IMPLEMENTATION/ ADMINISTRATIVE GUIDE FOR FULLY INSURED EMPLOYERS

MEDICA®

INTRODUCTION

Thank you for choosing Medica. This guide is designed to help you implement and administer your organization's Medica health plan on behalf of your employees. We also provide ongoing personal and technical support to help you resolve issues and answer questions. These resources, along with detailed information about eligibility, administration, enrollment, contracts and billing procedures, are all included in this guide.

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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: **(866) 894-8052** (TTY: **711**)
Fax: **(952) 992-3021**
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.

Online Support

We encourage you to visit **Medica.com** anytime — day or night. Click on 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.

Medica Employer Services

To make it easier to do business with us, Medica offers Employer Services®, an online application that gives you immediate, secure access to health care benefits information.

Through Employer Services, you can conduct your enrollment and billing online in real time. In addition, information is available electronically through.

- Medica Employer Services eBilling
- Medica Employer Services Enrollment

To sign up for Employer Services, contact your account manager. You'll need to designate a HR Administrator for your group. The Administrator can:

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

View the **Employer Services user guide**.

Have a general question about Medica Employer Services or experience a technical issue while using Medica Employer Services? Contact the Employer Services customer support at **(866) 894-8052**.

Emails From Medica

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

- Medica Employer Services (DoNotReply@BenefitFocus.com)
- Electronic monthly administrative invoice ready notification (DoNotReply@BenefitFocus.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 No Reply (@healthaccountservices.com)
- Medica Dental through Delta Dental (DeltaDentalConnect@DeltaDentalNE.org)
- Medica 4Members (Medica4Me@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*, 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**.

Employer Trainings

Throughout the year, Medica periodically offers a number of topical seminars designed specifically for employers. Group administrator training covers the basics of ongoing administration, from how to get started, to adding new employees, where to get your questions answered and more. A health and wellness expert will also share strategies and tools to engage your employees in healthier lifestyles and help make the most of their Medica plan.

To register or see current offerings, go to **MedicaTraining.com**.

GETTING STARTED

Account Setup

There are multiple ways to set up your plans through groups, subgroups, and divisions depending on your reporting, location or billing requirements.

Group ID

Each client will have a group ID assigned. Plan availability is broken out by the group ID. Sometimes an employer will have different plan options for different populations. In these situations, different subgroups or divisions may be used to support enrollment requirements.

Foundational Questionnaire

The foundational questionnaire will help build out your account structure. Components of the questionnaire help your Medica implementation team determine if subgroups or divisions are needed to administer your account.

Reporting Requirements

Claims experience is broken out by the group ID. Often, an employer will have different locations or different classes of employees and request that each division has its own group number for claims experience reasons.

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

Subgroups or Divisions

Within a group ID, you can break your membership down further by assigning each member to a specific subgroup or division. Through Medica Employer Services you can then download your invoice and sort it any way needed.

Billing requirements

Subgroup IDs may be applied if your group requires separate billing or invoices based on population (i.e. location, department, union vs. non-union). Example:

Account Name: Joe's Garage
Group ID: A12345
Subgroup: Joe's Garage – Hill Valley
Subgroup ID: A12345-123
Subgroup: Joe's Garage – Great Falls
Subgroup ID: A12345-124
Billing invoices can be run at the group or subgroup level.

***Note**: If you need assistance in determining if additional subgroups are needed for billing purposes, please contact your Medica account manager.*

Master Group Contracts

This document in conjunction with the certificate(s) of coverage is the formal agreement between your organization and Medica. The master group contract defines:

- The contract's effective date
- Termination provisions of the contract
- Your responsibilities as an employer under the contract
- 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/MemberSite** or contact customer service to request them.

**Medica will 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 the primary identifier for them with an alternate 12-digit ID number. While you will still provide us the SSN of each enrollee, we will assign an alternate 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. If they participate in the Fit Choices health club reimbursement program, they will also need to present their new card at their gym.*

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), it's a good idea for them to review the information and learn how their plan works. The welcome kit should be saved in a safe place and employees should carry their ID card at all times so that it's available when they need care.

Register

Encourage your employees to sign up for the Medica programs and services that help them take charge of their benefits and make informed decisions about their health. They will need only a few minutes and the information on their ID card to create a username and password for **Medica.com/MemberSite**.

Learn How Their Plan Works

Encourage your employees to review their plan information when it arrives. They should review their copays, coinsurance and out-of-pocket costs. They should also understand how their out-of-pocket costs might change if they get care from a provider who is not in their network, or how they're covered if they need care 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. Central, Monday through Friday (closed 8 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/MemberSite** – Members can login to find personal health plan documents, links to pharmacy information, coverage information and health and wellness information.

ELIGIBILITY ADMINISTRATION

COBRA

When an employee is terminating their Medica coverage, please send the termination notice to Medica immediately. You do not need to wait until the end of their COBRA election period.

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

- Please remind your vendor that Medica needs to have all enrollment requests submitted via the Employer Services portal.
- Requests should be submitted within the time allowed on your Master Group Contract (MGC). This will help ensure that enrollment is accurate and completed in a timely manner.
- Do not send COBRA paid-through reports or COBRA election forms to Medica. These documents provide more information than needed and we want to protect our members by receiving only necessary information.

View the **COBRA enrollment tip sheet**.

Medicare Part D

Medicare Part D notices are sent by Medica annually.

Notices are required each year to be sent prior to Medicare open enrollment which starts Oct. 15. Medica completes the mailing by late-September to early October. The notice is mailed to only those members and their covered dependents who are eligible for Medicare Part D, or who will be eligible in the next 12 months. The notice will include details on the creditable or non-creditable status of the member's prescription drug coverage. Employers will be mailed a cover letter and sample notices prior to the mailing so they will be aware what their employees will be receiving.

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. Medica will notify members that their coverage will terminate at the end of the month in which the member turns 26. We will also send a copy of the notification to you. Members whose coverage ends may be eligible for COBRA/continuation.

Below are the state requirements around full time students that extend beyond the age 26. Medica will keep dependents on until the appropriate student age as noted below at the request of the group. Medica does not track full-time student eligibility.

STATE	MAXIMUM DEPENDENT AGE	FULL-TIME STUDENT AGE
IA	26	27
NE*	26	26

* Extended coverage can be requested for dependents up to the age of 30 based on state criteria. To qualify for extended coverage, the dependent must be unmarried, be a resident of Nebraska and not covered under any other health plan.

Disabled Dependent Review

Disabled dependents over the maximum dependent age who are neither full-time students nor employed on a full-time basis are eligible for coverage for as long as they continue to meet disabled dependent criteria. A dependent child may be an adult. There is no upper age range for a disabled dependent.

Medica does not conduct a medical review for disabled dependents. We rely on the member's primary care physician to indicate that the member is disabled. If Medica's Request For Extended Coverage Form is completed and signed by the member's physician, the dependent will be enrolled with a disabled status.

Any dependents reaching the age of 26 will be reviewed by our eligibility team. Once approved as disabled no further action will be taken. If not, a completed **Request For Extended Coverage Form** will be needed to continue coverage. The Maximum Dependent Age letter sent to the member will provide instructions for obtaining and completing the **Request For Extended Coverage Form**. They have 31 calendar days from the date the dependent

reaches age 26 to complete and return the form to us. If they do not return the form within the 31 days, the dependent will be terminated from the plan.

Explanation of Benefits

An explanation of benefits (EOB) will be provided to members for all in-network and out-of-network claims, including claims where the member liability is a flat dollar copayment.

Coordination of Benefits (COB)

Coordination of benefits occurs when a person is covered under more than one insurance plan at the same time. COB can occur with Medicare, Medical Assistance, individual policies or commercial plans through other employers. It requires that payment of benefits be coordinated by all programs to eliminate over insurance or duplication of benefits. COB allows for reimbursement of up to 100% of allowable charges, which means out-of-pocket expenses (e.g. co-payments and deductibles) are minimized or even eliminated.

Medica reviews enrollment and claim data to determine those members most likely to have other insurance and contact them directly to verify the information. A letter will be sent to the member asking them to verify whether they have other insurance. If the member responds to the letter, the system is updated accordingly and no further contact is necessary. Claims will not be held during this process. If there is no response from the member, Medica assumes there is no other insurance.

A member traditionally would not be contacted more than once per year; however, in certain situations in which the member's COB information changes multiple times within a year, the member may be contacted more than once.

ENROLLMENT

Enrollment Options

Enrollment can be done online through Employer Services or electronic file.

Spreadsheet

Spreadsheets can be used for your initial enrollment submission to Medica and can also be used in certain instances for your open enrollment updates. Medica's spreadsheet templates must be used. Ask your account manager for more information about this option.

Employer Services

You can quickly and easily log into the secure website to enroll new employees and/or dependents at Medica Employer Services Enrollment.

Frequently Asked Questions

When can employees enroll?

Examples of when employees can enroll: during open enrollment, when an employee is newly eligible, or following a special enrollment event (such as loss of other coverage in certain instances, birth, adoption, marriage).

Please refer to your Certificate of Coverage for a more detailed description of when employees can enroll.

Are social security numbers (SSN) required?

- SSN is 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 social security numbers for "active covered individuals" covered under the plan, this would include dependents.
- If the employee is a non-US citizen without an assigned SSN, Medica requires their work visa number be submitted.

What is the process for retroactive terminations?

The Patient Protection and Affordable Care Act ("PPACA") includes legislation prohibiting group health plans and health insurance issuers offering group or individual coverage from rescinding coverage with respect to an enrollee once the enrollee is covered under the plan, except where the individual commits fraud, makes an intentional misrepresentation of material fact or non-payment.

A rescission is defined as any cancellation or discontinuance of coverage that has a retroactive effect. This means that retroactive terminations by employers are rescissions and would only be allowed for non-payment of premiums or contributions from the employee or if the retroactive termination were for fraud or intentional misrepresentation of a material fact.

Medica's standard retro termination process is 60 days for fully-funded groups and will remain in place for those allowable retroactive terminations – i.e. non-payment. If a contribution has been made by the employee or in the case of an employer contributing 100% of the premium then the termination must be prospective.

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BILLING & PAYMENT

Monthly Billing

Here are the basics behind the billing process at Medica.

- Each month, invoices are generated on the 13th for the upcoming month. For example, your August invoice would generate on July 13. You will receive an email within 2-3 business days notifying you the invoice is available to view.
- The invoices you receive will include the following:
  1. Invoice summary – includes what is billed at a plan level.
  2. Invoice detail – includes subscriber level detail.

Enrollment changes are not accepted when communicated on your invoice. You must submit the appropriate changes through the enrollment process. Refer to the enrollment section of this guide for detailed information.

If you have questions specific to your account, please contact our billing representatives at **(866) 894-8052**.

When Premiums Are Due

Premiums are due on the first of each month. Be sure to pay your premium on time to avoid termination of your group's coverage.

Monthly Payment Options

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

- Set-up recurring automatic withdrawals from your account (ACH). You can set this process in the Medica Employer Services system. 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.
- Set-up a one-time automatic withdrawal from your account (ACH, non-recurring). This option is also accessed through the Medica Employer Services billing by simply clicking the payment submit button.
- Check payments can be mailed using the address on the payment remittance slip on your invoice, going directly to the bank lockbox.

Please contact your account manager to discuss payment options.

Medica Employer Services Electronic Billing

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

You will receive a monthly e-mail 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.
- Pay bills online.

We recommend that you give at least two users access to online billing for back up purposes.

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NETWORK ACCESS

Continuity of Care

In the event that 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 for one or more of the following conditions:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy beyond the first trimester of pregnancy
- A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase.

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 120 days. Direct members to contact customer service at the number on the back of their ID card for details on how to request continuity of care.

Care Availability

Medica will provide access to all provider specialties for members living in Medica's service area. Medica will 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 customer service at the number on the back of their ID card to start the approval process.

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COMMONLY USED HEALTH INSURANCE TERMS

Benefit Design
The process a health plan uses to determine which benefits or level of benefits to offer to enrollees, the degree to which enrollees will be expected to share the costs of such benefits, and how enrollees can access medical care through the health plan.

Copay
A fixed dollar amount that you pay when you see a doctor, fill a prescription or receive 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 pre-existing medical conditions and establishing privacy requirements.

Network
The group of physicians, hospitals and other medical care providers with whom Medica contracts to deliver medical services to its members.

Out-of-Pocket Maximum
The total amount of charges for covered services an enrollee may have to pay each plan year in deductibles, copays and coinsurance. Once the maximum is met, the plan pays 100 percent of the covered charges received from network providers, up to the applicable lifetime maximum.

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

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Your best resource is the Employer Service Center.

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