

Medical Plans

Each of us has different needs for medical coverage, and your decision should be based on your personal situation. There are things you may want to consider as you determine which plan is right for you and your family. Before selecting a medical plan option, review the ADP TotalSource benefit summaries found in your enrollment kit.

Ask yourself:

- What Plan options have been made available to me?
- What are my expected medical expenses for the coming year?
- What would my out-of-pocket expenses be under the Plans available to me?
- What will my premium responsibility be for this Plan?
- Are my physicians in the Plan network?
- Is there a pre-existing condition clause?
- Do I have any other sources of coverage?

ADP TotalSource offers more than one Plan design wherever possible. The insurance carriers for these Plans will vary according to geographic location. The following are general descriptions of the Medical Plan designs that may be available to you.

PLAN DESIGNS

Health Maintenance Organization (HMO)

A HMO is a comprehensive group medical plan with a network of physicians and hospitals. Affordable benefits are available to you when these networks are used. At enrollment, you select a primary care physician (PCP) for yourself and each covered dependent. Your PCP manages the health care for you and your dependents authorizing specialist services, hospital procedures, lab work, and diagnostic testing. Without a PCP authorization for these services, they will not be covered. Additionally, if you receive treatment from a non-participating network provider your expenses will not be covered. Payment for non-covered expenses will be your responsibility. When you receive medical care, you show your identification (ID) card and pay your portion of the charges, usually in the form of a co-payment. There are no claim forms to file. You may change your PCP at any time by contacting the HMO carrier directly.

Open Access

An Open Access product is a comprehensive group medical plan with a network of physicians and hospitals that gives you the freedom to see any doctor in the network, including specialists, without a referral. You are encouraged to select a PCP, but it is not required. The Open Access feature is often associated with traditional HMO products where you must use the network of providers and hospitals in order to have services covered by the plan. In some instances, there will be a Point of Service (POS) Plan with Open Access, where you have direct access to network specialists and you can also visit any non-participating physician and receive out-of-network benefits with a deductible and higher co-payments.

Point of Service (POS)

A POS is a plan similar to a HMO, but also offers coverage for medical care obtained outside the provider network or without required referrals. You receive the highest benefit level when the network of physicians and hospitals is used. A PCP manages the health care for you and your dependents. At enrollment, you must select a PCP for yourself and each covered dependent. Your PCP must authorize specialist services, hospital procedures, lab work, and diagnostic testing. When you receive medical care inside the network, you show your ID card and pay your portion of the charges, usually in the form of a co-payment. However, unlike a HMO, you can be covered for services received from providers outside the network. In this case you may have to pay the bill up-front and file a claim form for reimbursement. Benefits for these services are lower, which means your out-of-pocket expenses may be higher. The percentage of coverage is based on charges the insurance company approves.

Preferred Provider Organization (PPO)

A PPO is a group of hospitals and physicians that contract to provide comprehensive medical service on a fee-for-service basis. These health care providers are referred to as network providers. Because network providers exchange discounted services for increased volume, you (the insured) have out-of-pocket costs that are lower than a non-negotiated fee schedule. PPOs offer both in-network and out-of-network coverage. The levels of coverage are higher and the out-of-pocket expenses are lower if you use participating network providers. When you receive medical care from a participating network provider, you must show your ID card and pay the appropriate co-payment, coinsurance, or deductible, if applicable. There are no claim forms to file. When you receive medical care from a provider outside the participating provider network, you may have to pay the medical bill up-front and file a claim form for reimbursement. Out-of-network reimbursements are based on what the insurance company determines to be usual, customary, and reasonable fees.

Indemnity Plan

An Indemnity Plan, commonly referred to as "traditional insurance," is offered in areas where other products are not available. There is no provider network. Therefore, you may receive treatment from any licensed medical provider. Indemnity Plan designs have deductibles and co-insurance just like PPO Plans. In most cases your health care provider will require you to pay for services up-front and then file a claim with the insurance company for reimbursement. Reimbursements are based on what the insurance company determines to be usual, customary, and reasonable fees.

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Consumer Choice Option (CCO) – Georgia Residents Only

Georgia law requires health insurance carriers to offer a Consumer Choice Option (CCO) to Georgia residents enrolling in an HMO, POS or PPO Plan. This option allows you, a Georgia resident, to receive services from a non-network provider while still being covered at the in-network benefit level. However, the non-network provider that you, the Georgia resident, chooses must first agree to accept the insurance carrier's fee schedule of reimbursement and to comply with the carrier's utilization management programs. If you, as a Georgia resident, elect the CCO on the enrollment application, you will pay an additional 17.5% of the monthly premium for HMO and POS, and an additional 10% of the monthly premium for PPO Plans. You, as a Georgia resident, may elect the CCO at Open enrollment, when newly hired, or when a qualifying change-in-status occurs. You pay the additional premium for the CCO in its entirety. You may contact the Employee Service Center to determine the monthly premium.

Transition of Care

If you are in an active course of treatment or become pregnant when you change plans, you may not be able to continue with your current treating physician or durable medical equipment provider. However, depending on the plan and/or carrier you have selected, if you are in an active course of treatment or you became pregnant before the plan effective date, the medical carrier might authorize you to continue to receive care from a non-participating treating physician or to be covered for non-covered, rented durable plan and/or medical carrier you select and does not apply to all plans. An active course of treatment is defined as a planned program of services rendered by a physician or durable medical equipment provider starting on the date a physician first renders service to correct or treat the diagnosed condition and covering a defined number of services or period of treatment. You should contact the Employee Service Center for assistance.