

MEDICA®

HOW TO GET THE CARE YOU NEED

Medica Commercial Fully Insured

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Your guide to Medica

Medica is here for you

We are happy to have you as a member. Your health care coverage is a valuable resource to help you receive quality care. This guide explains some of your health care options and has important information about your rights and responsibilities as a consumer. It also tells where to find more information if you need it.

File it

Please read and save this document. It may help whenever you have questions about your coverage. Some Medica members use a file folder to keep all of their health care information in one place. Typical items you may want to include in your health care file are:

- Your coverage document, called a "Certificate of Coverage," is available on your secure account. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site.
- "Summary of Benefits and Coverage" document
- Any "Explanation of Benefits" you receive
- Information from your health care provider or clinic
- Information about your prescriptions
- Information about eye care
- Receipts for copayments, prescriptions or other medical expenses

Some programs and services may not be available to all members, depending upon your health insurance plan.

If any information in this guide conflicts with your coverage document, your coverage document will govern in all respects.

FIND WHAT YOU NEED ONLINE

Commercial Fully Insured Members Only

If you are a Commercial fully insured member, get the information you need about your benefits online. Go to **medica.com/members** and select your plan name (listed on your Medica ID card as *Care Type*). Throughout this document, we'll let you know whenever more information is available online.

Do you need help?

Do you need answers or more information about your health care coverage?

Visit **medica.com** or contact Customer Service. You'll find their contact information in the Important phone numbers section at the back of this guide.

Farm Bureau Members Only

Go to **medica.com/FarmBureauLogin** for information about your plan. Refer to the *Important phone numbers* section of this guide for your dedicated Customer Service number.

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ABOUT YOUR COVERAGE

Your coverage document, called a “Certificate of Coverage,” explains what is and is not covered by your health insurance plan. It also explains what portion, if any, you will pay for health services. Throughout this guide, we use the term “coverage document” to refer to your Certificate of Coverage. You can access your coverage document by logging into your secure account. Go to your member portal (listed on the inside cover of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site.

In most cases you can find answers to questions about your health insurance benefits in your coverage document. If you cannot find what you need, call Customer Service. You'll find their number in the *Important phone numbers* section of this guide or on the back of your Medica ID card.

Deductibles, copayments or coinsurance may apply

Payment of a deductible, copayment or coinsurance may be required for services received from a provider, hospital or for a prescription at a pharmacy.

- **Deductible**—the amount you pay each year before your insurance starts to pay (for example, \$1,000).
- **Copayment**—a fixed dollar amount you pay upfront for some services or prescriptions (for example, \$25).
- **Coinsurance**—a percentage of the charges that you pay for a given service (for example, 25% coinsurance).

See your coverage document for the complete definitions of these terms and whether they apply to your plan.

The most common copayment or coinsurance amounts are listed on your Medica ID card. Find a complete listing of your copayments or coinsurance in your coverage document by logging into your secure account. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site.

How to submit claims

Network providers will submit claims for you. Claims for services received from a non-network provider must be submitted on an itemized claim form by you or the non-network provider to the address on the back of your Medica ID card. Most non-network providers have the proper claim form. If not, you can download the form online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet)

and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find forms*; or call Customer Service. If you paid for non-network services and will be submitting the claim yourself, include copies of any bills, receipts or itemized statements from all providers.

Please note that non-network claims must be submitted within 365 days from the date of service. Please see your coverage document for details.

Coverage for hospital services

If you need care at a hospital, coverage for outpatient and inpatient care varies by plan. In some cases—such as care for children or transplant services—you may need to go to specialty hospitals. Also, if you receive emergency services and require hospitalization, refer to your coverage document to learn how to receive your highest level of coverage. You also may contact Customer Service for more information about your benefits and to make sure that the hospital you want to use is in your plan's network. You can look up network hospitals online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*.

Post-mastectomy coverage is available

The *Women's Health and Cancer Rights Act* requires health insurers and group health plans that cover mastectomies to provide certain benefits if a member chooses reconstructive surgery after a mastectomy. The law also requires health plans to provide members with written notice that this coverage is available.

Refer to your coverage document to see how your plan covers the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a balanced look.
- The cost of prosthesis and the treatment of any physical complications resulting from mastectomy. This includes treatment of lymphedema, the swelling sometimes caused by surgery.

Some members may have to pay a deductible, copayment or coinsurance. The amount will be consistent with the deductibles, copayments or coinsurance for other benefits in your plan. To determine the amount you would have to pay, see your coverage document.

CONNECTING YOU TO THE CARE YOU NEED

At Medica, we will do our best to make sure you and your family receive the very best health care. We start by connecting you with health care providers who deliver the care you need.

Your primary care provider

Your primary care provider is your medical “home.” This is the provider you choose to see on a regular basis.

There are four types of primary care providers. Some work only with women or children. If you need to choose a primary care provider, the following descriptions can help you decide which type would best meet your needs.

Family practice—Doctors who provide care for the whole family—all ages, all genders, each organ system and every type of disease. This specialty provides continuing, comprehensive health care for the individual and family.

Internists—Doctors who specialize in complex illnesses of adults, especially medical conditions that affect internal organs.

Pediatricians—Doctors who specialize in taking care of the general health needs of children, from birth to about age 17.

Obstetricians/gynecologists (OB/GYN)—Doctors who specialize in pregnancy, childbirth and diseases/problems of the female reproductive system. They are also trained in routine preventive and reproductive services.

To learn about the qualifications of a primary or specialty provider, you can contact the State Board of Medical Practice or State Board of Medical Examiners. You also can check your state’s government website.

Important! If you see a provider who’s not in your plan’s network, you usually submit your own claim and **your costs may be significantly higher**. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *See member tips* to find the *Out-of-Network Care* tip sheet.

Finding a physician or facility

There is a fast, easy online tool you can use to search for health care providers in your plan’s network. You can search for primary care physicians, specialists, clinics, hospitals and other

care providers. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*.

Please confirm with the provider’s office that they are part of your plan’s network before your first visit. If you have questions about whether your provider or clinic is in your plan’s network, your benefits or coverage, call the Customer Service number on the back of your Medica ID card.

How providers are added to our network

When a provider wants to join a Medica network, we look at that provider’s education and experience. We do this to make sure you have access to providers who meet our quality standards.

Making appointments

When you are sick or need to see a provider for preventive care, simply contact your primary care provider to make an appointment. Make sure your provider is in your plan’s network. Show your Medica ID card at each visit.

Before seeking services from a network provider, you may request an estimate of the allowable amount the specified provider has contracted with Medica to receive for a specified health service, and the portion of that amount that you must pay. If you requests an estimate, Medica will provide the information within 10 business days of receiving a complete request.

The amount Medica provides is only intended to be a good faith estimate and is not legally binding.

Specialty care

Perhaps you and your primary care provider have decided that you need to see a specialist. Coverage for specialty care varies by plan. Some plans require a referral from your primary care provider, while others do not. Keep in mind that it may take up to six weeks to get a specialist appointment.

Medica has procedures for seeing specialists of many kinds. To be sure that you receive maximum coverage, read your coverage document and follow the steps outlined there. You can access your coverage document any time on your secure account online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site.

Behavioral health services: Mental health and substance abuse care

If you or a family member needs mental health or substance abuse services, follow the steps outlined in your coverage document. You can also call Customer Service or Medica's designated mental health and substance abuse care provider for assistance. See the *Important Phone Numbers* section of this guide.

If you have an emergency, call 911.

Care after regular clinic hours

If possible, you should make an appointment to see your primary care provider first. Your primary care provider is the person who knows the most about your medical history. Even when the clinic is closed, you can call and leave a message for your provider. Many clinics have on-call staff that can help you get the care you need.

If after-hours care from your regular clinic isn't available, you can access virtual care or visit an urgent care or retail health clinic in your plan's network. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*. For most members, help finding a location close to you is available through the Medica nurse line service. If this service is available to you, the toll-free number is listed on the back of your Medica ID card.

Retail health clinics

Retail health clinics are staffed with licensed providers who can treat common illnesses and provide certain preventive services for people older than 18 months. Some of the illnesses they can treat are the common cold, sore throat or an ear infection. They can't treat life-threatening emergencies. These clinics provide after-hours care and are located in many retail stores, grocery stores or pharmacies. Search for locations online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*. (Please note, retail health clinics may not be available in some areas.)

Retail health clinics have daytime and evening hours. Some also are open on weekends and holidays. You don't need to make an appointment, just walk in. Care is given on a first-come, first-served basis.

EXAMPLES: HOW TO DECIDE WHERE TO GO FOR CARE

Sometimes you need to decide what to do when you have a health question. Here are some examples of things that come up in everyday life.

Fussy child. Your 2-year-old child has been fussy all day. She has a fever and doesn't want to eat. She is tugging at her ear and is starting to cry.

Options:

- 1) If it's a weekday, contact your child's primary clinic and describe your child's behavior to your provider. You may be directed to come in to the clinic.
- 2) If it's an evening or weekend, call your child's clinic, but if it's closed, call Medica nurse line and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility. Medica nurse line can help you find a facility close to your home.

Sore throat. You have a sore throat, feel achy all over and have a fever.

Options:

- 1) If it's a weekday, contact your primary clinic and describe your symptoms to your provider. You may be directed to come in to the clinic.
- 2) If it's an evening or weekend, call your clinic, but if it's closed, call Medica nurse line and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility. The Medica nurse line can help you find a facility close to your home.

Asthma. Your 7-year-old son has asthma. After playing in the back yard with his friends all day, he's coughing, wheezing and complaining that his chest feels tight.

Immediately help him take his quick-relief medicine. Follow the asthma action plan given to him by his doctor. Call his doctor or, if needed, take him directly to the emergency room.

Note: See the Important phone numbers in this guide for the nurse line phone number for your plan.

Virtual care

Also known as online care or e-visits, virtual care is a convenient way to connect with your provider through email, telephone or webcam. You receive a diagnosis, treatment plan and prescription (if needed). Virtual care may cost less and be a time-saving option for non-urgent medical symptoms like allergies, pink eye and sinus infections. Most benefit plans cover virtual care. Check your coverage document or find a virtual care provider online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*.

Urgent care

If your primary care clinic is closed, urgent care is a good place to go for things like earaches, strep throat, fever, a sprained ankle or minor cuts. Urgent care centers are staffed by doctors and nurses, but they are not for life-threatening emergencies. They are open days and evenings and many have weekend and holiday hours. You don't need to make an appointment, just walk in. Care is given on a first-come, first-served basis.

Search for locations by going to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*; or call Customer Service.

Emergency care

A medical emergency is something that needs treatment right away. It requires prompt medical attention to: preserve life; avoid serious physical or mental harm; avoid serious damage to body functions, organs or parts; or because there is continuing severe pain. If you have an emergency, go to the emergency room. Emergency room services are usually offered at a hospital.

If your condition doesn't need treatment right away, go to your primary care clinic. If that office is closed, go to an urgent care or convenience care/retail health clinic. If you go to the emergency room, it will cost you a lot more than care elsewhere. It also may take more of your time because emergency rooms treat patients with the most serious cases first.

Please only go to the emergency room for true emergencies so the doctors and nurses are able to treat people with serious problems right away.

If you or a family member has one of the conditions listed below, go to an emergency room immediately or call 911.

Medical emergencies may include:

- Poisoning or drug overdose
- Trouble breathing or shortness of breath
- Pain or pressure in your chest or above your stomach
- Warning signs of stroke: sudden dizziness or change in vision; sudden weakness or numbness; trouble speaking or understanding speech
- Vomiting that won't stop
- Bleeding that won't stop after 10 minutes of pressure
- Coughing up blood or throwing up blood
- Sudden, sharp pain anywhere in the body
- Loss of consciousness or convulsions
- Broken bones or fractures
- Injury to your spine
- Major burns
- Wanting to hurt other people or yourself
- Change in mental status, such as unusual behavior

Medical emergencies are always covered at the in-network level, even if the provider is not in your plan's network.

Care when you travel

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If you travel out of Medica's service area and need care, you may be able to get in-network coverage by visiting a provider in our Travel Program Network. Find a Travel Program provider online. Go your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then click on *Find a physician or facility*. (Medica Choice Passport members can receive in-network coverage by seeing a provider in their plan's nationwide network).

Farm Bureau Members Only

Costs are always lowest when using network providers

Your costs are lowest when you choose a doctor or clinic that's in your Nebraska Farm Bureau Member Health Plan CHI network. Your network includes primary care physicians, specialists and hospitals near you. You are free to see any network physician or specialist without a referral from your primary care doctor.

If you choose to see a provider who's not in your plan's network, you will not have coverage (except for emergency care) and you will have to pay full cost for the services. For information about your costs, call Customer Service.

If you plan to travel outside the United States, contact Customer Service before leaving the country to find out about any special requirements for getting any care you may need. Your plan covers emergency medical treatment. Please see your coverage document for specific details.

Carry your Medica ID card when you travel. It has many important telephone numbers to help you access advice about your health care and coverage. Most Medica members who are ill can call the Medica nurse line for health care advice. If this service is available to you, the phone number will be listed on the back of your Medica ID card.

24-hour advisor and nurse line

Often, the help you need may be available by phone! Medica nurse line is staffed 24 hours a day, seven days a week. Advisors and nurses can answer your questions and recommend when you should make an appointment to see your doctor, go to a retail health clinic, an urgent care center or the emergency room.

Call Medica nurse line to:

- Talk with an experienced advisor or nurse
- Ask health care questions and learn self-care tips
- Get help finding a provider or an urgent care facility in your plan's network

If this service is available to you, the toll-free phone number is listed on your Medica ID card.

The information offered by Medica nurse line is not meant to provide a medical diagnosis or treatment. Always seek the advice of your doctor or other qualified health care provider if you have questions about a medical condition.

Pharmacy services: Your prescription drug benefits

The Medica drug list is comprised of drugs that provide the most value and have proven safety and effectiveness. This list is divided into three groups (generic, preferred brand and non-preferred brand), which determine your share of the costs. Generic drugs have the lowest copayment or coinsurance. The drug list is reviewed and updated regularly by independent physicians and pharmacists. If a drug is on the list, it does not guarantee coverage because certain limitations may apply. For more information or to see which drugs your plan covers, go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site.

Exception process

Please see your coverage document for specific information on your pharmacy benefits. Some plans may not offer an exception process.

The physicians and pharmacists who help develop and maintain the drug list try to include medications for all therapeutic needs. Still, there are times when you may need a medication that is not covered and your doctor may request an exception. We review these requests based on independent standards to determine when an exception will be granted. You and your doctor will be notified when an exception request is approved or denied.

MEETING YOUR INDIVIDUAL HEALTH CARE NEEDS

No two Medica members are alike or have exactly the same needs. That's why Medica offers additional services. We want to make it easier to access the care you need.

Interpreter services

Clear communication is important when talking about your insurance benefits. Do you need help in a language other than English? Customer Service can connect you with an interpreter. Medica works with a service that provides interpreter services in more than 150 languages. In some cases, you also may have

the right to receive certain written notices in a language other than English.

Services for TTY users

TTY users, call **711** to reach a representative who can answer your questions.

Continuity of care

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If your provider is not in your plan's network, you may not need to change providers immediately to receive the highest level of benefits.

When do you have a right to "continuity of care" with a doctor who is not in your plan's network? It can happen if Medica terminates its contract with your provider without cause.* It can also happen if you are a new Medica member because your employer changed health plans and your current provider is not in your plan's network.

** Note: Continuity of care does not apply when Medica terminates a provider's contract for cause.*

Continuity of care may apply:

1. If your health coverage changes or you have special health needs.

In certain situations, you may have a right to continue care with your current provider at the highest level of benefits.

Upon request, Medica may authorize continuity of care for up to 120 days for the following conditions:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy after the first trimester
- A physical or mental disability that prevents you from engaging in one or more major life activities, provided that the disability can be expected to last at least one year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase
- If you have a short life expectancy. Authorization to continue receiving services from your current provider may extend to the remainder of your life if a doctor certifies that your life expectancy is 180 days or less.

Farm Bureau Members Only

If Medica terminates its contract with your provider without cause,* you may not need to change providers immediately to receive the highest level of benefits.

**Note: Continuity of care does not apply when Medica terminates a provider's contract for cause.*

Continuity of care may apply:

1. If you are a member of a Nebraska Farm Bureau plan and you have special needs.

In certain situations, you may have a right to continue care with your current provider at the highest level of benefits. Medica may authorize continuity of care up to 90 days or until the active course of treatment is complete for the following conditions.

Medical criteria:

- An ongoing course of treatment for a life-threatening condition;
- An ongoing course of treatment for a serious acute condition, such as chemotherapy;
- Pregnancy in the second or third trimesters, through the postpartum period; or
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

Length of time treatment may be approved:

- Until the course of treatment is complete, or 90 days, whichever is shorter.
- Continuation of services treatment may extend to the remainder of the member's life, if life expectancy is 180 days or less.

2. If you have special language or culture needs.

Upon request, Medica may authorize continuity of care for up to 120 days:

- If you are receiving culturally appropriate services and Medica does not have a network provider who has special expertise in the delivery of those culturally appropriate services within certain time and distance requirements.
- If you do not speak English and Medica does not have a network provider who can communicate with you, either directly or through an interpreter, within certain time and distance requirements

3. If you are a member of a Wisconsin plan and your provider was a Medica network provider until recently.

Wisconsin members, you may be eligible for continuity of care if your provider was listed in your Medica provider directory at the last enrollment period. You may be able to continue receiving care from your primary care physician through the end of the current contract period. You may be able to continue receiving care from any other type of provider for up to 90 days. If you are in the second or third trimester of pregnancy, you may be able to continue care with your provider through post-partum care.

Your provider must agree to these requirements.

When a continuity of care request is made, your provider must agree to:

- Follow Medica's prior authorization requirements.
- Provide Medica with all necessary medical information related to your care.
- Accept as payment in full either Medica's network provider reimbursement or the provider's customary charge for this service, whichever is less.

How Medica makes a decision

We may require medical records or other supporting documents to review your request. We consider each request on a case-by-case basis. If your request is denied, we will explain the criteria we used to make our decision. Coverage will not be provided for services or treatments that are not otherwise covered.

If Medica authorizes your request to continue care with your current provider, Medica will explain how long continuity of care will be provided. After that time, your services or treatment will need to be moved to a provider in your plan's network for you to receive benefits at the highest level.

Please see your policy document for more information.

Advance directives: Making your wishes known

Laws on advance directives provide guidance about instructions you can write telling your doctors and family what kind of care you want if you are too sick to make health care decisions yourself.

An example of someone who is not able to make these decisions might be a person who has suffered a head injury and is in a coma. Another could be a patient with advanced Alzheimer's disease, or a person in the last stages of cancer.

An advance directive is a written instruction, such as a living will or health care power of attorney. Your instructions must be written and also must be signed by a witness. A living will tells others what kind of care you want if you are not able to tell them yourself. A health care power of attorney allows someone else you choose to make care decisions on your behalf.

Creating an advance directive is not difficult, and it helps protect your right to make choices about your medical care. It also helps your physician and family by providing guidelines for care.

Your Medica coverage does not require you to create advance directives. We are simply informing you of the option to do so, as required by law. For more information about advance directives, contact your state's agency on aging or visit their website.

KEEPING YOURSELF AND YOUR FAMILY HEALTHY

One of the easiest ways to prevent illness and stay healthy is to make sure all members of your family follow the recommendations for screenings, preventive services and immunizations. You may want to follow the guidelines developed by the U.S. Preventive Services Task Force. Go to [medica.com/prevention](https://www.medicare.com/prevention) to learn which routine or preventive services are recommended for you. It is important that you discuss your care needs with your doctor. Your family's health history may affect what care you need.

Please review your policy document to determine if or how these services are covered for you.

OUR ROLE IN YOUR HEALTH CARE

Keeping health care affordable

Note: The following two paragraphs apply only to members who have coverage under a health maintenance organization (HMO) plan. Please see your coverage document to determine whether this applies to you.

As a non-profit organization, Medica works with you and your doctor to help keep health care affordable and accessible.

HMOs must keep a reserve fund to provide quality healthcare coverage during a year when the organization does not make a profit. Medica uses a portion of any profit to improve health care coverage for our members.

Quality improvement

The Medica Quality Improvement program is made up of the projects and activities Medica performs to improve care, service, access and safety for our members. Medica chooses projects based on the best opportunities to improve care, service and safety for the greatest number of members.

These are just some of the areas we focus on:

- How can we help our members with chronic health problems?
- How can we help our members adopt healthy lifestyles and receive preventive care services?
- How can we help our members be sure the care they receive is safe?
- Do our complaint or grievances and appeals processes work fairly and efficiently?
- How can we improve Medica's work processes to serve our members better?

After a project is selected, a goal or measurement is established. The effectiveness of the improvement is measured throughout the project. Every three months, Medica prepares a progress report with updates on each project.

The Quality Improvement program is led by licensed physicians. Quality Improvement activities are supported by departments and staff throughout Medica. Medica's Quality Improvement Subcommittee directs and oversees the program. It reports to the Medical Committee of the Medica Board of Directors, which reports to the full Medica Board of Directors.

Medica always welcomes member feedback! If you'd like to share your comments or suggestions or would like more information about the Medica Quality Improvement program, please contact Customer Service at the numbers listed in the *Important phone numbers* section of this guide.

If you get a survey from Medica asking about care and services, we encourage you to respond. This information helps us measure how we are doing.

Care coordination

Medica supports quality, cost-effective health outcomes that meet the needs of our members. Care coordination involves many people working together with your health care provider. Together, they help evaluate the available care options before making decisions.

One aspect of care coordination is care support. We reach out by phone to members who have a critical event or diagnosis that requires using several health care resources. We will help you navigate the health care system to get the appropriate care and services for your needs.

A Medica case manager is a registered nurse or social worker who is able to help you with your medical, social and everyday needs. Your Medica case manager will work with you to create a plan to keep you healthy and safe in your home.

Utilization management is another care coordination service. Utilization management helps make sure that the care and services you are receiving are appropriate and covered by your plan. Otherwise coverage might be denied. It is used in a small number of cases. Sometimes this means you will get a call from a nurse because we want to help coordinate your care.

This is especially important if your Medica plan requires prior authorization from Medica before you get certain services.

If coverage for some service is denied, it is important for you to know that Medica does not reward anyone for denying coverage. The doctors or other people who decide whether a service or care is covered are paid the same, no matter what they decide. No one making these decisions is trying to limit or reduce your coverage. Keeping you healthy is very important. We want you to get the care you need. We do not want you to under-use the care available to you. That is why we so often recommend that members get checkups, health screenings and immunizations.

If you have questions or comments about case management or utilization management and wish to speak to a representative of the Health Services department, please contact Customer

Service at the numbers listed in the *Important phone numbers* section of this guide. Language assistance is available.

If coverage is denied, you can appeal. See the *How Do I File a Complaint?* section in your coverage document online. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site. Or call Customer Service for more information. The number is listed in the *Important phone numbers* section of this guide.

Referrals and prior authorization

Some health services require you or your provider to notify us before you have the service. Even if your doctor recommends you have the service or see an out-of-network provider, Medica may require that we approve the request before you have the appointment. This is known as "prior authorization." This also includes referrals to providers who are not in our network and certain types of network providers. You or your provider can contact Customer Service at the phone number listed on the back of your ID card.

Services that may require prior authorization from Medica include, but are not limited to:

- Certain reconstructive or restorative surgery
- Organ and bone marrow transplant
- Home health care
- Certain medical supplies and durable medical equipment

This is not a complete list. You can view more in your coverage document, available on your secure account. Go to your member portal (listed in the *Find What You Need Online* section of this booklet) and select your plan name (listed on your Medica ID card as *Care Type*), then log in to your secure member site or contact Customer Service for assistance.

If we deny coverage for a service, it is important for you to know that Medica does not reward anyone for denying coverage. Medica pays the doctors or other people who decide whether to cover a service or care the same, no matter what they decide. No one making these decisions tries to limit or reduce your coverage. Keeping you healthy is very important. We want you to get the care you need. We do not want you to under-use the care available to you. That is why we so often recommend that members get checkups, health screenings and immunizations.

If you have questions or comments about case management or utilization management and wish to speak to a representative

of the Health Services department, please contact Customer Service at the numbers listed in the *Important phone numbers* section of this guide.

If we deny coverage for a service you can appeal. See the *How Do I File a Complaint?* section in your coverage document. Or call Customer Service for more information. The number is listed in the *Important phone numbers* section of this guide. For more information about the appeal rights under your plan, see your coverage document. You may also contact us through our website at **medica.com**.

Clinical practice guidelines

Medica follows evidence-based clinical practice guidelines developed by the U.S. Preventive Services Task Force (**uspreventiveservicestaskforce.org**). Medica maintains clinical practice guidelines for all providers in our network. These guidelines are available online. Visit **medica.com/providers** and select *Policies and Guidelines*. Select *Preventive Services* from the list under *Clinical Guidelines*.

Evaluating the safety and effectiveness of new medical technologies and medications

Medica is interested in the newest advances in medicine, including behavioral health. We review new devices and procedures and new uses of existing technologies to decide if they are included in your coverage. Medica uses many sources to evaluate new medical technology and procedures and behavioral health treatments/therapies. We thoroughly review clinical and scientific evidence. We consider the technology's safety, effectiveness and effect on health outcomes. We also review laws and regulations and get input from local physician groups about community practice standards. Medica's main concern when making coverage decisions is whether a new technology or procedure will improve health care for our members.

Medica also continually reviews new medications and the use of existing medications for new medical conditions. Independent physicians and pharmacists from various specialties review medications in all therapeutic categories to determine whether to add them to the Medica drug list based on their safety, effectiveness and value. For more information about the drug list, see the *Pharmacy services* section of this guide.

COMPLAINTS AND APPEALS/ GRIEVANCES

There may be a time when we deny a claim, a prior authorization request or a request for services or care. We have formal complaint procedures outlined for each state. Your coverage document outlines the steps to file a complaint. Please follow these procedures if you want a decision to be reconsidered. You may also choose to designate a representative to act on your behalf. If you choose to do so, contact Medica for an *Appointment of Representation* form, which allows Medica to discuss your appeal with your designated representative.

How to file a complaint

You can file a complaint in writing or by telephone. For more information, call Customer Service at the number in the *Important phone numbers* section of this guide or refer to the number on the back of your ID card. Additionally, we investigate your complaints about quality of care problems, but Minnesota state law does not allow us to share details of the outcome of this review. State regulators in some states review quality of care cases involving Medica.

How to request an expedited review of a coverage decision

If your attending provider believes that Medica's decision requires a quicker review because a delay could seriously harm your life, health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment you are seeking, we will review your request and notify you and your provider of our decision no later than 72 hours after receiving the request.

MINNESOTA COMMERCIAL FULLY INSURED MEMBERS ONLY

Complaints and Appeals

Plan Type: Minnesota fully insured plans

First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to designate a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain an *Appointment of Representation* form, which will allow Medica to discuss your case with your designated representative. We will review any testimony, explanation or other information we receive from you, Medica staff members, providers or others.

For questions about your rights, this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also may file a complaint any time with the Department of Commerce. They can be reached at 651-539-1600 or 1-800-657-3602 (outside metro only) regarding insurance benefits.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

For more information or to request diagnosis or treatment codes related to a decision, please call Medica at the following phone numbers:

Mail: Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minnesota/St. Paul area: 952-945-8000
Outside Minneapolis/St. Paul area: 1-800-952-3455
TTY users, call 711.

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally, Medica will communicate a decision to you within 10 calendar days from receipt of the complaint. If you remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. If you need assistance with completing the complaint form Medica will help you. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, Medica will communicate a decision to you within 30 calendar days. If you remain dissatisfied with Medica's decision, you may pursue an appeal as described below under the section "Second Level of Review". Medica's second level of review must be completed before you have the right to submit a request for external review.

Procedures for complaints that require a medical determination:

1. If a decision was based on medical necessity, you have one year from the date of the decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 30 calendar days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level review is being conducted.

Second Level of Review

If you remain dissatisfied with Medica's decision after your first level review, you may pursue a second level of review. Your request must be submitted to Medica within one year following the date of Medica's first level review decision. Generally, the second level review is optional if the complaint requires a medical determination and you may file a request for external review. Medica will inform you whether the second level of review is optional or required.

1. Medica's Second Level of Review Options

- **Hearing.** Under this process, you present your case to a committee, either in person or in writing. If this second level of review is required, Medica will notify you of the decision within 30 calendar days of your appeal request. If the second level of review is optional, Medica will notify you of the decision within 45 calendar days of your appeal request.
- **Written reconsideration.** Under this process, the committee will review your appeal. Medica will notify you of the decision within 30 calendar days of your appeal request.

External Review

You may choose to have your case reviewed by an external review organization. This process is coordinated by the Minnesota Department of Commerce. The Minnesota Department of Commerce can be reached at locally at 651-539-1600 or their toll free number 800-657-3602. You may submit additional information to be reviewed by the external review organization. You must submit your written request for external review within six months from the date of Medica's decision. You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours.

The external review organization's decision is not binding on you, but it is binding on Medica. Medica may seek judicial review on grounds that the decision was arbitrary and capricious or involved an abuse of discretion. To make a request for external review, contact the Minnesota Department of Commerce at the numbers listed above. You must include a \$25 filing fee at the time of the request for external review, unless waived by the Department. The fee will be refunded if Medica's decision is completely overturned.

Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's appeal determination, you have the right to file a civil action suit under ERISA Section 502(a).

NORTH DAKOTA COMMERCIAL FULLY INSURED MEMBERS ONLY

Complaints and Appeals

Plan Type: North Dakota fully insured plans

Right to Appeal a Decision

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a first level appeal. You have one year from the date of the decision to file an appeal. Your appeal will be completed no later than 30 calendar days from receipt of your request. If waiting the standard 30-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level appeal review is being conducted.

You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain an *Appointment of Representation* form, which will allow Medica to discuss your appeal with your designated representative. We will review any testimony, explanation or other information we receive from you, Medica staff members, providers or others.

For questions about your rights, this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You may also file a complaint with your state regulator at any time. You may contact the North Dakota Insurance Commissioner at 1-800-247-0560 to file a complaint.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

For more information or to request diagnosis or treatment codes related to a decision, please call Medica at the following phone numbers:

Mail: Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minnesota/St. Paul area: 952-945-8000
Outside Minneapolis/St. Paul area: 1-800-952-3455
TTY users, call 711.

Additional Levels of Review

If you remain dissatisfied with Medica's decision after your first level appeal, you may pursue additional levels of review. You have the option of requesting a voluntary second level appeal. The Medica second level of review is optional. You may also request an independent review of Medica's decision by an external review organization upon completion of either your first level or second level appeal if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination.

Below is a description of Medica's Voluntary Second Level of Review and External Review Procedures:

1. Medica's Voluntary Second Level of Review Options

- Hearing or file review. If you would like to request a voluntary second level appeal, your request must be submitted in writing to Medica within one year following the date of Medica's first level review decision. To file a request for a second level appeal, additional information or assistance, please contact Medica at the address and telephone numbers listed above. Under this process, you present your case to a committee, either in person or in writing. Medica will notify you of its decision within 45 calendar days of your appeal request.

2. External Review Option

For decisions that involve a medical necessity or experimental/investigative determination, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. Your request must be submitted in writing to the North Dakota Commissioner within four (4) months following the date of Medica's review decision. An independent entity designated by the North Dakota Commissioner of Insurance will conduct the external review. You may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 45 days from when your request is received. If waiting the standard 45-day turnaround time might jeopardize your life, health or ability to regain maximum function, or you received emergency services and have not been discharged from the facility, you or your attending provider may request an expedited, 72-hour external review. You must include a \$25 filing fee at the time of the request for external review, unless waived by the Commissioner. The fee will be refunded if Medica's decision is completely overturned. To submit a request for external review, contact North Dakota Commissioner of Insurance at the following address:

North Dakota Commissioner of Insurance
600 E. Boulevard Avenue
Bismarck, ND 58505

Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's appeal determination, you have the right to file a civil action suit under ERISA Section 502(a).

SOUTH DAKOTA COMMERCIAL FULLY INSURED MEMBERS ONLY

Complaints and Appeals

Plan Type: South Dakota fully insured plans

Right to Appeal a Decision

If you are dissatisfied with Medica's decision, you can call or write us at the telephone numbers and address listed below to request a first level appeal. You have one year from the date of the decision to file an appeal. Medica will provide written notice of its first level review decision to you within 30 calendar days from receipt of your request. For pre-service appeals, if Medica does not issue a decision within 30 days, you have the right to request an external review, as described below. If waiting the standard 30-day turnaround time might jeopardize your health or your ability to retain maximum function, or your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment you are requesting, you or your attending provider may request an expedited, 72-hour appeal review. In such cases, you may also have the right to request an external review while your first level appeal review is being conducted.

You may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you choose to do so, contact Medica to obtain an *Appointment of Representation* form, which will allow Medica to discuss your appeal with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or for employer group plans not governed by ERISA, you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789. You also have the right at any time during this process to file a complaint with the South Dakota Division of Insurance. They can be reached at: South Dakota Division of Insurance, Department of Revenue and Regulations, 124 S. Euclid Ave., 2nd Floor, Pierre, SD 57501. Telephone 605-773-3563 and Fax 605-773-5369.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St. Paul area: 952-945-8000
Outside Minneapolis/St. Paul area: 1-800-952-3455
TTY users, call 711.

Additional Levels of Review

If you remain dissatisfied with Medica's decision after your first level appeal, you may pursue additional levels of review. You have the option of requesting a voluntary second level appeal. The Medica second level of review is optional. You may also request an independent review of Medica's decision by an external review organization upon completion of either your first level or second level appeal if your case involves medical necessity, investigative/experimental procedures or a rescission of a policy determination.

Below is a description of Medica's Voluntary Second Level of Review and External Review Procedures:

1. Medica's Voluntary Second Level of Review Options

- **Hearing or file review.** If you would like to request a voluntary second level appeal, your request must be submitted in writing to Medica within 4 months following the date of Medica's first level review decision. To file a request for a second level appeal, additional information or assistance, please contact Medica at the address and telephone numbers listed above. Under this process, you present your case to a committee, either in person or in writing. Medica will notify you of its decision within 45 calendar days of your appeal request.

2. External Review Option

For decisions that involve a medical necessity or experimental/investigative determination, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an independent health care professional at an external review organization. This process is coordinated by the South Dakota Division of Insurance. Your request must be submitted in writing to the South Dakota Division of Insurance within four (4) months following the date of Medica's review decision. You may submit additional information to the external review organization. You will be notified of the external review organization's decision within 45 days from when we receive your request. However, (a) if waiting the standard 45-day turnaround time might jeopardize your health or your ability to regain maximum function; (b) if you received emergency services and you have not been discharged from the facility; or (c) for investigative/experimental procedures where your physician certifies in writing that treatment would be less effective if not promptly initiated, you or your attending provider may request an expedited, 72-hour external review. In the case of a request for an expedited external review, you may make your request orally directly to South Dakota Division of Insurance at the numbers listed above.

The external review organization's decision is binding on you and on Medica. Only one external review request is permitted for each adverse determination. To make a request for external review, contact Medica Customer Service or the South Dakota Division of Insurance at the numbers listed above to obtain an "External Review Request" form. You must submit the form to the South Dakota Division of Insurance to request an external review. You must include a \$25 filing fee made payable to South Dakota Division of Insurance at the time of the request for external review.

Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's appeal determination, you have the right to file a civil action suit under ERISA Section 502(a).

WISCONSIN COMMERCIAL FULLY INSURED MEMBERS ONLY

Complaints and Appeals

Plan Type: Wisconsin fully insured plans

Right to File a Complaint

If you are not satisfied with how Medica provides services or administers your benefits, you can call Customer Service at the phone numbers below. Our representatives can explain your benefits and any administrative procedures, address your questions and informally resolve complaints. If we cannot resolve the complaint to your satisfaction through this informal process, you have the right to file a formal grievance with Medica.

At any time you also have the right to file a complaint with the Office of the Wisconsin Commissioner of Insurance by calling 1-800-236-8517. If you have questions about your rights or this notice, or if you need assistance, contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Or, for employer group plans not governed by the Employee Retirement Income Security Act of 1974 (ERISA), you can contact the Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789.

Right to File a Grievance

To file a grievance, write down your concerns and mail or deliver your grievance (in any form) to Medica at the address below. Include copies of any supporting documents. If you need help, someone else can write on your behalf, including a Medica Customer Service representative.

At any time during the process, you may designate someone to act on your behalf. If you choose this option, contact Medica to obtain an *Appointment of Representation* form. This allows us to discuss your grievance with the person you designate. A grievance panel will review any testimony, explanation or other information we receive from you, Medica staff members, providers or others. You may choose one of the following options for your grievance.

Medica's Grievance Process:

You present your case to a grievance panel, either in person (a hearing) or in writing (a file review). Medica will notify you of its decision within 30 calendar days of the date from when your request for a hearing or file review is received.

You or your health care provider may request an expedited 72-hour grievance review if:

- waiting the standard 30 days might jeopardize your life, health or ability to regain maximum function; or would subject you to severe pain that cannot be managed without the care or treatment you are asking for; or
- a physician with knowledge of your medical condition determines that the grievance should be expedited.

In such cases, you also may have the right to request an external review while we review your grievance.

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Customer Service, Route 0501, PO Box 9310, Minneapolis MN 55440-9310

Telephone: Minneapolis/St. Paul area: 952-945-8000
Outside Minneapolis/St. Paul area: 1-800-952-3455
TTY users, call 711.

Right to External Review

You or a person you designate have the right to request an independent external review if your claim involves:

- an adverse determination (a decision that involves a medical necessity determination),
- experimental treatment (a treatment that is not yet proven to be effective), or
- a rescission (cancellation) of your coverage.

You have four months from the date of the grievance determination letter to request an external review. Medica will coordinate this review.

You may submit additional information for the external review organization to consider. The review organization will notify you of their decision within 45 calendar days. If waiting the standard 45 days might jeopardize your life, health or ability to regain maximum function, or subject you to severe pain that cannot be managed without the care or treatment you are asking for, you or your health care provider may request a 72-hour expedited review.

The decision by the external review organization is binding (final) for both you and for Medica. For more information or to request an external review, contact us at the address and phone numbers listed.

Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's grievance determination, you have the right to file a civil action suit under ERISA Section 502(a).

FARM BUREAU MEMBERS ONLY

Complaints and Appeals

Nebraska Farm Bureau

Information Related to this Decision

If you have any questions related to this claim, please refer to your Policy or contact Medica Customer Service at the phone numbers or address listed below.

First Level of Review

If you are dissatisfied with Medica's decision, you can call or write us at the phone numbers and address listed below to request a review. You may choose to appoint a representative to act on your behalf at any time during the review process or external review process. If you choose to do so, contact Medica to obtain a *Appointment of Representation* form, which will allow Medica to discuss your case with your authorized representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others.

You also have the right at any time to file a complaint with the Nebraska Department of Insurance at 1-877-564-7323. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

At any time and at no cost to you, you may request a written copy from Medica of:

- The rule or guideline used to make our decision,
- The clinical judgment used to apply the terms of your plan to your medical circumstances, and
- Any other document or information related to this review.

To request an appeal, additional information, if you need diagnosis and/or treatment code information regarding the services referenced in this communication or assistance, please contact Medica at the following address and telephone numbers:

Mail: Medica Customer Service, Route CP595, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-838-4517

TTY users, please call 711

Procedures for complaints that do not involve a medical determination:

1. If you contact Medica to express a complaint verbally and remain dissatisfied with Medica's decision, Medica will provide you with a complaint form to submit your complaint in writing. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, you have one year from the date of the decision to file an appeal. The written complaint is considered a first level review. Medica will communicate a decision to you within 15 business days. If Medica cannot make a decision within 15 business days, you will be notified of the reason and Medica may take up to an additional 15 business days to issue a written decision to you.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have 180 days from the date of the decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level review. Your appeal will be completed no later than 15 business days from receipt of your request. Your attending provider may request an expedited, 72 -hour appeal review, if he/she believes it is warranted. You may also request an expedited review if waiting the standard 15-day turnaround time might jeopardize your life, health or ability to regain maximum function, or if this timeframe would subject you to severe pain that cannot be managed without the care or treatment you are requesting. In such cases, you may also have the right to request an external review while your first level review is being conducted.

External Review

If your claim involves an adverse determination, investigative/experimental treatment, or a rescission of a policy, you or your authorized representative have four months from the date of the appeal determination letter to file a request for an independent external review. This process is coordinated through the Nebraska Insurance Division. You should submit your written request to Nebraska Department of Insurance at P.O. Box 82089, Lincoln, NE 68501-2089 (www.doi.nebraska.gov). You may submit additional information to be reviewed by the external review organization.

You will be notified of the review organization's decision within 45 days. If an expedited review is requested and approved, a decision will be provided within 72 hours. The external review organization's decision is binding on you and Medica.

Right to Civil Action

If your employer group plan is governed by ERISA and you are not satisfied with Medica's appeal determination, you have the right to file a civil action suit under ERISA Section 502(a). No civil action for benefits may be brought more than three years after the time a claim for benefits is required to have been submitted under your plan.

APPENDIX

How Medica protects your privacy

Effective: June 11, 2003

Revised: September 23, 2013

Summary

There are several state and federal laws requiring Medica Health Plans, Medica Health Plans of Wisconsin and Medica Insurance Company (collectively, "Medica") to protect its members' personal health information. The most comprehensive regulations were issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These regulations have been updated from time to time. Essentially, HIPAA regulations require entities like Medica to provide you with information about how your protected health information may be used and disclosed, and to whom. This notice explains what your protected health information is. Regulations also describe how Medica must protect this information and how you can access your protected health information. Medica must follow the terms of its privacy notice. Medica may also change or amend its privacy notice as the laws and regulations change. However, if the notice is materially changed, Medica will make the revised privacy notice available to you.

There are also state and federal laws requiring Medica to protect your non-public personal *financial* information. The most comprehensive regulations were issued under the Gramm-Leach-Bliley Act ("GLBA"). The GLBA requires Medica to provide you with a notice about how your non-public personal financial information may be used and disclosed, and to whom.

When the law permits use and disclosure

The law permits Medica to use and disclose your personal health information for purposes of treatment, payment and health care operations without first obtaining your authorization. There are other limited circumstances when Medica may use and disclose your personal health information without your authorization, such as public health, regulatory and law enforcement activities. Whether personal health information is used or disclosed with or without your authorization, Medica uses and discloses personal health information only to those persons who need to know and only the minimum amount necessary to perform the required activity.

Your privacy rights

The law also gives you rights to access, copy and amend your personal health information. You have the right to

request restrictions on certain uses and disclosures of your personal health information. You also have the right to obtain information about how and when your personal health information has been used and disclosed.

These duties, responsibilities and rights are described in more detail below.

Medica Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED UNDER STATE AND FEDERAL LAW, INCLUDING HIPAA, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

What is PHI?

Medica is committed to protecting and maintaining the privacy and confidentiality of information that relates to your past, present or future physical or mental health, health care services and payment for those services. HIPAA refers to this information as "protected health information" or "PHI." PHI includes information related to diagnosis and treatment plans, as well as demographic information such as name, address, telephone number, age, date of birth and health history.

How does Medica protect your PHI?

Medica takes its responsibility of protecting your PHI seriously. Where possible, Medica de-identifies PHI. Medica uses and discloses only the minimum amount of PHI necessary for treatment, payment and operations, or to comply with legal or similar requirements. In addition to physical and technical safeguards, Medica has administrative safeguards such as policies and procedures that require Medica's employees to protect your PHI. Medica also provides training on privacy and security to its employees.

Medica protects the PHI of former members just as it protects the PHI of current members.

Under what circumstances does Medica use or disclose PHI?

Medica receives, maintains, uses and shares PHI only as needed to conduct or support: (i) treatment related activities, such as referring you to a doctor; (ii) payment-related activities, such as paying a claim for medical services; and (iii) health care operations, such as developing wellness programs. Additional examples of these activities include:

- Enrollment and eligibility, benefits management and utilization management
- Customer services
- Coordination of care
- Health improvement and disease management (for example, sending information on treatment alternatives or other health-related benefits)
- Premium billing and claims administration
- Complaints and appeals, underwriting, actuarial studies and premium rating (however, Medica is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes)
- Credentialing and quality assurance
- Business planning or management and general administrative activities (for example, employee training and supervision, legal consultation, accounting, auditing)
- Medica may, from time to time, contact you with important information about your health plan benefits. Such contacts may include telephone, mail or electronic mail messages.

With whom does Medica share PHI?

Medica shares PHI for treatment, payment and health care operations with your health care providers and other businesses that assist it in its operations. These businesses are called “business associates” in the HIPAA regulations. Medica requires these business associates to follow the same laws and regulations that Medica follows.

Public health, law enforcement and health care oversight.

There are also other activities where the law allows or requires Medica to use or disclose your PHI without your authorization.

Examples of these activities include:

- Public health activities (such as disease intervention);
- Health care oversight activities required by law or regulation (such as professional licensing, member satisfaction surveys, quality surveys or insurance regulation);
- Law enforcement purposes (such as fraud prevention or in response to a subpoena or court order);
- Assisting in the avoidance of a serious and imminent threat to health or safety; and
- Reporting instances of abuse, neglect, domestic violence or other crimes.

Employee Benefit Plans. Medica has policies that limit the disclosure of PHI to employers. However, Medica must share some PHI (for example, enrollment information) with a group policyholder to administer its business. The group policyholder is responsible for protecting the PHI from being used for purposes other than health plan benefits.

Research. Medica may use or release PHI for research. Medica will ensure that only the minimum amount of information that identifies you will be disclosed or used for research. HIPAA allows Medica to disclose a very limited amount of your PHI, called a “limited data set” for research without your authorization. You have the right to opt-out of disclosing your PHI for research by contacting Medica as described below. If Medica uses any identifiers, Medica will request your permission first.

Family Members. Under some circumstances Medica may disclose information about you to a family member. However, Medica cannot disclose information about one spouse to another spouse, without permission. Medica may disclose some information about minor children to their parents. You should know, however, that state laws do not allow Medica to disclose certain information about minors—even to their parents.

When does Medica need your permission to use or disclose your PHI?

From time to time, Medica may need to use or disclose PHI where the laws require Medica to get your permission. Medica will not be able to release the PHI until you have provided a valid authorization. In this situation, you do not have to allow Medica to use or disclose your PHI. Medica will not take any action against you if you decide not to give your permission. You, or someone you authorize (such as under a power of attorney or court-appointed guardian), may cancel an authorization you have given, except to the extent that Medica has already relied on and acted on your permission.

Your authorization is generally required for uses and disclosures of PHI not described in this notice, as well as uses and disclosures in connection with:

- Psychotherapy Notes. Medica must obtain your permission before making most uses and disclosures of psychotherapy notes.
- Marketing. Subject to limited exceptions, Medica must also obtain your permission before using or disclosing your PHI for marketing purposes.
- Sales. Additionally, Medica is not permitted to sell your PHI without your permission. However, there are some limited

exceptions to this rule—such as where the purpose of the disclosure of PHI is for research or public health activities.

What are your rights to your PHI?

You have the following rights with regard to the PHI that Medica has about you. You, or your personal representative on your behalf, may:

Request restrictions of disclosure. You may ask Medica to limit how it uses and discloses PHI about you. Your request must be in writing and be specific as to the restriction requested and to whom it applies. Medica is not required to always agree to your restriction. However, if Medica does agree, Medica will abide by your request.

Request confidential communications. You may ask Medica to send your PHI to a different address or by fax instead of mail. Your request must be in writing. Medica will agree to your request if it is able.

Inspect or obtain a copy of your PHI. Medica keeps a designated record set of its members' medical records, billing records, enrollment information and other PHI used to make decisions about members and their benefits. You have the right to inspect and get a copy of your PHI maintained in this designated record set. Your request must be in writing on Medica's form. If the PHI is maintained electronically in a designated record set, you have a right to obtain a copy of it in electronic form. Medica will respond to your request within thirty (30) days of receipt. Medica may charge you a reasonable amount for providing copies. You should know that not all the information Medica maintains is available to you and there are certain times when other individuals, such as your doctor, may ask Medica not to disclose information to you.

Request a change to your PHI. If you think there is a mistake in your PHI or information is missing, you may send Medica a written request to make a correction or addition. Medica may not be able to agree to make the change. For example, if Medica received the information from a clinic, Medica cannot change the clinic information—only the clinic can. If Medica cannot make the change, it will let you know within thirty (30) days. You may send a statement explaining why you disagree, and Medica will respond to you. Your request, Medica's disagreement and your statement of disagreement will be maintained in Medica's designated record set.

Request an accounting of disclosures. You have the right to receive a list of disclosures Medica has made of your PHI. There are certain disclosures Medica does not have to track. For example, Medica is not required to list the times it disclosed your PHI when you gave Medica permission to disclose it. Medica is also not required to identify disclosures

it made that go back more than six (6) years from the date you asked for the listing.

Receive a notice in the event of a breach. Medica will notify you, as required under federal regulations, of an unauthorized release, access, use or disclosure of your PHI. "Unauthorized" means that the release, access, use or disclosure was not authorized by you or permitted by law without your authorization. The federal regulations further define what is and what is not a "breach." Not every violation of HIPAA, therefore, will constitute a breach requiring a notice.

Request a copy of this notice. You may ask for a separate paper copy of this notice.

TO EXERCISE ANY OF THESE RIGHTS, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

File a complaint or grievance about Medica's privacy practices. If you feel your privacy rights have been violated by Medica, you may file a complaint. You will not be retaliated against for filing a complaint. To file a complaint with Medica, please contact Customer Service at the contact information listed above. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. To do so, write to the Office for Civil Rights, U.S. Department of Health & Human Services, 233 N. Michigan Ave. Suite 240, Chicago, IL 60601.

About this notice

Medica is required by law to maintain the privacy of PHI and to provide this notice. Medica is required to follow the terms and conditions of this notice. However, Medica may change this notice and its privacy practices, as long as the change is consistent with state and federal law. If Medica makes a material change to this notice, it will make the revised notice available to you within sixty (60) days of such change.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE EXPLAINS HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS INTENDED FOR MEDICA MEMBERS.

How does Medica protect your information?

Medica takes its responsibility of protecting your information seriously. Medica maintains measures to protect your information from unauthorized use or disclosure. These measures include the use of policies and procedures, physical,

electronic and procedural safeguards, secured files and buildings and restrictions on who and how your information may be accessed.

What information does Medica collect?

Medica may collect information about you including your name, street address, telephone number, date of birth, medical information, social security number, premium payment and claims history information.

How does Medica collect your information?

Medica collects information about you in a variety of ways. Medica obtains such information about you from:

- You, on your application for insurance coverage
- You, concerning your transactions with Medica, its affiliates or others
- Your physician, health care provider or other participants in the health care system
- Your employer
- Other third parties

Under what circumstances does Medica use or disclose non-public personal financial information?

Medica uses your non-public financial information for its everyday business operations. This includes using your information to perform certain activities in order to implement and administer the product or service in which you are enrolled. Examples of these activities include enrollment, customer service, processing premium payment, claims payment transactions and benefit management.

Medica may disclose your information to the following entities for the following purposes:

- To Medica's affiliates to provide certain products and services.
- To Medica's contracted vendors who provide certain products and services on Medica's behalf.
- To a regulatory authority, government agency or a law enforcement official as permitted or required by law, subpoena or court order.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT CUSTOMER SERVICE AT THE TELEPHONE NUMBER ON THE BACK OF YOUR MEDICA ID CARD, OR CONTACT MEDICA AT P.O. BOX 9310, MINNEAPOLIS, MN 55440-9310.

Authorization for routine business purposes

Upon enrollment, you authorized Medica to use and disclose your personal health information for routine business purposes. As long as you are continually insured by Medica, that authorization serves as your consent to allow Medica to use your information in such circumstances.

Member rights and responsibilities

As a Medica member, you have the right to:

1. Available and accessible services, including emergency services (defined in your coverage document) 24 hours a day, seven days a week;
2. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage;
3. Participate with providers in making decisions about your health care, including the right to refuse treatment recommended to you by Medica or any provider;
4. Be treated with respect and recognition of your dignity, and privacy of your medical and financial records maintained by Medica or any network provider in accordance with existing law;
5. Voice complaints or file an appeal about Medica and/or the care provided. File a complaint about issues related to benefits. Contact the state regulator listed on the back of your Medica ID card. Or review the Complaints and appeals/grievances section of this guide. You may also contact Customer Service for more information about filing a complaint or how to begin legal proceedings. You may begin a legal proceeding if you have a problem with Medica or any provider; and
6. Receive information about Medica, its services, its network providers, and members' rights and responsibilities. Make recommendations regarding the Medica member rights and responsibility policy

Member responsibilities:

To increase the likelihood that you maintain good health and receive the best quality care, it is important that you take an active role in your health care by:

1. Establishing a relationship with a network provider before becoming ill, as this allows for continuity of care;

2. Providing information health care professionals need to determine the appropriate care. This objective is best obtained when you share:
 - a. Information about lifestyle practices; and
 - b. Personal health history;
3. Following the plans and instructions for care that have been mutually agreed upon with practitioners providing health care.
4. Practicing self-care by knowing:
 - a. How to recognize common health problems and what to do when they occur;
 - b. When and where to seek appropriate help; and
 - c. How to prevent health problems from recurring;
5. Practicing preventive health care by:
 - a. Having the appropriate tests, exams and immunizations recommended for your gender and age as described in your coverage document; and
 - b. Engaging in healthy lifestyle choices (such as exercise, proper diet and rest).

Medica has identified some additional rights and responsibilities, including your:

1. Right to privacy.
2. Right to make recommendations regarding Medica's members' rights and responsibilities statement.
3. Responsibility to participate in understanding your health problems, participate in developing mutually agreed-upon treatment goals to the degree possible and to follow the plans that you have agreed on with your health care professional.

How Medica pays health care providers

Network providers

Network providers are paid using various types of contractual arrangements, which are intended to promote the delivery of health care in a cost-efficient and effective manner. These arrangements are not intended to affect your access to health care. These payment methods may include:

- A fee-for-service method, such as per service or percentage of charges;
- A risk-sharing arrangement, such as an amount per day, per stay, per episode, per case, per period of illness, per member or per service with targeted outcome; or
- A pay-for-performance program.

The methods by which specific network providers are paid may change from time to time. Methods also vary by network providers.

Fee-for-service

Fee-for-service payment means that the network provider is paid a fee for each service provided. If the payment is per service, the network provider's payment is determined according to a set fee schedule. The amount the network provider receives is the lesser of the fee schedule or what the network provider would have otherwise billed. If the payment is percentage of charges, the network provider's payment is a set percentage of the provider's charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

Risk-sharing

Risk-sharing payment means that the network provider is paid a specific amount for a particular unit of service, such as an amount per day, per stay, per episode, per case, per period of illness, per member or per service with targeted outcome. If the amount paid is less than the cost of providing or arranging for a member's health services, the network provider may bear some of the shortfall. If the amount paid to the network provider is more than the cost of providing or arranging a member's health services, the network provider may keep some of the excess. In other risk-sharing arrangements, the network provider accepts a portion of the financial risk for the provision of covered services to all members enrolled in a particular Medica product.

Non-network providers

When a service from a non-network provider is covered, the non-network provider is paid a fee for each covered service that is provided. This payment may be less than the charges billed by the non-network provider. If this happens, members are responsible for paying the difference. Go to [medica.com/MemberTips](https://www.medica.com/MemberTips) to find more information.

MEDICA FINANCIALS

The chart on the next page has important information for all Medica members. We hope you will take a moment to read it. On the right is a list of Medica's assets, liabilities, revenue and expenses for the 2017 fiscal year. Beside that are the results for 2018. By comparing the 2018 results to 2017, you can see how Medica has performed in each category.

HERE ARE SOME KEY TERMS

Assets:

Items of value that Medica owns

Expenses:

Costs of providing health care benefits to members

Liabilities:

Amounts Medica owes on the assets

Net Assets:

The net worth of the company

Net Income:

Income after taxes

Revenue:

Premiums and fees collected for providing health care coverage and administrative services

2018 FINANCIAL STATEMENT

Combined Balance Sheet (in thousands):	December 31,	
	2018	2017
Assets:		
Cash and investments	1,716,141	1,140,675
Other assets	573,313	413,027
Total Assets	\$2,289,454	\$1,553,702
Liabilities and Net Assets:		
Claims payable	540,533	356,031
Other liabilities	594,750	300,886
Total Liabilities	1,135,283	656,917
Net Assets	1,154,171	896,785
Total Liabilities and Net Assets	\$2,289,454	\$1,553,702
Combined Statement of Operation and Changes in Net Assets (in thousands):	December 31,	
	2018	2017
Revenue:		
Premiums, net of reinsurance	4,351,496	3,724,868
Administrative service contract fees	145,080	116,715
Total Revenue	\$4,496,576	\$3,841,583
Expenses:		
Medical and other benefits, net of reinsurance	3,413,888	3,189,270
Other operating expenses	687,223	485,742
Total Expenses	\$4,101,111	\$3,675,012
Operating Income	\$395,465	166,571
Investment income, income taxes and other non-operating expenses	(108,222)	(10,245)
Net unrealized gains (losses) on investment	(29,857)	2,650
Change in Net Assets	\$257,386	158,976

Above financial statements are compiled and consolidated under Generally Accepted Accounting Principles.

IMPORTANT PHONE NUMBERS



Customer Service - Commercial Fully Insured Members

Customer Service is available to answer questions about your plan 7 a.m. - 8 p.m. Central, Monday through Friday (closed 8-9 a.m. Thursday) and 9 a.m. - 3 p.m. Central, Saturday.

Please have your Medica ID card available when you call.

- Call the number on the back of your ID card. Or call Medica's general Customer Service number at **952-945-8000** or **1-800-952-3455** (TTY users, call **711**).
- If you don't have an ID card and don't know your member ID number, simply stay on the line until after the recorded message and a representative will help you.
- Some plans have their own dedicated Customer Service phone number. If yours does, you'll find it on your ID card.

Behavioral Health Services - Commercial Fully Insured Members

If you or a family member needs mental health or substance abuse services, contact Medica Behavioral Health at **1-800-848-8327** (TTY users call **711**).

Please have your ID card available when you call.

Medica CallLink - Commercial Fully Insured Members

Medica CallLink®* connects you with advisors and nurses. Get trusted answers, information and support for a wide range of health concerns.

Call the number on the back of your ID card 24 hours a day, seven days a week, or call **1-800-962-9497** (TTY users call **711**).

You can also chat live online with an advisor or nurse by logging on to **mymedica.com**.

**Medica CallLink may not be included in all plans.*

Customer Service – Farm Bureau Members Only

Customer Service is available to answer questions about your plan 8 a.m. - 6 p.m. Central, Monday through Friday (9 a.m. - 6 p.m. Central, Thursday).

Call the Customer Service number on the back of your ID card. Or call **1-888-838-4517** (TTY users, call **711**).

Health Advocate NurseLine – Farm Bureau Members

Health AdvocateSM NurseLine connects you with advisors and nurses. Get trusted answers, information and support for a wide range of health concerns.

Call the number on the back of your ID card 24 hours a day, seven days a week, or call **1-866-668-6548** (TTY users, call **711**).

You can also chat live online with an advisor or nurse by logging on to **medica.com/FarmBureauLogin**.

