BEDROCK
MANUFACTURING

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SINCE 1897

SHINOLA
DETROIT

2019

EMPLOYEE BENEFITS

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See **page 32** for important information concerning Medicare Part D coverage.

WELCOME

AT BEDROCK MANUFACTURING FAMILY OF COMPANIES*, WE ARE COMMITTED TO YOUR HEALTH AND WELL-BEING. IT'S JUST ONE REASON WE'RE PROUD TO PROVIDE YOU AND YOUR FAMILY WITH VALUABLE AND SIGNIFICANT BENEFITS.

This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the 2019 Plan Year.

*The Bedrock Manufacturing family of companies includes Bedrock Manufacturing, CC Filson, Filson Corp, Filson Manufacturing, and Shinola.

YOU AND YOUR FAMILY HAVE UNIQUE NEEDS, WHICH IS WHY BEDROCK GROUP OFFERS A VARIETY OF BENEFIT PLANS FROM WHICH YOU MAY CHOOSE.

Consider your spouse/domestic partner's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

ELIGIBILITY

If you are a full-time employee of Bedrock Manufacturing who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the Medical, Dental, Vision, Life and Disability Plans, along with the Flexible Spending Accounts (FSAs) and additional benefits.

If you are a part-time employee of Bedrock Manufacturing who is regularly scheduled to work at least 20-29 hours per week, you are eligible to participate in the Medical, Dental and Voluntary Life along with the Flexible Spending Accounts (FSAs) and additional benefits.

ELIGIBLE DEPENDENTS

Dependents eligible for coverage in the Bedrock Manufacturing benefits plans include:

- Your legal spouse/domestic partner (or common-law spouse in states which recognize common-law marriages).
- Dependent children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse/ domestic partner).
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26.
- Verification of dependent eligibility will be required upon enrollment. Note that BCBS requires a signed affidavit for coverage of domestic partners or common law spouses. Please contact Human Resources for a copy of the affidavit.

WHEN DOES COVERAGE BEGIN?

The elections you make are effective the first of the month after hire. Due to IRS regulations, once you have made your choices for the 2019 Plan Year, you can't change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

ELIGIBILITY & ENROLLMENT

THINGS TO CONSIDER

Take the following situations into account before you enroll to make sure you have the right coverage.

- Does your spouse/domestic partner have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) and/or update your beneficiary designation?
- Did any of your covered children reach their 26th birthday this year? If so, they are no longer eligible for benefits unless they meet specific criteria. Additional details can be found in the Eligible Dependents section of this Guide.

QUALIFYING LIFE EVENTS

When one of the following events occurs, you have 30 days from the date of the event to notify Human Resources and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse/domestic partner's employment status (resulting in a loss or gain of
- Change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid
- Change in your address or location that may affect the coverage for which you are eligible

Your change in coverage must be consistent with your change in status.

PREPARING TO ENROLL

Bedrock Manufacturing provides its employees the best coverage possible. As a committed partner in your health, Bedrock Group will be absorbing a significant amount of the costs. Your share of the contributions for Medical, Dental, Vision and FSA benefits is deducted on a pre-tax basis, which lessens your tax liability.

Please note that employee contributions for medical, dental and vision coverage vary depending on the level of coverage you select. In general, the more coverage you have, the higher your employee contribution will be.

Keep in mind that you may select any combination of Medical, Dental and/or Vision Plan coverage categories. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of Bedrock Group, must elect coverage for yourself in order to elect any dependent coverage. You have the option to select coverage from the following categories:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

Be sure to have the Social Security numbers and birth dates for any eligible dependent(s) that you plan to enroll. You cannot enroll your dependent(s) without this information.

TIP: YOU CANNOT CHANGE YOUR BENEFIT SELECTIONS DURING THE PLAN YEAR UNLESS YOU HAVE A QUALIFYING LIFE EVENT, SUCH AS A CHANGE IN YOUR MARITAL STATUS.

1 IN 5 EMPLOYEES REGRETS THEIR BENEFITS CHOICES.*

DON'T BE THE ONE.

According to a recent national poll of full-time, benefits-eligible employees, 1 in 5 people say they often regret their benefit choices. We want you to be happy with your benefits.

ALEX BENEFITS COUNSELOR

To find a plan that provides the right level of coverage for your needs and that doesn't take too much money out of your paycheck, please visit ALEX®. ALEX® provides personalized, confidential benefits guidance on any computer, tablet, or smartphone. Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for you and your family.

Get personalized, confidential benefits guidance on any device at **https://www.myalex.com/bedrock/2019**

*Source: The 2017 ALEX Benefits Communication Survey (Research Conducted by Harris Poll®)

OUR MEDICAL COVERAGE HELPS YOU MAINTAIN YOUR WELL-BEING THROUGH PREVENTIVE CARE AND ACCESS TO AN EXTENSIVE NETWORK OF PROVIDERS, AS WELL AS AFFORDABLE PRESCRIPTION MEDICATION.

Medical benefits are offered through BlueCross BlueShield of Michigan. It is up to you to choose the Plan that best matches your needs. Please keep in mind that the option you elect will be in place for all of the 2019 PlanYear,unless you have a Qualifying Life Event.

HOW TO FIND A PROVIDER

To see a current list of BlueCross BlueShield of Michigan network providers online, go to www.bcbsm.com. If you do not have internet access, please call BlueCross BlueShield of Michigan Customer Care at 313-225-9000 for assistance.

HEALTH CARE COST TRANSPARENCY

High Deductible Health Plans and tools such as Flexible Spending Accounts have helped put the power of health care spending in consumers' hands. This means you have control over how your health care dollars are spent. But with the cost of services varying widely even within the same network and geographic area, how can you be sure you're getting the most bang for your health care buck? Enter Health Care Cost Transparency tools. These online tools, which are available through most major health insurance carriers, allow consumers to compare costs for everything from prescription drugs to major surgeries. For more information, visit www.bcbsm.com.

MEDICAL BENEFITS

MEDICAL PLAN SUMMARY

The chart below gives a summary of the 2019 medical coverage provided by BlueCross BlueShield of Michigan. All covered services are subject to medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	HDHP		PPO BUY-UP	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
ANNUAL DEDUCTIBLE				
Individual	$2,000	$4,000	$1,250	$2,500
Family	$4,000	$8,000	$2,500	$5,000
Coinsurance (Plan Pays)	80%*	60%*	80%*	60%*
ANNUAL OUT-OF-POCKET MAX INCLUDES DEDUCTIBLE				
Individual	$4,000	$8,000	$3,500	$7,000
Family	$6,850	$13,700	$7,000	$14,000
ANNUAL OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)				
Outpatient Services	80%*	60%*	$25 copay	60%*
Specialist Services	80%*	60%*	$40 copay	60%*
Preventative Care	100%	60%*	100%	60%*
Urgent Care	80%*	60%*	$50 copay	60%*
Emergency Room	80%*	60%*	$200 copay	$200 copay
SPECIALTY RX DEDUCTIBLES				
Generic	80%*	Reimburses 75% of approved amount*	$10 copay	Reimburses 75% of approved amount, less member copay
Preferred	80%*		$40 copay	
Non - Preferred	80%*		$80 copay	
MAIL - ORDER (90-DAY SUPPLY)				
Generic	$2,000	Not covered	$25 copay	Not covered
Preferred	$4,000		$100 copay	
Non - Preferred	80%*		$200 copay	

*AFTER DEDUCTABLE

If you are enrolled in the PPO plan, when one individual has met the deductible, benefits begin to pay at the coinsurance level for that individual. If you have several covered dependents, all charges used to apply toward an “individual” deductible will be applied toward the “family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for the remainder of the calendar year. No member may contribute more than the individual deductible amount toward the “family” deductible.

The deductible works differently with the HDHP plan. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. If more than one person in a family is covered under the HDHP, coinsurance will not apply until the family deductible has been met.

MEDICAL BENEFITS

HAWAII RESIDENTS ONLY

MEDICAL PLAN SUMMARY

The chart below gives a summary of the 2019 medical coverage provided by Kaiser. All covered services are subject to medical necessity as determined by the Plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	KAISER HMO
	IN NETWORK
ANNUAL DEDUCTIBLE	
Individual	$200
Family	$400
Coinsurance (Plan Pays)	80%
ANNUAL OUT-OF-POCKET MAX INCLUDES DEDUCTIBLE	
Individual	$2,200
Family	$4,400
ANNUAL OUT-OF-POCKET MAX (INCLUDES DEDUCTIBLE)	
Office Visit (PCP)	$15
Specialist Services	$15
Preventative Care	100%
Emergency Room	80%
SPECIALTY RX DEDUCTIBLES	
Generic	$20
Brand	50%
Specialty	50% after RX deductible
RETAIL RX (30-DAY SUPPLY)	
Individual	$250
Family	$500

QUESTIONS & ANSWERS: GENERIC DRUGS

WHAT IS A GENERIC DRUG?

When a new, FDA-approved drug goes on the market, it may have patent or exclusivity protection that enables the manufacturer to sell the drug exclusively for a period of time. When those expire or no longer serve as a barrier to approval, other companies can make it in generic form.

ARE GENERIC DRUGS AS EFFECTIVE AS BRAND-NAME DRUGS?

Yes. A generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA requires generic drugs have the same high quality, strength, purity and stability as brand-name drugs.

ARE GENERIC DRUGS AS SAFE AS BRAND-NAME DRUGS?

Yes. The FDA must approve the generic drug before it can be marketed.

ARE GENERIC DRUGS THAT MUCH CHEAPER THAN BRAND-NAME MEDICATIONS?

Yes. On average, the cost of a generic drug is 80 to 85% lower than the brand-name equivalent.

IS THERE A GENERIC EQUIVALENT FOR MY BRAND-NAME DRUG?

To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov to view a catalog of FDA-approved drug products, as well as drug labeling information.

Source: www.fda.gov

MEDICAL BENEFITS

TELEMEDICINE

FROM BCBS

You and your dependents are now able to see a doctor anytime, anywhere using Blue Cross online visits award-winning and easy-to-use online health care technology. Blue Cross online visits' doctors are board-certified doctors who can be consulted online for common, nonemergency illnesses, such as:

-
- Sinus and respiratory infections
- Colds, flu and seasonal allergies
- Urinary tract infections
- Vomiting
- Diarrhea
- Headache
- Strains and sprains
- Rashes

NO APPOINTMENT NEEDED

You can get fast, convenient, affordable online health care 24 hours a day, seven days a week, wherever you are in the U.S. Average wait time to visit with the doctor is 3 minutes. Just choose an available doctor, click and go. It's as simple as using your mobile device or computer to meet with a doctor face-to-face, online, when:

- Your primary care doctor isn't available
- You can't leave your home or workplace
- You're on vacation or traveling for work
- You're caring for children or a family member and can't leave home
- You're looking for affordable after-hours care

If you are enrolled in the HDHP your online visit will be charged the same as a doctor's office visit and will be subject to the annual deductible and coinsurance. **PPO Members will have NO COPAY.**

If you're new to online visits, sign up after Jan. 1, 2018. Be sure to add your Blue Cross or Blue Care Network health plan information.

If you currently use Blue Cross' 24/7 online health care from Amwell®, use the new app, website or phone number after Jan. 1, 2018. You don't need a service key. Your login information stays the same and will be transferred to our new site. Verify your password and your account information. You may need to re-enter some information.

SERVICES ARE CURRENTLY LIMITED OR EXCLUDED IN THE FOLLOWING STATES:

Alaska + Louisiana

- Consultation and prescribing can occur with the exception of controlled substances for locally based providers.

Indiana + New Jersey

- Provider may consult with member but cannot prescribe medication unless there has been a prior in-person relationship.

Arkansas + Texas

- Provider may only consult with member if there has been a prior in-person relationship.

HERE'S WHAT YOU NEED TO DO TO USE ONLINE VISITS

- Mobile – Download the BCBSM Online VisitsSM app
- Web – Visit bcbsmonlinevisits.com
- Phone – Call 1-844-606-1608

DENTAL BENEFITS

ROUTINE PREVENTIVE CARE SUCH AS REGULAR DENTAL CHECKUPS CAN HELP LOWER YOUR RISK OF STROKE AND HEART DISEASE.

Bedrock Manufacturing's dental coverage will provide you and your family affordable options for overall health. Coverage is available from Delta Dental of Michigan.

NETWORK DENTISTS

Your Plan's in-network dentists have agreed to charge lower fees, which helps keep money in your pocket. If you choose to use a dentist who doesn't participate in your Plan's network, you may experience higher out-of-pocket costs even though the in-network and out-of-network coinsurance levels are the same.

This is because you will not have the advantage of the lower negotiated fees and your provider may bill you for charges which exceed Delta's Reasonable and Customary allowance (R&C). To find a network dentist, visit Delta at www.Deltadentalmi.com.

DENTAL BENEFITS

DENTAL PLAN SUMMARY

The chart below gives a summary of the 2019 dental coverage provided by Delta Dental. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	METLIFE DENTAL
	IN NETWORK & OUT OF NETWORK
ANNUAL DEDUCTIBLE	
Individual	$50
Family	$150
ANNUAL MAXIMUM	
Per person	$2,000
COVERED SERVICES	
Preventative Services Oral Exams, Routine cleanings, Bitewing X-rays, Fluoride applications, Sealants, Space maintainers, Panoramic X-rays	100%
Basic Services Full mouth X-rays, Fillings, Oral surgery, Simple Extractions	80%*
Major Services Oral surgery, Complex extractions, Denture adjustments and repairs, Root canal therapy, Periodontics, Crowns, Dentures, Bridges	50%*
Orthodontics Adults and Children	50%*
Orthodontics Lifetime Maximum	$2,000

***AFTER DEDUCTIBLE**

TIP: DAILY CLEANING AND REGULAR VISITS TO THE DENTIST'S OFFICE WILL HELP PREVENT UNWANTED HEALTH CONCERNS AND MEDICAL PROCEDURES, SAVING YOU TIME AND MONEY IN THE LONG RUN.

VISION BENEFITS

IF YOU WEAR GLASSES OR CONTACTS, CHANCES ARE YOU ALREADY HAVE A STEADY APPOINTMENT WITH AN EYE DOCTOR. BUT EVEN THOSE WITH PERFECT EYESIGHT SHOULD HAVE THEIR VISION CHECKED ON A REGULAR BASIS.

To ensure that you and your family have access to quality vision care, Bedrock Manufacturing offers a comprehensive vision benefit provided by VSP.

VISION BENEFITS

VISION PLAN SUMMARY

Vision Plan benefits are available to full-time employees on a voluntary basis. The chart below gives a summary of the 2019 vision coverage provided by VSP. All out-of-network services are subject to Reasonable and Customary (R&C) limitations. In-network copayments are paid directly to the provider. Out-of-network services will be reimbursed up to the scheduled amounts below.

	VSP	
	IN NETWORK	**OUT OF NETWORK**
COVERED MATERIALS		
Single Vision	$25 copay	Up to $30
Lenses Bifocal	$25 copay	Up to $30
Lenses	$25 copay	Up to $65
Retail Frame Equivalent	Up to $130*	Up to $70
Contacts[1]	Covered in full	Up to $210
Examination	$10	Up to $45
Examination	Once per 12 months	
Lenses	Once per 12 months	
Frames	Once per 12 months	
Contacts	Once per 12 months	

[1]Medically necessary contact lenses are non-elective contact lenses perscribed when certain medial conditions hinder vision correction through regular eyeglasses.

*After copay

* Coverage includes lenses and frames **or** contacts during the period year.

TIP: ACCORDING TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION, AN ESTIMATED 61 MILLION AMERICAN ADULTS ARE AT HIGH RISK FOR SERIOUS VISION LOSS, BUT ONLY HALF VISITED AN EYE DOCTOR IN THE PAST 12 MONTHS.

TAKE CHARGE OF YOUR HEALTHCARE SPENDING WITH A HEALTH SAVINGS ACCOUNT(HSA).

Contributions to an HSA are tax-free, and no matter what, the money in the account is yours. Use it to pay for eligible medical expenses when you are enrolled in the HSA Plan.

Your HSA can be used for qualified expenses, including those of your spouse and/or dependent(s), even if they are not covered by your Plan.

Health Equity will issue you a debit card, giving you direct access to your account balance. When you have a qualified medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' office visits, eye exams, prescription expenses and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

You may not enroll or contribute to an HSA if you are enrolled in the Health Care Flexible Spending Account.

ELIGIBILITY

You are eligible to open and fund an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse/domestic partner's health plan, health care flexible spending account or health reimbursement account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE for Life insurance.
- You have not received Veterans Administration medical benefits.

HEALTH SAVINGS ACCOUNT

INDIVIDUALLY OWNED ACCOUNT

You own and administer your Health Savings Account. You determine how much you'll contribute to the account, when to use the money to pay for qualified medical expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

HOW TO ENROLL

You must elect the HDHP with Bedrock Group. You will need to complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. Bedrock Group will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

MAXIMIZE YOUR TAX SAVINGS

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with Health Equity). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2019, contributions are limited to the following:

Individual: $3,500
Family: $7,000
Catch-Up Contribution (ages 55+): $1,000

The Bedrock Group HSA will be established with Health Equity. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.healthequity.com.

TIP: FUNDS IN YOUR HSA WILL ROLL OVER FROM YEAR TO YEAR, ALLOWING YOU TO SAVE MONEY FOR FUTURE MEDICAL EXPENSES.

FLEXIBLE SPENDING ACCOUNTS (FSAS) ALLOW YOU TO SET ASIDE PRE-TAX PAYROLL DEDUCTIONS TO PAY FOR OUT-OF-POCKET HEALTH CARE EXPENSES—

Such as deductibles, copays and coinsurance, as well as dependent care expenses.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

You can contribute up to $2,550 for qualified medical expenses with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, allowing you to avoid waiting for reimbursement.

Bedrock Manufacturing implemented a rollover option in 2016. You may no longer have to worry about losing the funds you do not use. You will now be able to carry over up to $500 of your remaining FSA balance into the following plan year, minimizing the impact of the IRS "use or lose" rule.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

FLEXIBLE SPENDING ACCOUNTS

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA as well—whether or not you elect any other benefits. The Dependent Care FSA allows you to set aside pre-tax funds to help pay for expenses associated with caring for elder or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you are allowed to set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.
- Expenses are reimbursable as long as the provider is not anyone considered your dependent for income tax purposes.
- In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

ELIGIBLE DEPENDENT CARE

Flexible Spending Account Expenses
This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. The dependent must be a child younger than the age of 13 and claimed as a dependent on your federal income tax return or a disabled dependent who spends at least eight hours a day in your home.

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individual you claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the Flexible Spending Account programs.

HOW TO USE THE ACCOUNT

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

Once you incur an eligible expense, submit a claim form along with the required documentation. If you have a question about a reimbursement, contact Discovery Benefits. Should you need to submit a receipt, you will receive email notifications to log in to your account to view receipt reminders. The receipt reminder will display the documentation required and your next steps. If you do not have an email address on file, a receipt reminder will be mailed.

MANAGE YOUR ACCOUNT WISELY.
IF YOU HAVE MONEY REMAINING IN YOUR DEPENDENT CARE FSA AT THE END OF THE YEAR, YOU FORFEIT IT. IN OTHER WORDS:
"USE IT OR LOSE IT."

COMMUTER BENEFITS

A COMMUTER BENEFITS PLAN IS A GREAT WAY TO REDUCE YOUR COMMUTING EXPENSES BY ALLOWING YOU TO SET ASIDE PRE-TAX MONEY FOR QUALIFIED TRANSIT AND PARKING EXPENSES YOU INCUR WHILE GETTING TO AND FROM WORK.

TRANSIT BENEFIT

Pay for transportation to and from work tax-free. Common eligible expenses include transportation through train, bus, subway and ferry. Up to $255 per month can be contributed on a pre-tax basis.

PARKING BENEFIT

Pay for parking at or near your regular place of employment tax-free. Up to $255 per month can be contributed on a pre-tax basis.

SIMPLE ACCESS TO YOUR FUNDS

With the Discover Benefits debit card, you can pay providers at the time of service directly from your transit and/or parking account. If the parking facility does not accept debit card payments, you may also pay out of pocket and then submit a reimbursement request. Parking claims may be submitted to Discovery Benefits online through the consumer web portal.

Parking and transit receipts are not required by Discovery Benefits to reimburse claims. It is recommended, however, that you keep receipts for your own records.

FLEXIBLE SPENDING PLANS

ADDITIONAL INFORMATION

ADDITIONAL PLAN FEATURES

- 24/7 online account access
- Mobile apps and text alerts
- Single sign-on for all reimbursement accounts
- Use the same debit card to access both Health Care and Dependent Care funds

GENERAL RULES AND RESTRICTIONS

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the current calendar year plan year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot actively participate (contribute) in an HSA and be enrolled in the Health Care FSA.
- You cannot participate in Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You cannot change your FSA election in the middle of the Plan Year unless you experience a Qualifying Life Event like marriage, divorce or birth of a child.
- You cannot carry over any remaining balances in your Dependent Care account at the end of the year (use it or lose it); however, you will be able to carry over up to $500 of your Health Care account into the following plan year.
- You have until March 31 to submit claims for expenses you incurred during the previous calendar year.
- You must re-enroll in the FSA each year – elections will not carry over from year to year.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. This means that you must always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Failure to provide proof that an expense was valid can result in your card being turned off and your expense being deemed taxable.

TIP: IF AT ANY TIME AN EMPLOYEE SEPARATES EMPLOYMENT WITH BEDROCK MANUFACTURING, ALL FSA DOLLARS WILL BE FORFEITED UPON TERMINATION PER IRS REGULATIONS.

SURVIVOR BENEFITS

DISCUSSING WHAT MIGHT HAPPEN TO YOUR FAMILY IF YOU WERE NOT AROUND TO PROVIDE FOR THEM ISN'T ALWAYS THE EASIEST CONVERSATION, BUT IT IS NECESSARY.

Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected. If you have Life insurance now, chances are you can take comfort in knowing those who depend on you will be provided for.

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Life and Accidental Death and Dismemberment (AD&D) benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

Bedrock Manufacturing provides employees with Basic Life and AD&D insurance through Lincoln Financial, which guarantees that loved ones, such as a spouse/domestic partner or other designated survivor(s), continue to receive part of an employee's benefits after a death.

Your Basic Life and AD&D insurance benefit is 1x your base annual earnings, up to $250,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

SURVIVOR BENEFITS

BENEFICIARY DESIGNATION

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Bedrock Manufacturing. Benefits payable for a dependent's death under the Lincoln Financial insurance are payable to you.

It is important that your beneficiary designation is clear so that there will be no question as to your intentions. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. If the beneficiary is not legally related, insert the words "Not Related" in the relationship field.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages.

ALL PERCENTAGES SHOULD TOTAL TO 100%.

For example:

PRIMARY	CONTINGENT
Mary J. Doe, Wife (34%)	Joseph W Doe, Son (50%)
Jane Doe, Daughter (33%)	Jane Doe, Daughter (50%)
John Doe Son (33%)	**OR** Estate of the Insured (100%)

If there is insufficient space for your beneficiary designations, leave it blank and attach a separate sheet of paper indicating your designations and share percentages. If you need assistance, contact Human Resources or your own legal counsel.

IN GENERAL, THE AMOUNT OF LIFE INSURANCE YOU PURCHASE SHOULD COVER LIVING, PERSONAL AND HOUSEHOLD EXPENSES FOR YOUR FAMILY FOR AT LEAST A YEAR.

SURVIVOR BENEFITS

LIFE INSURANCE

Eligible employees may purchase Voluntary Life insurance for themselves and their families. Premiums are paid through post-tax payroll deductions.

BASIC LIFE / AD&D	
COVERAGE AMOUNT	1X YOUR BASIC ANNUAL EARNINGS
WHO PAYS	BEDROCK MANUFACTURING PAYS THE FULL COST OF COVERAGE
BENEFITS PAYABLE	IF YOU DIE, LOSE A LIMB OR SUFFER PARALYSIS IN AN ACCIDENT
MAXIMUM BENEFIT	$250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A

VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	$10,000 INCREMENTS
WHO PAYS	YOU PAY THE FULL COST OF COVERAGE
BENEFITS PAYABLE	IF YOU DIE WHILE COVERED UNDER THE PLAN; THIS BENEFIT IS IN ADDITION TO YOUR BASIC LIFE/AD&D BENEFIT
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	FOR ELECTIONS GREATER THAN $200,000

VOLUNTARY SPOUSE /DOMESTIC PARTNER LIFE	
COVERAGE AMOUNT	$10,000 INCREMENTS
WHO PAYS	YOU PAY THE FULL COST OF COVERAGE
BENEFITS PAYABLE	IF YOU DIE WHILE COVERED UNDER THE PLAN; THIS BENEFIT IS IN ADDITION TO YOUR BASIC LIFE/AD&D BENEFIT
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	FOR ELECTIONS GREATER THAN $30,000

VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$2,500 INCREMENTS
WHO PAYS	YOU PAY THE FULL COST OF COVERAGE
BENEFITS PAYABLE	IF YOU DIE WHILE COVERED UNDER THE PLAN; THIS BENEFIT IS IN ADDITION TO YOUR BASIC LIFE/AD&D BENEFIT
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	N/A

BEDROCK MANUFACTURING OFFERS DISABILITY COVERAGE TO PROTECT YOU AGAINST AN UNFORTUNATE OR DEBILITATING INJURY.

This insurance protects a portion of your income until you can return to work, or until you reach retirement age.

SHORT TERM DISABILITY (STD) INSURANCE

STD insurance protects a portion of your income if you become partially or totally disabled for a short period of time. It replaces 60% of your income, up to a maximum weekly benefit of $2,500, depending on your current annual earnings. You must be sick or disabled for at least 8 days before you can receive a benefit payment. Payments may last up to 12 weeks. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description for details or contact Human Resources for specific benefits.

LONG TERM DISABILITY (LTD) INSURANCE

LTD insurance protects a portion of your income if you become partially or totally disabled for an extended period of time. This insurance replaces 60% of your income, up to a maximum of $12,500 per month, depending on your current annual earnings. You must be sick or disabled for at least 90 days before you can receive a benefit payment.

Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Certain exclusions, along with any pre-existing condition limitations, may apply. Please refer to your Summary Plan Description for details or contact Human Resources for specific benefits.

NOTES

DISABILITY INSURANCE IS NOT THE SAME AS WORKERS' COMPENSATION.
THE INJURY OR ILLNESS DOES NOT HAVE TO BE THE RESULT OF A WORKPLACE INCIDENT.

INCOME PROTECTION

LEGALZOOM LIFEPLAN

LifePlan™ is a comprehensive employee benefit that provides integrated legal, financial, tax and insurance services to help members confidently navigate the major and daily life events their families face including marriage, home purchase, childbirth, retirement and end of life planning.

HERE'S WHAT YOU GET

- 500+ person success center readily available to serve you
- Convenient access (phone, mobile app, web) to handle all of your matters seamlessly
- Instant scheduling of certified attorneys and accountants through our national network
- Annual check-ins to anticipate and respond to your life changes as they happen
- Unlimited secure digital storage for your most important documents and personal memories

LEGAL ADVICE

Attorney advice sessions across a spectrum of common legal matters including:

- Family – Marriage, divorce, child custody / child support
- Financial – Bankruptcy, lawsuits, debt, collections, small claims
- Real Estate – Foreclosure, home sales,
- landlord/tenant issues
- Estate Planning – Last will, living will, power of attorney, living trust, trust funding
- Other – Personal injury, property damage

TAX ADVICE

Tax advice sessions through our partner, 1-800Accountant

FINANCIAL ADVICE

Unlimited financial advice sessions with an independent certified financial advisor through a LegalZoom business partner.

INSURANCE ADVICE

Unlimited insurance advice sessions with an independent certified insurance agent through a LegalZoom business partner.

AN ATTORNEY-ASSISTED ESTATE PLAN

Last will or living trust, an advanced healthcare directive (living will) and a financial power of attorney.

ATTORNEY CONSULTED LEGAL LIBRARY

Standardized legal agreements for over 150 legal matters including Business Agreements, A davits, Landlord / Tenant forms, Non-Disclosure Agreements, Promissory Notes, and many more.

10% OFF OVER 40 COMPREHENSIVE PRODUCTS & SERVICES INCLUDING

Business Services – LLCs, Incorporations, DBAs, Non-profits and many more Intellectual Property – Trademarks, Copyrights, Patents and many more Personal Services – Divorce, Name Changes, Real Estate leases, and many more.

DOCUMENT REVIEW

Legal review of LegalZoom and non-LegalZoom documents.

ID THEFT PROTECTION

Full Service Identity Restoration, $1M Identity Insurance, 1 Bureau Credit Monitoring and more.

This is a general overview and is for illustrative purposes only. Plans and services vary state to state. See our plan contract for your state of residence for complete terms, coverage, amounts, conditions, and exclusions.
LegalZoom is not a law firm or a substitute for an attorney or law firm and does not provide legal advice or services.

ADDITIONAL BENEFITS

BEDROCK MANUFACTURING KNOWS THE VALUE OF WELL-ROUNDED, BALANCED EMPLOYEES, WHICH IS WHY WE OFFER ADDITIONAL BENEFITS TO HELP YOU MANAGE YOUR LIFE.

EMPLOYEE ASSISTANCE PROGRAM

Bedrock Manufacturing cares about you and your family's total health management—mental, emotional and physical. For that reason, we provide an Employee Assistance Program (EAP) at no cost to you.

This service connects you with the best mental health and counseling services. Whether you are interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can speak with helpful resources. The EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Bedrock Manufacturing. You may also access information, benefits, educational materials and more either by phone at 888-628-4824 or online at www.GuidanceResources.com (username = LFGsupport; password = LFGsupport1).

THE PROGRAM PROVIDES REFERRALS TO HELP WITH:

- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

401K RETIREMENT SAVINGS PLAN

All new hires will be automatically enrolled in 401k at 6% payroll deductions upon eligibility. Employees are eligible for 401K, the 1st of the month after 3 months of employment. To opt out, you must go online at www.TA-Retirement.com. The 401K provider is Transamerica. The website is: www.TA-Retirement.com. Once you log in follow the instructions to set up a new account. This is also how you sign up and/or change contribution amounts. Phone access is available at (800) 401-8726. You can log in or make changes at any time but changes are only effective the 1st of each month.

PLAN SUMMARY

- The plan has a "Safe Harbor Match" that allows you to get a match of up to 4% of your salary and it's 100% vested after 2 years. All you need to do is make sure you are contributing 6% of your pay into the 401(k) (see table below).
- The company will pay much of the Administrative costs of providing and operating the plan.
- There is an independent financial advisor to advise on the plan and support participant education and investment
- Transamerica provides an opportunity for Pre-tax and after tax (Roth) savings.
- There is a menu of 12 Investment options, plus the opportunity to develop investments options to fit individual objectives.

401K MATCHING SCHEDULE

SALARY DEFERRAL ELECTION	COMPANY MATCH
1%	100%
2%	100%
3%	50%
4%	50%
5%	50%
6%	50%

A 6% deferral election means a 4% company match. Vesting is 100% after 2 years credited service years.

NOTES

2019 MONTHLY PREMIUMS

Premium contributions for your elected benefits will be deducted from your paycheck on a pre-tax basis for medical, dental, vision benefits. Voluntary life insurance premiums will be deducted on a post-tax basis. Your level of coverage will determine your monthly premium.

FULL-TIME EMPLOYEES

COVERAGE		EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
MEDICAL (BCBS OF MICHIGAN)	HDHP	$31.50	$157.50	$110.25	$315.00
	PPO	$68.25	$349.65	$252.00	$577.50
DENTAL (DELTA)		$6.50	$35.00	$40.00	$85.00
VISION (VSP)		$2.04	$5.16	$4.81	$13.22

PART-TIME EMPLOYEES

COVERAGE		EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
MEDICAL (BCBS OF MICHIGAN)	HDHP	$85.05	$520.80	$383.25	$882.00
	PPO	$147.00	$664.65	$509.25	$1,110.90
DENTAL (DELTA)		$8.50	$35.00	$40.00	$85.00
VISION (VSP)		$6.81	$11.47	$11.73	$18.89

		EMPLOYEE	SPOUSE
	Age Bands	Premium Rates/$1,000	
VOLUNTARY LIFE AND AD&D (LINCOLN FINANCIAL)	Younger than 25	$0.081	$0.081
	Age 25-29	$0.081	$0.081
	Age 30-34	$0.079	$0.079
	Age 35-39	$0.113	$0.113
	Age 40-44	$0.182	$0.182
	Age 45-49	$0.320	$0.320
	Age 50-54	$0.490	$0.490
	Age 55-59	$0.824	$0.824
	Age 60-64	$1.030	$1.030
	Age 65-69	$1.560	$1.560
	Age 70-74	$3.074	$3.074
	Older than 75	$3.074	$3.074
	CHILD LIFE		
	Premium/$1,000	$0.146	

GLOSSARY

COINSURANCE

Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

COPAY

The fixed amount, as determined by your insurance plan, you pay for health care services received.

DEDUCTIBLE

The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventive care.

EMPLOYEE CONTRIBUTION

The biweekly amount you pay for your insurance coverage.

EXPLANATION OF BENEFITS

A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

FLEXIBLE SPENDING ACCOUNTS (FSAS)

An option that allows participants to set aside pre-tax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period). There are two types of FSAs: the Health Care FSA and the Dependent Care FSA.

- Health Care FSA – With the Health Care FSA, participants can use their accounts to cover eligible medical expenses such as copays, eye exams, prescriptions and more. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code. Please note that over-the-counter medications are not eligible for reimbursement without a doctor's prescription with the Health Care FSA.
- Dependent Care FSA– A Dependent Care FSA – helps to reimburse participants for eligible expenses associated with caring for a qualified dependent, such as a dependent younger than age 13 or another dependent that may be incapable of self-care. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Both accounts are "use it or lose it," meaning that funds not used by the end of the plan year will be lost.

HEALTH CARE COST TRANSPARENCY

Also known as Market Transparency or Medical Transparency. Health care provider costs can vary widely, even within the same geographic area. To make it easier for you to get the most cost effective health care products and services, online cost transparency tools, which are typically available through health insurance carriers, allow you to search an extensive national database to compare costs for everything from prescription drugs and office visits to MRIs and major surgeries.

HEALTH SAVINGS ACCOUNT (HSA)

A personal health care bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, meaning if you change jobs your account goes with you.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Plan option that provides choice, flexibility and control when it comes to spending money on health care. Preventive care is covered at 100% with in network providers, there are no copays, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

IN-NETWORK

In-network providers are doctors, hospitals and other providers that contract with your insurance company to provide health care services at discounted rates.

CONTINUED ON NEXT PAGE

GLOSSARY

OUT-OF-NETWORK

Out-of-network providers are doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

OUT-OF-POCKET MAXIMUM

Also known as an out-of-pocket limit. The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond the Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

OVER-THE-COUNTER(OTC) MEDICATIONS

Medications typically made available without a prescription.

PRESCRIPTION MEDICATIONS

Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preferred or Non-Preferred.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preferred or Non-Preferred versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher co-payments.

REASONABLE AND CUSTOMARY ALLOWANCE (R&C)

Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a medical service in a geographic region based on what providers in the area usually charge for the same or similar medical service.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

SUMMARY PLAN DESCRIPTION (SPD)

It is a summary of the material provisions of the plan document, and is the main vehicle for communicating plan rights and obligations to participants and beneficiaries.

REQUIRED NOTICES

IMPORTANT NOTICE FROM BEDROCK MANUFACTURING ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE UNDER THE BLUE CROSS BLUE SHIELD OF MICHIGAN PLAN(S)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bedrock Manufacturing and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Bedrock Manufacturing has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Michigan plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Bedrock Manufacturing coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.
If you do decide to join a Medicare drug plan and drop your current

Bedrock Manufacturing coverage, be aware that you and your dependents will not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Bedrock Manufacturing and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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REQUIRED NOTICES

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed at the end of these notices for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Bedrock Manufacturing changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227).
- TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 01, 2018
Name of Entity/Sender: Bedrock Manufacturing
Contact—Position/Office: Human Resources
Address: 485 Milwaukee Ave.
Detroit, MI 48202
Phone Number: 313-334-7613

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources at 313 334 7613.

HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The Notice of Privacy Practices has been recently updated. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 313 334 7613.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you

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or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

LOSS OF ELIGIBILITY INCLUDES BUT IS NOT LIMITED TO:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 313 334 7613.

IMPORTANT CONTACTS

MEDICAL & PHARMACY
BlueCross BlueShield of Michigan
313-225-9000
www.bcbsm.com

DENTAL
Delta Dental of Michigan
800-524-0149
www.deltadentalmi.com

VISION
VSP
800-877-7195
www.vsp.com

HEALTH SAVINGS ACCT.
Health Equity
866-346-5800
www.healthequity.com

FLEXIBLE SPENDING ACCT.
Discovery Benefits
866-451-3245
www.discoverybenefits.com

LIFE AND AD&D
Lincoln Financial
800-423-2765
(Select Option 1 for claims/
Option2 for administration and
other questions)
www.Lincoln4Benefits.com

DISABILITY
Lincoln Financial
800-423-2765
(Select Option 1 for claims/
Option 2 for administration and
other questions)
www.Lincoln4Benefits.com

EMPLOYEE ASSISTANCE PROGRAM
Lincoln Financial (ComPsych)
888-628-4824
www.GuidanceResources.com
Username: LFGsupport
Password: LFGsupport1

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