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

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.

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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 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/Employers** 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 representative 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 Dental through Delta Dental: **DeltaDentalConnect@DeltaDentalMNAdmin.org**
- Be.Well by Media: **MedicaMemberComm@Email-Medica.com**
- Virgin Pulse: @virginpulse.com

Stay updated

Stay in the loop with important Medica updates, industry news, fun and informative events, and more through our monthly employer e-newsletter, *Employer Update*. Group administrators automatically receive it, but if you want more team members included, just reach out to your account representative.

Explore **Medica.com/Employers** for useful resources to streamline health plan administration, including forms, worksite wellness tools, and member materials. Don't miss our **Monthly Health and Wellness Toolkit**, spotlighting a new topic each month to promote healthy living and care services awareness.

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

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 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 member 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 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), have them review the information and learn how their plan works. They should also save 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 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.

Medica Member app

- Members should 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

We want 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" in the "Tools" section – 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 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)

Coordination of benefits (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**.

Please 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 30772
Salt Lake City, UT 84130-0772

Or fax to:
1 (844) 280-3838

Electronic file feeds

You will be assigned an electronic eligibility analyst that will help with the set-up, testing of the feeds, and discrepancy reports throughout the year. Eligibility files are pushed to Medica via SFTP.

Electronic Eligibility Management System (EEMS)
EEMS provides HR benefits staff a user-friendly, intuitive, self-service application to verify eligibility transactions. The system minimizes the lag time between an employer's HR system and EEMS. The shorter the delay, the lower chances exist for service issues to affect your employees and their families. Designated users are automatically notified of file completion and are able to immediately view file transaction results using the web-based interface.

Frequently asked enrollment questions

How do I make enrollment-related changes?

Use Employer eServices (changes are made in real-time 24/7) or the **Group Enrollment/Change/Cancellation Form** to:

- Add a new employee
- 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

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 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)

Use **Employer eServices** or the **Group Enrollment/Change/Cancellation Form** for these changes. Please refer to your plan document or your summary plan description for more detail.

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

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.

- Monthly invoices are generated a month in advance electronically. See the Invoice Schedule on the next page for timelines.
- A remittance coupon, which includes the remittance address, is provided on the first page of your invoice once printed.
- Enrollment changes are not accepted when communicated on your billing invoice. You must submit the appropriate changes through your preferred enrollment process. Refer to the enrollment section of this Guide for detailed information.

You'll receive 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 via **Employer eServices**, you can do so and then request an adjustment invoice. Your changes will be reflected in the online adjustment invoice that is requested. This adjustment invoice combined with your current invoice, will provide a more up-to-date payment amount due for that month.

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

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.

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.

When premiums are due

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

Invoice schedule

Your remittance is due to Medica on the first of each month with a 10-day grace period. See the invoice schedule below for specific timelines.

Run Day of Month	Invoice Charge	Invoice Type*	Due Date	Description	Draft Date**
5th workday	Shared savings	NEB	Immediate	Shared savings	ACH draft on the 10th of next month
11th	Medical admin fees	ELG	1st of next month	ASO admin fee is a roll-up of all fees. Invoice also includes stop loss, which can be rolled-up with ASO	ACH draft on the 10th of next month
11th	Stop loss premiums	ELG	1st of next month	Invoiced with medical admin fees, unless admin fees are billed by percent of claims	ACH draft on the 10th of next month

Invoices are available for viewing on Employer eServices 24 - 48 hours following generation day.
Some of these invoices may not apply to your account, depending on your product selection. Ask your Account Manager if you have questions on what invoices you will receive.

* NEB = Non-Eligibility Based; ELG = Eligibility; ACH = Automated Clearinghouse
** NEB invoices are generated on the 5th work day of the month, however, employers set up with ACH will have the NEB draft on the 10th of the month. Note: If the 10th falls on a weekend or holiday, it will draft on the next business day.

Claims + Banking

Shared savings

The Shared Savings program applies additional provider discounts to non-network services incurred by members (claims that are out of the Medica service area). If your group has the Travel Program, where members have access to a national network for in-network providers through the United HealthCare PPO Options network, this may not come up often. In addition to this network, United HealthCare also leases networks from other organizations in locations where United HealthCare does not have providers. While these providers are considered non-network, we can still take advantage of these lease agreements and apply a provider discount. There is an administration fee associated to this Shared Savings Plan; 35% of the provider savings is charged back to the client.

Claim payment

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

Claim funding

Benefit demand deposit bank account

A demand deposit bank account (DDA) is required in order to charge claim payments processed for all self-funded customers. Therefore, it is important to address this step early in the implementation process. Once signed bank account authorization document(s) have been received from you, it generally takes 7 to 10 business days to open a bank account during non-peak implementation periods. However, November 15 is the standard cutoff for opening a bank account for new business effective January 1.

The bank account is a non-interest bearing, demand deposit account established to support your claim liability charges. It directs the transfer of funds from your external funding bank account to Medica for reimbursement of claim payments made on your behalf.

Medica's designated bank of choice is Bank of America

Stop-loss reimbursements

Individual stop-loss reimbursements

If your group is due to receive an individual stop-loss reimbursement under $150K, the reimbursement is automatically deducted from the amount due on the funding advice as provider checks and electronic payments are issued. The individual stop loss reimbursements are included on the monthly eServices banking reports "Detail Report for Transfer Evaluation" and the daily "Charged Claim Activity" report under transaction code 0600 by member. The stop loss reimbursements are also included in eServices under "claims" and can be located on the "Payment by Month" report under suffix "AL" and on the "Large Loss" report under individual health pooling.

Please note: *If a stop loss reimbursement is over $150K it is not automatically released by the individual stop loss system. These reimbursements are reviewed by the Financial Underwriter and Stop Loss Analyst. Once approved, they are released manually. Once a reimbursement is released, whether by the individual stop loss system or manually, it takes 4 to 5 business days for the reimbursement to be placed in the bank account.*

Aggregate stop-loss refunds

Aggregate stop loss is reconciled on an annual basis within up to 150 days (5 months) following the contract period. If a refund is due to your group, Medica will email the reconciliation to your group administrator. The employer will receive a monthly aggregate stop loss report available with the monthly banking reports in Employer eServices.

Establishing a funds transfer

Medica supports daily or weekly funds transfers via wire transfer or electronically via Automated Clearinghouse (ACH). Keep in mind wire transfers occur on the same day while ACH transfers occur the next day.

We require a minimum balance (imprest balance) be maintained in this bank account at all times. We also offer banking reports by the 10th business day of the following month.

Imprest balance

Imprest balances are stated at the point of renewal but are subject to change throughout the year.

- The imprest balance amount is based on 6 days of expected claims at the point of renewal or new group set up for weekly funding, if daily funding the imprest required balance is a lower amount.
- The minimum balance is calculated by Underwriting based on anticipated value of claims, number of banking days, funding method (wire or ACH) and financial condition.
- Once a week, you will receive a “Funding Advice” email through the Employer eServices portal. The email includes total cleared claim payments from the prior week and the amount needed to replenish the imprest balance. If you choose to fund daily, you will receive a daily “Funding Advice” email.
- As the year progresses, if realized claims consistently exceed the 6-day reserve you have funded with your imprest balance, the imprest balance amount may need to change.

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.

Hours of Operation

Monday, Tuesday, Wednesday, Friday
from 8 a.m. to 5 p.m.
Thursday from 9 a.m. to 5 p.m.

Phone: 1 (952) 992-2200

1 (800) 936-6880

Fax: 1 (952) 992-3199

Email: MedicaServiceCenter@Medica.com

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