Implementation/Administrative Guide for Maximum Liability Employers

For employers headquartered in Minnesota, North Dakota, South Dakota, and western Wisconsin

Medica®

Introduction

Thanks for choosing Medica. This guide assists in implementing and administering your organization's Medica health plan for employees. We offer ongoing personal and technical support for issue resolution. Detailed information on eligibility, administration, enrollment, contracts, and billing procedures is included for your reference.

We appreciate the opportunity to support your organization's health goals.

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Administrative resources

Telephone + email support

The Employer Service Center is the place to call when you have questions about benefits, enrollment, claims and more — and need answers fast. It's also your best resource for routine, day-to-day questions and concerns.

Phone: **1 (800) 936-6880** (TTY: **711**)
Fax: **1 (952) 992-3199**
Email: **MedicaServiceCenter@Medica.com**

Hours of Operation:
Monday-Wednesday and Friday from 8 a.m. to 5 p.m.
Thursday from 9 a.m. to 5 p.m.

Explore Medica.com for Support

Visit **Medica.com** at any time for valuable information. Click on the For Employers tab to access details about our products, value-added health and wellness programs, online publications, and the latest Medica news. Our online resources are available day or night to assist you.

Employer eServices

Employer eServices makes it easy to do business with us. It's an online application that gives you immediate, secure access to health care benefits information.

Through **Employer eServices**, you can conduct your enrollment and billing online in real time.The administrator can:

- Add users
- Deactivate users
- Assign functional permissions, including eligibility and billing, to users in your organization

Have a general question about Employer eServices or experiencing a technical issue? Contact Employer eServices customer support at **1 (800) 651-5465**.

Emails from Medica

Below is a list of Medica email addresses that you and/or your employees may receive emails from and can sometimes get caught in SPAM filters. Please provide this list to your IT department.

- Employer eServices: **Employer_eServices@UHC.com**
- Medica Employer Communications: **Employer.Comm@medica-email.com**
- My Health Rewards by Medica: **Medica@healthyemail.com**
- Medica CDH: @healthaccountservices.com
- Medica ONESource: @healthaccountservices.com
- Medica Do Not Reply: @healthaccountservices.com
- Delta Dental products available to Medica groups: **DeltaDentalConnect@DeltaDentalMNAdmin.org**
- Virgin Pulse: @virginpulse.com

Keeping in touch

Stay in the loop about important Medica developments, insurance industry news, fun and informative events and more through *Employer Update*, Medica's monthly employer e-newsletter.

Visit **Medica.com/Employers** for a variety of resources to help administer your plan, including: forms, worksite wellness resources, member materials and more.

Our **Monthly Health and Wellness Toolkit** focuses on select topics and Medica resources each month to raise awareness about care services and encourage healthy living.

Tell us how we can help. If there's an issue you'd like us to address, email us at **Employer.Comm@Medica.com**. You can also visit our **Employer News and Events webpage** to access past issues of *Employer Update*, view recorded trainings, and see upcoming trainings.

Getting started

Group numbers

Each plan design will have at least one five-digit group number assigned to it. All of your five-digit group numbers will roll to one six-digit master group number.

Administrative services agreement (ASA)

This document is the formal agreement between your organization and Medica Self-Insured (MSI), which defines:

- The contract effective date
- Termination provisions of the contract
- Your responsibilities under the terms of the agreement
- MSI's responsibilities under the terms of the agreement
- Payment arrangements
- Billing information

Medica identification (ID) cards

Medica ID cards are mailed within three to ten business days. Members will receive two ID cards per family*. If members require additional cards they can log in to **Medica.com/SignIn** or contact customer service to request them.

**Medica will automatically issue additional ID cards for any dependents over the age of 16.*

Alternate member ID number

To protect your employees' and their dependents' confidential health care information, we've replaced the Social Security Number (SSN) as the primary identifier for them with an alternate 12-digit member ID number. While you will still provide us the SSN of each enrollee, we will assign an alternate member ID for each enrollee record. This eliminates the public disclosure of SSNs on any external enrollee communications including all correspondence, websites, ID cards, letters and Explanations of Benefits.

Note: *Please remind your employees to present their new ID card when they visit their provider.*

Next steps for employees

Remind employees to watch the mail for their ID card and member welcome kit. When it arrives (the ID card usually arrives first), employees should review the information and learn how their plan works. The welcome kit should be stored in a safe place and employees should carry their ID card at all times so that it's available when they need care.

Register

Employees should register at **Medica.com/SignIn** to sign up for the Medica programs and services that help them take charge of their benefits and make informed decisions about their health.

Understanding the plan

Urge employees to take the time to understand their plan by reviewing the information upon arrival. Emphasize the importance of examining details such as copays, coinsurance, and out-of-pocket costs. It's crucial for them to grasp how seeking care from an out-of-network provider might impact costs, and to be aware of coverage details while traveling.

Know where to go for help and information

Questions are sure to come up when employees start using their plan. Help them out by promoting these helpful Medica resources:

- Customer Service – Open 7 a.m. to 8 p.m. CT, Monday through Friday (closed 8 a.m. to 9 a.m. Thursdays), and Saturday from 9 a.m. to 3 p.m. Employees can find the phone number on the back their ID card.
- **Medica.com/SignIn** – Members can login to find personal health plan documents, links to pharmacy information, coverage information and health and wellness information.

Translation services

Medica wants to ensure all of your employees can make informed decisions about their care and benefits, regardless of their native language. The preferred method to help our members who aren't fluent in English is to direct them to Medica Member Services, where they can identify their language choice. We've developed email messages in 11 languages that direct non-English-speaking members to call Medica Member Services for access to an interpreter. Contact your account representative to request the email message(s).

Eligibility administration

COBRA

When an employee terminates their Medica coverage, send the termination notice to us immediately. You don't need to wait until the end of their COBRA election period.

If you use a vendor for your COBRA administration, please share the following reminders with them:

- We need to have all enrollment requests submitted on the appropriate Medica forms
- Don't send COBRA paid-through reports or COBRA election forms to us — these documents provide more information than needed, and we want to protect our members by only receiving necessary information
- Only use the **Group Enrollment/Change/ Cancellation form** when notifying us of COBRA enrollments or terminations
- Send the form to the address/fax listed on the bottom of the form or upload the completed form electronically via secure document upload on **Medica.com/Employers** (choose "Upload group enrollment documents"— our enrollment department can't accept forms via email)
- View the **COBRA enrollment tip sheet**

Medicare Part D

- We send notices about Medicare Part D annually, before the Medicare open enrollment period starting on Oct. 15 (typically by late September or early October, if Medica's services for Medicare Part D were purchased.)
- We only send the notice to eligible members and their dependents; it explains if their prescription drug coverage is creditable or non-creditable
- Employers also get a cover letter and sample notices before the mailing so they know what their employees will be getting

Maximum dependent age

Dependents are defined by the Affordable Care Act (ACA) as children under the age of 26, regardless of student status or marital status. We'll notify members that their coverage will terminate at the end of the month in which the member turns 26. We'll also send a copy of the notification to you. Members whose coverage ends may be eligible for COBRA/continuation.

We've listed the state requirements around full-time students that extend beyond the age 26. We'll keep dependents on until the appropriate student age as noted below at the request of the group. We also don't track full-time student eligibility

STATE	MAXIMUM DEPENDENT AGE	FULL-TIME STUDENT AGE
MN	26	26
WI	26	No Limit
ND	26	26
SD	26	30

Disabled dependent review

If you have a dependent who's disabled and over the maximum age limit, they can still be covered as long as they meet the disabled dependent criteria. There's also no upper age limit for disabled dependents. Please note: We don't review the dependent's medical condition. Instead, we rely on the primary care physician to confirm that the dependent is disabled. To enroll the dependent as disabled, the member's physician must complete and sign the **Request for Extended Coverage Form**.

When a dependent reaches age 26, our eligibility team will review them. If they're already noted as disabled, no further action is needed. Otherwise, a completed Request for Extended Coverage Form is required to continue coverage. The member will get a Maximum Dependent Age letter with instructions on how to obtain and complete the form. They'll then have 31 days to return the form to us. If the form isn't returned within 31 days, we'll have to remove the dependent from the plan.

Coordination of benefits (COB)

COB happens when someone has more than one insurance plan. This can be with Medicare, Medical Assistance, individual policies, or commercial plans from other employers. To prevent getting too much insurance or double payments, all programs need to work together to coordinate benefit payments. That can help reduce out-of-pocket expenses like copayments and deductibles.

We check enrollment and claim data to find out who's most likely to have other insurance, and send a letter to members to verify if they have other insurance. When there is other insurance, Medica or Rawlings (our vendor) may need to reach out to you to confirm employment status in order to determine which insurance should pay first. Claims are not held during this process.

Medicare reclamation

When Centers for Medicare and Medicaid Services (CMS) pay a claim they believe should have been paid by a Group Health Plan (GHP), they issue a notice requesting payment to the employer and GHP of the member. The notice sent by CMS is called a Medicare Reclamation Notice. As an employer group, you can pay the debt or appeal (dispute) the debt. Responses to these notices must be made within 60 days of the demand letter or it will be considered delinquent. If you receive one of these notices, please contact your account team for assistance right away.

Subrogation

If a member receives benefits for a condition or injury caused by a third party, and later receives payment for that same condition or injury from another party, the plan has the right to recover any payments already made. The process of recovering earlier payments is called subrogation. Some examples where this might happen:

- Animal bites
- Your business or premise liability (slips and falls)
- Disputed workers' compensation cases
- Medical malpractice
- Motor vehicle accidents

Medica uses a number of different methods to identify potential subrogation cases:

- From claims data
- From the members who call in to notify us
- From a provider
- From an attorney

When a potential subrogation issue is identified, both the member and the employer may be contacted by Medica or our subrogation vendor Optum for additional information.

Enrollment

Enrollment options

Enrollment can be done online through Employer eServices, electronic file, by spreadsheet (initial and Open Enrollment only) or by mail.

Upload enrollment forms securely on **Medica.com**. You can securely upload enrollment documents **here**.

Note: *We can only accept Medica's Group Enrollment/Change/Cancellation form and Medica-approved enrollment spreadsheets (which can be requested through your Medica representative) through this method. We have four different enrollment spreadsheets available based on group size, if a group is new to Medica, or if it has renewed.*

Employer eServices

Once you have access, you can quickly and easily sign into the secure website to enroll new employees and/or dependents at **EmployereServices.com**.

Mail

Mail enrollment information or changes to:

Medica
P.O. Box 30986
Salt Lake City, UT 84130-0986

Or fax to:
1 (844) 280-3838

Frequently asked enrollment questions

Which form should I use?

TO...	USE...
Add a new employee	Enrollment/Change/ Cancellation Form
Add a dependent	
Terminate coverage for an existing employee	
Change an employee address	
Change an employee name	
Change from one plan option to another plan option at open enrollment or special enrollment	Medica Plan Selection Form

How do we order the necessary forms?

Enrollment forms and tips for employers are also available in the "Guides and forms" section at **Medica.com/Employers**.

Note: *We update these forms on a regular basis. Given that, you should print them as needed rather than keeping a large supply on hand.*

Call the Employer Service Center at **1 (952) 992-2200** or **1 (800) 936-6880** to ensure you get the correct form(s). Our Service Center can provide you with the appropriate form(s) to enroll participants or make participant-directed changes.

When can employees enroll?

Here are examples of when employees can enroll:

- During open enrollment
- When an employee is newly eligible
- After a special enrollment event (such as loss of other coverage in certain instances, birth, adoption, marriage)

Please refer to your Plan Document for a more detailed description of when employees can enroll.

Are Social Security numbers (SSN) required?

- SSNs are required for the subscriber/employee and all dependents.
- The Federal Centers for Medicare and Medicaid Services (CMS) requires health plans to provide quarterly reports to comply with Medicare Secondary Payer requirements. CMS requires SSNs for active covered individuals covered under the plan, this would include dependents.
- If the employee is a non-US citizen without an assigned SSN, we'll require them to submit their work visa number. We'll use the visa number, but it can't include any alpha characters or punctuation marks and must be nine digits. Use the first five digits of the visa number followed by four zeros at the end.

What's the process for retroactive terminations?

The Patient Protection and Affordable Care Act (PPACA) has a law that says group health plans and health insurance issuers can't cancel or discontinue someone's coverage once they're already covered, unless the person lied, committed fraud, or didn't pay their premiums. If coverage is cancelled retroactively (meaning it's cancelled back in time), it's called a rescission, and it's only allowed for non-payment or for fraud or lying.

Our usual process is to allow retroactive terminations up to 60 days for self-insured groups for non-payment. Any requests for changes beyond 60 days need to go through the account team or Employer Service Center. If the employee has paid any contributions or if the employer pays the entire premium, the termination must be done prospectively (meaning it can only happen starting from a certain date in the future).

Billing + payment

Administrative billing

We generate administrative bills on the 22nd of each month for the upcoming month. You'll get an email within two to three business days letting you know that you can view the invoice on **EmployereServices.com.**

Invoices will include:

- Current invoice summary — provides a summary of what's being billed at a plan level
- Invoice detail — provides subscriber level detail of the invoice
- Adjustment invoice (if applicable) — includes details on any enrollment adjustments

Please note: Enrollment changes can't be made by communicating them on your invoice. If you need to make changes to your enrollment, you'll need to submit them through your preferred enrollment process.

Have questions about your billing? Contact our billing representatives at **1 (800) 892-8354.**

Employer eServices electronic billing

Electronic billing solutions through Employer eServices provide simplified invoices, downloadable data, and real-time calculations and payments. Employer eServices is a standard service available to all our customers.

You'll get a monthly email notification when your invoice is ready for review and payment. You can then:

- View current activity or prior period activity (up to 12 months)
- Download, save, and print invoice detail into a spreadsheet application such as Excel
- Request an adjusted invoice to reflect eligibility changes
- Pay bills online

We recommend that you give at least two users access to online billing for back up purposes. Paper invoices are not generated when a group has electronic billing.

Our eligibility and billing systems are linked. If you need to make multiple eligibility changes, you can do so on **EmployereServices.com** and then request an adjustment invoice. Your changes will be reflected in the online adjustment invoice that's requested. This adjustment invoice, combined with your current invoice, will provide a more up-to-date payment amount due for that month.

When premiums are due

Your remittance is generally due to us on the first of each month with a 10-day grace period.

Monthly payment options

Below are payment options available to you to pay for your monthly premiums.

1. Direct debit, also known as Automated Clearinghouse (ACH). The fee and/or premium is withdrawn from your bank account on the 10th of the month. If the 10th falls on a weekend, the ACH draft will occur on the next business day.
2. Online payment remittance through Employer eServices billing. You simply click the payment submit button.
3. Electronic Funds Transfer (EFT) i.e. wire transfers. These are customer initiated.
4. Check.

Year-end reconciliation

Medica will conduct reconciliation after the third calendar month following the close of each plan year. This year-end reconciliation is completed to true-up actual results after three months of run-out claims plus residual IBNR (incurred but not reported) claims estimate. If a refund is available, and the group renews with Medica, the employer group will receive a percentage of the surplus back, based upon the group size.

Network access

Continuity of care

If a member's physician or hospital is no longer part of their health plan's network, members may request authorization from Medica to continue with their existing primary care physician, clinic, specialist, or hospital for ongoing outpatient services. Medica's Nurse Case Managers will review their request to identify if they are engaged in a current course of treatment. Examples are provided below. A full list can be referenced in your Certificate of Coverage.

- An ongoing course of treatment for an acute condition
- An ongoing course of treatment for a chronic condition
- 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.

Medica may require medical records and other supporting documentation from a member's physician in support of the request and will consider each request on a case-by-case basis. Once approved, authorization will be granted at the highest benefit level up to the period defined by their plan. Direct members to contact Member Services at the number on the back of their ID card for details on how to request continuity of care.

Care availability

We'll provide access to all provider specialties for members living in our service area. We'll also provide in-network coverage for a member to see an out-of-network provider in the following circumstances:

- There are no participating providers for primary care, general hospital services, or mental health services within 30 miles/minutes of the member's current address. Primary care would be family practice, internists, and ob/gyns.
- There are no participating providers for specialty physician, specialized hospital services, skilled nursing facility, or ancillary service within 60 miles/minutes of the member's current address.

To qualify, members must get approval and should call Member Services at the number on the back of their ID card to start the approval process.

Commonly used health insurance terms

Benefit design

The process a health plan uses to decide what health care services will be covered for its members, how much the member will pay for these services, and how members can access medical care through the plan.

Copay

A fixed dollar amount you pay when you see a doctor, fill a prescription, or get other services.

Coinsurance

The percentage of the covered charges that you pay.

Deductible

The amount you must pay each year before your health plan begins paying benefits.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law that protects people who change jobs or who have preexisting medical conditions and establishing privacy requirements.

Network

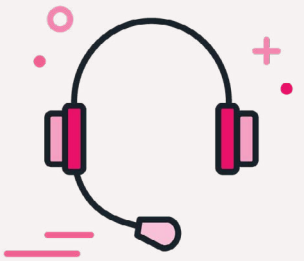
The group of physicians, hospitals, and other medical care providers a health plan contracts with to deliver medical services to its members.

Out-of-pocket maximum

The most an enrollee would have to pay in a year for covered services in deductibles, copays, and coinsurance. After reaching this maximum, the health plan will pay for all covered charges from in-network providers, up to the lifetime maximum.

Drug list

A listing of drugs, classified by therapeutic category or disease class, which are considered preferred therapies for a given managed population.



Questions? Contact us.

Your best resource is the Employer Service Center.

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