For employers headquartered in IA and NE

Implementation/Administrative Guide for Maximum Liability Employers

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.

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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 (866) 894-8052** (TTY: **711**)
Fax: **1 (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 Medica Employer Services, 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 Medica Employer Services or experience a technical issue while using Medica Employer Services? Contact Medica Employer Services customer support at **1 (866) 894-8052**.

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.

- Medica Employer Services (**DoNotReply@BenefitFocus.com**)
- Electronic monthly administrative invoice ready notification (**DoNotReply@BenefitFocus.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 No Reply (@healthaccountservices.com)
- Delta Dental products available to Medica groups (**DeltaDentalConnect@DeltaDentalNE.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*, Medica's monthly employer e-newsletter.

Visit **Medica.com/Employers** for a variety of resources to help administer your plan, including: form, 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

Account ID and plan ID(s)

Each client will be assigned an Account ID. Plan options will be differentiated by the Plan ID assigned. Sometimes an employer will have different plan options for different populations.

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 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 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 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 manager to request the email message(s).

Eligibility administration

COBRA

When an employee is terminating their Medica coverage, please complete the termination immediately using Medica Employer Services. 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 Medica 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.

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 all subscribers. 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 of 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	26
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

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 Medica Employer Services or electronic file.

Spreadsheet

Spreadsheets are 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 broker or Medica account manager for more information about this option.

Medica Employer Services

You can quickly and easily log into the secure website to enroll new employees and/or dependents at **Medica Employer Services.** To sign up for Medica Employer Services, contact your account manager.

Frequently asked enrollment 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 Plan Docs 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 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.

Billing + payment

Invoices

Here are the basics behind the billing process at Medica.

- Each month, invoices are generated on or around 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 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 Medica Employer Services. 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 **1 (866) 894-8052**.

When premiums are due

Premiums are due 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.

- Set-up recurring automatic withdrawals from your account via Automated Clearinghouse (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 date you choose, between the 1st and 10th of each month. If that date 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.

Please contact your broker or Medica account manager to discuss payment options.

Medica Employer Services electronic billing

Electronic billing solutions through Medica Employer Services provide simplified invoices, downloadable data and real-time calculations and payments. Medica 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.

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

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.

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.

Questions? Contact us.

Your best resource is the Employer Service Center.

Hours of Operation

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

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Medica®