A Guide to Your Benefits
2019

LAMERS
The Passenger Professionals®

Lamers Bus Lines, Inc. offers a comprehensive suite of benefits to promote health and financial security for you and your family. This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you.

Benefit Basics

As a Lamers Bus Lines, Inc. employee, you may be eligible for the benefits summarized in this booklet depending on how many hours your regularly work. You will generally be eligible for the benefits summarized in this booklet if you regularly work at least 40 hours per week. Additional information about the benefits described in this booklet and information about the benefits that are available to employees who regularly work less than 40 hours can be obtained by contacting Human Resources.

Benefits are effective on the first day of the month following 60 days of employment.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26.

Once your benefit elections become effective, they remain in effect until the end of the year. You may only change coverage within 30 days of a qualified life event.

Qualified Life Events

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

For more information about your benefit, contact your Human Resources.

Cost of Your Benefits

Lamers Bus Lines, Inc. pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Tax Treatment	Who Pays
Medical Coverage	Pre-tax	Lamers Bus Lines & You
Voluntary Dental Coverage	Pre-tax	You
Voluntary Vision Coverage	Pre-tax	You
Life and ADD Insurance Coverage		Lamers Bus Lines
Voluntary Additional Life Insurance Coverage	After-tax	You
Short Term Disability		Lamers Bus Lines
Voluntary Long Term Disability	After-tax	You

Medical Coverage

Lamers Bus Lines, Inc. offers a choice of medical plan options so you can choose the plan that best meets your needs – and those of your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs.

.Plan Provisions	HSA – $2,700 Ded, 100%		$2,500 Ded, 80%	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Anthem		**Anthem**	
Annual Deductible- Embedded (Individual/Family)	$2,700 / $5,400	$5,000 / $10,000	$2,500 / $5,000	$5,000 / $10,000
Coinsurance	100%	80%	80%	60%
Out-of-Pocket Maximum	Includes Ded, Coins, Copays		Includes Ded, Coins, Copays	
	$6,350 / $12,700	$12,700 / $25,400	$6,350 / $12,700	$12,700 / $25,400
Annual Maximum	Unlimited		Unlimited	
Preventive Care	100%	80% after deductible	80% after deductible	60% after deductible
Primary Physician Office Visit	Deductible then $45 copay	80% after deductible	$35 copay	60% after deductible
Specialist Office Visit	Deductible then $70 copay	80% after deductible	$70 copay	60% after deductible
Hospital Services	100% after deductible	80% after deductible	80% after deductible	60% after deductible
Urgent Care	Deductible then $100 copay	80% after deductible	$100 Copay	60% after deductible
Emergency Room Care	Deductible then $250 copay		80% after $250 Copay	
Retail Prescription Drugs (30-day supply) Generic Brand Preferred Brand Non-preferred Specialty	Deductible, then $15 copay $45 copay $85 copay $300 copay		$15 copay $45 copay $85 copay $300 copay	
Mail Order Prescription Drugs (90-day supply) Generic Brand Preferred Brand Non-preferred Specialty	Deductible, then $45 $135 $255 $600		$45 $135 $255 $600	

- This is a synopsis of coverage only; the benefits summary contains exclusions and limitations that are not shown here. Please refer to the Summary Benefit Comparison (SBC) for the full scope of coverage.
- In-network services are based on negotiated charges; out-of-network services are based on Reasonable & Customary (R&C) charges.

2019 Health Savings Account Information

Employees enrolled in the Lamers Bus Lines health plan who are not enrolled in Medicare, must have a Health Savings Account set up in order to receive the Lamers Bus Lines contribution. Employees who are enrolled in Medicare are not allowed to contribute to an HSA, per IRS rules.

Employer contributions will be made per pay period. Singles will receive $11.50 per pay period, Employee + Children and Employee + Spouse, $17.25, and Family will receive $23.00.

Employees may also contribute to their Health Savings Account by payroll deduction. These contributions are pre-tax and your account balance rolls over from year to year.

Below are some general facts about Health Savings Accounts.

Who is eligible to establish an H.S.A.?

- Is covered by an H.S.A. compatible HDHP
- Is not enrolled in and receiving Medicare benefits
- Is not claimed as a dependent on another person's tax return
- Is not covered by any other type of health insurance plan (including coverage under a spouse's plan) - this does not apply to dental, vision, disability or long term care

What is the maximum annual contribution?

- Single - $3,500
- Family - $7,000

What is the catch-up contribution?

- $1,000 (55 years or older)

How are contributions made?

- Individual check, employer check, ATM online account transfer, automatic transfer, payroll deduction

Is there a penalty for early withdrawal?

- Yes, if under 65 years old, there is a 20% penalty for withdrawals not used for qualified medical expenses

Where can I get a list of qualified medical expenses?

- **www.irs.gov/pub/irs-pdf/p502.pdf**

Is it portable?

- Yes, money in the account remains with the account holder. Transfers allowed from IRA (one- time/lifetime), HRA, FSA. Specific rules apply.

What are the tax advantages?

- Contributions are tax deductible; distributions are tax free as long as used for qualified medical expenses; employer contributions are deductible to business; interest grows tax deferred. You must file a Schedule I (Form 8889) each year with your Federal Tax Return.

How is the account titled?

- Just like an IRA - no joint accounts. Individual ownership only. Spouse can be agent on the account and receive his/her own check card. No trusts allowed; however, trust can be beneficiary.

Voluntary Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

The Lamers Bus Lines, Inc. offers you a dental plan with Anthem:

Plan Provision	Anthem			
	Buy-Up (High) Plan		Base (Low) Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50/$150		$50/$150	
Annual Maximum (per person)	$1,000		$1,000	
Diagnostic and Preventive Care: Includes cleanings, fluoride treatments, sealants x-rays, and oral evaluation	No deductible on 100% 100%		No deductible on 100% 100%	
Basic Services: Includes fillings, and simple extractions Waiting Period	Deductible Applies 80% None		Deductible Applies 50% None	
Major Services: Includes oral surgery, surgical & nonsurgical periodontics/endodontics, crowns, inlays/onlays, bridges/dentures, Waiting Period	Deductible Applies 50% None		Not covered	
OON Reimbursement Methodology	90th U&C		90th U&C	

Voluntary Vision Coverage

The vision plan, offered through Anthem, covers routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses if you need them.

	Anthem Blue Vision	
	In-Network	**Out-of-Network**
Copay Exam, Materials	$20/$20 copay	N/A
Exam	100% after copay	Up to $42
Frequency • Exam • Lenses • Frames	Once in every 12 months Once in every 12 months Once in every 24 months	
Frames Allowance (Retail)	Up to $130, then 20% off any balance	Up to $45
Lenses • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses	Covered in Full	Up to $40 Up to $60 Up to $80
Contact Lenses • Contact Lens Fit and Follow-up • Elective • Necessary	100% if medically necessary Up to $130 Covered in Full	N/A Up to $105 Up to $210
Other Benefits • LASIK Coverage (Add'l Materials Discount)	Discounts may apply	N/A

Life and Accidental Death & Dismemberment (AD&D) Insurance Coverage

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment. Lamers Bus Lines, Inc. provides you with $10,000 of Life and AD&D insurance.

Voluntary Additional Life Insurance & ADD

Additional Life Insurance can be purchased in increments of $10,000 up to 5 times your salary or $300,000 including spousal and dependent additional coverage. This is available to all eligible employees.

Disability Insurance Coverage

The goal of Lamers Bus Lines, Inc. Disability Insurance Plans is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Lamers Bus Lines, Inc. provides eligible employees with short term disability and the option to purchase long term disability. Please see your Human Resources for more information.

Short-Term Disability (STD): Anthem

- Covers 60% of your weekly pre-disability earnings -- up to a $1,000 weekly maximum.
- Benefits begin on day one for disabilities caused by an accident, the eighth day for disabilities due to an injury or illness and continue to the earlier of recovery or 13 weeks.

Voluntary Long-Term Disability (LTD): Anthem

- Covers 60% of your monthly pre-disability earnings up to $6,000 per month.
- Benefits begin after ninety days of disability or illness and continue to the earlier of recovery or normal retirement age.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. They work in a similar way to a savings account but for qualified expenses. Each pay period, funds are deducted from your pay on a pre-tax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA **(must be enrolled in Anthem $2,500 deductible plan to participate)**	Medical, dental and vision care expenses that are not covered by your medical, dental, or vision plan (such as coinsurance, deductible, and copays)	Maximum contribution is $2,650 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

Important Information About FSAs

Your FSA elections will be in effect from January 1 through December 31.

Please plan your contributions carefully. If you do not spend your total election, it will not be reimbursed. This is known as the "Use it or Lose it" rule, and is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

The Advantages of an FSA

With a FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year.

Save on Your Taxes

Here is an example of how much you can save when you use the FSA to pay for your predictable dental, vision and dependent care expenses

	With Limited FSA	Without Limited FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$14,256	$14,850
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$33,744	$33,150
Tax savings with the Health Care and Dependent Care FSA	**$594**	

**This is an example only, and may not reflect your actual experience. It assumes a 22% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will also save on any state and local taxes as well.*

Contact Information

Plan	Whom To Call	Phone Number	Website
Medical Plan	Anthem	1-833-578-4439	To find a provider go to www.anthem.com When prompted for a network use the below: Blue Preferred Plus POS – In Wisconsin Blue Preferred Plus HSA – In Wisconsin Blue Access PPO – Outside of Wisconsin Blue Access HSA – Outside of Wisconsin
Voluntary Dental Plan	Anthem	1-844-729-1565	www.anthem.com
Voluntary Vision Plan	Anthem	1-866-723-0515	www.anthem.com
Life & AD&D Insurance	Anthem	1-800-813-5682	www.anthemlife.com
Voluntary Life Insurance	Anthem	1-800-813-5682	www.anthemlife.com
Short-Term Disability Insurance	Anthem	1-800-813-5682	www.anthemlife.com
Voluntary Long-Term Disability Insurance	Anthem	1-800-813-5682	www.anthemlife.com
Flexible Spending Accounts	Benefit Advantage	920-339-0351 Fax 920-339-0038	www.benefitadvantage.com

About this Guide

This benefit summary provides selected highlights of Lamers Bus Lines, Inc. employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between information provided through this summary and the actual terms of the policies, contracts and plan documents are governed by the terms of these policies, contracts and plan documents. Lamers Bus Lines, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.

2019 Plan Year Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICES

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Cobra Notification

Model General Notice Of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information
Sherry Eisch
Lamers Bus Lines
920-496-3600 ext: 10150

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 10/31/2016)

HIPAA SPECIAL ENROLLMENT NOTICE

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 enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as 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 [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within [insert "60 days" or any longer period that applies under the plan] after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within [insert "60 days" or any longer period that applies under the plan] after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Sherry Eisch at 920.496.3600 ext. 10150.