EMPLOYER PROVIDED PLANS

How to Get the Care You Need

Employer Provided Self-Insured Plans

Medica®

How to get the care you need

Your guide to Medica

We are happy to have you as a member. Your health care coverage is a valuable resource to help you receive quality care. This guide explains some of your health care options and has important information about your rights and responsibilities as a consumer. It also tells where to find more information if you need it.

Please note: Your health plan is self-insured, which means benefits are paid by the plan sponsor, usually your employer. Medica provides claims administration services for the plan, but does not insure the plan. Throughout this booklet, all self-insured covered persons will be referred to as "members" rather than the formal title of "self-insured covered persons."

File it

Please read and save this document. It may help whenever you have questions about your coverage. Some Medica members use a file folder to keep all of their health care information in one place. Typical items you may want to include in your health care file are:

- Your coverage document, called a "Plan Document" or "Summary Plan Description," is available on your secure member website at **Medica.com/SignIn.**
- "Summary of Benefits and Coverage" document
- Any "Explanation of Benefits" you receive
- Information from your health care provider or clinic
- Information about your prescriptions
- Information about eye care
- Receipts for copayments, prescriptions, or other medical expenses

Some programs and services may not be available to all members, depending upon your health insurance plan.

If any information in this guide conflicts with your coverage document, your coverage document will govern in all respects.

Find what you need online

Get the information you need about your benefits online at **Medica.com/SignIn.** Throughout this document, we'll let you know whenever more information is available online.

If you need help or additional information, you can also contact Member Services. You'll find their contact information in the *Important phone numbers* section at the end of this guide.

Contents

About your coverage

Your coverage document, called a "Plan Document" or "Summary Plan Description," explains what is and is not covered by your health insurance plan. It also explains what portion, if any, you will pay for health services. Throughout this guide, we use the term "coverage document." To access your coverage document, go to **Medica.com/SignIn.**

In most cases you can find answers to questions about your health insurance benefits in your coverage document. If you cannot find what you need, call Member Services. You'll find their number in the *Important phone numbers* section of this guide or on your Medica ID card.

Deductibles, copayments, or coinsurance may apply

Payment of a deductible, copayment, or coinsurance may be required for services received from a provider, hospital, or for a prescription filled at a pharmacy.

- **Deductible** — the amount you pay each year before your insurance starts to pay (for example, $1,000).
- **Copayment** — a fixed dollar amount you pay upfront for some services or prescriptions (for example, $25).
- **Coinsurance** — a percentage of the charges that you pay for a given service (for example, 25% coinsurance).

See your coverage document for the complete definitions of these terms and whether they apply to your plan.

Find a complete listing of your copayments or coinsurance in your coverage document by logging into your secure member account at **Medica.com/SignIn.**

How to submit claims

Network providers will submit claims for you. Claims for services received from a non-network provider must be submitted on an itemized claim form by you or the non-network provider to the address on the back of your Medica ID card. Most non-network providers have the proper claim form. If not, you can download the form from your secure member website at **Medica.com/SignIn** or call Member Services. If you paid for services from a non-network provider and will be submitting the claim yourself, include copies of any bills, receipts, or itemized statements from all providers.

Please note that non-network claims must be submitted within 365 days from the date of service. Please see your coverage document for details.

Coverage for hospital services

If you need care at a hospital, coverage for outpatient and inpatient care varies by plan. In some cases — such as care for children or transplant services — you may need to go to specialty hospitals. Also, if you are out of your provider network and require hospitalization, refer to your coverage document to learn how to receive your highest level of coverage. You also may contact Member Services for more information about your benefits and to make sure that the hospital you want to use is in your plan's network. Look up network hospitals in your online member website at **Medica.com/SignIn.**

Post-mastectomy coverage is available

The *Women's Health and Cancer Rights Act* requires health insurers and group health plans that cover mastectomies to provide certain benefits if a member chooses reconstructive surgery after a mastectomy. The law also requires health plans to provide members with written notice that this coverage is available.

Refer to your coverage document to see how your plan covers the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a balanced look.
- The cost of prosthesis and the treatment of any physical complications resulting from mastectomy. This includes treatment of lymphedema, the swelling sometimes caused by surgery.

Some members may have to pay a deductible, copayment, or coinsurance. The amount will be consistent with the deductibles, copayments, or coinsurance for other benefits in your plan. To determine the amount you would have to pay, see your coverage document.

Connecting you to the care you need

At Medica, we will do our best to make sure you and your family receive the very best health care. We start by connecting you with health care providers who deliver the care you need.

Your primary care provider

Your primary care provider is your medical "home." This is the provider you choose to see on a regular basis.

There are four types of primary care providers. Some work only with women or children. If you need to choose a primary care provider, the following descriptions can help you decide which type would best meet your needs.

Family practice: Doctors who provide care for the whole family — all ages, all genders, each organ system, and every type of disease. This specialty provides continuing, comprehensive health care for the individual and family.

Internists: Doctors who specialize in complex illnesses of adults, especially medical conditions that affect internal organs.

Pediatricians: Doctors who specialize in taking care of the general health needs of children, from birth to about age 17.

Obstetricians/gynecologists (OB/GYN): Doctors who specialize in pregnancy, childbirth, and diseases/problems of the female reproductive system. They are also trained in routine preventive and reproductive services.

To learn about the qualifications of a primary or specialty provider, you can contact the State Board of Medical Practice or State Board of Medical Examiners. You also can check your state's government website.

Important! If you see a provider who's not in your plan's network, you usually submit your own claim and *your costs may be significantly higher*. Find more detailed information about out-of-network costs and how they're calculated in our *Out-of-Network Care* tip sheet at **Medica.com/MemberTips.**

Finding a physician or facility

There is a fast, easy online tool you can use to search for health care providers in your plan's network. You can search for primary care physicians, specialists, clinics, hospitals, and other care providers. Go to **Medica.com/FindCare** and select your plan name (listed on your Medica ID card as *Care Type)*.

Please confirm with the provider's office that they are part of your plan's network before your first visit. If you have questions about whether your provider or clinic is in your plan's network, your benefits or coverage, call the Member Services number on the back of your Medica ID card.

How providers are added to our network

When a provider wants to join a Medica network, we look at that provider's education and experience. We do this to make sure you have access to providers who meet our quality standards.

Making appointments

When you are sick or need to see a provider for preventive care, simply contact your primary care provider to make an appointment. Make sure your provider is in your plan's network. Show your Medica ID card at each visit.

Before seeking services from a network provider, you may request an estimate of the allowable amount the specified provider has contracted with Medica to receive for a specified health service, and the portion of that amount you must pay. Go to **Medica.com/SignIn** to estimate your costs.

The amount Medica provides is only intended to be a good faith estimate and is not legally binding.

Specialty care

Perhaps you and your primary care provider have decided that you need to see a specialist. Coverage for specialty care varies by plan. Some plans require a referral from your primary care provider, while others do not. Keep in mind that it may take up to six weeks to get a specialist appointment.

Medica has procedures for seeing specialists of many kinds. To be sure that you receive maximum coverage, read your coverage document and follow the steps outlined there. You can access your coverage document any time in your secure online member website at **Medica.com/SignIn.**

Behavioral health services: Mental health and substance use care

If you or a family member needs mental health or substance use services, follow the steps outlined in your coverage document. You can also call Member Services or Medica's designated mental health and substance use care provider for assistance. See your coverage document for details. Refer to the *Important phone numbers* at the back of this guide for contact information.

If you have an emergency, call 911.

Live and Work Well online resources

Medica's Live and Work Well website* offers health resources and personalized support services to help you and those you care about live the healthiest life possible. The Live and Work Well site is available 24/7 for confidential access to professional care, self-help programs and a variety of helpful information.

- Search for topics on career and workplace, mental and physical health, addiction, recovery and resiliency, and more.
- Take assessments for depression, anxiety, alcohol use, recovery, and post-traumatic stress disorder (PTSD).
- Access the substance use disorder (SUD) helpline and online chat, a free, confidential resource available to you or a loved one.
- Receive direct access to a substance use recovery advocate 24 hours a day, 7 days a week via phone at **(855) 780-5955** or live chat.
- Get expert decision support to better understand appropriate SUD treatment options for your personal situation.
- Schedule a clinical evaluation with a licensed substance use treatment provider, usually within 24 hours.

Go to **LiveAndWorkWell.com**. To view the educational content and provider search, enter access code MEDICA.

- Create an account to access all self-help resources and the claims center.
- Enter your Medica member ID number during registration

**This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This program is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.*

Care after regular clinic hours

If possible, you should make an appointment to see your primary care provider first. Your primary care provider is the person who knows the most about your medical history. Even when the clinic is closed, you can call and leave a message for your provider. Many clinics have on-call staff that can help you get the care you need.

If after-hours care from your regular clinic isn't available, you can access virtual care or visit an urgent care or retail health clinic in your plan's network. Go to your member website at **Medica.com/SignIn** to search for care options in your network. For most members, help finding a location close to you is available through Medica CallLink, 24-hour advisor and nurse line. If this service is available to you, the toll-free number is listed on the back of your Medica ID card.

Retail health clinics

Retail health clinics are staffed with licensed providers who can treat common illnesses and provide certain preventive services for people older than 18 months. Some of the illnesses they can treat are the common cold, sore throat, or an ear infection. They can't treat life-threatening emergencies. These clinics provide after-hours care and are located in many retail stores, grocery stores, or pharmacies. Search for locations online at **Medica.com/FindCare** and select your plan name (listed on your Medica ID card as *Care Type*). (Please note, retail health clinics may not be available in some areas.)

Retail health clinics have daytime and evening hours. Some also are open on weekends and holidays. You don't need to make an appointment, just walk in. Care is given on a first-come, first-served basis.

Virtual care

Also known as online care or e-visits, virtual care is a convenient way to connect with your provider through email, telephone or webcam. You receive a diagnosis, treatment plan, and prescription (if needed). Virtual care may cost less and be a time-saving option for non-urgent medical symptoms like allergies, pink eye, and sinus infections. Most benefit plans cover virtual care. To check your coverage document and find virtual care providers, go to **Medica.com/SignIn.**

Urgent care

If your primary care clinic is closed, urgent care is a good place to go for things like earaches, strep throat, fever, a sprained ankle, or minor cuts. Urgent care centers are staffed by doctors and nurses, but they are not for life-threatening emergencies. They are open days and evenings and many have weekend and holiday hours. You don't need to make an appointment, just walk in. Care is given on a first-come, first-served basis. Search for locations by going to **Medica.com/FindCare** and select your plan name (listed on your Medica ID card as *Care Type*).

Emergency care

A medical emergency is something that needs treatment right away. It requires prompt medical attention to: preserve life; avoid serious physical or mental harm; avoid serious damage to body functions, organs or parts; or because there is continuing severe pain. If you have an emergency, go to the emergency room. Emergency room services are usually offered at a hospital.

If your condition doesn't need treatment right away, go to your primary care clinic. If that office is closed, go to a retail health or urgent care clinic. If you go to the emergency room, it will cost you a lot more than care elsewhere. It also may take more of your time because emergency rooms treat patients with the most serious cases first.

Please only go to the emergency room for true emergencies so the doctors and nurses are able to treat people with serious problems right away.

Examples: How to decide where to go for care

Sometimes you need to decide what to do when you have a health question. Here are some examples of things that come up in everyday life.

Fussy child. Your 2-year-old child has been fussy all day. She has a fever and doesn't want to eat. She is tugging at her ear and is starting to cry.

Options:

1. If it's a weekday, contact your child's primary clinic and describe your child's behavior to your provider. You may be directed to come in to the clinic.
2. If it's an evening or weekend, call your child's clinic, but if it's closed, call Medica CallLink and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility. The Medica CallLink line can help you find a facility close to your home.

Sore throat. You have a sore throat, feel achy all over, and have a fever.

Options:

1. If it's a weekday, contact your primary clinic and describe your symptoms to your provider. You may be directed to come in to the clinic.
2. If it's an evening or weekend, call your clinic, but if it's closed, call Medica CallLink and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility. The Medica CallLink line can help you find a facility close to your home.

Asthma. Your 7-year-old son has asthma. After playing in the back yard with his friends all day, he's coughing, wheezing, and complaining that his chest feels tight.

Immediately help him take his quick-relief medicine. Follow the asthma action plan given to him by his doctor. Call his doctor or, if needed, take him directly to the emergency room.

Medica CallLink is not included in all plans. If this service is available to you, the toll-free phone number is listed on your Medica ID card.

If you or a family member has one of the conditions listed below, go to an emergency room immediately or call 911.

Medical emergencies may include:

- Poisoning or drug overdose
- Trouble breathing or shortness of breath
- Pain or pressure in your chest or above your stomach
- Warning signs of stroke: sudden dizziness or change in vision; sudden weakness or numbness; trouble speaking or understanding speech
- Vomiting that won't stop
- Bleeding that won't stop after 10 minutes of pressure
- Coughing up blood or throwing up blood
- Sudden, sharp pain anywhere in the body
- Loss of consciousness or convulsions
- Broken bones or fractures
- Injury to your spine
- Major burns
- Wanting to hurt other people or yourself
- Change in mental status, such as unusual behavior

Medical emergencies are always covered at the in-network level, even if the provider is not in your plan's network.

Care when you travel

If you travel out of Medica's service area and need care, you may be able to get in-network coverage by visiting a provider in our Travel Program Network. Find a Travel Program provider online at **Medica.com/FindCare** then select your plan name (listed on your Medica ID card as *Care Type*). (Medica Choice Passport and Medica Choice National members can receive in-network coverage by seeing a provider in their plan's nationwide network.)

If you plan to travel outside the United States, contact Member Services before leaving the country to find out about any special requirements for getting any care you may need. Your plan covers emergency medical treatment. Please see your coverage document for specific details.

Carry your Medica ID card when you travel. It has many important telephone numbers to help you access advice about your health care and coverage. Most Medica members who are ill can call the Medica CallLink, 24-hour advisor and nurse line, for health care advice. If this service is available to you, the phone number will be listed on your Medica ID card.

24-hour advisor and nurse line

Often, the help you need may be available by phone! Medica CallLink® is staffed 24 hours a day, seven days a week. Advisors and nurses can answer your questions and recommend when you should make an appointment to see your doctor, go to a retail health clinic, an urgent care center, or the emergency room.

Call Medica CallLink to:

- Talk with an experienced advisor or nurse
- Ask health care questions and learn self-care tips
- Get help finding a provider or an urgent care facility in your plan's network

**Medica CallLink is not included in all plans. If this service is available to you, the toll-free phone number is listed on your Medica ID card.*

The information offered by Medica CallLink is not meant to provide a medical diagnosis or treatment. Always seek the advice of your doctor or other qualified health care provider if you have questions about a medical condition.

Pharmacy services: Your prescription drug benefits

Note: Some Medica members have pharmacy benefits administered by an organization other than Medica. Please see your coverage document if you are unsure who administers these benefits.

The Medica drug list is comprised of drugs that provide the most value and have proven safety and effectiveness. This list is divided into three groups (generic, preferred brand, and non-preferred brand), which determine your share of the costs. Generic drugs have the lowest copayment or coinsurance. The drug list is reviewed and updated regularly by independent physicians and pharmacists. If a drug is on the list, it does not guarantee coverage because certain limitations may apply. For more information or to see what drugs your plan covers, go to **Medica.com/SignIn.**

Please see your coverage document for specific information on your pharmacy benefit and to determine if an exception process for the drug list is available to you. Some plans may not have an exception process. If you have any questions on your pharmacy benefit, you also may call Member Services at the number on the back of your Medica ID card.

Meeting your individual health care needs

No two Medica members are alike or have exactly the same needs. That's why Medica offers additional services. We want to make it easier to access the care you need.

Interpreter services

Clear communication is important when talking about your insurance benefits. Do you need help in a language other than English? Member Services can connect you with an interpreter. Medica works with a service that provides interpreter services in more than 150 languages. In some cases, you also may have the right to receive certain written notices in a language other than English.

Services for TTY users

TTY users, call **711** to reach a representative who can answer your questions.

Continuity of care

If your provider is not in your plan's network, you may not need to change providers immediately to receive the highest level of benefits.

When do you have "continuity of care" with a doctor who is not in your plan's network? It can happen if Medica terminates its contract with your provider without cause.* It can also happen if you are a new Medica member because your employer changed health plans and your current provider is not in your plan's network.

** Note: Continuity of care does not apply when Medica terminates a provider's contract for cause. Coverage will not be provided for services or treatments that are not otherwise covered under this certificate.*

Continuity of care may apply:

1. If you are member of a self-insured ERISA plan or a North Dakota, South Dakota, Iowa, or Nebraska self-insured non-ERISA plan, the following applies to you:

In certain situations, you may continue care with your current provider at the highest level of benefits.

Upon request, Medica may authorize continuity of care for up to 90 days for the following conditions (120 days for Minnesota non-ERISA members):

- An ongoing course of treatment for a serious acute condition
- An ongoing course of treatment for a chronic condition
- Scheduled non-elective surgery, including postoperative care
- Pregnant and undergoing a course of treatment for pregnancy; health services may continue to be provided through the completion of postpartum care
- Undergoing a course of institutional or inpatient care from the provider or facility
- If you have a short life expectancy; authorization to continue receiving services from your current provider may extend to the remainder of your life if a doctor certifies that your life expectancy is 180 days or less
- If you are a member of an Iowa self-insured non-ERISA plan and you are pregnant in your second or third trimester of pregnancy and you have an involuntary change in health plans, you may request that we cover the services of your physician specialist who is not a network provider. Coverage shall continue through postpartum care related to child birth and delivery.

2. If you are a member of a Minnesota self-insured non-ERISA plan, the following applies to you:

In certain situations, you may continue care with your current provider at the highest level of benefits.

Upon request, Medica may authorize continuity of care for up to 120 days for the following conditions:

- An ongoing course of treatment for an acute condition;

- A life-threatening mental or physical illness;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled non-elective surgery, including postoperative care;
- Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care;
- A physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or
- A disabling or chronic condition that is in an acute phase
- An ongoing course of treatment for a chronic condition
- If you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services within certain time and distance requirements
- If you do not speak English and Medica does not have a network provider who can communicate with you, either directly or through an interpreter, within certain time and distance requirements

3. If you are a member of a Wisconsin self-insured non-ERISA plan, the following applies to you:

In certain situations, you may have a right to continue care with your current provider at the highest level of benefits.

In-network benefits will continue to apply to health services you received from a provider (1) if that provider was listed as a network provider in the provider directory at your last enrollment period or your last coverage renewal period, or (2) you are new to Medica because your employer terminated its health plan, and your current treating provider is not a network provider for the following periods of time:

- For up to 90 days if you were undergoing a current course of treatment, including but not limited to, treatment for one or more of the following conditions, at the time of termination:
    a. An ongoing course of treatment for a serious acute condition;
    b. An ongoing course of treatment for a chronic condition;
    c. Undergoing a course of institutional or inpatient care from the provider or facility;
    d. Scheduled non-elective surgery, including postoperative care;
    e. If your course of treatment is maternity care, health services may be continued to be provided by the terminated provider through the completion of postpartum care for you and your infant
- Authorization to continue to receive services from your current provider may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.
- In addition, for health services received from a primary care physician whom you have chosen to receive services from and who is no longer a network provider, until the end of your current contract year as stated in your employer's Contract.

In-network benefits will not continue to be applied to health services you receive from a provider:

- Whose contract is terminated for cause or for misconduct on the part of the provider

4. Your provider must agree to these requirements.

When a continuity of care request is made, your provider must agree to:

- Follow Medica's prior authorization requirements
- Provide Medica with all necessary medical information related to your care
- Accept as payment in full either Medica's network provider reimbursement of the provider's customary charge for this service, whichever is less

How Medica makes a decision

We may require medical records or other supporting documents to review your request. We consider each request on a case-by-case basis. If your request is denied, we will explain the criteria we used to make our decision. Coverage will not be provided for services or treatments that are not otherwise covered.

If Medica authorizes your request to continue care with your current provider, Medica will explain how long continuity of care will be provided. After that time, your services or treatment will need to be moved to a provider in your plan's network for you to receive benefits at the highest level.

Please see your policy document for more information.

Advance directives: Making your wishes known

Laws on advance directives provide guidance about instructions you can write telling your doctors and family what kind of care you want if you are too sick to make health care decisions yourself.

An example of someone who is not able to make these decisions might be a person who has suffered a head injury and is in a coma. Another could be a patient with advanced Alzheimer's disease, or a person in the last stages of cancer.

An advance directive is a written instruction, such as a living will or health care power of attorney. Your instructions must be written and also must be signed by a witness. A living will tells others what kind of care you want if you are not able to tell them yourself. A health care power of attorney allows someone else you choose to make care decisions on your behalf.

Creating an advance directive is not difficult, and it helps protect your right to make choices about your medical care. It also helps your physician and family by providing guidelines for care.

Your health care coverage from Medica does not require you to create an advance directive. We are simply informing you of the option to do so. For more information about advance directives, contact your state's agency on aging or visit their website.

Keeping yourself and your family healthy

One of the easiest ways to prevent illness and stay healthy is to make sure all members of your family follow the recommendations for screenings, preventive services and immunizations. You may want to follow the guidelines developed by the U.S. Preventive Services Task Force. Go to **Medica.com/Prevention** to learn which routine or preventive services are recommended for you. It is important that you discuss your care needs with your doctor. Your family's health history may affect what care you need.

Please review your coverage document to determine if or how these services are covered for you.

Our role in your health care

Quality improvement

Medica's Quality Improvement program is made up of the projects and activities Medica performs to improve care, service, health equity, access and safety for our members. Medica chooses projects based on the best opportunities to improve care, service and safety for the greatest number of members.

These are just some of the areas we focus on:

- How can we help our members with chronic health problems?
- How can we help our members adopt healthy lifestyles and receive preventive care services?
- How can we help our members be sure the care they receive is safe?
- Do our complaint or grievances and appeals processes work fairly and efficiently?
- How can we improve Medica's work processes to serve our members better?
- Do our members receive quality mental health and substance abuse care and service?

Medica sets goals and measurements after we select a quality improvement project. We measure the effectiveness of the improvement throughout the project. Every three months, Medica prepares a progress report with updates on each project.

The Quality Improvement program is led by licensed physicians. Quality Improvement activities are supported by departments and staff throughout Medica. Medica's Quality Improvement Subcommittee directs and oversees the program. The committee reports to the Medica Board of Directors.

Medica always welcomes member feedback! If you'd like to share your comments or suggestions or would like more information about Medica's Quality Improvement program, please contact Member Services at the numbers listed in the *Important phone numbers* section of this guide.

If you get a survey from Medica asking about care and services, we encourage you to respond. This information helps to improve our programs and services.

Care coordination

Medica supports quality, cost-effective health outcomes that meet the needs of our members. Care coordination involves many people working together with your health care provider. Together, they help evaluate the available care options before making decisions.

One aspect of care coordination is care support. We reach out by phone to members who have a critical event or diagnosis that requires using several health care resources. We will help you navigate the health care system to get the appropriate care and services for your needs.

A Medica case manager is a registered nurse or social worker who is able to help you with your medical, social and everyday needs. Your Medica case manager will work with you to create a plan to keep you healthy and safe in your home.

Utilization management is another care coordination service. Utilization management helps make sure that the care and services you are receiving are appropriate and covered by your plan. Otherwise coverage might be denied. It is used in a small number of cases. Sometimes this means you will get a call from a nurse because we want to help coordinate your care.

This is especially important if your Medica plan requires prior authorization from Medica before you get certain services.

If coverage for some service is denied, it is important for you to know that Medica does not reward anyone for denying coverage. The doctors or other people who decide whether a service or care is covered are paid the same, no matter what they decide. No one making these decisions is trying to limit or reduce your coverage. Keeping you healthy is very important. We want you to get the care you need. We do not want you to under-use the care available to you. That is why we so often recommend that members get checkups, health screenings, and immunizations.

If you have questions or comments about case management or utilization management and wish to speak to a representative of the Health Services department, please contact Member Services at the numbers listed in the *Important phone numbers* section of this guide.

If coverage is denied, you can appeal. See the *How Do I File a Complaint*? section in your coverage document, or call Member Services for more information. The number is listed in the *Important phone numbers* section of this guide.

Referrals and prior authorization

Some health services require you or your provider to notify us before you have the service. Even if your doctor recommends you have the service or see an out-of-network provider, Medica may require that we approve the request before you have the appointment. This is known as "prior authorization." This also includes referrals to providers who are not in our network and certain types of network providers. You or your provider can contact Member Services at the phone number listed on the back of your ID card.

Services that may require prior authorization from Medica include, but are not limited to:

- Certain reconstructive or restorative surgery
- Organ and bone marrow transplant
- Home health care
- Certain medical supplies and durable medical equipment

This is not a complete list. You can view more in your coverage document, available at **Medica.com/SignIn** or contact Member Services for assistance.

If we deny coverage for a service, it is important for you to know that Medica does not reward anyone for denying coverage. Medica pays the doctors or other people who decide whether to cover a service or care the same, no matter what they decide. No one making these decisions tries to limit or reduce your coverage. Keeping you healthy is very important. We want you to get the care you need. We do not want you to under-use the care available to you. That is why we so often recommend that members get checkups, health screenings, and immunizations.

If you're a member of a non-ERISA self-insured group in Minnesota, the following may apply: If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60

days of coverage under this plan. In order to obtain coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

If you have questions or comments about case management or utilization management and wish to speak to a representative of the Health Services department, please contact Member Services at the numbers listed in the *Important phone numbers* section of this guide. Language assistance also is available.

If we deny coverage for a service you can appeal. See the *How Do I File a Complaint*? section in your coverage document. Or call Member Services for more information. The number is listed in the *Important phone numbers* section of this guide. For more information about the appeal rights under your plan, see your coverage document. You may also contact us through our website at **Medica.com**.

Clinical practice guidelines

Medica follows evidence-based clinical practice guidelines developed by the U.S. Preventive Services Task Force (**uspreventiveservicestaskforce.org**). Medica maintains clinical practice guidelines for all providers in our network. Visit **Medica.com/ClinicalGuidelines** and select *Preventive Services*.

Evaluating the safety and effectiveness of new medical technologies and medications

Medica is interested in the newest advances in medicine, including behavioral health. We review new devices and procedures and new uses of existing technologies to decide if they are included in your coverage. Medica uses many sources to evaluate new medical technology and procedures and behavioral health treatments/therapies. We thoroughly review clinical and scientific evidence. We consider the technology's safety, effectiveness and effect on health outcomes. We also review laws and regulations and get input from local physician groups about community practice standards. Medica's main concern when making coverage decisions is whether a new technology or procedure will improve health care for our members.

Medica also continually reviews new medications and the use of existing medications for new medical conditions. Independent physicians and pharmacists from various specialties review medications in all therapeutic categories to determine whether to add them to the Medica drug list based on their safety, effectiveness and value. For more information about the drug list, see the *Pharmacy services* section of this guide.

Complaints

There may be a time when we deny a claim, a prior authorization request or a request for services or care. We have formal complaint procedures outlined for each state. Your coverage document outlines the steps to file a complaint. Please follow these procedures if you want a decision to be reconsidered. You may also choose to designate a representative to act on your behalf. If you choose to do so, contact Medica for an *a Release of Information* form, which allows Medica to discuss your appeal with your designated representative.

How to file a complaint

You can file a complaint in writing or by telephone. For more information, call Member Services at the number in the *Important phone numbers* section of this guide or refer to the number on the back of your ID card.

Additionally, we investigate your complaints about quality of care problems, but Minnesota state law does not allow us to share details of the outcome of this review. State regulators in some states review quality of care cases involving Medica.

Requesting an expedited appeal review

If your attending provider believes that Medica's decision requires a quicker review because a delay could seriously harm your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking, we will review your request and notify you and your provider of our decision no later than 72 hours after receiving the request.

For more information on filing complaints and appeals, review your coverage document.

See the *Complaints and Appeals* documents below for instructions on how to request an expedited appeal review.

Complaints and Appeals

Plan Type: Medica Self-Insured (MSI) ERISA groups

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document, or contact Medica Self Insured (Medica) Member Services at the phone numbers or address listed below.

Right to Appeal this Decision

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request an appeal. You must request an appeal within 180 days following receipt of Medica's initial decision to file an appeal. Your appeal will be completed no later than 30 days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your appeal review is being conducted.

You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your appeal with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501,
PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St Paul area: 952-945-8000
Outside Minneapolis/St Paul area:
1-800-952-3455
TTY users, please call 711

Right to External Review

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. This review will be coordinated by Medica. Your request must be submitted in writing to Medica within four (4) months following the date you receive Medica's review decision. You may submit additional information to be reviewed by the external review organization. You will be notified of the review organization's decision within 45 days. If waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour external review. There is no cost to you for the external review. The decision rendered by the external review organization is final. It is binding on both you and your employer. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Right to Civil Action

If you are dissatisfied following Medica's initial appeal decision, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Complaints and Appeals

Plan Type: Medica Health Plan Solutions (MHPS) ERISA groups

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document, or contact Medica Member Services at the phone numbers or address listed below.

First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request an appeal. You must request an appeal within 180 days following receipt of Medica's initial decision to file an appeal. Your appeal will be completed no later than 30 days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your appeal review is being conducted.

You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your appeal with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route CP565HPS, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-866-839-4060
TTY users, please call 711

Right to External Review

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. This review will be coordinated by Medica. Your request must be submitted in writing to Medica within four (4) months following the date you receive Medica's review decision. You may submit additional information to be reviewed by the external review organization. You will be notified of the review organization's decision within 45 days. If waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour external review. There is no cost to you for the external review. The decision rendered by the external review organization is final. It is binding on both you and your employer. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Right to Civil Action

If you are dissatisfied following Medica's appeal decision, you have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act.

Complaints and Appeals

Plan Type: Medica Health Plan Solutions (MHPS) Non-ERISA groups in Iowa

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document or contact Medica Member Services at the phone numbers or address listed below.

First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also have the right at any time to file a complaint with the Iowa Insurance Division. They can be reached at: 1-877-955-1212.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-866-209-4222
TTY users, please call 711

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally, and you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, you have one year following receipt of Medica's initial decision to file an appeal. The written complaint is considered a first level internal review. Medica will communicate a decision to you within 30 calendar days of receipt of the complaint.

Procedures for complaints that require a medical determination:

If this decision was based on medical necessity, you have 180 days following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 30 calendar days from receipt of your request. If your request does not contain all the information Medica needs to make a determination, Medica may request additional information. Medica will notify you of its decision within 15 days of receiving the additional information. If you do not respond to Medica's request within 45 days, your claim may be denied

Your attending provider may request an expedited, 72 –hour appeal review, if he/she believes it is warranted. You may also request an expedited review if waiting the standard 30 calendar day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting. In such cases, you may also have the right to request an external review while your first level review is being conducted. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review Option

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. You or your authorized representative have four months from the date you receive the appeal determination letter to file a request for an independent external review. There is no cost to you for the external review except for any applicable State filing fees. External reviews regarding rescission of policy are coordinated through Medica. You should submit your written request to Medica at the address on this page. All other external reviews are coordinated through the Iowa Insurance Division. You should submit your written request to Iowa Insurance Division at 1963 Bell Avenue, Suite 100 Des Moines, IA 50315 (fax: 1-515-281-3059, phone: 1-877-955-1212, email: iid.marketregulation@iid.iowa.gov or online: www.iid.iowa.gov.

You, your designated representative, and /or your provider may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided by the external review organization within 72 hours.

Complaints and Appeals

Plan Type: Medica Self-Insured (MSI)
Non-ERISA groups in Minnesota

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document or contact Medica Self-Insured (Medica) Member Services at the phone numbers or address listed below.

Right to Appeal a Decision

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also have the right at any time to file a complaint with the Minnesota Department of Commerce. They can be reached at: (651) 539-1600 or outside of the Metro area 1-800-657-3602.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501,
PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St Paul area: 952-945-8000
Outside Minneapolis/St Paul area:
1-800-952-3455
TTY users, please call 711

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally, Medica will communicate a decision to you within 10 calendar days from receipt of the complaint. If you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. If you need assistance with completing the complaint form Medica will help you. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, Medica will communicate a decision to you within 30 calendar days. If you remain dissatisfied with Medica's decision, you may pursue an appeal as described below under the section "Second Level of Review". Medica's second level of review must be completed before you have the right to submit a request for external review.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have one year following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 15 calendar days from receipt of your request. If Medica cannot provide its determination within 15 days, Medica may take an additional 4 days and will notify you of the extension and the reason relating to it. If waiting the standard 15-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72 hour appeal review. In such cases, you may also have the right to request an external review while your first level review is being conducted.

Second Level of Review

If you remain dissatisfied with Medica's decision after your first level review, you may pursue a second level of review. Your request must be submitted to Medica within one year following receipt of Medica's first level review decision. Generally, the second level review is optional if the complaint requires a medical determination and you may file a request for external review. Medica will inform you whether the second level of review is optional or required.

1. Medica's Second Level of Review Options

- Hearing. Under this process, you present your case to a committee, either in person or via teleconference. If this second level of review is required, Medica will notify you of the decision within 30 calendar days of your appeal request. If the second level of review is optional, Medica will notify you of the decision within 45 calendar days of your appeal request.
- Written reconsideration. Under this process, the committee will review your appeal. Medica will notify you of the decision within 30 calendar days of your appeal request.

External review option

You may choose to have your case reviewed by an external review organization. This process is coordinated by the Minnesota Department of Commerce. The Minnesota Department of Commerce can be reached at: (651) 539-1600 or outside of the Metro area 1-800-657-3602. You may submit additional information to be reviewed by the external review organization. You must submit your written request for external review within six months from the date you receive Medica's decision. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours.

The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To make a request for external review, contact the Minnesota Department of Commerce at the numbers listed above. There is no cost to you except for the required filing fee. You must include a $25.00 filing fee at the time of the request for external review, unless waived by the Department. The fee will be refunded if Medica's decision is completely overturned.

Complaints and Appeals

Plan Type: Medica Health Plan Solutions (MHPS) Non-ERISA groups in Nebraska

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document or contact Medica Member Services at the phone numbers or address listed below.

First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also have the right at any time to file a complaint with the Nebraska Department of Insurance. They can be reached at: 1-877-564- 7323.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-866-209-4222
TTY users, please call 711

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally, and you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, you have one year following receipt of Medica's initial decision to file an appeal. The written complaint is considered a first level review. Medica will communicate a decision to you within 15 business days. If Medica cannot make a decision within 15 business days, you will be notified you of the reason and Medica may take up to an additional 15 business days to issue a written decision to you.

Procedures for complaints that require a medical determination:

If this decision was based on medical necessity, you have 180 days following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 15 business days from receipt of your request. Your attending provider may request an expedited, 72 –hour appeal review, if he/she believes it is warranted. You may also request an expedited review if waiting the standard 15 business day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting. In such cases, you may also have the right to request an external review while your first level review is being conducted.

External Review Option

For decisions that involve a medical necessity determination, investigative/experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy, you or your authorized representative have four months from the date you receive Medica's decision to file a request for an independent external review. There is no cost to you for the external review except for any applicable State filing fees. This process is coordinated through the Nebraska Insurance Division. You may submit your written request through Nebraska Insurance Division's portal at: https://doi.nebraska.gov/consumer/appealing-denied-health-claim. This online application replaces the need to complete forms and submit them to the Department by mail or fax. Printable versions of external review forms are also available on the Department's website at: https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Chapter87ExternalReviewForms.pdf or they can be mailed to you upon request by calling the Department at 1-877-564-7323 (toll-free in Nebraska) or 402-471-0888. You may submit additional information to be reviewed by the external review organization. You will need to authorize the release of your medical records for your request to be sent to the independent review organization. In most circumstances you must complete the internal review described above, before you proceed to external review.

You, your designated representative, and /or your provider may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided by the external review organization within 72 hours.

Complaints and Appeals

Plan Type: Medica Self-Insured (MSI)
Non-ERISA groups in North Dakota

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document, or contact Medica Member Services at the phone numbers or address listed below.

Right to Appeal a Decision

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a first level appeal. You have one year following receipt of Medica's initial decision to file an appeal. Your appeal will be completed no later than 30 calendar days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level appeal review is being conducted.

You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your appeal with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You may also file a complaint with your state regulator at any time. You may contact the North Dakota Insurance Commissioner at 1-800-247-0560 to file a complaint.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, or if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501,
PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St Paul area: 952-945-8000
Outside Minneapolis/St Paul area:
1-800-952-3455
TTY users, please call 711

Additional Levels of Review

If you remain dissatisfied with Medica's decision after your first level appeal, you may pursue additional levels of review. You have the option of requesting a voluntary second level appeal. The Medica second level of review is optional. You may also request an independent review of Medica's decision by an external review organization upon completion of either your first level or second level appeal if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination.

Below is a description of Medica's Voluntary Second Level of Review and External Review Procedures:

1. Medica's Voluntary Second Level of Review Options

- Hearing or file review. If you would like to request a voluntary second level appeal, your request must be submitted in writing to Medica within one year following receipt of Medica's first level review decision. To file a request for a second level appeal, additional information or assistance, please contact Medica at the address and telephone numbers listed above. Under this process, you present your case to a committee, either in person, via teleconference or in writing. Medica will notify you of its decision within 45 calendar days of your appeal request.

2. External Review Option

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. Your request must be submitted in writing to Medica within four (4) months following the date you receive Medica's review decision. An independent entity designated by the North Dakota Commissioner of Insurance will conduct the external review. You may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 45 days from receipt of your request. If waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or you received emergency services and have not been discharged from the facility, you or your attending provider may request an expedited, 72-hour external review. There is no cost to you except for the required filing fee. You may receive a request to pay a $25 filing fee. The fee will be refunded if Medica's decision is overturned. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Complaints and Appeals

Plan type: Medica Self-Insured (MSI) Non-ERISA groups in Wisconsin

Information Related to this Decision

If you have any questions related to this claim, please refer to your Plan Document, or contact Medica Member Services at the phone numbers or address listed below.

Right to File a Complaint

If you have a question or are dissatisfied with some aspect of service received from Medica, you can call Medica Member Services at the phone numbers listed below. Member Services Representatives can explain benefit provisions and administrative procedures to address inquiries and informally resolve complaints. If the matter cannot be resolved informally to your satisfaction, you have the right to file a formal grievance with Medica.

You also have the right at any time to file a complaint with the Office of the Commissioner of Insurance by calling 1-800-236-8517. For questions about your rights, this notice, or for assistance, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789.

Right to File a Grievance

If you are dissatisfied with Medica's provision of services, claims practices, or administration, you may file a formal grievance. To file a grievance, you or anyone else on your behalf, including a Medica Member Services Representative, should write down your concerns and mail or deliver your grievance (in any form) along with copies of any supporting documents to Medica at the address listed below.

You may choose to designate a representative to act on your behalf at any time during the grievance or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your grievance with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others. You may select one of the following options for your grievance:

Medica's Grievance Process:

Hearing or file review. Under this process, you present your case to a grievance panel, either in person or in writing. Medica will notify you of its decision within 30 calendar days of your grievance request.

If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour grievance review. In such cases, you may also have the right to request an external review while your grievance review is being conducted.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request a grievance, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Member Services, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St Paul area: 952-945-8000
Outside Minneapolis/St Paul area: 1-800-952-3455
TTY users, please call 711

Right to External Review

If your claim involves an adverse determination, experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy or certificate, you or your authorized representative have four months from the date you receive the grievance determination letter to file a request for an independent external review. This review will be coordinated by Medica. You may submit additional information to be reviewed by the external review organization. You will be notified of the review organization's decision within 45 days. If waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour external review. There is no cost to you for the external review. The decision rendered by the external review organization is final. It is binding on both you and Medica. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Appendix

Member rights

As a Medica member, you have the right to:

1. Receive information about Medica, its services, its network of practitioners and providers, and member rights and responsibilities.
2. Be treated with respect and recognition of your dignity and your right to privacy.
3. Participate with practitioners in making decisions about your health care.
4. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. Voice complaints or appeals about Medica or the care its network provides.
6. Make recommendations regarding the Medica member rights and responsibilities policy

Member responsibilities

To increase the likelihood that you maintain good health and receive the best quality care, it is important that you take an active role in your health care by:

1. Supplying information (to the extent possible) that Medica, and its network practitioners and providers need in order to provide care.
2. Following plans and instructions for care that you have agreed to with network practitioners.
3. Understanding your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Protecting your privacy

Medica respects your privacy and has policies and procedures in place to protect the privacy of your personal health information.

Only staff members who have a need to handle your personal health information do so.

Medica's privacy policy limits oral discussion of personal health information to staff with a need to know to process claims or provide other services that you need. Staff members do not discuss your personal health information in public places, such as on an elevator, in the cafeteria or other open spaces.

- The security of all personal health information that comes to us via electronic files and transmissions is also protected.
- Visit **Medica.com** and scroll to the bottom to select *Privacy.*
- If you would like more information about Medica's policies and procedures for disclosure of personal health information and how it is used in making coverage decisions, please contact Customer Service at the number on the back of your Medica ID card.

If you have questions about the privacy practices of your self-insured plan, please contact your plan administrator.

How Medica pays health care providers

Network providers

Network providers are paid using various types of contractual arrangements, which are intended to promote the delivery of health care in a cost-efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include:

- A fee-for-service method, such as per service or percentage of charges;
- a per episode arrangement, such as an amount per day, per stay, per case, or per period of illness; or
- a risk-sharing/value-based arrangement.

The methods by which specific network providers are paid may change from time to time. Methods also vary by network providers.

Fee-for-service and per episode arrangement

Fee-for-service and per episode arrangement payment means that the network provider is paid a fee for each service or episode of care provided. These payments are determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage

of charges, the network provider's payment is a set percentage of the provider's billed charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

Risk-sharing and value-based arrangements

Medica also has risk-sharing/value-based contracting arrangements with a number of providers. These contracts include various quality and efficiency measures designed to encourage high quality and efficient total care for members. Such arrangements may involve claims withhold and gain-sharing or risk-sharing arrangements between Medica and such providers. Amounts paid or returned under these arrangements are not considered when determining the amounts you must pay for health services under this certificate.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, members may be responsible for paying the difference, in addition to any applicable copayment, coinsurance, or deductible amounts.

Important phone numbers

Member Services

Member Services is available to answer questions about your plan 7 a.m. - 8 p.m. CT, Monday through Friday (closed 8 - 9 a.m. Thursday) and 9 a.m. - 3 p.m. CT, Saturday.

Please have your Medica ID card available when you call.

- Call the number on the back of your ID card.
- If you don't have an ID card and don't know your member ID number, simply stay on the line until after the recorded message and a representative will help you.
- Some plans have their own dedicated Member Services phone number. If yours does, you'll find it on your ID card.

Behavioral Health Services

If you or a family member needs mental health or substance use services, contact Medica Behavioral Health at **(800) 848-8327** (TTY users call **711**).

Please have your ID card available when you call.

Medica CallLink®

Medica CallLink* connects you with advisors and nurses. Get trusted answers, information and support for a wide range of health concerns.

Call the number on the back of your ID card 24 hours a day, seven days a week, or call **(800) 962-9497** (TTY users call **711**).

**Medica CallLink is not included in all plans. If this service is available to you, the toll-free phone number is listed on your Medica ID card.*

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

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 http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

Si vous voulez une assistance gratuite pour traduire ces informations, appelez le numéro indiqué dans ce document ou au dos de votre carte d'identification Medica.

နမ့ၢ်အဲၣ်ဒိးတၢ်ကျိးထံစၢၤကလီနု့ၢ်နၤတၢ်ဂ့ၢ်တၢ်ကျိၤအံၤလၢအကလီန့ၣ်, ကိးလီတဲစိနီၣ်ဂံၢ်လၢအပၣ်ယှာ်လၢလံာ်တီလံာ်မီအပူၤအံၤမ့တမ့ၢ်ဖဲနန့ၢ်နိၣ်ခဲလၢ်အှၣ်သးခးကွ့အလိၢ်ခံတကပၤအဖီခိၣ်န့ၣ်တက့ၢ်.

Kung nais mo ng libreng tulong sa pagsasalin ng impormasyong ito, tawagan ang numero na kasama sa dokumentong ito o sa likod ng iyong Kard ng Medica ID.

ይህን መረጃ ለመተርጎም ነጻ እርዳታ የሚፈልጉ ከሆነ በዝ ህ ሰነድ ውስጥ ያለውን ቁጥር ወይም Medica መታወቅያ ካርድዎ በስተጀርባ ያለውን ይደውሉ።

Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'déé' námboo biká'ígíįjį' béésh bee hodíilnih.

Wenn Sie bei der Übersetzung dieser Informationen kostenlose Hilfe in Anspruch nehmen möchten, rufen Sie bitte die in diesem Dokument oder auf der Rückseite Ihrer Medica-ID-Karte angegebene Nummer an.

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