Summit Express

Owner Operator

Medical Plan Options

Effective Date: December 1, 2017

CALL SOURCEONE TO ENROLL 1-800-436-3544

OPEN ENROLLMENT MONDAY NOV 6TH - WEDNESDAY NOV 22TH

MONDAY - FRIDAY 8:00 AM - 5:00 PM (ET)

PLEASE HAVE COVERED DEPENDENTS' SOCIAL SECURITY NUMBERS AND BIRTHDATES READY WHEN YOU CALL

*ALL DRIVERS MUST CALL IN, EVEN IF YOU ARE WAIVING COVERAGE

	Option 1 *Tall Tree*	Option 2 *Tall Tree*	Option 3 *Tall Tree*
PLAN TYPE	Minimum Essential Coverage	Enhanced MEC	Enhanced MEC Plus
Network	PHCS / MultiPlan	PHCS / MultiPlan	PHCS / MultiPlan
Deductible	**$0 Ind/$0 Fam**	**$0 Ind/$0 Fam**	**$0 Ind/$0 Fam**
Preventive and Wellness	100%	100%	100%
Teledoc Phone, Video or Mobile App Access to U.S. Board-Certified Doctor 24 Hours, 7 Days a Week	**NA**	**No Copay or Charge**	**No Copay or Charge**
Physician copay	**N/A**	**$20 Copay**	**$20 Copay, plan pays 60%**
Specialist copay	**N/A**	**$40 Copay**	**$40 Copay, plan pays 60%**
Urgent Care Copay	**N/A**	**$50 Copay**	**$50 Copay, Plan pays 60%**
RX Deductible	**N/A**	**N/A**	**N/A**
Generic / Preferred Brand / Non-Preferred Brand	**N/A**	**$10 Copay / Not Covered / Not Covered**	**$10 Copay / $40 Copay / $80 Copay**
Specialty High Cost & Compounds	**N/A**	**Not Covered**	**Not Covered**
Diagnostic Lab work	**N/A**	$50 Copay	$50 Copay
Imaging/Radiology (CT/PET Scan, MRIs)	**N/A**	$400 Copay	$500 Copay
Hospital Facility and Inpatient Services	**N/A**	Not Covered	$500 Copay, then Plan pays 60% (Plan payment based on 125% of Medicare Allowable Payment) Limited to 5 days
Outpatient Copay (Hospital Facility)	Not Covered	Not Covered	Not Covered
Emergency Room Facilities	**N/A**	Not Covered	Not Covered
Coinsurance	**N/A**	100%	100%
Out of Pocket Maximum (Incl. Ded.)	**N/A**	$6,500 Ind/$13,000 Fam	$5,500 Ind/$13,000 Fam
Medicare Reimbursement % Level	**N/A**	N/A	125%
Lifetime Maximum	Unlimited	Unlimited	Unlimited
	Option 1 Minimum Essential Coverage	**Option 2** Enhanced MEC	**Option 3** Enhanced MEC Plus
	Weekly Pre-Tax Deduction	**Weekly Pre-Tax Deduction**	**Weekly Pre-Tax Deduction**
	Employee Only $20.33	Employee Only $47.60	Employee Only $79.71
	Employee & Spouse $24.50	Employee & Spouse $74.53	Employee & Spouse $144.59
	Employee &Child(ren) $25.13	Employee &Child(ren) $78.59	Employee &Child(ren) $125.61
	Employee & Family $28.79	Employee & Family $102.22	Employee & Family $192.95

This is only a brief summary of benefits and rates. Please refer to the proposal and/or SPD for more details.

SourceOne Insurance

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	Option 4 *Tall Tree*	Option 5 *Tall Tree*	Option 6 *Tall Tree*
PLAN TYPE	**Basic Minimum Value Plan**	**Minimum Value Plan**	**Minimum Value Plan Plus**
Network	**PHCS / MultiPlan**	**PHCS / MultiPlan**	**PHCS / MultiPlan**
Deductible	**$6,500 Ind/$13,700 Fam**	**$0 Ind/$0 Fam**	**$0 Ind/$0 Fam**
Preventive and Wellness	100%	100%	100%
Teledoc Phone, Video or Mobile App Access to U.S. Board-Certified Doctor 24 Hours, 7 Days a Week	**No Copay or Charge**	**No Copay or Charge**	**No Copay or Charge**
Physician copay	**$50 Copay, plan pays 60%**	**$20 Copay**	**$20 Copay**
Specialist copay	**$70 Copay, plan pays 60%**	**$40 Copay**	**$40 Copay**
Urgent Care Copay	**$70 Copay, plan pays 60%**	**$50 Copay**	**$50 Copay**
RX Deductible	**N/A**	**N/A**	**N/A**
Generic / Preferred Brand / Non-Preferred Brand	**Deductible / Deductible / Not Covered**	**$10 Copay / Not Covered / Not Covered**	**$10 Copay / $40 Copay / $80 Copay**
Specialty High Cost & Compounds	**Not Covered**	**Not Covered**	**Not Covered**
Diagnostic Lab work	Deductible, then Plan pays 100%	$50 Copay, Then The Plan pays 100%	$50 Copay, Then The Plan pays 100%
Imaging/Radiology (CT/PET Scan, MRIs)	Deductible, then Plan pays 100%	Not Covered	$50 Copay, Then The Plan pays 100%
Hospital Facility and Inpatient Services	Deductible, then Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)	$400 Copay, then Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)	$400 Copay, then Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)
Outpatient Copay (Hospital Facility)	Not Covered	Not Covered	$400 Copay then plan pays 100%; plan payment based on 125% of Medicare
Emergency Room Facilities	Deductible, then Plan pays 100%	$400 Copay,then Plan pays 100% (Plan payment based on 125% of Medicare Allowable Payment)	$400 copay then Plan pays 100%(Plan payment based on 125% of Medicare)
Coinsurance	100%	100%	100%
Out of Pocket Maximum (Incl. Ded.)	$6,500 Ind/$13,700 Fam	$2,000 Ind/$13,200 Fam	$2,000 Ind/$13,200 Fam
Medicare Reimbursement % Level	125%	125%	125%
Lifetime Maximum	Unlimited	Unlimited	Unlimited
	Option 4	**Option 5**	**Option 6**
	Basic Minimum Value Plan	**Minimum Value Plan**	**Minimum Value Plan Plus**
	Weekly Pre-Tax Deduction	**Weekly Pre-Tax Deduction**	**Weekly Pre-Tax Deduction**
	Employee Only $94.69	Employee Only $104.22	Employee Only $142.12
	Employee & Spouse $175.79	Employee & Spouse $191.41	Employee & Spouse $269.50
	Employee &Child(ren) $152.64	Employee &Child(ren) $165.91	Employee &Child(ren) $232.25
	Employee & Family $234.78	Employee & Family $256.40	Employee & Family $364.43

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SUMMIT EXPRESS ENROLLMENT FORM
OWNER OPERATOR DRIVERS
COVERAGE EFFECTIVE 1/1/18

TALL TREE ADMINISTRATORS

SECTION 1 - EMPLOYEE INFORMATION

Name (Last, First, MI):		
Gender: ☐ Male ☐ Female	DOB (MM/DD/YY) / /	SS#: - -
Address:		
City: State: Zip:	Daytime Phone:	
Hire Date: / /	Eligibility Effective Date: 01 / 01 / 2018	
Email address:		

SECTION 2 – COVERAGE ELECTIONS OR WAIVER OF COVERAGE – CIRCLE ONLY ONE OR CHECK COVERAGE DECLINED

	Single	EE +SP	EE +Children	Family
MEC	$20.33	$24.50	$25.13	$28.79
Enhanced MEC	$47.60	$74.53	$78.59	$102.22
Enhanced MEC +	$79.71	$144.59	$125.61	$192.95
Basic MVP	$94.69	$175.79	$152.64	$234.78
MVP	$104.22	$191.41	$165.91	$256.40
MVP+	$142.12	$269.50	$232.25	$364.43

COVERAGE DECLINED

	☐ Medical	

I have elected not to apply for coverage at this time for myself or my dependents (if any). I have coverage from: (check one)
☐ Medicare ☐ Medicaid ☐ Spouse Plan ☐ Parent Plan ☐ Individual Plan ☐ Military Plan
List current carrier and ID number-

I understand that if I waive this coverage and do not have valid coverage in another plan, in accordance with IRS rules, I must pay a fee. The fee is called the individual shared responsibility payment. The fee is sometimes called the "penalty," "fine," or "individual mandate." The 2017 penalty is $695.00 for an individual, $347.50 for children under 18 with a family maximum of $2085.00
Note: You will not be able to enroll until the next open enrollment or you have a Qualified Event.

Employee must sign here ***only if you are*** declining coverage

X	Date:

SECTION 3 – LEGAL SPOUSE'S INFORMATION

Name (Last, First, MI):		
Gender: ☐ Male ☐ Female	DOB (MM/DD/YY) / /	SS#: - -
Name of Spouse's Employer (or "Not Employed"):		
Is there other insurance ☐ Yes ☐ No If spouse is covered by another Health Insurance Plan you must complete the "Other Insurance" section.		

SECTION 4 – LEGAL DEPENDENT CHILDREN INFORMATION

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 5 - EMPLOYEE SIGNATURE

Please read carefully before signing: Under penalties of perjury, I certify that the information on this enrollment form is true and complete. I hereby apply for this coverage. I authorize my employer to make the necessary payroll deductions. I authorized any health care provider to release all information pertaining to care provided to me or my dependents. A photocopy of this authorization shall be valid as the original.

X	Date:

I understand I may not drop my coverage unless there is a Qualifying Event (QE) or the Plan has an Open Enrollment period. Changes must be submitted within 30 days of Qualifying Event

SECTION 6 – OTHER INSURANCE INFORMATION

Name of Health Plan:		
Group or policy #:	Phone Number:	Date Coverage Began:

Name of all individuals covered under this plan an any additional explanations or information about this coverage:

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 7 – ELECTRONIC DATA INFORMATION

For your security and privacy you can log into our secure website to view your eligibility, view claim history and access your Explanation of Benefits for any claim that has been processed for you or your family members. In addition, you will be linked to the PPO network and other valuable information. Visit www.talltreehealth.com.

OFFICE USE ONLY

☐ Regular Enrollment: Completed within 31 days of eligible date.	Effective Date:
Annual Salary	☐ Hourly ☐ Salary

Locations:		
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Employer Group Representative Signature	
X	Date: