INDIVIDUAL + FAMILY

How to Get the Care You Need

Medica Individual and Family Health Plans

Medica®

How to get the care you need

Your guide to Medica

We are happy to have you as a member. Your health coverage is a valuable resource to help you receive quality health 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.

This guide has been developed for Medica's Individual and Family members. Please take a few minutes to review this guide. You may not need all of this information today, but it may be helpful in the future.

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 Plan documents, called a "Policy of Coverage" or "Summary of Benefits and Coverage (SBC)". To find out what is covered by your plan, see your Plan documents. You can access them online at **Medica.com/SignIn**.
- Any "Explanation of Benefits" you receive
- Information from your provider or clinic
- Immunization records for each family member
- Information about your prescriptions
- Information about dental or orthodontic care
- 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 Policy of Coverage document, then your Policy of Coverage document will govern in all respects.

Find what you need online

Get the information you need about your benefits online at **Medica.com/SignIn**.

Throughout this document, we'll let you know whenever more information is available online. See the *Important phone numbers* section at the end of this guide.

Contents

About your coverage

Your "Policy of Coverage" is a document that 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 "policy document" to refer to your Policy of Coverage. To find out what is covered by your plan, see your Plan documents. You can access them online at **Medica.com/SignIn**.

In most cases, you can find answers to questions about your health insurance benefits in your policy document. If you cannot find what you need, call Member Services. You'll find their number in the Important phone numbers section of this guide or 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, $30). Payment may be required at the time of service at the provider's office.
- **Coinsurance** — a percentage of the charges that you pay for a given service (for example, 30% coinsurance).

You can find a complete listing of all your copayments or coinsurance in your policy document or by calling Member Services. See the Important phone numbers section of this guide.

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

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. Send these claims to the address on the back of your Medica ID card. Most non-network providers will have the proper claim form.

If your provider doesn't, you can download the form:

1. Go to **Medica.com/SignIn**
2. Select *Documents* in the navigation

Or call Member Services. If you paid for services from a non-network provider and will be submitting the claim yourself, include copies of any bills, receipts or itemized statements from all providers.

Please note that claims for non-network providers must be submitted within 365 days from the date of service. Please see your policy 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 are out of your Medica plan's service area and require hospitalization, refer to your policy document to learn how to receive your highest level of coverage. You also may contact Member Services 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:

1. Go to **Medica.com/GetCare**

2. Find your state and select your plan name (listed on your Medica ID card as *Care Type*)

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 policy 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 policy 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.

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.

1. Go to **Medica.com/GetCare**
2. Find your state and select your plan name (listed on your Medica ID card as *Care Type*)

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 Member Services number on the back of your Medica ID card.

Important! Many Medica plans **do not** offer out-of-network benefits. To see if your plan has out-of-network benefits, refer to your plan document. If you see a provider who's not in your plan's network, your costs may be significantly higher or you may have to pay for the full cost of the service. For more detailed information about out-of-network costs and how they're calculated, refer to your policy document, call Member Services, or visit **Medica.com/shop/individual-and-family/individual-and-family-faq/surprise-or-balance-billing.**

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. Call your provider to make sure they are in your plan's network.

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. Go to **Medica.com/SignIn** to estimate your costs.

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 decide you need to see a specialist. Coverage for specialty care varies by plan. Keep in mind that it may take up to six weeks to get a specialist appointment.

Do you need help finding a specialist or scheduling an appointment? Health Advocate can help you find the right providers and schedule appointments with hard-to-reach specialists and critical care providers. Health Advocate is an independent service available to all of our Individual and Family members and their extended family—even if the family member does not have Medica coverage. Call Health Advocate at **(866) 668-6548**.

Medica has procedures for seeing specialists of many kinds. To be sure that you receive maximum coverage, read your policy document and follow the steps outlined there. You can access your policy document any time. To search for locations:

1. Go to **Medica.com/SignIn**
2. Select *Plan Documents* in the page footer

How providers are added to our network

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

Behavioral health services: Mental health and substance use care

If you or a family member needs mental health or substance use services, you should follow the steps outlined in your policy document. Refer to the Important phone numbers in this guide. You also can call Member Services. If you have an emergency, call 911.

Care after regular clinic hours

If possible, 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, visit a retail health or urgent care clinic in your plan's network. These are included in the online provider search tool on **Medica.com**. For most members, help finding a location close to you is available through NurseLine™ by HealthAdvocate℠. You can contact the NurseLine at **(866) 668-6548**. To search retail and urgent care clinics:

1. Go to **Medica.com/GetCare**
2. Find your state and select your plan name (listed on your Medica ID card as *Care Type*)

Retail health clinics and online care

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. Clinics like Minute Clinic® provide after-hours care and are located in many retail stores, grocery stores or pharmacies.

To search for locations:

1. Go to **Medica.com/GetCare**
2. Find your state and select your plan name (listed on your Medica ID card as *Care Type*)

Please note that 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.

Don't want to leave your home? You can also visit amwell® or virtuwell® (not available in Kansas, Missouri, Nebraska or Oklahoma*) for an online or virtual visit. Go to **Medica.com/GetCare** to get started.

**To use virtuwell, you must live in or be visiting the following states: Arizona, California, Colorado, Connecticut, Iowa, Michigan, Minnesota, New York, North Dakota, Pennsylvania, South Dakota, Virginia or Wisconsin.*

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.

To search for locations:

1. Go to **Medica.com/GetCare**
2. Find your state and select your plan name (listed on your Medica ID card as *Care Type*)

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.

Hospitals usually offer emergency room services. If you experience an emergency, visit an emergency room. But please do not go to an emergency room for a minor problem or routine health concern. 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 persons in those situations right away.

If your condition doesn't need treatment right away, go to your primary care clinic. If that office is closed, use an urgent care, a convenience care/ retail health clinic or an online visit with virtuwell. com (not available in Kansas, Missouri, Nebraska and Oklahoma).

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

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 NurseLine™ by HealthAdvocate℠ and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility NurseLine™ by HealthAdvocate℠ 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 NurseLine™ by HealthAdvocate℠ and talk with an advisor or nurse. You may be directed to go to the closest retail health clinic or urgent care facility. The NurseLine™ by HealthAdvocate℠ 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.

- 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.

24-hour nurse advice line

Often, the help you need may be available by phone! Medica offers the NurseLine by HealthAdvocate for those times when you want some advice about what to do next. Nurses are available 24 hours a day, seven days a week. They answer thousands of calls each year from Medica members.

You can talk with an experienced registered nurse who can answer health care questions and/or give self-care tips. Nurses can also recommend when you should make an appointment with your doctor, or go to a retail health clinic, an urgent care center or the emergency room.

You also can get help finding a provider or, if necessary, an urgent care facility, in Medica's network. Call the NurseLine at **(866) 668-6548**.

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

Support for managing your health: ActiveHealth

Health improvement is ongoing and you are a unique person, not a disease or a symptom. That's why we offer a health and wellness online tool through ActiveHealth. This program supports individuals by helping them make health behavior changes and manage health conditions.

ActiveHealth helps you take control of your health. The program provides you with resources and tools to help improve your health. Plus, earn rewards when you download the app and complete health and wellness goals. This includes:

- Health assessment
- Set goals
- Health actions

To enroll and get started, log in to your secure member site at **Medica.com/SignIn**. Or download the ActiveHealth app on the App Store or Google Play.

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? Member Services 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 assist.

Tobacco: Kick the habit for good

Whether you are thinking of quitting, ready to quit or have the urge to start smoking again, Medica can help.

Medica offers a stop smoking (tobacco cessation) program through Healthy Living with Medica that provides guidance and support throughout the quitting process. If you use tobacco and are thinking about quitting, go to **Medica.com/SignIn**.

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 has a wide variety of generic and brand-name drugs. It is reviewed and updated by an independent group of physicians and pharmacists. You can find a list of covered drugs by going to **Medica.com/SignIn**, then logging in and selecting *Medications* in the navigation.

Pharmacy Benefits

Your plan includes prescription drug coverage and a range of convenient services and options for filing and managing your prescriptions

Your drugs will be covered under one of seven different price categories (called tiers) that are arranged according to drug costs. Your cost may vary depending on which tier your drug belongs.

Drug tiers;

- Preventive drugs are covered at 100%
- Retail drugs are divided into three tiers: generic, preferred brand and non-preferred brand
- Specialty drugs are divided into two tiers: preferred specialty and non-preferred specialty
- Before you fill your prescription, check to see if it is covered. Check your policy document online.
    1. Go to **Medica.com/SignIn**
    2. Select *Documents* in the navigation

Or call the Member Services number on the back of your ID card for more information.

Exception Process

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

The physicians and pharmacists who develop and maintain the drug list work 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 will review these requests and you will be notified if an exception request is approved or denied.

Continuity of care

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 an Arizona, Iowa, Kansas, Missouri, North Dakota, Nebraska or Oklahoma 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. Authorization to continue to receive services from your primary care provider, specialist or hospital may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.

- An ongoing course of treatment for a life-threatening condition
- An ongoing course of treatment for a serious acute condition, such as chemotherapy
- Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations
- 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 postpartum period

- 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

2. If you are a member of a Minnesota plan and 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.

If Medica's contract with your primary care provider or specialist ends, Medica may authorize continuity of care for up to 120 days* or until the active course of treatment is complete for the following conditions.

- An ongoing course of treatment for a life-threatening physical or mental condition
- An ongoing course of treatment for a serious acute condition, such as chemotherapy
- 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 postpartum period
- 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
- Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations
- A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase
- 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

**Note: Authorization to continue to receive services from your primary care provider, specialist or hospital may extend to the remainder of your life if a physician, advanced practice registered nurse or physician assistant certifies that your life expectancy is 180 days or less.*

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

Wisconsin members may be eligible for continuity of care if your provider was listed in your Medica provider directory at the last enrollment period or your last coverage renewal period.

Benefits will continue to apply to health services you received from a provider who terminates his/her participation if such provider was listed as a network provider in the provider directory at your last enrollment period or your last coverage renewal period for the following periods of time:

1. For health services received from a primary care physician whom you have chosen to receive services from and who is no longer a network provider, until the later of:

- The anniversary of your original effective date
- This policy renewal date, or
- 90 days after the provider's participation terminates

2. For health services received from a network provider who is not a primary care physician and who is no longer a network provider, for up to 90 days if you were undergoing a current course of treatment, including but not limited to, treatment for one or more of the following conditions at the time of termination:

- An ongoing course of treatment for a life-threatening condition

- An ongoing course of treatment for a serious acute condition, such as chemotherapy
- Undergoing a course of institutional or inpatient care from the provider or facility, when continuity of care is required under the Federal Consolidated Appropriations Act of 2020 and its implementing regulations
- Scheduled non-elective surgery, including postoperative care
- 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

3. Authorization to continue to receive services from your current provider may extend to the remainder of your life if a physician certifies that your life expectancy is 180 days or less.

Benefits will not continue to be applied to health services you receive from a provider whose contract is terminated for misconduct on the part of the provider.

Provider Terms

If your provider agrees to comply with Medica's prior authorization requirements, provides Medica with all necessary medical information related to your care, and accepts as payment in full the lesser of Medica's network provider reimbursement or the provider's customary charge for the service, then the provider will not be permitted to bill you for the amount in excess of your in-network deductible and coinsurance or copay described in your Benefit Chart.

If your provider does not agree to these terms, in addition to the deductible and coinsurance described in your Benefit Chart for in-network benefits, you will be responsible for any charges in excess of the non-network provider reimbursement amount.

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 and provide you with your appeal rights. 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 move 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.

The name says it all. Your instructions are written in advance, before something happens, such as a head injury that causes a coma, Alzheimer's or the last stages of cancer. It's not hard to make an advance directive and it helps protect your right to make choices about your medical care.

An advance directive is a written instruction, such as a living will or health care power of attorney. Your instructions must be written and must also 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.

Your Medica coverage does not require you to create advance directives. We are simply letting you know about your option to do so. 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** 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

Quality improvement

Medica's Quality Improvement program is made up of the projects and activities Medica performs to improve care, service, access, health equity 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?
- Do our members receive quality mental health and substance abuse care and service?

Medica sets goals and measurements after we select a quality improvement project. We measure the effectiveness of the improvement 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. The committee reports to the 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 Medica's Quality Improvement program, please contact Member Services at the numbers listed in the Important phone numbers (italicize) 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 to improve our programs and services.

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 Member Services at the numbers listed in the Important phone numbers section of this guide.

If coverage is denied, you can appeal. See the Complaints section of your policy document.

1. Go to **Medica.com/SignIn**
2. Select *Documents* in the navigation

Or call Member Services for more information. The number is listed in the Important phone numbers section of this guide.

Using Disease and Case Management Services

If you have a serious or chronic health condition, disease management and case management services may be available to you at no additional cost. Call us at **(866) 905-7430** to hear the benefits. A registered nurse works with you to complete an assessment to help decide what benefits and resources could help you. You also will develop personal health goals, and receive support and follow up. This program is voluntary and you decide if, or how long, you stay with the program.

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 Member Services 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:

- Reconstructive or restorative surgery
- Organ and bone marrow transplant
- Home health care
- Medical supplies and durable medical equipment
- This is not a complete list. Contact Member Services to determine whether a service or procedure may require prior authorization.

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 Member Services at the numbers listed in the Important phone numbers section of this guide. Language assistance also is available.

If we deny coverage for a service you can appeal. See the Complaints section in your coverage document. Or call Member Services 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 also may contact us through our website at **Medica.com /Contact**.

If you're a member of a Minnesota plan, the following may apply: If you are a new Medica member and have a prior authorization for services from your former health plan, Medica will accept that prior authorization for at least the first 60 days of coverage under this plan. In order to obtain coverage for this 60-day period, you or your provider must send Medica documentation of the previous prior authorization. For coverage to continue after the 60-day period, you, someone on your behalf or your attending provider should submit a request for prior authorization to Medica prior to the end of this 60-day period.

If you need help with an appeal you can also contact Health Advocate. Health Advocate is an independent company that can assist you in working with Medica

to make an appeal. You can call Health Advocate at **(866) 668-6548**.

Clinical practice guidelines

Medica follows evidence-based clinical practice guidelines and works with the Institute for Clinical Systems Improvement (ICSI) to maintain clinical practice guidelines for all providers in our plan networks. These guidelines are available by going to **Medica.com/ClinicalGuidelines**. They can also be requested by calling Member Services at the number on the back of your ID card.

Evaluating 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 therapeutics 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

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 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. Call Member Services at the number listed on your ID card or in the Important phone numbers section of this guide or refer to your coverage document for more information.

Additionally, we investigate your complaints about quality of care problems, but state laws can prevent us from sharing details about the outcome of this review. State regulators in some states review quality of care cases involving Medica.

Requesting an expedited appeal review

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.

See the *Complaints and Appeals* documents below for instructions on how to request an expedited appeal review.

If you need help with an appeal you can also contact Health Advocate. Health Advocate is an independent company that can assist you in working with Medica to make an appeal. You can call Health Advocate at **(866) 668-6548.**

Complaints and Appeals

Arizona Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level Internal 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 Release of Information 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 Arizona Department of Insurance Consumer Services at 1-602-364-2499 or 1-(800) 325-2548 (outside Phoenix).

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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
TTY users, please call 711

Procedures for a 1st Level Expedited Review (For Urgently Needed Services Not Yet Provided):

1. You have 60 days from the date you received the initial decision to make a request for a 1st level expedited review.
2. If your attending provider believes that an expedited, 1 business day appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days for services not yet received might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 1 business day after receiving the request.

Procedures for a 1st Level Standard Appeal (For Non-Urgent Services and Denied Claims):

1. You have 2 years from the date you received the initial decision to submit your written request for a 1st level standard appeal. You can call or write us at the phone numbers and address listed above to request a standard appeal.
2. Your appeal will be completed no later than 30 calendar days from receipt of your request for denied services that have not yet been received. For denied claims, we will notify you within 60 calendar days from receipt of your request.

Expedited External Review (For Urgently Needed Services Not Yet Provided)

1. 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 Medica at the address listed within 5 business days following the date you receive Medica's appeal decision. An independent entity designated by the Arizona Department of Insurance and Financial Institutions will conduct the external review.
   Upon receipt of your request Medica will notify the Director of the Department of Insurance and Financial Institutions ("Director") within 1 business day. The Director assign and submit your case to the independent review organization (IRO) within 2 business days. You may submit additional information to be reviewed by the external review organization. The IRO will notify the Director of their decision within 72 hours and the Director will notify you within 1 business day after receiving the decision. There is no cost to you for the external review.
2. For decision that involve contract coverage disputes, you may choose to have your case reviewed by the Director. Your request must be submitted in writing to Medica at the address listed above within 5 business days following the date you receive Medica's appeal decision. You may submit additional information to be reviewed by the Director. You will be notified of the Director's decision within 15 business days. However, there are times when the Director is unable to make a decision and may forward your case to an IRO for an external review. If that happens the IRO will have 21 days to make a decision and send it to the Director, the Director will have 5 business days to send you the final decision.

Standard External Review

1. For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an independent review organization. Your request must be submitted in writing to Medica at the address listed above within four (4) months following the date you receive Medica's appeal decision. An independent entity designated by the Arizona Department of Insurance and Financial Institutions will conduct the external review.
   submit your case to the IRO within 5 days. You may submit additional information to be reviewed by the external review organization. The IRO will notify the Director of their decision within 21 days and the Director will notify you within 5 business day after receiving the decision. There is no cost to you for the external review.
2. For decision that involve contract coverage disputes, you may choose to have your case reviewed by the Director. Your request must be submitted in writing to Medica at the address listed above within four (4) months following the date you

receive Medica's appeal decision. You may submit additional information to be reviewed by the Director. You will be notified of the Director's decision within 15 business days. However, there are times when the Director is unable to make a decision and may forward your case to the independent review organization for an external review. If that happens the independent review organization will have 21 days to make a decision and send it to the Director, the Director will have 5 business days to send you the final decision.

Office of Administrative Hearings

If you disagree with the Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). You must make your request for a hearings within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Right to Civil Action

No civil action for benefits may be brought more than two years after the time a claim for benefits is required to have been submitted under this Policy.

Complaints and Appeals

Iowa Appeal Rights - Individual and Family Plans

Information Related to this Decision

If you have any questions related to this claim, please refer to your Policy or contact Medica Member Services 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 Release of Information 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 Iowa Insurance Division at 1-877-955-1212.

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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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 you 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 following receipt of Medica's initial decision to file an appeal. The written complaint is considered a first level internal review. Medica will communicate a decision to you within 30 calendar days of receipt of the complaint.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have 180 days following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level internal review. Your appeal will be completed no later than 30 calendar days from receipt of your request.
2. If your attending provider believes that an expedited, 72 hour appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or if you are appealing a rescission of your policy, you may choose to have your case reviewed by an external review organization. You or your authorized representative have four months from the date you receive the appeal determination letter to file a request for an independent external review. External reviews regarding rescission of policy are coordinated through Medica. You should submit your written request to Medica at the address on this page. All other external reviews are coordinated through the Iowa Insurance Division. You should submit your written request to Iowa Insurance Division at 1963 Bell Ave, Suite 100, Des Moines, IA 50315 or email: iid.marketregulation@iid.iowa.gov. If you have questions you may call the Iowa Insurance Division at 515-654-6600.

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. There is no cost to you for the external review except for any applicable State filing fees. If an expedited review is requested and approved, a decision will be provided within 72 hours.

Right to Civil Action

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 this Policy.

Complaints and Appeals

Kansas Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level - Internal 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 Release of Information 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 Kansas Insurance Commissioner, Consumer Assistance Division at 1-800-432-2484.

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, or 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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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, Medica will communicate a decision to you within 10 business 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. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, you have one year following receipt of Medica's initial decision to file an appeal. The written complaint is considered a first level internal appeal review. Medica will communicate a decision to you within 30 calendar days of receipt of the complaint.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have 180 days following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level internal review appeal. Your appeal will be completed no later than 30 calendar days from receipt of your request.
2. If your attending provider believes that an expedited, 72 –hour appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review

For decisions that involve a medical necessity determination, investigative/experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy, you or your authorized representative have 120 days from the date you receive Medica's decision to file a request for an independent external review. External reviews regarding rescission of policy are coordinated through Medica. You should submit your written request to Medica at the address on this page. All other external reviews are coordinated through the Kansas Insurance Commissioner. Submit your written request to the Kansas Insurance Department at 1300 SW Arrowhead Rd., Topeka, KS 66604, fax: 785-296-5806, or email: webcomplaints@ksinsurance.com. Tel. 800-432-2484 for questions related to external review. In most circumstances you must complete the internal review described above, before you proceed to external review.

You, your designated representative, and /or your provider may submit additional information to be reviewed by the external review organization. You will be notified of the external review organization's decision within 30 business days. If an expedited review is requested and approved, a decision will be provided by the external review organization within 72 hours. There is no cost to you for the external review except for any applicable State filing fees.

The decision of the external review organization may be reviewed directly by the district court at the request of either you or Medica. The review by the district court shall be a new review, but will include review of the decisions previously made on the issue. In no event shall more than one external review be available for any request arising out of the same set of facts during a period of 12 consecutive months, beginning on the date of the initial request for external review. You may not pursue, either concurrently or sequentially, an external review process under both federal and state law.

Right to Civil Action

No civil action for benefits may be brought more than five years after the time a claim for benefits is required to have been submitted under this Policy.

Complaints and Appeals

Minnesota Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level - Internal 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 Release of Information 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.

At any time, you also have the right to file a complaint with the Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602 (outside of metro area only).

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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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, Medica will send you our decision within 10 calendar days from when we received your 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 send you our decision within 30 calendar days. If you remain dissatisfied with Medica's decision, you have the right to submit a request for external review.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have one year following receipt of Medica's initial 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 calendar days from when we received your request. If Medica cannot provide its determination within 15 days, Medica may take an additional 4 days and will notify you of the extension and the reason relating to it.
2. If your attending provider believes that an expedited appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 15 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hour after receiving the request.

External Review Option

You may choose to have your case reviewed by an external review organization. This process is coordinated by the Minnesota Department of Commerce and you must submit your written request for external review within six months from the date you receive Medica's decision. Submit your written request to The Minnesota Department of Commerce 85 7th Place East Suite 280, St. Paul, MN, 55101-2198 at 651-539-1600 or their toll free number 800-657-3602.

You, your designated representative, and /or your provider 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. If an expedited review is requested and approved, a decision will be provided by the external review organization 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 request an external review, contact the Minnesota Department of Commerce at the numbers listed above. There is no cost to you except for the required filing fee. You must include a $25.00 filing fee at the time of the request. The Department of Commerce will refund the filing fee if the review organization completely reverses Medica's decision.

Complaints regarding fraudulent marketing practices or agent misrepresentation cannot be submitted for external review.

Civil Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Complaints and Appeals

Missouri Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level - Internal 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 Release of Information 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 Missouri Department of Insurance at 1-800-726-7390.

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 file a grievance, request additional information, or 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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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 you 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 following receipt of Medica's initial decision to file a grievance. The written complaint is considered a first level internal grievance review. Medica will complete its investigation of your written complaint within 20 working days. Medica will provide written notice of its first level of review decision to you within 5 working days from the completion of the investigation. If Medica cannot complete the investigation within 20 working days, you will be notified of the reason and Medica may take up to an additional 30 working days, but no later than 60 calendar 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 following receipt of Medica's notification of its initial decision to file a grievance. You can call or write us at the phone numbers and address listed above to request a first level internal grievance review. Medica will complete its investigation of your written complaint within 20 working days. Medica will provide written notice of its first level of review decision to you within 5 working days from the completion of the investigation. If Medica cannot complete the investigation within 20 working days, you will be notified of the reason and Medica may take up to an additional 30 working days, but no later than 60 calendar days to issue a written decision to you.

   If your grievance is related to an initial decision by Medica that did not grant a prior authorization request made before or during an ongoing service, Medica will provide written notice of the decision within 30 calendar days from receipt of your request.
2. If your attending provider believes that an expedited, 72 –hour review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review Option

For decisions that involve a medical necessity determination, investigative/experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy, you or your authorized representative may file a request for an independent external review. You do not have to exhaust Medica's internal review process before you can request an independent external review. This process is coordinated through the Missouri Department of Insurance. Missouri Department of Insurance will process your complaint as any other member complaint; however, if the complaint remains unresolved after completion of the Missouri Department of Insurance review, it will be forwarded to an independent external review organization.

Submit your written request to the Missouri Department of Insurance at P.O. Box 690, Jefferson City, MO, 65101-0690. Tel. 800-726-7390, fax 573-526-4898 or online: www.insurance.mo.gov for questions related to external review. There is no cost to you for the external review except for any applicable State filing fees. You, your designated representative, and /or your provider may submit additional information to be reviewed by the external review organization. The external review organization will render an opinion to the Missouri Department of Insurance within 20 calendar days. The external review organization may request additional time for its review, but not to exceed 5 calendar days. Missouri Department of Insurance will notify you in writing of its decision within 25 calendar days, but no later than 45 calendar days, after the receipt of the request for external review. If an expedited review is requested and approved, a decision will be provided to you by the Missouri Department of Insurance within 72 hours.

Right to Civil Action

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 this Policy.

Complaints and Appeals

Nebraska Appeal Rights - Individual and Family Plans

Information Related to this Decision

If you have any questions related to this claim, please refer to your Policy or contact Medica Member Services 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 Release of Information 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.

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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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, Medica will communicate a decision to you within 10 business 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. The complaint form can be mailed to the address listed above.
2. If you submit your complaint in writing, you have one year following receipt of Medica's initial 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 following receipt of Medica's initial 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 business 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 Option

For decisions that involve a medical necessity determination, investigative/experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy, you or your authorized representative have four months from the date you receive Medica's decision to file a request for an independent external review. There is no cost to you for the external review except for any applicable State filing fees. This process is coordinated through the Nebraska Insurance Division. You may submit your written request through Nebraska Insurance Division's portal at: https://doi.nebraska.gov/consumer/appealing-denied-health-claim. This online application replaces the need to complete forms and submit them to the Department by mail or fax. Printable versions of external review forms are also available on the Department's website at: https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/Chapter87ExternalReviewForms.pdf or they can be mailed to you upon request by calling the Department at 1-877-564-7323 (toll-free in Nebraska) or 402-471-0888. You may submit additional information to be reviewed by the external review organization. You will need to authorize the release of your medical records for your request to be sent to the independent review organization. In most circumstances you must complete the internal review described above, before you proceed to external review.

You, your designated representative, and /or your provider 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. If an expedited review is requested and approved, a decision will be provided by the external review organization within 72 hours.

Right to Civil Action

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 this Policy.

Complaints and Appeals

North Dakota Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level - Internal Appeal 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 an appeal. You have one year following receipt of Medica's initial decision to request an appeal. At any time, you may choose to designate a representative to act on your behalf at any time during the appeal or external review process. If you do so, contact Medica to obtain a Release of Information 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.

You may also file a complaint with the North Dakota Insurance Commissioner at 1-800-247-0560.

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, or 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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
TTY users, please call 711

Your appeal will be completed no later than 30 calendar days from receipt of your request.

If you believe that an expedited, 72 hour appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review Option

For decisions that involve a medical necessity or experimental/investigative determination, claims subject to the No Surprise Act under the Consolidated Appropriations Act, 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 Medica within four (4) months following the date you receive 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 receipt of your request. 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. There is no cost to you except for the required filing fee. You may receive a request to pay a $25 filing fee. The fee will be refunded if Medica's decision is overturned. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Civil Action

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 this Policy.

Complaints and Appeals

Oklahoma Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

First Level - Internal 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 Release of Information 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 Oklahoma Insurance Department at 1-800-522-0071 (in State only) or 1-405-521-2828.

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, or 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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
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 you 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 following receipt of Medica's initial decision to file an appeal. The written complaint is considered a first level internal appeal review. Medica will communicate a decision to you within 30 calendar days of receipt of the complaint.

Procedures for complaints that require a medical determination:

1. If this decision was based on medical necessity, you have 180 days following receipt of Medica's initial decision to file an appeal. You can call or write us at the phone numbers and address listed above to request a first level internal review appeal. Your appeal will be completed no later than 30 calendar days from receipt of your request.
2. If your attending provider believes that an expedited, 72 hour appeal review is warranted, your attending provider may make this request on your behalf. An expedited review is appropriate if waiting the standard 30 calendar days might jeopardize your life, health or ability to regain maximum function, or if the standard 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. Medica will notify you and your attending provider by telephone of its decision no later than 72 hours after receiving the request.

External Review

For decisions that involve a medical necessity determination, investigative/experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy, you or your authorized representative have 4 months from the date you receive Medica's decision to file a request for an independent external review. There is no cost to you for the external review except for any applicable State filing fees. This process is coordinated through the Oklahoma Insurance Department. Submit your written request to the Oklahoma Insurance Department at 400 NE 50th Street, Oklahoma City, OK 73105. Tel. 800-522-0071 (in State only) or 405-521-2828 for questions related to external review. You will need to authorize the release of your medical records for your request to be sent to the independent review organization. In most circumstances you must complete the internal review described above, before you proceed to external review.

You, your designated representative, and /or your provider 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. If an expedited review is requested and approved, a decision will be provided by the external review organization within 72 hours.

Right to Civil Action

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 this Policy.

Complaints and Appeals

Wisconsin Appeal Rights - Individual and Family Plans

Information Related to this Decision

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

Right to File a Complaint

If you have a question or are dissatisfied with some aspect of service received from Medica, you can call Medica Member Services at the phone numbers listed below. Customer Service Representatives can explain benefit provisions and administrative procedures to address inquiries and informally resolve complaints. If the matter cannot be resolved informally to your satisfaction, you have the right to file a formal grievance with Medica.

You also have the right at any time to file a complaint with the Office of the Commissioner of Insurance at PO Box 7873, Madison, WI, 53707-7873 or by calling 1-800-236-8517.

Right to File a Grievance

If you are dissatisfied with Medica's provision of services, claims practices, or administration, you may file a formal grievance. To file a grievance, you or anyone else on your behalf, including a Medica Customer Service Representative, should 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.

You may choose to designate a representative to act on your behalf at any time during the grievance or external review process. If you choose to do so, contact Medica to obtain a Release of Information form, which will allow Medica to discuss your grievance with your designated representative. We will review any testimony, explanation, or other information we receive from you, Medica staff members, providers, or others. You may select one of the following options for your grievance:

Medica's Grievance Process:

Hearing or file review. Under this process, you present your case to a grievance panel, either in person or in writing. Medica will notify you of its decision within 30 calendar days of your grievance request.

If waiting the standard 30 calendar 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 grievance review. In such cases, you may also have the right to request an external review while your grievance review is being conducted.

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 a grievance, 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 Member Services, Route CP595IFB, PO Box 9310, Minneapolis MN 55440-9310

Telephone: 1-888-592-8211
TTY users, please call 711

Right to External Review

If your claim involves an adverse determination, experimental treatment, claims subject to the No Surprise Act under the Consolidated Appropriations Act, or a rescission of a policy or certificate, you or your authorized representative have four months from the date you receive the grievance determination letter to file a request for an independent external review. This review will be coordinated by Medica. 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 waiting the standard 45-day turnaround time 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 requesting, you or your attending provider may request an expedited, 72 hour external review. There is no cost to you for the external review. The decision rendered by the external review organization is final, and is binding on both you and Medica. For more information or to submit a request for external review, contact Medica at the address and phone numbers listed above.

Appendix

How Medica protects your privacy

Effective: June 11, 2003
Revised: May 13, 2022

Summary

There are several state and federal laws requiring Medica Health Plans, Medica Community Health Plan, Medica Regional Insurance Company 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 in the following Privacy Notice.

Medica's 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. Medica also protects cultural information such as race, ethnicity, and language the same as all other PHI.

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) healthcare operations, such as developing wellness programs. Additional examples of these activities include:

- Enrollment and eligibility, benefits management, and utilization management
- Customer service
- 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. However, Medica will not use cultural information, such as race, ethnicity, and language, for purposes of underwriting, rate setting or denial of coverage or benefits.

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);
- Healthcare 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 Member Services 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 Member Services 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, Member Services, 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 Member Services 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:

As a Medica member, you have the right to:

1. Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. Be treated with respect and recognition of your dignity and your right to privacy.
3. Participate with practitioners in making decisions about your health care.
4. A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. Voice complaints or appeals about the organization or the care it provides.
6. Make recommendations regarding the organization's member rights and responsibilities 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. Supplying information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
2. Following plans and instructions for care that you have agreed to with your practitioners.
3. Understanding your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

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 per episode arrangement, such as an amount per day, per stay, per case, or per period of illness;
- or a risk-sharing/value-based arrangement.

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

Fee-for-service and per episode arrangement

Fee-for-service and per episode arrangement payment means that the network provider is paid a fee for each service or episode of care provided. These payments are 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 billed charge. The amount paid to the network provider, less any applicable copayment, coinsurance or deductible, is considered to be payment in full.

Risk-sharing and value-based arrangements

Medica also has risk-sharing/value-based contracting arrangements with a number of providers. These contracts include various quality and efficiency measures designed to encourage high quality and efficient total care for members. Such arrangements may involve claims withhold and gain-sharing or risk-sharing arrangements between Medica and such providers. Amounts paid or returned under these arrangements are not considered when determining the amounts you must pay for health services under this certificate.

Non-network providers

When a non-emergency service from a non-network provider is covered, the non-network provider is paid

a fee for each covered service that is provided. If the Surprise Billing protections of your Policy do not apply to a covered non-network benefit, the non-network provider reimbursement may be less than the charges billed by the non-network provider. If this happens, members may be responsible for paying the difference, in addition to any applicable copayment, coinsurance, or deductible amounts. Charges in excess of the non-network provider reimbursement amount do not accumulate to your deductible or out-of-pocket maximum.

How Medica pays brokers

The Consolidated Appropriations Act of 2021 (CAA) requires health insurance issuers offering individual health insurance coverage to disclose to a potential or existing policyholder the amount of direct or indirect compensation provided to a broker associated with enrolling the policyholder in individual health insurance coverage.

For new enrollments, this disclosure must be made prior to finalizing plan selection and included on any documentation confirming initial enrollment. For enrollment renewals, the required disclosure must be provided to the policyholder with the renewal notice.

For more information about this required disclosure, and to view the amount of direct or indirect compensation associated with your enrollment, please see **Medica.com/BrokerDisclosure.**

2022 Financial statements

Medica is a non-profit organization committed to transparency about our financial performance. The table 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, revenues and expenses for the 2021 fiscal year. Beside that are the results for 2022. By comparing the 2022 results to 2021, 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 covered services to members

Liabilities:
Amounts Medica owes on the assets

Net Assets:
The net worth of the company

Change in Net Assets:
Income after taxes

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

2022 Financial statements

Consolidated Balance Sheet (in thousands):	2022	2021
Assets:		
Cash and investments	2,425,745	2,863,738
Other assets	1,181,230	1,014,925
Total Assets	**3,606,975**	**3,878,663**
Liabilities and Net Assets:		
Claims payable	557,598	536,079
Other liabilities	647,203	758,280
Total Liabilities	**1,204,801**	**1,294,359**
Net Assets	2,402,174	2,584,304
Total Liabilities and Net Assets	**3,606,975**	**3,878,663**

Consolidated Statement of Operation and Changes in Net Assets (in thousands):	2022	2021
Revenue:		
Premiums, net of reinsurance	5,868,829	4,418,965
Administrative service contract fees	143,938	114,230
Total Revenues	**6,012,767**	**4,533,195**
Expenses:		
Medical and other benefits, net of reinsurance	5,088,914	3,751,501
Other operating expenses	869,276	654,798
Total Expenses	**5,958,190**	**4,406,299**
Operating Income	**54,577**	**126,896**
Investment income, income taxes and other non-operating expenses	(236,707)	55,264
Change in net assets	(182,130)	182,160

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

Important phone numbers

Member Services

Sometimes it's easiest to pick up the phone and talk with someone who can help. That is Member Services, available to answer questions about your health care plan 8 a.m. – 6 p.m. CT, Monday through Friday (9 a.m. – 6 p.m. CT, Thursday).

Please have your Medica ID card available when you call.

- Medica® Applause®, Medica Encore℠, Medica Individual Choice℠, Medica Solo℠, Symphony®, Symphony® for HSA, Medica Direct Value℠ and Medica Direct HSA℠: (888) 592-8211
- Altru Prime by Medica℠: (800) 918-6474
- Bold by M Health Fairview and Medica℠: (877) 335-8984
- Balance by Medica℠: (877) 329-8310
- Elevate by Medica℠ – Iowa: (866) 810-5296
- Elevate by Medica℠ – Nebraska: (866) 810-5296
- Empower by Medica℠: (877) 328-1363
- Engage by Medica℠: (866) 510-7425
- Harmony by Medica℠: (866) 839-3961
- Inspire by Medica℠: (866) 269-6805
- North Memorial Acclaim by Medica℠: (855) 887-4259
- Medica with CHI Health℠: (866) 269-6803
- Medica Connect℠: (866) 416-7438
- Medica Insure℠ – Iowa: (800) 918-6165
- Medica Insure℠ – Nebraska: (800) 918-6164
- Medica with MU Health Care℠: (877) 329-8270
- Medica Pinnacle℠: (877) 347-0267
- Medica Quest℠: (866) 582-7035
- Medica with Healthier You℠: (866) 317-1179

NurseLine by HealthAdvocate

NurseLine by HealthAdvocate 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, seven days a week. Or call **(866) 668-6548** (TTY: **711**).

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

Medica stop smoking program

If you use tobacco and are thinking of quitting, Healthy Living with Medica can help. To use the stop smoking program, go to **Medica.com/SignIn**. You can also contact our Health Services department for assistance. Or call the Member Services number on the back of your ID card and ask to speak to a nurse about quitting smoking.

Medica behavioral health

If you or a family member needs mental health or substance use services, call Medica behavioral health at **(800) 848-8327** (TTY: **711**). Please have your ID card available when you call.

Discrimination is Against the Law

Medica complies with applicable Federal civil rights laws and will not discriminate against any person on the basis of race, color, national origin, age, disability or sex. Medica:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: TTY communication and written information in other formats (large print, audio, other formats).
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, call the number included in this document or on the back of your Medica ID card. If you believe that Medica has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, Mail Route CP250, PO Box 9310, Minneapolis, MN 55443-9310, 952-992-3422 (phone/fax), TTY 711, civilrightscoordinator@medica.com.

You can file a grievance in person or by mail, fax, or email. You may also contact the Civil Rights Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you want free help translating this information, call the number included in this document or on the back of your Medica ID card.

Si desea asistencia gratuita para traducir esta información, llame al número que figura en este documento o en la parte posterior de su tarjeta de identificación de Medica.

Yog koj xav tau kev pab dawb kom txhais daim ntawv no, hu rau tus xov tooj nyob hauv daim ntawv no los yog nyob nraum qab ntawm koj daim npav Medica ID.

如果您需要免費翻譯此資訊，請致電本文檔中或者在您的 Medica ID卡背面包含的號碼。

Nếu quý vị muốn trợ giúp dịch thông tin này miễn phí, hãy gọi vào số có trong tài liệu này hoặc ở mặt sau thẻ ID Medica của quý vị.

Odeeffannoo kana gargaarsa tolaan akka isinii hiikamu yoo barbaaddan, lakkoobsa barruu kana keessatti argamu ykn ka dugda kaardii Waraqaa Eenyummaa Medica irra jiruun bilbila'a.

إذا كنت تريد مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الوارد في هذه الوثيقة أو على ظهر بطاقة تعريف ميديكا الخاصة بك.

Если Вы хотите получить бесплатную помощь в переводе этой информации, позвоните по номеру телефона, указанному в данном документе и на обратной стороне Вашей индентификационной карты Medica.

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປຂໍ້ມູນນີ້ຟຣີ, ໃຫ້ໂທຫາເລກໝາຍທີ່ມີຢູ່ໃນເອກະສານນີ້ ຫຼື ຢູ່ດ້ານຫຼັງຂອງບັດ Medica ຂອງທ່ານ.

이 정보를 번역하는 데 무료로 도움을 받고 싶으시면, 이 문서에 포함된 전화번호나 Medica ID 카드 뒷면의 전화번호로 전화하십시오.

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Ako želite besplatnu pomoć za prijevod ovih informacija, nazovite broj naveden u ovom dokumentu ili na poleđini svoje ID kartice Medica.

Díí t'áá jíík'e shá ata' hodoonih nínízingo éí ninaaltsoos Medica bee néího'dílzinígí bine'dée' námboo biká'ígííjį' béésh bee hodíilnih.

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