Implementation/Administrative Guide for Self-insured Employers (COSMOS)

Medica

Introduction

Thanks for choosing Medica as your partner in delivering quality health care to your employees. This guide serves as your essential tool for implementing and administering your organization's health plan.

What to expect:

- Comprehensive resources for seamless plan implementation and administration
- Ongoing personal and technical support to answer questions and resolve issues
- In-depth information into eligibility, administration, enrollment, contracts, and billing procedures
- A dedicated team committed to ensuring your employees receive the best care and experience

Navigating healthcare complexities can be challenging, but we're here to assist you every step of the way.

Administrative resources

Telephone + email support

The Employer Service Center is your resource for help with benefits, enrollment, claims, and more.

Phone: **1 (952) 992-2200** or **1 (800)-936-6880** (TTY: **711**)
Fax: **1 (952) 992-3199**
Email: **medicaservicecenter@medica.com**

Hours of operation:
Monday - Wednesday and Friday, 8 a.m. - 5 p.m. CT
Thursday, 9 a.m. - 5 p.m. CT

Online support

We encourage you to visit **Medica.com** anytime — day or night. Choose the "For Employers" tab for a wealth of information about our products, value-added health and wellness programs, online versions of our publications, and the most recent Medica news.

Employer eServices®

Employer eServices® is a secure, online application that gives you immediate access to your benefits information. It also lets you enroll and manage billing online in real time. Plus you'll find all of your information at **EmployereServices.com**.

To sign up for Employer eServices, contact your Account Manager and designate a Client Master Administrator (CMA) for your group. Your CMA can add and deactivate users, and assign functional permissions like eligibility and billing to users in your organization.

For more information, check out the **Employer eServices User Guide**. Have questions or technical issues? Contact Employer eServices customer support at **1 (800) 651-5465**.

Emails from Medica

You and/or your employees may receive emails from the following list. Please provide this list to your IT department so they're not flagged as SPAM.

- Employer eServices: **Employer_EServices@UHC.com**
- Electronic monthly administrative invoice ready notification: **NoReply@Notifications.UHC.com**
- Medica Employer Communications: **Employer.Comm@Email-Medica.com**
- My Health Rewards by Medica: **Medica@HealthyEmail.com**
- Medica CDH: @HealthAccountServices.com
- Medica ONESource: @HealthAccountServices.com
- Medica Do Not Reply: @HealthAccountServices.com
- Medica Dental through Delta Dental: **DeltaDentalConnect@DeltaDentalMNAdmin.org**
- Be.Well by Medica: **MedicaMemberComm@Email-Medica.com**
- 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, our monthly employer e-newsletter.

Visit **Medica.com/Employers** for helpful resources to help you administer your health plan, including forms, worksite wellness resources, and member materials. And check out our **Monthly Health and Wellness Toolkit**, which focuses on a new topic each month to promote healthy living and raise awareness about care services.

Got a question or concern? We're here to help. Email us at **Employer.Comm@Medica.com**, and we'll be happy to assist you.

Getting started

Account setup

There are multiple ways to set up your plans through group numbers, departments, and/or master group numbers, depending on your reporting, location, or billing requirements.

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.

Medica Online Reporting (MOR)

Our online reporting tool, MOR, is available to self-insured clients on the COSMOS platform. MOR lets you generate reports by total employer at the Federal Tax ID level, with drill-down capabilities to group numbers and reporting categories.

Check out the **MOR User Guide** to learn how to use MOR to locate important information about your plan. It covers everything from basic navigation to specific page content details, so you can get the most out of this powerful reporting tool.

Reporting requirements

Claims experience is broken out by the five-digit group number. Employers often will have different locations or different classes of employees and request that each location/class have its own group number for claims experience reasons. With this request, each location must be set up with its own five-digit group number.

Depending on your group's reporting requirements, you may need additional group numbers or more master group numbers.

Departments (reporting category 1)

Within a five-digit group number, you can further break down your membership by assigning each member to a specific department. This option is available when you get your bills via Employer eServices. Employer eServices also lets you download your invoice and sort it as needed.

Master group numbers

This six-digit master group number ties all the five-digit group numbers together. Each master group number that's created will generate its own billing invoice.

Billing requirements

For example, if your group has three plans, there will be a total of three five-digit group numbers. Each master group number (or location) would also have its own set of three five-digit group numbers under it.

Location 1 – Master Number: 123456
Plan A, Group #11111
Plan B, Group #22222
Plan C, Group #33333

Location 2 – Master Number: 234567
Plan A, Group #44444
Plan B, Group #55555
Plan C, Group #66666

Billing invoices are run at the master group level. So if you have two master group numbers, you'll get two billing invoices (same invoice date, two separate bills).

Note: If you need help determining the number of group numbers, figuring what departments are needed, and/or the number of master group numbers your group will need, contact your Medica Account Manager.

Stop-loss contract

If you've purchased a stop loss service from us, this document is the formal agreement between your organization and Medica Self-Insured (MSI). It defines:

- The contract's effective date
- The contract's termination provisions
- The stop-loss schedule and rates
- Available records and reports

Administrative Services Agreement (ASA)

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

- The contract's effective date
- The contract's termination provisions
- 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 seven to 10 business days. Members will get two ID cards per family*. If the member is on an Elect product, each family member will get an ID card with their respective clinic name on it. If members need extra cards, they can sign in to **Medica.com/SignIn** or contact Member Services to request them.

**We'll automatically issue additional ID cards for any dependents over the age of 16.*

Alternate ID number

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

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

Next steps for your employees

Remind employees to watch the mail for their ID card and member Welcome Kit. When it arrives (the ID card usually arrives first), have them review the information and learn how their plan works. They should also store the Welcome Kit in a safe place and carry their ID card at all times so they'll have it when they need care.

Register

Employees should sign up for the Medica programs and services that help them take charge of their benefits and make informed decisions about their health. They'll only need a few minutes and the information on their ID card to create a user name and password for their member website at **Medica.com/SignIn.**

Download the app

Your employees who might be on the go can also access their health plan information, including a digital ID card, through our app. They can download the app by searching "Medica Member" in the App Store or Google Play.

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

Your employees will probably have questions when they start using their plans. Help them out by promoting these helpful resources:

- **Member Services**
  - Monday - Friday, 7 a.m. - 8 p.m. CT, (closed Thursday, 8 - 9 a.m. CT)
  - Saturday, 9 a.m. - 3 p.m. CT
  - Note: The Member Services phone number is on the back of their ID card
- **Medica CallLink®**
  - Staffed with advisors and nurses who can offer advice and answer questions 24/7 at **1 (800) 962-9497.**
- **Member website**
  - Members can create an account at **Medica.com/SignIn** to access their member ID card and find their health plan documents, links to pharmacy information, coverage information, health and wellness information, and more.
- **Member app**
  - Members can search "Medica Member" in the App Store or Google Play to access their health plan information, download their ID card to their mobile wallet, find in-network providers, and more.

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 manager 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

For self-funded groups, we offer a buy-up option for Medicare Part D services.

- 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 manager 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 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**. **Please 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 representatives 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 Manager 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.

Claim funding

Claim invoices are generated each Monday for claims processed the previous week. Invoices are emailed securely to you by a Medica billing representative.

- Claims payment is due within two days of receipt of the invoice. If you have selected the administrative fees to be billed on a percent-of-claims basis these fees will be calculated and presented on each claim invoice.

Claim payment

Medica-initiated direct debit, also known as Automated Clearinghouse (ACH).

Benefit exceptions

Self-insured clients are responsible for approval of any benefit exceptions over $2,000. If an exception needs to be considered for either clinical or administrative reasons, your Account Manager will work with you to review the request and manage the process.

Clinical

There are times when an exception to Medica's clinical policy may be medically warranted based on unique circumstances. Exception requests from Medica's Medical Directors are sent for review and sign off.

Administrative

While Medica strives for 100% accuracy, there are times where errors are made to the detriment of the member such as a benefit misquote. Exception requests for administrative errors will be sent by your account manager for review and sign off.

Stop-loss reimbursements

Specific stop-loss reimbursements

If your group is due to receive a specific stop-loss reimbursement:

- You'll get a secure email with the individual stop-loss detail on Monday or Tuesday
- The money will be refunded into your bank account the following Wednesday via Automated Clearing House (ACH)
- Generally, settlement is on the same day as claim funding

Also, when individuals have exceeded the stop-loss deductible you'll get a monthly specific stop-loss report via secure email.

Aggregate stop-loss refunds

- Aggregate stop-losses are reconciled annually and completed within 45 days after the end of the contract period (refer to your stop-loss contract for more information)
- If a refund is due, we'll email the reconciliation reports to your group's administrator and/or broker, if applicable
- The refund will be issued via ACH or check to your group's bank account within 45 days after the end of the contract period
- You'll get a monthly aggregate stop-loss report through secure email that includes monthly and year-to-date accumulative aggregate claim totals

Invoice schedule

RUN DAY OF MONTH	INVOICED CHARGE	INVOICE TYPE**	DUE DATE	DESCRIPTION	DRAFT DATE
Every Monday	Claims paid	Claim Invoice	Every Wednesday	Included on the weekly claim invoice	ACH draft on Wednesday following the invoice
22nd	Medical Admin Fees	Monthly Admin Invoice	1st of next month	ASO admin fee. Component detail determined at implementation.	ACH draft on 10th of next month
22nd	Stop Loss Premiums	Monthly Admin Invoice	1st of next month	Invoiced with Medical Admin fees, unless admin fees are billed by percent of claims.	ACH draft on 10th of next month

For Medica ONESource products, you will receive an email when the fee funding notification is available.

Fee Funding Notification – On the 11th of each month, you will receive a notification that the Fee Funding Invoice is available. This invoiced amount will be automatically charged to the account you have provided to Medica ONESource. You do not need a separate payment.

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? We're here to help.

Contact the Employer Service Center at **1 (952) 992-2200** or **1 (800) 936-6880**

Fax: **1 (952) 992-3199**

Email us at **MedicaServiceCenter@Medica.com**.

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