Exam | \$5 copay | \$55 benefit allowance |
| Frames | Basic coverage paid in full* | \$55 benefit allowance |
| Lenses | | |
| • Single vision | Basic coverage paid in full with | \$60 benefit allowance |
| • Bifocal | \$10 copayment at time materials are ordered. | \$70 benefit allowance |
| • Trifocal | | \$80 benefit allowance |
| • Lenticular | paid in full after \$10 copay if necessary, covered up to \$90 (including exam) if elective | \$110 benefit allowance |
| • Contacts | | \$180 benefit allowance if necessary, \$100 benefit allowance if elective |
| Frequency | once per participant in 24 months | |
| Election | 2-year enrollment commitment | |

Vision Plan Price Tags

| Vision Plan | | 2010 Annual Employee Cost | Weekly Deduction |
|--------------|-------------------|---------------------------|------------------|
| Basic | Employee Only | \$ 52 | \$1.00 |
| | Employee + one | \$105 | \$2.02 |
| | Employee + family | \$156 | \$3.00 |

Note: the premiums listed above apply only to the employees hired on or after 1/1/2009.

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Reimbursement for Health Care Spending Account (HCSA)

Cooper Tire & Rubber Company will again offer prepaid benefits card service to those enrolled in the Health Care Spending Account (HCSA).

Your prepaid benefits card can be used to pay for qualified health care expenses (medical, Rx, dental, vision and over the counter meds/supplies), not covered through the health plan, without having to pay cash up front. This process will continue until your HCSA account is depleted.

If you were enrolled in the HCSA option for 2009, please retain the Benny card that you received, if you wish to again enroll in the plan for 2010. Only new entrants each year will automatically receive a new card.

Participants should keep all receipts on file. Receipts are needed for either substantiation that the debit card was indeed used for eligible qualified medical expenses and/or possible IRS audit.

If you do not use your debit card, you will need to file a reimbursement request form.

Extension for HCSA claims

In 2005, the IRS extended the date to deplete the balance in Health Care Spending Accounts (HCSA) by 2 1/2 months. So, if you have a balance in your HCSA account at the end of 2010, you can submit eligible claims incurred during the first 2 1/2 months of 2010 for reimbursement.

Health Design Plus will process claims on a first-in, first-out method. If you have outstanding claims for 2010, HDP will process those before any claims incurred in 2011. Once your 2010 account is depleted (by March 15, 2011), your 2011 claims will then be applied to the amount you choose to contribute to your HCSA account during open enrollment for 2010.

Any balance left in the account after March 15, 2011, will be forfeited.

Health Care Spending Account (HCSA)

Cooper offers pre-tax spending account benefits to pay for eligible out-of-pocket expenses related to health care. Through the Health Care Spending Account (HCSA), you can choose to contribute funds on a pre-tax basis to pay for eligible out-of-pocket health care expenses.

Eligible expenses include copays, deductibles, and your share of expenses [excluding any premium you pay for the cost of the plans] under the Medical/Prescription Drug, Dental or Vision plans. Funds to be used for these expenses are deducted from your paycheck in equal amounts each pay period before taxes are withheld, which means you pay less in taxes.

You can contribute from \$260 to \$5,000 per year to your HCSA to cover eligible out-of-pocket expenses.

Be careful in your planning. You should contribute no more than you expect to pay up to March 15, 2011 because, under the IRS regulations, any remaining balance left in your account after March 15, 2011 will be forfeited.

The IRS has also approved **over-the-counter drugs** for reimbursement through a HCSA. This is especially helpful for people who remedy chronic health problems by regularly taking an over-the-counter medicine. However, there are some limitations. Only over-the-counter drugs purchased to alleviate or treat an illness or injury are eligible.

So what's covered? Here's an example:

You purchase an antacid, an allergy medicine, a pain reliever, and a cold medicine from a pharmacy, none of which require a physician's prescription. You also purchase dietary supplements (vitamins) without a physician's prescription to maintain your family's general health. You submit a claim for reimbursement from your HCSA (with a valid receipt) for all of these expenses, since these items are not covered by the medical/prescription drug plan.

The amount you spent to purchase the antacid, allergy medicine, pain reliever, and cold medicine is considered an eligible expense for medical care and is reimbursable through your HCSA. However, the dietary supplements (vitamins) are not considered medical care by the IRS, and are not reimbursable.

Note: You cannot choose to contribute to the HCSA if you have chosen the Health Savings Option.

When enrolling in a Health Care Spending Account, ask yourself:

- What were my health needs in previous years, and will those needs change in 2010?
- How often am I or my dependents likely to see a doctor or dentist in 2010?
- Am I expecting a child next year?
- Do I or my dependents need glasses or contact lenses?
- What prescriptions, deductibles and copays do I expect in 2010?

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Worksheets & Examples

Health Savings Account (HSA)

Health Savings Account Worksheet

Use the following exercise to estimate how much you could set aside in a Health Savings Account (HSA).

1 Anticipated out-of-pocket Medical/Prescription Drug, Dental and Vision Plan expenses for 2010. \$ _____

+

2 Other eligible out-of-pocket health care expenses not covered by the Medical/Prescription Drug, Dental or Vision Plans. \$ _____

+

3 Additional amount to save for future use or in the event of major illness or injury. \$ _____

Annual Total

(\$260 minimum,

\$3,050 maximum for employee only,

\$6,150 for employee plus one or more.)

=

\$ _____

Health Care Spending Account (HCSA)

Eligible Expenses

Your HCSA can be used to reimburse yourself for **deductibles, co-pays, co-insurance** and **items not covered** by Spectrum.

The following is a condensed list of covered items. For a complete listing, log on to www.irs.gov/formspubs/page/0,,id=11563,00.html or call 1-800-TAX-FORM (1-800-829-3676) and ask for Publication #502, *Medical and Dental Expenses.*; and Publication # 969, Health Savings Accounts and other Tax-Favored Health Plans.

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Artificial Limb
- Artificial Teeth
- Birth Control Pills
- Braille Books and Magazines
- Chiropractor
- Contact Lenses
- Crutches
- Dental Treatment
- Drug Addiction
- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Health Institute
- Hearing Aids
- Hospital Services
- Laboratory Fees
- Medical Services
- Medicines
- Nursing Home
- Osteopath
- Oxygen
- Psychiatric Care
- Sterilization
- Stop-Smoking Programs
- Surgery
- Wheelchair
- Wig
- X-ray

Health Care Spending Account Worksheet

Use the following exercise to estimate how much you should set aside in a Health Care Spending Account (HCSA).

| | | |
|--|--|----------|
| 1 | Anticipated out-of-pocket Medical/Prescription Drug, Dental and Vision Plan expenses for 2010 (e.g., deductibles and copays) | \$ _____ |
| | + | |
| 2 | Plan expenses greater than the maximum benefit | \$ _____ |
| | + | |
| 3 | Other eligible out-of-pocket health care expenses not covered by the Medical/ Prescription Drug, Dental or Vision Plans. | \$ _____ |
| | = | |
| Annual Total (\$260 minimum; \$5,000 maximum) | | \$ _____ |

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HCSA Tax Advantages

The following table is an example of a single employee earning \$35,000 a year, with and without using the Health Care Spending Account.

| | No Contribution | | Contribution |
|---------------------------------|-----------------|-------------------|--------------|
| Annual pay (taxable income): | \$35,000 | | \$35,000 |
| Pre-tax contribution: | — 0 | | — 800 |
| Taxable income: | \$35,000 | SAME | \$34,200 |
| Estimated taxes*: | — 8,750 | | — 8,550 |
| After-tax health care expenses: | — 800 | | — 0 |
| Take-home pay: | \$25,450 | SAVE \$200 | \$25,650 |

As you can see, using the Health Care Spending Account saved this person \$200 that would otherwise have been paid in taxes for that year.

*Assumes a 25% tax rate