Implementation/Administrative Guide for Fully Insured Employers

For employers headquartered in IA and NE

Medica®

Introduction

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

What to expect:

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

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

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Administrative resources

Telephone + email support

The Employer Service Center is the place to call when you have questions about benefits, enrollment, claims and more — and need answers fast. It's also your best resource for routine, day-to-day questions and concerns.

Phone: **1 (866) 894-8052** (TTY: **711**)
Fax: **(952) 992-3199**
Email: **MedicaServiceCenter@Medica.com**

Hours of Operation:
Monday-Wednesday and Friday from 8 a.m. to 5 p.m.
Thursday from 9 a.m. to 5 p.m.

Online support

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

Medica Employer Services

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

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

- Medica Employer Services eBilling
- Medica Employer Services Enrollment

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

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

Have a general question about Medica Employer Services or experience a technical issue? Contact Medica Employer Services customer support at **1 (866) 894-8052.**

Emails from Medica

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

- Medica Employer Services: **DoNotReply@BenefitFocus.com**
- Electronic monthly administrative invoice ready notification: **DoNotReply@BenefitFocus.com**
- Medica Employer Communications: **Employer.Comm@Email-Medica.com**
- My Health Rewards by Medica: **Medica@HealthyEmail.com**
- Medica CDH: @healthaccountservices.com
- Medica ONESource: @healthaccountservices.com
- Medica Do Not Reply: @healthaccountservices.com
- Delta Dental products available to Medica groups: **DeltaDentalConnect@DeltaDentalNE.org**
- Be.Well by Medica: **MedicaMemberComm@Email-Medica.com**
- Virgin Pulse: @virginpulse.com

Keeping in touch

Stay in the loop about important Medica developments, insurance industry news, fun and informative events and more through *Employer Update*, Medica's monthly employer e-newsletter.

Visit **Medica.com/Employers** for a variety of resources to help administer your plan, including: forms, worksite wellness resources, member materials and more.

Our **Monthly Health and Wellness Toolkit** focuses on select topics and Medica resources each month to raise awareness about care services and encourage healthy living.

Tell us how we can help. If there's an issue you'd like us to address, email us at **Employer.Comm@Medica.com**. You can also visit our **Employer News and Events webpage** to access past issues of *Employer Update*, view recorded trainings, and see upcoming trainings.

Getting started

Account setup

There are multiple ways to set up your plans through groups, subgroups, and divisions depending on the needs of your group.

Group ID

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

Foundational structure document

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

Reporting requirements

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

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

Subgroups or divisions

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

Billing requirements

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

Account Name: Joe's Garage

Group ID: A12345

Subgroup: Joe's Garage – Hill Valley

Subgroup ID: A12345-123

Subgroup: Joe's Garage – Great Falls

Subgroup ID: A12345-124

Billing invoices can be run at the group or subgroup level.

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

Master group contract

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

- The contract's effective date
- Termination provisions of the contract
- Your responsibilities as an employer under the contract
- Billing information

Medica identification (ID cards)

Medica ID cards are mailed within three to ten business days. Members will receive two ID cards per family*. If members require additional cards they can log in to **Medica.com/SignIn** or contact Member Services to request them.

**Medica will automatically issue additional ID cards for any dependents over the age of 16.*

Alternate member ID number

To protect your employees' and their dependents' confidential health care information, we've replaced the Social Security Number (SSN) as the primary identifier for them with an alternate 12-digit ID number. While you will still provide us the SSN of each enrollee, we will assign an alternate ID for each enrollee record. This eliminates the public disclosure of SSNs on any external enrollee communications including all correspondence, websites, ID cards, letters and Explanations of Benefits.

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

Next steps for employees

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

Register

Employees should register at **Medica.com/SignIn** to sign up for the Medica programs and services that help them take charge of their benefits and make informed decisions about their health.

Understanding the plan

Urge employees to take the time to understand their plan by reviewing the information upon arrival. Emphasize the importance of examining details such as copays, coinsurance, and out-of-pocket costs. It's crucial for them to grasp how seeking care from an out-of-network provider might impact costs, and to be aware of coverage details while traveling.

Know where to go for help and information

Questions are sure to come up when employees start using their plan. Help them out by promoting these helpful Medica resources:

- Member Services – Open 7 a.m. to 8 p.m. CT, Monday through Friday (closed 8 a.m. to 9 a.m. Thursdays), and Saturday from 9 a.m. to 3 p.m. Employees can find the phone number on the back their ID card.
- **Medica.com/SignIn** – Members can login to find personal health plan documents, links to pharmacy information, coverage information and health and wellness information.

Translation services

Medica wants to ensure all of your employees can make informed decisions about their care and benefits, regardless of their native language. The preferred method to help our members who aren't fluent in English is to direct them to Medica Member Services, where they can identify their language choice. We've developed email messages in 11 languages that direct non-English-speaking members to call Medica Member Services for access to an interpreter. Contact your account representative to request the email message(s).

Eligibility administration

COBRA

When an employee terminates their Medica coverage, please complete the termination immediately using Medica Employer Services. You don't need to wait until the end of their COBRA election period.

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

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

Medicare Part D

Medicare Part D notices are sent by Medica annually. Notices are required each year to be sent prior to Medicare open enrollment which starts Oct. 15. Medica completes the mailing by late September to early October. The notice is mailed to all subscribers. The notice will include details on the creditable or non-creditable status of the member's prescription drug coverage. Employers will be mailed a cover letter and sample notices prior to the mailing so they will be aware of what their employees will be receiving.

Maximum dependent age

Dependents are defined by the Affordable Care Act (ACA) as children under the age of 26, regardless of student status or marital status. We'll notify members that their coverage will terminate at the end of the month in which the member turns 26. We'll also send a copy of the notification to you. Members whose coverage ends may be eligible for COBRA/continuation.

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

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

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

Disabled dependent review

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

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

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

obtaining and completing the **Request For Extended Coverage Form.** They have 31 calendar days from the date the dependent reaches age 26 to complete and return the form to us. If they do not return the form within the 31 days, the dependent will be terminated from the plan.

Explanation of benefits

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

Coordination of benefits

Coordination of benefits (COB) happens when someone has more than one insurance plan. This can be with Medicare, Medical Assistance, individual policies, or commercial plans from other employers. To prevent getting too much insurance or double payments, all programs need to work together to coordinate benefit payments. That can help reduce out-of-pocket expenses like copayments and deductibles.

We check enrollment and claim data to find out who's most likely to have other insurance, and send a letter to members to verify if they have other insurance. When there is other insurance, Medica or Rawlings (our vendor) may need to reach out to you to confirm employment status in order to determine which insurance should pay first. Claims are not held during this process.

Medicare reclamation

When Centers for Medicare and Medicaid Services (CMS) pay a claim they believe should have been paid by a Group Health Plan (GHP), they issue a notice requesting payment to the employer and GHP of the member. The notice sent by CMS is called a Medicare Reclamation Notice. As an employer group, you can pay the debt or appeal (dispute) the debt. Responses to these notices must be made within 60 days of the demand letter or it will be considered delinquent. If you receive one of these notices, please contact your account manager for assistance right away.

Subrogation

If a member receives benefits for a condition or injury caused by a third party, and later receives payment for that same condition or injury from another party, the plan has the right to recover any payments already made. The process of recovering earlier payments is called subrogation. Some examples where this might happen:

- Animal bites
- Your business or premise liability (slips and falls)
- Disputed workers' compensation cases
- Medical malpractice
- Motor vehicle accidents

Medica uses a number of different methods to identify potential subrogation cases:

- From claims data
- From the members who call in to notify us
- From a provider
- From an attorney

When a potential subrogation issue is identified, both the member and the employer may be contacted by Medica or our subrogation vendor Optum for additional information.

Enrollment

Enrollment options

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

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

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

Frequently asked enrollment questions

When can employees enroll?

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

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

Are social security numbers (SSN) required?

- SSN is required for the subscriber/employee and all dependents.
- The Federal Centers for Medicare and Medicaid Services (CMS) requires health plans to provide quarterly reports to comply with Medicare Secondary Payer requirements. CMS requires social security numbers for "active covered individuals" covered under the plan, this would include dependents.
- If the employee is a non-US citizen without an assigned SSN, Medica requires their work visa number be submitted.

What is the process for retroactive terminations?

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

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

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

Billing + payment

Invoices

Here are the basics behind the billing process at Medica.

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

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

If you have questions specific to your account, please

When premiums are due

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

Monthly payment options

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

- Set-up recurring automatic withdrawals from your account (ACH). You can set this process in the **Medica Employer Services** system. The fee and/or premium is withdrawn from your bank account on the 10th of the month. If the 10th falls on a weekend, the ACH draft will occur on the next business day.
- Set-up a one-time automatic withdrawal from your account (ACH, non-recurring). This option is also accessed through the Medica Employer Services billing by simply clicking the payment submit button.
- Check payments can be mailed using the address on the payment remittance slip on your invoice, going directly to the bank lockbox.
- Please contact your broker or Medica account manager to discuss payment options.

Medica Employer Services electronic billing

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

You will receive a monthly e-mail notification when your invoice is ready for review and payment. You can then:

- View current activity or prior period activity (up to 12 months)
- Download, save, and print invoice detail into a spreadsheet application such as Excel
- Pay bills online

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

Monthly invoice

See the following page for a guide to understanding your monthly invoice.

ABC Industries, Inc.
123 Main Street S.
GRAND ISLAND NE 68803

Group ID **A01234**	SubGroup ID	Division	Invoice Date **12/15/2023**	Billing Period **01/01/2024-02/01/2024**
Invoice # **987654**	Payment Due Date **01/01/2024**	Total Amount Due **$24,301.00**		

ACCOUNT SUMMARY	
Original Totals	
Previous Amount Due	$24,301.00
Payments	$24,301.00
Balance Forward	$0.00
Current Charges	$24,301.00
Fees/Credits	$0.00
Current Adjustment	$0.00
Total Amount Due	$24,301.00

Network access

Continuity of care

If a member's physician or hospital is no longer part of their health plan's network, members may request authorization from Medica to continue with their existing primary care physician, clinic, specialist, or hospital for ongoing outpatient services. Medica's Nurse Case Managers will review their request to identify if they are engaged in a current course of treatment. Examples are provided below. A full list can be referenced in your Certificate of Coverage.

- An ongoing course of treatment for an acute condition
- An ongoing course of treatment for a chronic condition
- Undergoing a course of institutional or inpatient care from the provider or facility
- Scheduled non-elective surgery, including postoperative care
- Pregnant and undergoing a course of treatment for pregnancy. Health services may continue to be provided through the completion of postpartum care.

Medica may require medical records and other supporting documentation from a member's physician in support of the request and will consider each request on a case-by-case basis. Once approved, authorization will be granted at the highest benefit level up to the period defined by their plan. Direct members to contact Member Services at the number on the back of their ID card for details on how to request continuity of care.

Care availability

Medica will provide access to all provider specialties for members living in Medica's service area. Medica will provide in-network coverage for a member to see an out-of-network provider in the following circumstances:

- There are no participating providers for primary care, general hospital services, or mental health services within 30 miles/minutes of the member's current address. Primary care would be family practice, internists, and ob/gyns.
- There are no participating providers for specialty physician, specialized hospital services, skilled nursing facility, or ancillary service within 60 miles/minutes of the member's current address.

To qualify, members must get approval and should call Member Services at the number on the back of their ID card to start the approval process.

Commonly used health insurance terms

Benefit design

The process a health plan uses to decide what health care services will be covered for its members, how much the member will pay for these services, and how members can access medical care through the plan.

Copay

A fixed dollar amount you pay when you see a doctor, fill a prescription, or get other services.

Coinsurance

The percentage of the covered charges that you pay.

Deductible

The amount you must pay each year before your health plan begins paying benefits.

Health Insurance Portability and Accountability Act (HIPAA)

A federal law that protects people who change jobs or who have preexisting medical conditions and establishing privacy requirements.

Network

The group of physicians, hospitals, and other medical care providers a health plan contracts with to deliver medical services to its members.

Out-of-pocket maximum

The most an enrollee would have to pay in a year for covered services in deductibles, copays, and coinsurance. After reaching this maximum, the health plan will pay for all covered charges from in-network providers, up to the lifetime maximum.

Drug list

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

Questions? Contact us.

Your best resource is the Employer Service Center.

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