# NOTICE OF SUMMARY MATERIAL MODIFICATION

Dear Participant and Beneficiaries,

This summary of material modification ("**SMM**") describes changes to Bellavance Trucking Medical Insurance ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

*If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.*

**Benefit Plan Impacted:** Medical Insurance

**Reason for SMM**

- Changes that increase premiums, deductibles, coinsurance, copayments

**Effective Date of Material Modification:** 01/01/2018

**Summary of Changes:**
Please see the attached document for a description of changes impacting your benefits or participation.

**Additional Information:**
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
Bellavance Trucking.
Krissy Bellavance
PO Box 398, Barre, VT 05641
krissyb@bellavancetrucking.com
(802) 479-9311

**General Plan Information:**
Plan Name: Bellavance Trucking's Health & Welfare Benefit Plan
Plan Number: 501
Plan Sponsor/Plan Administrator: Bellavance Trucking

**Summary of Material Modification 2**

This summary of material modification ("**SMM**") describes changes to Bellavance Trucking Health Reimbursement Accounts ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated below. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

*If this summary has been delivered to you by electronic means, you have the right to receive a written summary and may request a copy of this on a written paper document at no charge by contacting the plan administrator.*

**Benefit Plan Impacted:** Health Reimbursement Arrangement

**Reason for SMM**

- Provisions that establish new benefits or services that change the amount of HRA employer funding available to the employee if enrolled in a couple or family contract to meet the individual out of pocket limit

**Effective Date of Material Modification:** 01/01/2018

**Summary of Changes:**
Please see the attached document for a description of changes impacting your benefits or participation.

**Additional Information:**
Refer to your Summary Plan Description (SPD) for details of your benefit plans. If you have questions regarding this modification, contact the Plan Administrator at:
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# Memorandum

**To:** Bellavance Employees

**From:** Krissy Bellavance

**Date:** 11/3/2017

**Re:** 2018 Benefits and Open Enrollment

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OPEN ENROLMMENT FOR THE 2018 PLAN YEAR IS:
MONDAY 11/27/17 – WEDNESDAY 12/6/17

Please continue to read this memo even if you are not enrolled in the health plan, as there is information about other benefits that may pertain to you.

DENTAL & VISION

We are pleased to announce that we will continue to offer our In-House Dental and Vision plan. (The in-house dental plan is for employees who do not have other dental coverage) The Dental plan will be paid 100% by Bellavance for the employee and their dependents. In addition, Bellavance pays the vision premium for all our employees and if you choose to add a dependent(s) to the vision plan the weekly deductions are as follows: (vision deductions did not increase)

One Dependent.....$.80 per week
Family .....$2.85 per week

VOLUNTARY PRODUCTS

As a reminder, the following benefits are 100% employee-paid. Our offerings for 2018 include:

- Short Term Disability – provided by UNUM.
- Long Term Disability – provided by UNUM.
- Life Insurance (for employee, spouse and children) – provided by UNUM.
- AD&D – provided by UNUM

If you currently have any of these voluntary products, you will automatically be enrolled for 2018. If you want to add products or make changes to your current plan, you must do so before December 6, 2017 by contacting Krissy. We received a 14.7% increase to our long term disability rates and a 30% increase to our short term disability rates. I will reach out to employees with these products, and then you can decide if you want to continue with the coverage or not. Just like medical insurance our rates are based of claims data and enrollment. We had a high claim year for short term disability, so I was anticipating an increase (however, not a 30% increase). Our brokers are researching other companies offering these same products but there is no guarantee they will quote us or save us money. Stay tuned on this front!

MEDICAL PLAN

As we have disclosed in previous letters are transparent about the increase of our health care premium, as this is where we spend the bulk of our time worrying about how to pay for this coverage while maintaining a quality plan. Yet again, we are offering what VT Health Connect would say is a "platinum health plan"; meaning your potential out-of-pocket expenses are low compared to most other plans available. Our premium increase for 2018 is $84,300 and this is our only option. MVP's quote came in higher and Cigna declined to quote us. Below is what we have paid to BCBS in premium verses what they have paid out in medical claims for the last two and half years. (This does not include what we pay for the choice care credit card) As you can see, BCBS is paying out more than they are receiving from us in premium.

| | Premium Paid to BCBS | Claims paid out by BCBS |
|---|---|---|
| 2015 | $917,751.00 | $1,222,840.00 |
| 2016 | $922,981.00 | $1,045,810.00 |
| 2017 (through Aug) | $884,233.00 | $1,092,533.00 |

The rate increase will result in the following weekly payroll deductions beginning in 2018:

Single.....$60
Employee & Child(ren)..$105
Employee & Spouse.....$135
Family.....$155

*CHANGES TO THE PLAN*

- The deductible also increased $100.00 for the single person and $300.00 for the employee and dependent plans. Bellavance will continue to absorb that increase with the choice care card. Deducible is now $6550.00 for single plan and $13,300.00 for employee and dependent plans.

*REMINDERS ABOUT THE PLAN*

- We will continue to offer the tier "Employee and Children" and this has been priced $50 less per week than the family plan.
- The Choice Strategies Card will be funded $1,000 for single plans and $2,000 for all other plans
- The employee maximum out of pocket will remain the same as 2016 and 2017 - $2,000 for single plans and $4,000 for all other plans (you only have out of pocket expenses if you use the first dollar funds on the choice card).
- 2 person, employee & children and family plans – If only one person gets sick all bills are paid at a 100% after $7,350. In the past if one person was sick they had to hit the family deductible before all claims were covered in full.

*SUMMARY OF DEDUCTIBLE*

**Single Plan: Deductible $6,650**

- First $1,000 in medical bills/Rx – Bellavance pays
- Next $2,000 in medical bills/Rx – Employee pays (aka the Employee Bridge)
- Last $3,550 in medical bills/Rx – Bellavance pays
- Maximum out-of-pocket towards deductible per year for single plan: $2,000

**2-Person, Employee & Child(ren) and Family Plan Deductible $13,300**
**(max single person $7,350)**

- First $2,000 in medical bills/Rx – Bellavance pays
- Second $4,000 in medical bills/Rx – Employee pays (aka the Employee Bridge)
- Last $7,300 in medical bills/Rx – Bellavance pays
- Maximum out-of-pocket towards deductible per year for 2 person and family plan: $4,000

WRAP-UP

In an effort to make everything as clear as possible, I have assembled the following information, notes and reminders:

- If you are not making any changes to your health, vision or voluntary products, you do not need to do anything.
- We will continue to pay your vision premium. If you need to add/remove any dependents you must notify Krissy by 12/6/2017.
- Any 2017 medical bills must be paid prior to 12/31/2017 if you want to use the Choice Strategies Card. If you need to pay a 2017 medical bill after 12/31/2017, then you need to complete a manual claim. See Krissy for the manual claim form.
- If you need to pay a 2017 medical bill manually, you need to do so before 3/31/2018.
- To get your most current Choice Strategies balance, please call 888-278-2555, option 2. Enter your last 4 digits of your SSN and zip code.
- If you have paid your "employee bridge" in full for 2017 and need to apply for the catastrophic funds, you must contact Choice Strategies immediately. You only have until the beginning of March 2018 to apply for these funds. Choice Strategies can be reached at 888-278-2555.
- If you need to make any changes to you BC/BS plan, you need to notify Krissy and complete paperwork before 12/6/2017. There is no leeway on this date.
- There is always a period of time after the New Year where filling a prescription can be problematic. If you can't go without an Rx for January you may want to fill it the last week in December to avoid having to pay the Rx out-of-pocket and then having to apply for a refund.
- If you want to review your benefits or make open enrollment changes please contact Krissy.

I welcome your questions and the opportunity to explain any of this renewal information further. You can contact me at (w) 802/661-5535, (c) 802/249-8784 or krissyb@bellavancetrucking.com.

Thank you

*Krissy*

## Medical
## Premium Rates and Contributions

All amounts must be a Monthly format.

| Plan / Tier | Plan 1 | | |
|---|---|---|---|
| | Employer Cost | Employee Cost | Total Mo. Premium |
| **EE Group 1** | | | |
| EE Only | $307.07 | $260.00 | $567.07 |
| EE+Spouse (or EE+1 if 3-tier) | $472.78 | $585.00 | $1,057.78 |
| EE+Child(ren) | $418.22 | $455.00 | $873.22 |
| EE+Family (or EE+2 or more if 3-tier) | $839.51 | $671.67 | $1,511.18 |

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.bcbsvt.com/bluecare_cert. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.bcbsvt.com/glossary or call (800) 255-4550 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall **deductible**? | $6,650 individual / $13,300 family.<br><br>Co-insurance and co-payments do not apply to the deductible. This benefit combines your prescription drug and medical deductibles. | Generally, you must pay all of the costs from providers up to the deductible amount each plan year before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. Your plan year: 01/01/2018 through 12/31/2018. |
| Are there services covered before you meet your **deductible**? | Yes, preventive services | This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other **deductibles** for specific services? | No. There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| What is the **out-of-pocket limit** for this plan? | $6,650 individual plan. Family plans have an individual out-of-pocket limit of $7,350 and $13,300 aggregate family out-of-pocket limit.<br>Prescription drugs: $1,350 individual / $2,700 family. | The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| What is not included in the **out-of-pocket limit**? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Will you pay less if you use a **network provider**? | Yes. See www.bcbsvt.com/findadoctor or call (800) 255-4550 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a **specialist**? | No. | You can see the specialist you choose without a referral. |

*Deductible applies to these services.

All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge* for primary care physician and mental health / substance abuse | Not covered | Some services require prior approval. For clarification on mental health services visit www.bcbsvt.com/mental-health-primary-care. |
| | Specialist visit | No charge* | Not covered | Some services require prior approval. |
| | Other practitioner office visit | No charge* for chiropractic care, nutritional counseling, outpatient physical, speech, and occupational therapy | Not covered | Some services require prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined. Nutritional counseling benefits are covered up to 3 visits. There is no limit on the number of nutritional counseling visits for treatment of diabetes. |
| | Preventive care/Screening/ Immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For clarification on preventive services visit www.bcbsvt.com/preventive. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge* for office-based and outpatient hospital | Not covered | Some services require prior approval. |
| | Imaging (CT/PET scans, MRIs) | No charge* | Not covered | Most services require prior approval. |

*Deductible applies to these services.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition. More information about prescription drug coverage is at www.bcbsvt.com/rxcenter. | Generic drugs | No charge* | Not covered | Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval. |
| | Preferred brand drugs | No charge* | Not covered | Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval. |
| | Non-preferred brand drugs | No charge* | Not covered | Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval. |
| | Wellness drugs | No charge | Not covered | Up to a 30-day supply retail / 90-day supply home delivery for most prescription drugs. Some prescriptions require prior approval. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge* | Not covered | Some services require prior approval. |
| | Physician/surgeon fees | No charge* | Not covered | Some services require prior approval. |
| If you need immediate medical attention | Emergency room care | No charge* for facility and physician services | No charge* for facility and physician services | Must meet emergency criteria. |
| | Emergency medical transportation | No charge* | No charge* | Must meet emergency criteria. |
| | Urgent care | No charge* | No charge* | Applies to urgent care facilities. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge* | Not covered | Out-of-state inpatient care requires prior approval. |
| | Physician/surgeon fee | No charge* | Not covered | Some services require prior approval. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge* | Not covered | Some services require prior approval. |
| | Inpatient services | No charge* | Not covered | Includes facility and physician fees. Requires prior approval. |

*Deductible applies to these services.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office Visits | No charge* | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). For a list of services visit www.bcbsvt.com/preventive. |
| | Childbirth/delivery professional services | No charge* | Not covered | Out-of-state inpatient care requires prior approval. |
| | Childbirth/delivery facility services | No charge* | Not covered | Out-of-state inpatient care requires prior approval. |
| If you need help recovering or have other special health needs | Home health care | No charge* | Not covered | Home infusion therapy requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined. |
| | Rehabilitation services | No charge* inpatient; cardiac / pulmonary services no charge* | Not covered | Inpatient rehabilitation services require prior approval. |
| | Habilitation services | No charge* for inpatient services | Not covered | Requires prior approval. Outpatient physical, speech and occupational therapy benefits are covered up to 30 visits combined. |
| | Skilled nursing care (facility) | No charge* | Not covered | Requires prior approval. |
| | Durable medical equipment (including supplies) | No charge* | Not covered | May require prior approval. |
| | Hospice | No charge* | Not covered | None |
| If your child needs dental or eye care | Eye exam | $20 co-payment per child exam; $20 co-payment per adult exam | We pay up to our allowed price less your $20 co-payment | One routine exam per calendar year. |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

*Deductible applies to these services.

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic Surgery (except with prior approval for reconstruction)
- Dental care (child and adult)
- Hearing aids
- Infertility Medications
- Long-term care
- Routine foot care (except for treatment of diabetes)
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic Care (requires prior approval after 12 visits)
- Non-emergency care when traveling outside the U.S. (www.bcbsvt.com/coveragewhiletraveling)
- Private-duty nursing (covered up to 14 hours per plan year)
- Routine eye care (one routine eye exam per child and adult member per calendar year)

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov. You may also contact the plan at (800) 247-2583. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call (800) 318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: (800) 255-4550.

### Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## Coverage Examples

### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $6,650 |
| Specialist co-payment | $0 |
| Hospital (facility) co-payment | $0 |
| Other co-payment | $0 |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| Total Example Cost | $12,700 |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,650 |
| Co-payments | $0 |
| Co-insurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,710** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $6,650 |
| Specialist co-payment | $0 |
| Hospital (facility) co-payment | $0 |
| Other co-payment | $0 |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| Total Example Cost | $7,400 |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,650 |
| Co-payments | $0 |
| Co-insurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$6,710** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $6,650 |
| Specialist co-payment | $0 |
| Hospital (facility) co-payment | $0 |
| Other co-payment | $0 |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| Total Example Cost | $1,900 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,930 |
| Co-payments | $0 |
| Co-insurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,930** |

The plan would be responsible for the other costs of these EXAMPLE covered services.
The prescription drug out-of-pocket limit might not be included in the above Coverage Examples.

**Standard Plan Name:** TVHP-BCACDHP-6650-6650-0%-AGG-x-x-x-x-x-x-ACA-LARG(MD28401) TVHPC-Rx-C0%-1350-W-0-0-0-2-x-P(RX30482) CY 1023291 AW25, AW26, SW25, SW26

## NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

## For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

CHOICE™ STRATEGIES
a division of WageWorks

# Funding Sheet for:
# Bellavance and Sons Trucking Co.

**Employer ID: CHOBELLAV**
Plan Year 01/01– 12/31

## Employer Provided Accounts

**Health Reimbursement Account – HRA Bellavance/Terry Hill**
**Single- $1,000**
**Family- $2,000**

**Catastrophic Clause:**
**Single**- An additional $3,650 will be available after $2,000 of the shared responsibility has been satisfied
**Family** - An additional $7,300 will be available after $4,000 of the shared responsibility has been satisfied

After your responsibility has been met, submit all of the following:
a. A Shared Responsibility Form, available on our website, www.choice-strategies.com.
b. An Explanation of Benefits (EOB) demonstrating that your share of the responsibility has been met.
c. Proof of payment.

## Eligible Expenses

**Health Reimbursement Account (HRA) Bellavance/Terry Hill**

- Medical Deductible
- Prescriptions

**Useful Information:**

- The eligible expenses listed on this funding sheet are the ONLY eligible expenses.
- **If pharmacy expenses are eligible on your plan, please check our website www.choice-strategies.com for a list of participating pharmacies.**
- The dates of service must have occurred during the plan year.
- You have a 3-month run-out period to file claims manually for dates of service incurred during the previous plan year.
- Receipt notifications will be mailed to you monthly. Your response to receipt notifications is necessary under the provisions of the plan. No response may result in the ineligibility of the purchase and as a result your card may be temporarily deactivated.

**PLEASE KEEP ALL RECEIPTS AS THEY MAY BE REQUIRED TO SUBSTANTIATE PURCHASES MADE WITH THE CHOICE STRATEGIES CARD.™ THIS REQUIREMENT IS MANDATED BY FEDERAL REGULATIONS**